SYNAPSE
AUSTRALIA'S BRAIN INJURY ORGANISATION

Sexual changes

Acquired brain injury (ABI) can have a number of consequences for an individual's sexual functioning. Talking about sex can be embarrassing, but it is important for the person with brain injury and their loved ones to discuss the various issues.

In this article

Understanding from the family

Families and partners can have trouble understanding these sexual changes and can react negatively. A good understanding should be gained of how impulsivity, disinhibition and lack of awareness have caused sexual changes.

The brain injury survivor must be encouraged to take control over aspects of their life, when there is a reasonable expectation for responsible behaviour. When sexual behaviour is inappropriate, steps need to be taken to learn better ways for managing or compensating for the lapses in social skills.
All members of the family should work to become comfortable in discussing sexual issues, and assist in implementing behavioural modification techniques to manage behaviours.

Impulsive behaviour

Impulsivity, disinhibition and lack of awareness may lead to rehabilitation staff receiving unwanted sexual attention from the brain injury survivor. The medical team, family and friends need to have a common response to inappropriate sexual behaviour that will assist the person to regain control over sexual impulses. This behaviour can particularly be a problem for males from their late teens to mid twenties when their sexual urges are strongest. Some of this behaviour may include fantasising, lewd verbal responses, disrobing and or masturbating in public, impulsiveness and touching others

Common changes

Sexual changes are common after a brain injury. Although we are all sexual in nature, there is a great deal of stigma to sexual behaviour in the wrong place or time.

Some of the more common changes include

- loss of libido or sexual drive
- hyper-sexuality (increased desire for sex)
- inability to achieve or maintain erection
- inability to orgasm
- premature ejaculation
- pain and discomfort during sex
- sexual disinhibition, e.g. talking excessively about sex or inappropriate touching
- reduced sexual responsiveness or desire for intimacy.

These changes may be a direct result of damage which occurred to particular brain structures underlying sexual functioning. Other biological causes of sexual dysfunction may include damage to genital organs, muscles and bones, spinal cord and peripheral nerve damage, medical conditions, hormonal disturbance and side effects of medication and drugs.
Psychological and psychosocial changes can also have an impact on sexual function.

Some reasons for changes in sexual function

Some of the reasons for changes in sexual function include

- low motivation
- medication
- diabetes or hypertension (high blood pressure) can reduce libido
- depression
- stress and anxiety
- emotional reactions, e.g. anger, embarrassment, shame and fear of rejection
- personality changes
- cognitive problems, e.g. distractibility, perceptual disorders and memory problems
- problems with communication e.g. aphasia or missing social cues
- a loss of self-confidence regarding personal attractiveness
- poor social skills and impaired self control
- social avoidance and isolation
- relationship breakdown.

Assessment

Seeking professional advice can be an embarrassing and sensitive issue for many people as sex is usually a very personal and private aspect of life. People are often more likely to discuss sexual problems with their doctor during a visit for other health reasons. Assessment of sexual problems can be a vital first step in learning to manage or discover treatment options. Assessment may involve an interview, questionnaires, physical examination, and neurological and medical tests. In addition to a doctor, psychologists and psychiatrists may be involved in the assessment and treatment of sexual problems.

Management of sexual changes

Partners and family members' reactions

Partners and family members play a significant role in influencing the injured person's adjustment to physical and psychosocial changes that affect their sex life. Partners and family members may consider the following forms of coping:

developing greater understanding by seeking information on how to support the injured person

learning different techniques and compensatory strategies, e.g. different ways of giving and receiving pleasure with the person

altering expectations and negotiating about how often, how long and the type of sexual activity the person can achieve

being assertive and sensitively communicating personal views

making changes to lifestyle and routines that improve quality time together.

Children's social and sexual functioning

ABI can also affect children's social and sexual functioning whereby development may be arrested or they appear to revert to a previous level of development. In less common situations, a child may develop physical and behavioural changes earlier than their peers. This is often referred to as 'precocious puberty'. Families and schools may vary greatly in their approaches to educating children about sexual issues and behavioural management. Parents and teachers can access community resources, such as family planning, sexual health clinics and professionals specialising in ABI for support.

Masturbation

A family member may need to be told that masturbation is an appropriate way to deal with sexual urges, but in the privacy of their own room. It is important to establish ground rules to protect the rights and privacy of others, so when, where and how need to be discussed.

In some cases, a partner or spouse may continue in a caring role but no longer wish to maintain a sexual relationship. In this case, it needs to be stated clearly and consistently that masturbation will be the only option to sexual urges.

Treatment for sexual problems

Professionals can help individuals cope with a variety of physical and psychosocial changes. Following assessment, specific treatment of sexual problems may involve education, learning new skills and behavioural techniques, physical rehabilitation, aids and medical treatment. Specific forms of treatment may include psychological support, medical and surgical approaches.

Psychological support
A psychologist or social worker can provide sexual and marital counselling to couples to enhance their understanding of sexual changes, communication skills, problem-solving, conflict resolution and caring behaviours. Professionals may also provide literature, audio- visual aids and advice on sexual positions, techniques and aids. A psychiatrist may prescribe medication for either psychological or physical problems.

Medical and surgical approaches
The medical management of sexual problems is usually most applicable for musculoskeletal, neurochemical and vascular disorders. Some examples include hormonal replacement, new medication such as anti-spasticity drugs or a change of current medication, neurosurgical and orthopaedic procedures.

Case study
Jill's husband, Paul, experienced a number of personality changes after his brain injury.
In particular, Paul's behaviour was childlike and immature, and he became overly dependent upon Jill.
In many ways Jill felt like she had become Paul's mother rather than his wife, friend and lover.
The impact upon their sexual relationship was significant. Jill read some information about the effects of brain injury.

She then organised regular respite care and learned some behaviour management strategies for encouraging Paul to be more independent. As a result of Jill's increased understanding, some lifestyle changes and new skills, she and Paul now spend more quality time together and their sexual relationship has improved.

Another important issue is the increased vulnerability that people may experience due to cognitive impairment and emotional distress. In particular, the person may not sense when they are at risk, know how to cope with unwanted sexual advances or understand the consequences of their actions.

Family members and friends need to be aware of these issues and discuss any concerns with a professional.
Some people may not feel that it is possible to discuss these issues directly with the person with a brain injury. In such cases, a friend or another family member may be a more appropriate person to recommend self-protection strategies or remind the person about general safety issues.