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Sexual relationships following brain injury

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ABSTRACT *Brain injury affects sexual function in wide-ranging ways. It can have either a direct effect on sexual function or an indirect effect by means of the effect of brain injury on motor, sensory, cognitive, behavioural and emotional function. Studies of the nature and prevalence of sexual dysfunction following traumatic brain injury are reviewed. Means to determine the nature of such sexual problems are discussed and appropriate means of intervention outlined. A proactive approach to assessment and intervention is advocated.*

Introduction

Traumatic brain injury results in sudden changes in physical, sensory, cognitive, behavioural and emotional function. Where the injury is severe it commonly leads to life-long impairment and disability. The most troubling long-term sequelae are normally the cognitive and behavioural changes but all of these can have effects on sexual function either directly or through changes in wider aspects of personal relationships. Traumatic brain injury frequently results in damage to the frontal and temporal lobes, the pituitary and limbic system, all areas associated with sexual function. Sexual dysfunction resulting directly from damaged neuronal and endocrinological function can also occur following traumatic brain injury. In addition, brain injury can lead to loss of confidence, anxiety and depression with concomitant effects on sexual function.

Impact of brain injury on sexual function

The wide range of impairment which results from traumatic brain injury can have obvious effects on sexual function. For example, physical impairment such as spasticity, poor balance, poor control of fine movement and tremor (ataxia) all make sexual activity more difficult. Poor control over swallowing and consequent drooling has an obvious impact. Sensory impairments such as decreased sensation or hypersensitivity may affect sexual enjoyment. The loss of the sensations of taste and

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smell, which are particularly common following traumatic brain injury, may affect sexual arousal and satisfaction. Severe traumatic brain injury can lead to speech and communication problems in a number of ways. Injury may result in dysphasia (difficulty expressing thoughts in words), which can make it difficult for the person to develop a relationship or express love and affection. Dysarthria (difficulty articulating speech) can make the person sound strange or permanently drunk. Higher-level communication difficulties, such as turn-taking and sensitivity to others' needs, may hinder the person's ability to form or sustain relationships. All of these make interpersonal relationships in general more difficult but have particular ramifications for sexual relationships. Indeed, cognitive impairment in general can have profound effects on sexual relationships. These include poor concentration and being easily distracted, memory deficits (the person may badger their partner for sex when they have only just engaged in such activity or may forget significant occasions they have shared with their partner), problems in initiating activity and difficulties in general in forming and maintaining relationships.

Individuals with cognitive impairment are often perceived by their partners as having changed personalities compared to pre-injury. This leads to frequently heard statements such as "he is not the man I married" or "it's like living with a stranger". It is not uncommon for people recovering from traumatic brain injury to become suspicious or paranoid. And such suspicions often have a sexual content or focus. Disinhibited behaviour, including sexual disinhibition, is common and may deter potential or actual partners. People may become preoccupied by particular themes or show repetitive behaviour, both of which may have a sexual nature. Motivational changes are common following brain injury and occur in a number of ways. General drowsiness and lethargy may result, particularly from brain stem injuries. Some people show apathy in the absence of depression and there may be problems in the formulation of intentions and plans or in the initiation and implementation of these. Distraction and failure to pursue goals consistently may lead to a failure to achieve aims or targets. Lack of confidence, learned helplessness, anxiety and depression may also reduce motivation.

Following brain injury it is not uncommon for individuals to become less fastidious about their personal care. For example, at one extreme they may shower or bath less frequently and oral hygiene may be reduced. More subtle effects can be the loss of ability to monitor one's appearance and make judgements about dress sense and colour coordination.

It has been estimated that 25% of cases of erectile dysfunction can be attributed to prescribed drugs (Glass & Soni, 1999). Many of the drugs commonly prescribed to people with brain injury can have such an effect. These include anti-convulsants, which until recently have been prescribed prophylactically following traumatic brain injury. Although this practice is being discontinued (Schierhout & Roberts, 1998), they are still commonly prescribed, not only for seizure disorders, but also as mood stabilizers. Anti-depressants can have the effect of producing erectile dysfunction, as can anti-psychotics, anxiolytics and hypnotics, all of which are not uncommonly prescribed following brain injury. Anti-cholinergic drugs such as Procyclidine, often prescribed in association with anti-psychotics to prevent Parkinsonian side-effects,

also affect sexual function. Anti-hypertensives may be prescribed, particularly following cerebral haemorrhage.

Brain injury may result in direct neurological and endocrinological changes in sexual function such as reduced libido, erectile dysfunction, premature ejaculation and orgasmic difficulties. In general terms Kaufman (1981) describes the neuronal basis of sexual function thus: "in the cerebral cortex under the influence of the limbic system and the hypothalamus, psychologic stimuli are converted to neurophysiologic excitation. These excitatory impulses are transmitted to the genitalia." Horn and Zasler (1990) describe reflexogenic and psychogenic pathways. Temporal lobe dysfunction is associated with changes in sexual activation and hence with decreased sexual and genital arousal. Injuries to the hypothalamus may lead to total and irreversible loss of libido (Kosteljanetz, 1981). The thalamus, the hippocampus, the amygdala and the septal complex are all implicated in sexual stimulation (Horn & Zasler, 1990). Traumatic brain injury, via injury to the hypothalamic–pituitary–gonadal axis can result in endocrine dysfunction.

There is therefore a number of distinct ways in which sexual dysfunction may follow acquired brain injury. There may be neurological or endocrinological effects of the brain injury that have a direct effect on sexual function. Prescribed drugs commonly used following brain injury may impair sexual function. Loss of confidence in the injured person may lead to psychosexual dysfunction such as avoidance, erectile dysfunction or premature ejaculation. There may be a loss of libido either as a specific motivational effect of brain injury or as part of more general motivational deficits that commonly follow brain injury. Finally, changes in the person with the brain injury may lead their partner to withdraw as a result of (a) changes from an equal to a more dependent relationship and/or (b) the partner's clumsiness, tactlessness and loss of empathy.

Identifying the causes of sexual dysfunction following brain injury

Glass and Soni (1999) have suggested some criteria by which psychogenic sexual dysfunction can be distinguished from organically determined sexual dysfunction. If the cause is mainly psychological:

1. The onset is more likely to be acute;
2. The general relationship with the partner is more likely to be poor;
3. Symptoms may not be consistent in all situations or with all partners;
4. Major life events are often present;
5. Men with erectile dysfunction continue to have nocturnal or early morning erections;
6. There is a continued response to self-stimulation;
7. Investigations (such as urea and electrolytes, urine analysis, liver function tests, thyroxine, glucose, sex hormone concentrations) tend to be normal.

If the cause is mainly organic there is generally:

1. A slower onset;

2. A good or reasonable relationship with the partner;
3. The symptoms are consistent in all situations and with all partners;
4. New life events are rare;
5. Co-existing physical and mental health problems tend to be present;
6. Men with erectile dysfunction no longer experience nocturnal or early morning erections;
7. There is no response to self-stimulation;
8. There tend to be abnormal results from investigations.

Unfortunately these criteria do not necessarily readily apply to those with single-incident, non-progressive acquired brain damage such as traumatic brain injury. For example, neurological dysfunction in this case has an acute onset. Since such brain injuries commonly affect general aspects of relationships, the criterion concerning the relationship with the partner needs to be interpreted in relation to the pre-morbid relationship rather than the current relationship. Acquired brain injury is itself a major life event. O'Carroll *et al.* (1991) caution that rather than focusing unduly on the organic/psychogenic distinction, sexual dysfunction should be seen as a truly psychosomatic phenomenon.

Studies of the prevalence and nature of sexual dysfunction following brain injury

The frequency with which different sexual problems arise following brain injury has not been well researched. The studies that do exist have often involved small numbers of participants, wide variation in the nature and severity of the brain injuries sustained and wide variation in the time since injury in the samples studied. As a result it is probably not surprising that widely differing findings have been reported. Sandel *et al.* (1996) studied 42 male and female clients who had suffered quite severe traumatic brain injuries (mean PTA 54 days). They found that the participants were not reporting major sexual dysfunction. They found no relationship between sexual dysfunction and the severity of neuropsychological function but they did find that clients with areas of damage in the frontal lobes and in the right hemisphere of the brain reported more sexual activity. Interestingly, time since injury was inversely related to ratings of sexual arousal. In a study of 92 clients with comparably severe brain damage (average length of post-traumatic amnesia four weeks but ranging from less than 24 hours to more than 90 days) Kreuter *et al.* (1998) found 60% rated their sexual desire as unchanged. Of those who had a partner 89% were satisfied with their sexual lives and 75% were satisfied with the frequency of sexual activity. Almost two-thirds believed they were able to give their partner sexual pleasure. However, 30% of men reported decreased or absent ability to achieve an erection and decreased frequency of ejaculation. Level of disability as measured by the Glasgow Outcome Scale and the Sickness Impact Profile was a more important determinant of sexual functioning than severity of the initial brain injury as indicated by duration of PTA. Although nearly all participants had been

sexually active at the time of injury, more than a quarter had not engaged in any sexual activity with a partner since their injury. Young adults achieved better sexual adjustment than older ones.

Kreutzer and Zasler (1989) reported higher levels of sexual dysfunction in five single and 16 married participants. In their sample 57% reported decreased ability to maintain an erection and 57% reported decreased sexual drive. An even higher percentage (62%) reported reduced frequency of intercourse. A smaller number (14%) reported increased sexual drive and 14% reported improved ability to reach orgasm. The extent to which these difficulties were of psychological or neurological origin was not determined. However, two-thirds of the sample reported reduced self-confidence and half reported that they felt they had reduced sex appeal. Thirty-eight percent reported poorer communication with their partners. This sample consisted of four mild, five moderate and 12 severely brain injured clients as indicated by Glasgow Coma Scale scores. Garden *et al.* (1990) found higher rates of sexual dysfunction in both female clients and female partners. This was a very small study where there were 11 injured males and four injured females. Two out of the four female clients had problems with orgasm and two-thirds of the females' spouses reported such difficulties. It is not clear how severely injured the participants in this study were but only one male client and one female spouse (from different couples) reported that they no longer found their partner attractive.

A study of 19 male clients with relatively mild injuries (unconscious less than 24 hours, symptoms of post-concussional syndrome) found that 53% reported reduced libido and 42% erectile dysfunction (Kosteljanetz, 1981). These authors found that sexual dysfunction was more common among those with cognitive impairment. However, O'Carroll *et al.* (1991) failed to find a severity effect (although theirs was a postal study with only a 30% response rate and the authors point out that the more mildly injured had a lower response rate). The criterion for inclusion was admission for at least 24 hours following closed head injury. Fifty percent of male clients responded with Golombok-Rust Sexual Satisfaction (GRISS) profiles in the dysfunctional range. Clear associations were found between anxiety, depression and general psychopathology and sexual measures. Male clients were more dissatisfied as time increased after injury, a finding comparable with that of Sandel *et al.*, described above, who found lower sexual arousal longer after injury.

The Kosteljanetz (1981) study tested for testosterone levels and found no patient had a clinically subnormal level. However, Clark *et al.* (1988) found 24% of 21 men tested three to six months after major head injury had subnormal testosterone levels, with associated loss of libido and impotence.

Only one large scale study has been reported, that of Walker and Jablon (1961). However, their subjects were 739 men wounded in World War II and most of these men were likely to have had missile wounds, which can lead to rather different effects from the more common closed head injury which has been the focus of other studies. Eighty-seven percent of these reported no change in their sexual appetite while 60% reported that they were impotent.

Small samples, inadequate data concerning severity and nature of the injury, poor response rates leading to selection biases, and wide variation in time since

injury hamper attempts to interpret the findings of studies in this area. Few studies have systematically assessed the contribution of neurological, endocrinological and psychological factors to the sexual dysfunction reported. Nevertheless it does appear that sexual problems are common even after less severe traumatic brain injury and that they may increase rather than decrease with time since injury.

Impact of brain injury on general aspects of couple relationships

Davis and Schneider (1990) opined that the predominant issue relating to sexuality following traumatic brain injury concerns psychosocial issues related to disability as opposed to physiological or physical sexual ramifications. While empirical evidence for this proposition is absent, there is certainly strong evidence that traumatic brain injury can have strongly adverse effects on existing couple relationships. In the UK National Traumatic Brain Injury Study reported by Stillwell & Stillwell (1997) 30% of marriages in a sample of 234 ended in divorce within seven years of severe traumatic brain injury to one of the partners, compared with a seven year failure rate of 14%–18% in the general population. They found that these marriages failed at a uniform rate over the seven years and concluded that traumatic brain injury doubles the rate of marital breakdown. Wood and Yurdakul (1997) found male and female partners were equally likely to leave and that there was no relationship between age and separation. However, the longer the relationship had existed before injury the less likely couples were to separate. In this sample almost 50% had separated or divorced. The rates were higher in those with more severe brain injuries.

Anderson-Parente *et al.* (1990) in a small-scale and informal study of couple relationships following brain injury found that fewer than one-third remain married two years post-injury. Where the spouse had stayed, injuries were severe and the effects persistent. Those who stayed tended to focus on the positive aspects of the relationship and viewed the spouse with warmth and respect, not as a burden. It was also the case that in the couples who stayed together the partner perceived that the other still cared for them.

Gosling and Oddy (1999) conducted an in-depth study of 18 heterosexual couples where the male partner had sustained a brain injury not less than one and not more than seven years previously. All the couples had been in stable relationships at the time of the injury and were still together at the time of the study. All the men were ambulant and independent in self-care. All had been employed at the time of injury but had been unable to work since injury. All had a post-traumatic amnesia in excess of seven days. None had a previous psychiatric history.

There were considerable differences between the injured partner's perception of the marital relationship and that of the uninjured partner. Female partners rated their marital relationship as significantly worse than their partners rated it and significantly worse than their view of it before the injury. They also reported that their sexual satisfaction was significantly lower than before their partner's injury. Two-thirds reported that their sexual relationship had deteriorated and two reported a complete cessation. Only four out of the 18 rated it as the same or improved. Two couples reported that the male partner suffered from impotence.

Seven women reported that their partner's sexual interest had decreased and seven that it had stayed the same. Only two out of the 18 women reported an increase in their partner's sexual interest. There was no relationship between the change in the male partner's interest and the female partner's rating of marital or sexual satisfaction. Half the female partners reported that the brain injured person's sexual advances felt coercive at least half the time and this was correlated with lower sexual satisfaction on their part. However, 50% of the women also reported that they welcomed their partner's sexual advances at least sometimes. These women were under considerable stress and nearly two-thirds of them met the criteria for caseness on the General Health Questionnaire.

The major part of this study was qualitative rather than quantitative and involved using the 'grounded theory' method to analyse interview transcripts for themes (Henwood & Pidgeon, 1995). The following themes emerged. The first was of the extent of role change experienced by the non-injured partner. A typical statement was as follows:

All the decisions are mine, especially when it comes to money. I carry all the responsibilities while he just drifts through life with it all being rosy for him.

Many of the partners reported having to take on total responsibility for family decision making and organization.

Another theme was the non-injured partner's perception of the brain injured person's feelings as being grateful:

I know he's very grateful to me, he puts notes in cards to me at Christmas saying how he couldn't do without me. I wish he wouldn't do this because it reminds me that he is dependent on me and I am not entirely comfortable with that.

This theme of expressions of gratitude simply emphasizing the injured partner's newly acquired dependence was common, as was the complaint that the uninjured partner no longer knew how the injured person felt about them. Many mentioned the lack of expression of physical or emotional affection from their injured partner, although 12 did feel their partner still had positive feelings towards them. More generally, non-injured partners frequently reported dramatic and devastating changes in their relationship:

I was totally unprepared for the changes in our relationship. I knew he'd have memory problems and speech difficulties but I thought we'd still be a couple. The emotional side feels badly damaged, I really miss the intimacy and closeness. Suddenly we had none. There are times when I'd love to be swept off my feet and just loved for me. I don't want to get to 70 and not have felt that warmth and closeness again. I can see the frustrations setting in.

Many described their sexual relationship as being 'boring', or 'flat' or 'feeling wrong'. Many suggested that the change from a mutual, equitable relationship to

one of dependence/independence meant that they now felt more like a mother than a sexual partner to their spouse:

Because he's so dependent on me and I'm more like a mother to him, it doesn't feel right that we have sex. I know I'm not the only one who feels like that because, of the carers in the Support Group, about three other women said they felt the same.

Many reported the loss of a sharing relationship, the loss of equality and the loss of companionship. When asked to focus on the positive aspects of the relationship seven of the non-injured partners mentioned companionship and six mutual commitment. Half of them felt there would be little change in the future and the others expressed uncertainty or a deliberate attempt to take one day at a time and to avoid looking into the future. Several mentioned their fear that their situation would worsen. About half felt that they would benefit from some form of counselling or therapy, possibly including couple therapy.

Acquired brain injury, particularly traumatic brain injury, is much more common in males than in females. An attempt has been made to follow up the Gosling and Oddy study with a study of male partners. However, so far insufficient numbers have been interviewed to draw clear conclusions. Preliminary findings suggest that uninjured male partners also experience a change of role and the necessity to become the sole decision maker. They too mentioned the lack of emotional expression and difficulty in knowing the true feelings of the partner with the brain injury. They too liken their relationship to a parental, father/daughter relationship. However, they did not feel that counselling would be either necessary or beneficial to them. A further theme which emerged from male partners but not the female, was the difficulty in motivating their partner.

In conclusion this study found severe problems in marital and sexual relationships. Although only two couples reported physical sexual problems, two-thirds reported some form of deterioration in their sexual relationships. Nevertheless some wives did suggest a wish for more sexual interaction with their partners. The implications of the problems faced by partners of someone who has suffered a severe acquired brain injury need to be seen in a broad context. There may be a need for practical help as well as help with emotional aspects. Partners often have to cope suddenly with many added responsibilities at a time when they are coming to terms with the life threatening injury to their partner. The study further suggests the need to help the uninjured partner interpret and understand the behaviour of the injured partner and to help the injured person to express his/her feelings more often and appropriately. Statements of gratitude need to be discouraged, while discussion between both partners of their continuing friendship and their plans for the future need to be encouraged. At least for some couples encouragement to resume their sexual relationship may be appropriate. However, it should also be recognized that in other cases this may not be appropriate. Lezak (1988) has suggested that for some it may be easier to live with a sexually uninterested partner than one who wishes to resume a sexual relationship when other aspects of the relationship have completely changed. A common finding is that

partners can change their relationship to that of a care-giver but then find a sexual relationship is incompatible with this. This may explain why Anderson-Parente *et al.* (1990) found couples were more likely to stay together when the effects of the injury were severe and persistent.

Sexual offending following brain injury

It is not uncommon in clinical practice to find individuals who have committed sexual offences subsequent to their brain injury. Simpson *et al.* (1999) found that out of 477 admissions to a brain injury rehabilitation unit 29 males committed a total of 128 offences, although only 13% of these had led to a legal response. The most common were touching offences followed by exhibitionism. Children were the victims in 11% of the offences. Only two clients had a pre-injury history of sexual offending. No female clients had committed such an offence. Rosenbaum and Hoge (1989) found that of 31 consecutive referrals for marital violence more than 60% had a history of severe brain injury.

Treatment of sexual dysfunction following brain injury

There are few papers giving guidance on the treatment of sexual disorders following brain injury. Zasler and Horn (1990) emphasize the importance of a thorough assessment, including sexual history, sexual physical examination and clinical diagnostic testing as a basis for treatment. Kreutzer *et al.* (1994) commend education of family members regarding the impact of subtle linguistic and cognitive deficits, providing consistent and realistic information about behavioural difficulties and their likely impact on the family, giving on-going training in behavioural management and ensuring access to counselling and to support groups, with special attention to depressive and grief reactions in spouses. Price (1985) gave a number of sensible suggestions concerning such intervention. She suggests that it is important for professionals to be aware of the possibility of sexual problems and to initiate discussion on this issue. She wisely suggests that couple counselling may be best left to later stages in rehabilitation. People are often extremely anxious following brain injury, particularly after mild or moderate injuries and emphasis on the problem at this stage could well increase anxiety rather than reduce it. Price goes on to say that it is important to determine what changes are possible and to set appropriate goals. It may be necessary to help a couple accept what cannot be changed. Glass and Soni (1999) emphasize that for disability as a whole it is important to define sexuality in broader terms than simply physical function: "A person who is not able to use part of his or her body still has an equal right to full sexual expression". Like Kreutzer *et al.* (1994), Price recommends information for both the brain injured person and their partner. In accord with Gosling and Oddy, Price suggests that clients should be discouraged as far as possible from adopting a dependent role, as this is less sexually desirable. Price suggests the use of appropriate strategies to help clients cope with body image and sexual identity problems. She also suggests that single clients will need more help with dating and general social

skills than with sexual function *per se*. Self-control of inappropriate sexual behaviour should be encouraged by cognitive restructuring or health coaching statements and she recommends the use of extinction or time-out procedures for decreasing sexually inappropriate behaviour.

Zencius *et al.* (1990) described three cases of hypersexual behaviour treated by behavioural methods, whereas Britton (1998) described a pharmacological intervention (medroxyprogesterone) in a single case of hypersexuality following brain injury. Zasler and Horn (1990) suggest that, where hypersexuality is due to bi-temporal lobe injury (the Kluver–Bucy syndrome), carbamazepine is the treatment of choice.

Elliot and Biever (1996) suggest that sex counselling or therapy is appropriate as long as the client has sufficient cognitive abilities to participate actively. These authors further suggest that behavioural sex therapy can help evaluate the current level of functioning for those with organic problems and then help the couple adjust to an altered level of function. Zasler and Horn (1990) discuss the use of prostheses, injections and hormone therapy for those with sexual disorders following brain injury. A useful guide on sexual matters for people with brain injuries and their families has been provided by Griffiths and Lemburg (1993).

Ducharme and Gill (1990) suggest that sexual rehabilitation is the responsibility of all disciplines and that the client should be able to choose the person with whom he/she feels most comfortable to discuss sensitive topics. They recommend the PLISSIT model (Annon, 1974) as a means of providing a framework for staff to determine at which level they feel competent to work. There are four levels: (1) giving clients *permission* to raise sexual concerns; (2) providing *limited information* regarding sexual matters, such as allaying anxieties or misconceptions which obviously requires a knowledge of the impact of brain injury on sexual activity; (3) making *specific suggestions* about sexual issues, which requires staff to have had special training; and (4) *intensive therapy*, which would be the province only of those who have received training in sexual counseling. Mapou (1990) emphasizes the need to check on the sexual orientation of clients and provide adequate counselling for gay and lesbian individuals.

For many survivors of brain injury the major problem is establishing an intimate sexual relationship in the first place. Traumatic brain injury is most common among young adult males. The impact on their social behaviour makes the formation of relationships extremely difficult. Common effects include loss of subtlety in behaviour, misreading of social cues, repetitive statements and preoccupations, concrete and inflexible thinking and an inability to appreciate and take into account the needs of another. Disinhibition can be a major problem, with embarrassing and socially inappropriate sexual remarks or behaviour. Such behaviour can vary from the mildly discordant to the grossly inappropriate, such as groping or exposure. While this is more common among male clients it can occur with female clients. Some clients do form relationships, sometimes with individuals who have a degree of disability themselves. A study of those with spinal injuries found that relationships formed after injury tended to be more successful than those formed before (Crewe & Krause, 1988). There is no evidence on this point following brain injury but

clinical experience and logic would suggest that new relationships may well be more successful as there is no loss for the partner to come to terms with and they are aware of the brain injured person's disabilities when they enter the relationship.

Blackerby (1990) suggests that staff members should engage in role play with clients to help them gain dating and non-sexual social skills. However, even this dilution of boundaries can lead to confusion among clients and make other aspects of rehabilitation difficult. For single clients, clearly intervention based on helping them to modify their general social behaviour and approach to those in whom they have a sexual interest is indicated but the possibility of sexual dysfunction once such a relationship is available should not be overlooked.

Brain injury is known to have a devastating impact on a person's self-confidence. This is particularly the case with those who have suffered minor or moderate brain injuries. Those with more severe injuries often lack full awareness of the extent and nature of their disabilities, particularly their cognitive and behavioural ones. This lack of confidence can have a strongly negative influence on social and sexual behaviour. For those with more minor injuries timely reassurance can be extremely beneficial. However, if this is not available at an early stage, anxieties may become entrenched and difficult to shift. For the more severely injured, timing is also important. In this case there may be prolonged periods in hospital or rehabilitation and the desire or opportunity to engage in sexual behaviour may be delayed for several months. However, again, it is important for those engaged in their care and rehabilitation to be proactive in raising the topic of sexual function, albeit with sensitivity over timing.

Conclusion

Brain injury can impair sexual function in a number of different ways. There are few studies that provide information concerning the prevalence of such problems and even fewer that attempt to identify the cause of the difficulties reported. Those studies that have been reported suffer from small numbers, heterogeneous groups, insufficient information on the nature and severity of the injury and methodological problems concerning the representativeness of the clients sampled. Nevertheless it appears certain that sexual dysfunction is common following brain injury, and its multi-causal nature suggests that remedies need to embrace medical and psychological approaches. Skilled identification of the contributing factors in individual cases will be crucial for successful treatment. Perhaps the most difficult aspect to overcome is the perception of change in individuals by their partners. However, this difficulty should not prevent attempts to address the problem as improvement in the sexual relationship may provoke positive changes in more general aspects of the relationship.

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