Fact sheet

Sexual function

Changes to sexuality are common after traumatic brain injury.

Domain	Disability	Impact on sexuality
Physical	> weakness or paralysis on one side > restricted movement in hands, arms or legs > tremor > chronic pain > loss of sensation to touch > bowel dysfunction > bladder dysfunction > fatigue	> difficulty in transferring to and from bed > clumsiness in love making > some movements or positions can increase pain > parts of the body may not be aroused in response to touch > problems with applying contraceptives > fear of accidents, anxiety, embarrassment > inhibits sexual desire and increases feeling of vulnerability and anxiety > fatigue interferes with the sexual desire and the physical ability to initiate and sustain sexual activity
Cognitive	> memory problems > reduced concentration	> forgets having sex > distracted during sex > forgetting about contraception
Psychosocial	> lack of initiation > sexual disinhibition	> partner upset always having to initiate sex > complaints made about sexual disinhibition
Psychological	> depression > increased anxiety > fatigue > loss of confidence > poor self-image	> losing interest in sex or too tense to enjoy sex > partner frustrated or feeling rejected > thinking that an appliance (e.g. catheter) interferes with participation

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Sexual problems	> reduced sex drive > increased sex drive > problems with erections > ejaculation problems > vaginal dryness > orgasm problems	> unable to enjoy sex in the same way as before the injury > frequency of sex reduces or stop having sex > concern about capacity to have children > makes sex unpleasant > too embarrassed to ask for help
Social	> social isolation > relationship breakdown > partner may feel burdened with responsibility as carer > dependency, institutionalisation	> feeling lonely, having trouble meeting people > visiting a sex worker > lack of desire by partner related to difficulty separating carer role from that of partner > lack of privacy

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Central nervous system and sexuality

Prefrontal brain damage	Impairments	Impact on sexuality
Emotions and behaviour	> impulsive > disinhibited > attention and concentration limited > changeable moods > poor judgement	> difficulty relating to others > may not be easily aroused > aggressive sexual behaviour > wrong place or time > inappropriate sexual talk
Temporal lobe and limbic injuries		
Sensation	> taste and smell > hearing	> limits modes of arousal > partner may need to use more gestures
Cognition	> poor memory > poor decision making > slowed learning > slow information processing	> forgets having sex > chooses wrong time for sex
Emotions and behaviour	> seizure activity > impotence > overly sexual behaviour > changes in sex hormones	> unable to perform sexually > aggressive sexual behaviour

[1] Simpson 2004

Thalamic injuries		
Sensation	> loss of touch, pressure, position, pain and temperature	> pain associated with touch > clumsiness in touch > decreased arousal
Hypothalamic and pituitary gland injuries		
Physical	> change in sex hormones > loss of fluids > change of basic body regulation > precocious puberty	> changes in body > impotence > sterility > decreased sex drive
Cerebellar injuries		
Movement	> clumsy, uncoordinated movements > tremor of limbs > loss of balance > slurred speech	> difficulty performing sexual acts > may appear drunk to others > unable to use contraceptives > not attractive to partner
Brainstem injuries		
Physical	> sleep disturbance, lethargy > lack of drive	> partner must initiate and perform all sexual activity

[2]

Other possible causes of sexuality changes:

- **Drugs** - certain medications can dampen libido,
- **Associated injuries** - if, for example, the person sustained brain injury in an accident, they may have other injuries that directly affect their sexual functioning (eg spinal cord injury).
- **Relationship breakdown** - a couple experiencing problems are less likely to have sex.
- **Prior sexual difficulties** - brain injury can exacerbate any sexual problems the person was having before the injury occurred.
- **Other illnesses** (e.g. diabetes or hypertension can reduce libido)[3].

Why sexuality needs to be addressed - statistics

Traumatic brain injury (brain injury) impacts upon people's sexuality, with a number of studies finding between 50 and 60 per cent of people reporting some level of sexual disruption post injury[4].

People with a brain injury and their family members reported that only approximately 15 per cent of rehabilitation health professionals made enquiries about whether they had any sexual concerns during the rehabilitation episode[5].

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[2] Griffith and Lemberg 1993

[3] State Government Victoria: Department of Human Services 2005

[4] Kreutzer and Zasler, 1989; O'Carroll et al. 1991; Kreuter et al.1998

[5] Zinn, 1981; Kreuter et al 1998

Males following brain injury

Desire: 41 per cent reported decreased or greatly decreased desire. Only 12 per cent reported increased and 3 per cent greatly increased drive[6].

Erectile: 30 per cent reported erectile difficulties post injury[7].

Ejaculation: 40 per cent reported decreased or no experience of orgasm post injury[8].

Frequency: 54 per cent reported decreased or greatly decreased frequency post injury[9].

Satisfaction: 39 per cent reported decreased or greatly decreased satisfaction[10]. Couples reported increasing levels of sexual dissatisfaction over time[11].

Females following brain injury

Desire: 60 per cent reported unchanged desire, five per cent reported an increased desire, the remainder reported decreased desire[12].

Lubrication: 26 per cent reported difficulties with lubrication compared to eight per cent in non-equivalent control group[13].

Orgasm: 40 per cent reported decreased or no experience of orgasm post injury[14].

Frequency: Almost half report decreased to nil frequency of sexual activity post injury[15].

Assessment

Screening strategy

Question regarding sexuality on intake form or in initial assessment interview.

General Rehabilitation Assessment Sexuality Profile (GRASP)

The General Rehabilitation Assessment Sexuality Profile (GRASP) involves sexual history taking, sexual physical examination and clinical sexual diagnostic testing. GRASP is strictly for physician use only.

Sexual history should include demographic and biographical details, pre-morbid medical disorders, pre-injury psychosexual development, post-injury sexual functioning.

Generic measure of sexual functioning

The Golombok Rust Inventory of Sexual Satisfaction (GRISS) is a short 28-item questionnaire which assesses the existence and severity of sexual problems. The 12 subscales of impotence, premature ejaculation, anorgasmia, vaginismus, no communication, infrequency, male and

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[6] Ponsford, 2003

[7] Kreuter et al 1998

[8] Kreuter et al 1998

[9] Ponsford 2003

[10] Ponsford 2003

[11] O'Carroll et al 1991

[12] Kreuter et al 1998

[13] Hibbard et al 2000

[14] Kreuter et al 1998

[15] Kreuter et al 1998

female avoidance, male and female non sensuality, and male and female dissatisfaction are shown to have good reliability and validity[16].

Sexual Interest and Satisfaction Scale (SIS Scale)

A higher score on the Sexual Interest and Satisfaction Scale (SIS Scale) indicates better sexual adjustment[17].

Areas	Questions	Scale points
Sexual desire	How is your sexual desire now, compared to before injury?	Increased (3) Unchanged (2) Decreased (1) Non-existent (0)
Importance of sexuality	How important is sexuality to you now compared to before injury?	Increased (3) Unchanged (2) Decreased (1) Non-existent (0)
Perceived personal satisfaction	How are your possibilities and your ability to enjoy sexuality yourself?	Very satisfying (3) Rather satisfying (2) Rather dissatisfying (1) Rather dissatisfying (0)
Self-rated ability to give partner satisfaction	How are your possibilities and your ability to give your partner sexual fulfilment?	Very satisfying (3) Rather satisfying (2) Rather dissatisfying (1) Rather dissatisfying (0)
Self-rated ability to engage in intercourse	How is your ability to engage in intercourse now, compared to before injury?	Increased (3) Unchanged (2) Decreased (1) Non-existent (0)

[18]

[16] Rust & Golombok 2005

[17] Kreuter et al 1998

[18] Kreuter et al 1998

Sex education

Areas that may need to be addressed:

- sexual rights and responsibilities
- gay and lesbian issues
- the right to not be sexual if so desired
- self-pleasuring
- meeting people and establishing relationships
- keeping safe from sexual abuse/exploitation
- adjusting the sexual relationship with an existing partner
- accommodating physical disabilities
- assessing and treating sexual dysfunction
- sexual harassment and inappropriate sexual behaviour
- safer sex
- issues related to accessing sex workers
- fertility
- contraception
- pregnancy

Referral to specialist sexual health/therapy services

SHINE SA provides a range of sexual health services for people with disabilities and their parents, carers, workers and organisations. All services for clients are confidential.

Services provided by SHINE SA include:

- clinic services
- support for parents, carers, workers and organisations
- group sexuality education programs
- individual sexuality education programs
- therapeutic counselling
- professional education courses
- resource centre

Contact details

Southern Primary Health Care Team

Woodcroft Community Centre

175 Bains Road

Morphett Vale SA 5162

T: (08) 8325 8164

F: (08) 8325 8173

Northern Primary Health Care Team

43 Peachey Road

Davoren Park SA 5113

T: (08) 8252 7955

F: (08) 8252 7966

East/West Primary Health Care Team

GP Plus Health Care Centre

64c Woodville Road

Woodville SA 5011

T: (08) 8300 5300

F: (08) 8300 5399

Clinic appointments: (08) 8300 5301

Or visit SHINE SA for more information.

Sexual Health Hotline

Monday to Friday - 9am to 1pm

T: (08) 1300 883 793

F: (08) 8300 5399

Country callers (toll free): 1800 188 171

Sexual counselling - PLISSIT model

The PLISSIT model is a simple graded sexual counselling model that allows all rehabilitation staff to rate their level of skill and provide intervention to a level with which they feel comfortable.

Level of intervention	Examples of options
Permission Create an environment in which patients/clients know that it is alright to raise and discuss sexual concerns.	> availability of information resources > availability of sex education programs > use of screening questions > staff supporting each other in addressing sexuality issues > validate patient/client sexual concerns and encourage open discussion[19]
Limited information Address concerns by sharing information to reduce anxiety and clarify misconceptions.	> make information resources available > provide sex education programs[20] > include sexuality as topic in generic brain injury patient/relative education programs > provide information on contraception options[21] > information on accessible brothels

[19] Ducharme and Gill, 1990; Griffith and Lemberg, 1993

Specific suggestions Use particular strategies or suggest a particular course of action to address patient/client sexual concerns.	> provide strategies to address physical impairments to patient/client and partners[22] > continence and sexuality management[23] > referral to a urologist[24] > referral to doctor for assessment of sexual issues > attend group to build self-esteem > attend group addressing safer sex issues
Intensive therapy Provide expert help within their level of competence or refer the patient/client to appropriate expert or specialist service.	> treatment of endocrine dysfunction[25] > treatment of sexual dysfunction[26] > social skills training and community social integration[27] > teach appropriate masturbation skills[28] > sexual counselling[29]

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Provision of Information Resources

Books

Griffith, E. and Lemberg, S., *Sexuality and the Person with a Traumatic Brain Injury: A guide for Families*, Philadelphia: FA Davis Co., 1993

Gronwall, D., Wrightson, P., and Wadell, P. *Head Injury: The Facts - A Guide for Families and Care-givers*, Oxford: Oxford University Press, 1996

Simpson, G., *You and Me - An Education Program about Sex and Sexuality after Traumatic Brain Injury,* Sydney: Brain Injury Rehabilitation Unit, 1999

Websites

www.eBility.com

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[20] Medlar, 1998; Simpson, 1999a

[21] Zasler and Horn, 1990

[22] Neistadt and Frieda, 1987; Zasler and Horn, 1990; Burton, 1996

[23] Neistadt and Frieda, 1987; Zasler and Horn, 1990; Burton, 1996

[24] Ducharme and Gill, 1990

[25] Zasler and Horn, 1990

[26] Crenshaw, 1985; Zasler and Hall, 1990; Griffith and Lemberg, 1993

[27] Blackerby, 1990; Griffith and Lemberg, 1993

[28] Blackerby, 1990

[29] Valentich and Gripton, 1984-1986; Medlar, 1993

[30] Simpson 2001

References

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Dahllof, A, Gudjonsson, F, Kreuter, M, Siosteen, A, and Sullivan, M, 1998, *Sexual adjustment and its predictors after traumatic brain injury*, Brain Injury, vol. 12, pp. 209-217

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Maroun, F, O'Connell, R, and Woodrow, J, 1991, *Pyschosexual and psycho-social sequelae of closed head injury,* Brain Injury, vol. 10, pp.719-728

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Golombok, S, and Rust, J, 2005, *The GRISS: A psychometric instrument for the assessment of sexual dysfunction, Sexual Behaviour*, vol. 15, no. 2. pp 157-165

Simpson, G, 2001, *Addressing the sexual concerns of persons with traumatic brain injury in rehabilitation settings: A framework for action*, Brain Impairment, vol. 2 (2)

Simpson, G, 2004, *Sexuality after acquired brain injury*, Liverpool, Australia

Zinn, W, 1981, *Sexual problems in rehabilitation: Analysis and solutions*, International Rehabilitation Medicine, vol. 3, pp 18-25

For more information

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Resources accurate as at 3 February 2009. If you have any questions or wish to update the information, please contact Dr Maggie Killington