Module 6

Sexuality after traumatic brain injury: issues and strategies

Compiled by:

Grahame Simpson
Senior Social Worker
Brain Injury Rehabilitation Unit
Liverpool Hospital, Sydney

and

Ruth Orchison
Clinical Psychologist
Geriatric Rehabilitation Service
Liverpool Hospital, Sydney

Workshop overview

Aim

This workshop aims to increase awareness of the impact of traumatic brain injury (TBI) on people's sexuality, and increase participants' awareness of their own attitudes towards sexuality. It also offers participants useful strategies to enhance the sexual lives of clients with TBI, and to manage sexually inappropriate behaviour.

Rationale

Traumatic brain injury can have negative consequences for a person's sexual functioning. Staff often find this a challenging area of work. Increased awareness of one's own attitudes, combined with accurate information and practical skills, can enable staff to work more effectively in this area.

Outcomes

At the end of this session, participants should be able to:

- define sexuality
- identify sexuality issues for people with TBI, and how these issues affect their family members and workers in the field
- clarify personal and professional values on sexuality
- recognise the sexual rights and needs of clients with TBI
- recognise verbal and non-verbal components of communication about sexuality
- identify clients' special needs in verbal communication
- match verbal and non-verbal communication for clarity in dealing with clients' sexuality
- monitor non-verbal interactions with clients (eg. tone of voice) for more effective communication about sexuality
- identify strategies to address clients' sexual health concerns
- understand different causes of sexually inappropriate behaviour
- identify strategies for establishing professional boundaries between client and worker
- develop strategies for verbal feedback to clients about disinhibited sexual behaviour
- develop effective ways of responding to inappropriate sexual behaviour.

Evaluation

Some presenters may wish to evaluate the effectiveness of their training. For example, if the modules are provided as part of a training day, the organisers may want to evaluate the success of the program and the usefulness of this approach to the provision of the training.

A generic evaluation form has been provided in **How do I use this resource?**

This form is an example of how you may want to evaluate your training. It can be modified before you print it out, to make it specific to your training.

The evaluation can be completed at the conclusion of each module or at the completion of the training program (eg. several modules). The form can be distributed and collected by the presenter/s on the day, or returned by mail/email for feedback to a designated person to collate the responses for later feedback, to assist planning or to provide a training report (eg. as a Quality Assurance project).

The use of the evaluation tool will be specific to the type of training organised.

Summary outline — approximately 2 hours

Content	Resources	Suggested Timing
Introduction	**HO 6.1:** Workshop outline **OH 6.1:** Workshop outline	5 minutes
Awareness of sexuality issues	**HO 6.2:** Common changes to sexuality **HO 6.3:** Primary and secondary causes **HO 6.4:** Range of changes **WS 6.1**: Greg **WS 6.2**: Peter **WS 6.3**: Jane **WS 6.4**: Susan **OH 6.2**: Influences on decision-making	25 minutes
Sexual rights and responsibilities	**HO 6.5:** Sexual rights/responsibilities **HO 6.6:** Sexual needs and rights (a–d)	20 minutes
Communication about sexuality issues	**OH 6.3:** Communication **OH 6.4:** Matching verbal and non-verbal communication **OH 6.5:** Needs in verbal communication **OH 6.6:** Keep in mind **HO 6.7:** Our responses **HO 6.8:** Interviewing about sexuality **WS 6.5:** Scenario 1 **HO 6.9:** Treatment options (a–h)	40 minutes
Managing inappropriate sexual behaviour	**OH 6.7:** Sexually inappropriate behaviour **OH 6.8:** Targets of behaviour **OH 6.9, 6.10, 6.11:** Causes of behaviour **HO 6.10:** Conclusions **OH 6.12:** Professional boundaries **OH 6.13:** Verbal feedback **OH 6.14:** Other options	25 minutes
Workshop outcomes	**OH 6.15, 6.16** Information resources **HO 6.11:** Resources Use blank overhead and **HO 6.1** to review outcomes from introduction exercise Evaluation forms (if utilised) Close	10 minutes

Key strategies and concepts

This workshop has been designed so that the facilitator draws upon the experience of participants as an essential component.

The workshop involves a range of learning including brainstorming, case studies, case discussion and problem-solving, didactic input, and an impaired sexuality awareness exercise.

The underlying philosophy of the workshop recognises two different dimensions in addressing sexuality issues among people with TBI. The first is promoting sexual wellness, addressed in the first two-thirds of the workshop. This includes sexual function (eg. erectile problems, orgasm problems, ejaculatory problems, arousal problems), masturbation, physical positioning and sexuality, contraception, safer sex, pregnancy issues, accessing sex workers and the like. The second dimension is the management of sexually inappropriate behaviour (eg. inappropriate sexual talk or touching, exhibitionism, coercive sexual behaviours) addressed in the final third of the workshop.

Additionally, the workshop is based on recent developments in training around sexuality issues, where the emphasis has moved away from attitude change to training in knowledge and skills. Within this context, there is no expectation of participants having to share details of their own sexuality and sexual lives. This change in emphasis is reflected in the structure of the workshop. The first section is the only section that explicitly addresses the values and background influences of staff, that may affect their approach in dealing with client sexual health concerns. The remainder of the workshop focuses on increasing staff knowledge and skills in dealing with the sexual concerns of their clients.

Workshop outline

Resources	Content
Blank overhead	**Introduction** *(5 minutes)* Ask participants to introduce themselves and to say what they hope to achieve from the workshop. Write this information on the blank overhead – it will be needed again at the completion of the workshop.
OH 6.1 and **HO 6.1:** Workshop outline	Distribute the handout and explain the purpose and focus of the workshop.
	Awareness of sexuality issues **Defining sexuality** *(5 minutes)* Start by asking participants to define 'sexuality' by brainstorming associated terms and concepts. Emphasise that sexuality has as much to do with feelings, gender and relationships, as it has to do with sexual intercourse.
	Sexuality issues after TBI *(5 minutes)* Ask participants to brainstorm what issues are involved, including any issues they would like to explore during the workshop.
HO 6.2: Common changes to sexuality **HO 6.3:** Primary and secondary causes **HO 6.4:** Range of changes	Record answers on whiteboard or overhead (with the help of an assistant if possible). Make the distinction between 'sexual wellness' issues versus issues in managing sexually inappropriate behaviour (see the 'Key Strategies and Concepts' section). Explain that the workshop will address both dimensions of sexual behaviour, starting with promoting sexual wellness. Indicate which issues the workshop will cover. Then distribute **HO 6.2–4**.

Workshop outline continued

Resources	Content
	Activity – Case scenarios *(15 minutes)*
WS 6.1: Greg **WS 6.2:** Peter **WS 6.3:** Jane **WS 6.4:** Susan	Four case scenarios are provided. Break the group into pairs and give each pair two scenarios. One option is to read out the scenarios, so each pair can choose two that they feel are most relevant.
OH 6.2: Influences on decision making	Tell participants that they will be asked to brainstorm possible solutions to the problems presented. Emphasise that there are no right or wrong answers when brainstorming, only possibilities for action. Asking participants about influences on their thinking does NOT include asking for self-disclosure about sexual experiences. This section aims only to raise awareness of possible influences on clinical decision-making.
	Break into small groups for discussion on possible solutions to scenarios.
	After some discussion, but while still in small groups, present **OH 6.2** and ask participants to consider in their discussions what values from their own experiences, family and professional training influence their choice of solution for a scenario.
	Sexual rights and responsibilities **Activity – discussion** *(20 minutes)*
HO 6.5: Sexual rights and responsibilities	Ask participants to brainstorm what they think may be the sexual rights of people with TBI. Then provide **HO 6.5** to compare with answers. Ask participants how their own particular agencies respond to client sexual health concerns (eg. supportive, try to ignore, not even talked about). Is the agency approach consistent with supporting the sexual rights of their clients?
HO 6.6: Sexual needs and rights	Also provide **HO 6.6 (a–d)** and strongly recommend that participants read it over as a valuable resource and supplement to what has been discussed in the workshop.

Workshop outline continued

Resources	Content
OHT 6.3: Communication	**Communication** **Talk – Verbal and non-verbal components of communication about sexuality** *(10 minutes)* Communication is both **verbal** and **non-verbal**. People with TBI can retain the ability to respond to **tone of voice** even when understanding of the meaning of words is lost. Even when there is no loss of understanding, people who have had a TBI may respond to tone of voice instead of the actual words. **Emotion** is commonly revealed in tone of voice. In dealing with clients' sexual issues, workers' emotions (such as embarrassment or anger) can show in the tone of voice, even when the words used are appropriate for the situation. As workers, we need to listen to how we talk and we need to be able to speak unemotionally when that is necessary. **Body language** also provides important clues in communication, for example gesture is often used with people who have aphasia and no longer understand the meaning of words. **Emotion** is also revealed in **body language**. For example, when someone is angry he or she may move more quickly than when calm, or someone who is embarrassed may break **eye contact** and look away. **Clothing** also provides information in an interaction between people. If we are working with someone who has problems with disinhibition and control, our "don't touch" message will work better if we are not wearing provocative clothes.

Workshop outline continued

Resources	Content
OH 6.4: Matching verbal and non-verbal communication	**Talk – Matching verbal and non-verbal communication to get a message across effectively** Strategies for matching modes of communication include checking that words, tone of voice, facial expression, body language, eye contact, clothing (where appropriate) are all saying the same thing and that there is no confusion between different parts of the message. If the verbal message is "Masturbate in the bedroom, not the lounge" and the non-verbal message is disapproval, the client will conclude either that he/she is in trouble, or that masturbation is disgusting, or that the worker does not like him or her. The intention of confining sexual activities to private instead of public space may be missed altogether.
OH 6.5: Needs in verbal communication	**Talk – Clients' special needs in verbal communication** Clients with TBI have special needs in verbal communication about sexuality. Common needs are: • more time than the average person to take in information • more time to process information • more time to respond • more repetition • small chunks of information at a time • external limit-setting or prompts about appropriate behaviour
OH 6.6: Keep in mind	People with TBI are easily overloaded with too much information delivered too fast. People who have memory problems need a lot of repetition and reminders. Taking time to plan how best to deal with a client's sexual issues saves time in the long term. The longer an undesirable behaviour continues, the harder it is to change. There will be a short-term increase in work to tackle the problem, but a decrease in effort in the future once it is resolved. Inappropriate sexual behaviour is not *personal*. The client is not doing it to intentionally upset the worker. Rather, he or she is acting out the effects of the TBI while the worker is present. Keeping the focus on the behaviour that needs to be addressed, rather than feeling personally involved, helps to maintain distance between the worker and the client's behaviour.

Workshop outline continued

Resources	Content
HO 6.7: Our reactions	**Talk – Our responses** Apart from the issues already detailed, there may be times when a worker feels distressed in response to a client's sexual issue. **HO 6.7** gives some strategies to deal with such situations.
HO 6.8: Interviewing about sexuality	**Activity – Talking about sexuality** *(25 minutes)* Distribute **HO 6.8** and explain that this handout contains some of the general questions that you could ask a person with a TBI about their sexuality.
WS 6.5: Scenario 1	Break the group into pairs and give each pair the case scenario. Give participants ten minutes to brainstorm possible questions to the problems presented. Emphasise that there are no right or wrong answers when brainstorming. When time is up, ask the pairs to report on the ideas they came up with. Facilitator note: you are looking for three key types of responses: • *Validation* of the person's concern (eg. 'it sounds as if this problem has been difficult/ frustrating/ upsetting for you'), • *Normalising* the concern (eg. 'many people experience these sorts of difficulties after a TBI'), and • *Action* to address the concern (eg. 'if you are interested, I can organise for you to go and see someone about this').
	Talk – Treatment options *(5 minutes)* Following on from the brainstorming activity, the next issue that arises is what action can be taken. Briefly summarise the range of sexual health concerns identified both through the brainstorming session at the beginning of the workshop (see 'Sexuality Issues after TBI') as well as issues outlined in **HO 6.2** and **6.4**. Distribute **HO 6.9 (a–h)**, that outlines a number of common sexual health concerns experienced by people with TBI and relevant treatment options.

Workshop outline continued

Resources	Content
	Managing sexually inappropriate behaviour after TBI
	Brainstorming *(5 minutes)*
	Summarise the inappropriate behaviours the group identified in the brainstorming session at the beginning of the workshop. Ask if there are any other behaviours that staff have encountered?
OH 6.7: Sexually inappropriate behaviour after TBI	**Talk** *(10 minutes)*
	Show OH 6.7. These are the common types of inappropriate sexual behaviour encountered by staff working with clients with TBI. Touching genital areas refers to breast, buttocks or penis. Touching non-genital areas refers to anywhere else on the body including patting a person on the knee, touching a person's shoulder, arm, back, etc. Coercive sexual assault refers to the forcible grabbing of a person, attempting to undress a person, attempting to have non-consenting intercourse.
OH 6.8: Targets of behaviour	Show **OH 6.8** detailing the most common targets of inappropriate sexual behaviour. The findings show that staff are a significant target group.
OH 6.9, 6.10, 6.11: Cause of behaviour: disinhibition versus hypersexuality	Show **OH 6.9**. Most commonly, sexually inappropriate behaviour is the result of disinhibition not hypersexuality. We know this because low sex-drive is far more common than increased sex-drive after TBI. So a person can have low sex-drive but still act in a sexually disinhibited way. This is because different mechanisms within the brain are involved (see OH **6.10** and **6.11**).
	This is an important distinction. Disinhibition is best managed by a behavioural approach. Sometimes people wrongly assume disinhibited behaviour is due to an increased sexual drive or sexual frustration, assuming a strong underlying sex-drive. They then might try to link a person to a sex-worker or add medication to try and address the sex-drive issue.

Workshop outline continued

Resources	Content
HO 6.10: Conclusions	In most cases of sexually inappropriate behaviour, the best way to approach the problem will be through the use of behavioural interventions. Give out **HO 6.10**.
OH 6.12: Professional boundaries	**Talk – Management of sexually inappropriate behaviour: professional boundaries** *(15 minutes)* Workers need to maintain boundaries in relationships with clients, especially when issues about sexuality are concerned. It is useful to be able to **recognise covert** as well as **overt sexual connotations** in relationships with clients. Undesirable behaviours may not be frankly sexual. They may be more subtle, like a client's overly familiar greeting, "Helloooo darling, when are you going out with me?" **Limit-setting** prevents the client from developing unrealistic fantasies and protects the worker from feeling uncomfortable pressure to accept greater familiarity than is appropriate for a work relationship. It is appropriate to **set limits** on the relationship in a way that reduces ambiguity for the client and the worker. Setting boundaries does not mean being distant or unfriendly, but it does mean **stating where your boundaries** are, eg. "I like working with you, but I am your worker, not your girlfriend" or "I know you would like to kiss me, but I am your worker, not your girlfriend" or "Workers are not allowed to go to bed with their clients." Although workers often feel sorry for clients who have become socially isolated after a severe head injury, it is important to remember that **any socialising** that a worker and a client do together should be clearly stated to the client **as part of their working relationship**, eg. "I am taking you to the movies because it is my job; I am not your girlfriend." This reduces ambiguities in the relationship and will help the worker to set limits on unwanted sexual behaviours from the client.

Resources	Content
OH 6.13: Verbal feedback	**Talk – Management of sexually inappropriate behaviour: verbal feedback** The study by Simpson et al (1999) suggested that at least a third of incidents of sexually inappropriate behaviour were dealt with verbally. Note that the following specific type of verbal feedback is likely to be effective. Give **clear, simple and unambiguous** feedback, eg. "no touching" or "masturbate in your bedroom, not in the lounge." A worker cannot assume that clients will recognise hints that their behaviour is not appreciated. They need to be told directly. Feedback must be **matter-of-fact and firm**, without emotional tones of shock or nervousness or disapproval. Often, **unspoken rules** about appropriate social behaviour may need to be **spelled out**, e.g. "It is not OK to talk about my breasts." A prohibition about one behaviour needs to be followed by a **clear alternative**, eg. "It is OK to talk about what you want to do today" or by a distraction. This will help reduce perseveration on the undesired behaviour. **Discussing with other workers and family members** the approach you are taking and what behaviours you are seeking to change, will help to ensure that the client gets the same message from everyone. **Check a client's understanding** of what has been said by asking her or him to repeat the information. This is better than asking "Do you understand?" to which people will almost always say yes, whether or not they do understand. Use this approach with care and sensitivity, as it can easily sound to clients as though they are being treated like children.

Workshop outline continued

Resources	Content
OH 6.14: Other options	**Talk – Management of sexually inappropriate behaviour: other options** **Behavioural intervention** – a psychologist may be able to help by assessing the problem behaviours and developing a simple behaviour program to control or eliminate the problem (e.g. the scheduled use of rewards to reduce a client's inappropriate touching behaviours) **Structure the environment** – sometimes by structuring the environment, we can minimise the impact of inappropriate sexual behaviours. For example, a man who was grabbing at personal aides when they were showering him, only had the use of his right hand. By putting a washer in that hand, and approaching him from the left side, this problem was solved. **Medication** – In cases of more serious behaviours, medication may sometimes help. Depo Provera can reduce male testosterone level and reduce aggressive sexual behaviour. However, it does not work in every case and a doctor will be needed to assess this option. **Separation** – If the behaviours cannot be controlled in one environment (eg. at home), then separation may have to be considered, eg. placing the person with TBI into another environment. This can help to reduce the impact of the behaviours. **Legal system** – In some cases, the police will become involved, and the person charged with a crime. This can sometimes make an impact on the behaviour of the person with TBI, but is only a last resort.
HO 6.11: Resources **HO 6.1** Blank overhead with list of expectations (from Introduction to workshop) Evaluation forms	**Evaluation and resources** *(10 minutes)* Give out the Resources list for participants' future use and display **OH 6.15** and **OH 6.16**. Display the overhead that lists participants' expectations of the workshop. Ask the group to reflect on their expectations and discuss whether these have been achieved. Use **HO 6.1** for outcomes achieved. Ask them to complete the evaluation form (if utilised) Thank participants for their involvement!