# Acquired brain injury and sexual functioning in the outpatient and inpatient settings - clinical lessons and intervention suggestions

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BIRT
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A neurobehavioural service for acquired brain injury

# I. Brain injury impairs sexual functioning

- Traumatic brain injury is a life changing experience – it profoundly affects every aspect of the individual's functioning.
- Even in the case of mild injuries, the person may return to perform tasks they did prior to the injury, but this will require additional effort, more conscious control.
- The injury has an impact on physical, cognitive, emotional, behavioural and social functioning.
- Brain injury tends to have detrimental effects on sexual functioning. Survivors of TBI report decreased sexual functioning, as viewed by various measures.

# TBI, men and sexual functioning

- **Desire:** 41% reported decreased or greatly decreased desire. Only 12% reported increased and 3% greatly increased drive *(Ponsford, 2003)*.
- **Erectile:** 30% reported erectile difficulties post injury *(Kreuter et al 1998)*.
- **Ejaculation:** 40% reported decreased or no experience of orgasm post injury *(Kreuter et al 1998)*.
- **Frequency:** 54% reported decreased frequency of sexual activity post injury (Ponsford 2003).
- **Satisfaction:** 39% reported decreased or greatly decreased satisfaction *(Ponsford 2003).* Couples reported increasing levels of sexual dissatisfaction over time *(O'Carroll et al 1991)*.

# TBI, women and sexual functioning

- **Desire:** 60% unchanged desire, 5% increased desire, the rest reported decreased desire *(Kreuter et al 1998)*.
- **Lubrication:** 26% of women with TBI reported difficulties with lubrication compared to 8% in non-equivalent control group *(Hibbard et al 2000)*.
- **Orgasm:** 40% reported decreased or no experience of orgasm post injury *(Kreuter et al 1998)*.
- **Frequency:** Almost half report decreased to nil frequency of sexual activity post injury *(Kreuter et al 1998)*.

# II. Why is brain injury impacting on people's sexual functioning?

- After TBI, **physical intimacy** can be disrupted by changes in brain structure and function, including neurochemical and neuroendocrine changes. Physical intimacy can be affected by motor and sensory impairments, cognitive impairments, and emotional changes, including depression and anxiety.
- **Emotional intimacy** can be altered by a range of cognitive changes, including impairments in language, attention, memory, processing speed, initiation, awareness, self-monitoring, and social communication.
- Physical and emotional intimacy can also be affected by changes in relationship status.

# Physical sequelae of brain injury and sexuality

| Disability | Impact on sexuality |
|---|---|
| Weakness or paralysis on one side. Restricted movement in hands, arms or legs | Difficulty in transferring to and from bed |
| Tremor | Clumsiness in love making. |
| Chronic pain | Some movements or positions can increase pain. |
| Loss of sensation to touch | Parts of the body may not be aroused in response to touch. |
| Bowel dysfunction | Fear of accidents, anxiety, embarrassment. |
| Bladder dysfunction | Inhibits sexual desire and increases feeling of vulnerability and anxiety. |
| Fatigue | Fatigue interferes with the sexual desire and the physical ability to initiate and sustain sexual activity. |

# Cognitive sequelae of brain injury and sexuality

| Disability | Impact on sexuality |
|---|---|
| Reduced concentration | Person gets distracted during intercourse. |
| Memory difficulties | Person forgets having intercourse, or even partner. Woman forgets to take contraceptive pills on regular basis. |
| Language deficits | Person cannot verbalise his care and attraction to partner. |

# Behavioural sequelae of brain injury and sexuality

| Disability | Impact on sexuality |
| --- | --- |
| Lack of initiation | Partner upset having to always initiate intimacy. Client doesn't "care" enough about partner. |
| Disinhibition | Person gropes partner inappropriately in public places. Person makes rude remarks about partner's body (you're fat) or sexual functioning (you bore me). |

# Affective sequelae of brain injury and sexuality

| Disability | Impact on sexuality |
|---|---|
| Mood disorders (depression) | Sex loses its significance. Person lacks energy to invest in another. Anhedonia. |
| Anxiety disorders | Induces avoidant behaviour. No point investing in a relationship, as trauma can happen any time. |
| Loss of confidence and fragile self image | Will not attempt to initiate intercourse as preoccupied with failure. Can rage and demonstrate a catastrophic reaction when fails to perform. |

# Social sequelae of brain injury and sexuality

| Disability | Impact on sexuality |
|---|---|
| Social isolation | Difficulty in identifying partners. Compelled to use sex workers. |
| Burdened partner | Lack of time and energy to invest in romantic aspects of relationship. Lack of desire by lover related to difficulty separating carer role from that of partner. |
| Relationship breakdown | Increases isolation, depression, lack of available partner, etc. |
| Institutionalisation | Privacy to engage in sexual acts. Lack of partners. |

# Sexual sequelae of brain injury and sexuality

| Disability | Impact on sexuality |
|---|---|
| Reduced sex drive | Person does not enjoy intercourse as he did before. Doesn't initiate sexual acts. |
| Increased sex drive | Harasses co-workers, is involved in sexual crimes. |
| Erectile dysfunction | Reduce or refrain from intercourse. |
| Ejaculation problems | Concern about fertility and ability to have children. |
| Vaginal dryness | Intercourse is unpleasant and painful. |
| Anorgasmia | Lack of honesty with partner, reduced pleasure. |

# Central Nervous System affecting sexuality

| CNS structure | Function | Impact on sexuality |
|---|---|---|
| Prefrontal cortex | Impulsiveness<br>Disinhibited Behaviour<br>Unstable Mood<br>Sustained Attention Impairment | Say Rude Things<br>Inconsiderate<br>Egocentric<br>Wrong Time and Place to Initiate Intimacy |
| Limbic system (temporal lobe) | Seizural Activity<br>Memory Difficulty<br>Emotional Modulation<br>Hearing Impaired<br>Smell and Taste Impaired | Anxiety from Active Engagement<br>Limits mode of Arousal<br>Anger Outbursts |
| Thalamus | Sensory Information Not Conveyed<br>Arousal System Impaired | Clumsy Touching of Partner<br>Impaired Arousal |

# Central Nervous System affecting sexuality cont'd

| CNS structure | Function | Impact on sexuality |
|---|---|---|
| Hypothalamus | Regulation of Sexual Hormones<br>Regulation of Endocrine System | Impotence, Sterility, Gain in Weight |
| Cerebellum | Clumsy, Uncoordinated Movements<br>Tremor of Limbs<br>Loss of Balance<br>Slurred Speech | Clumsiness in Performing<br>Loss of Attraction |
| Brain stem | Input for Arousal and Alertness | Lack of Initiation, Lethargy |
| Spinal cord | Genital Innervation<br>Sympathetic Conduction of Information<br>Incontinance | Difficulties in Erection, Ejaculation, Lubrication, Orgasm |

# Additional potential reasons for sexual dysfunction

- **Medications and drugs** – certain medications can dampen libido. These include anti-epileptic drugs such as carbamazepine (Tegretol) or sodium valproate (Epilim). Anti-depressants can have the effect of making erections difficult as can major and minor tranquillisers. Medication for high blood pressure can have this effect.
- **Associated injuries** – Loss of a limb, spinal cord injuries, body scars (tracheostomy) can all affect sexual functioning.
- **Background illness** – diabetes or hypertension can reduce libido and impair sexual functioning.
- **Pre-morbid sexual difficulties** - brain injury can exacerbate any sexual problems the person was having before the injury occurred: hypoactive sexual desire, paraphilia, gender identity disorder, etc.

# III. Assessment of sexual dysfunction

- We understand that TBI affects (impairs) sexuality. However, we need to assess client to examine impact of injury in their individual life.
- Sounds simple, HOWEVER:
  - An “embarrassing”, taboo topic. Not typically addressed in social situations, certainly not respectable ones.
  - Clinician feels intrusive.
  - Consequentially, not enough clinical attention to sexual deficits.
- People with TBI and their family members reported that only approximately 15% of rehabilitation health professionals made enquiries about whether they had any sexual concerns during the rehabilitation episode *(Zinn, 1981; Kreuter et al 1998)*.

# Life History

- Infer on pre-morbid factors: Social engagement, number of friends; Prior romantic partners, intimate partners; significant relationship (marriage, divorce).
- Ask directly about functioning post-injury: have they engaged in sexual acts? Did they encounter any difficulties? Are there problems in self-indulgence (masturbation)?
- Recommend a sexual physical examination when relevant.

# Questionnaires

- Generic Measures:
  - The Derogatis Interview of Sexual Functioning (Derogatis, 1987).
  - The Golombok-Rust Inventory Sexual Satisfaction (GRISS) (Rust and Golombok, 1986).
- Brain Injury Specific Scales:
  - Psychosexual Assessment Questionnaire (Kreutzer, Zasler, 1989).
  - Sexual Interest and Satisfaction Scale (SIS) (Siosteen et al., 1990).

# SIS – sample items

## (Siosteen et al., 1990)

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

# Questionnaires for women

- Female Sexual Function Index (Rosen et al., 2000).
- Female Sexual Distress Scale (Derogatis et al., 2002).
- Sexual Function Questionnaire (SFQ) (Symonds, Boolell, Quirk, 2005).
  - The SFQ has 6 domains, four of which are specific to the main types of female sexual dysfunction: Female Sexual Arousal Disorder, Female Orgasm Disorder, Hypoactive Sexual Desire Disorder, and Pain Disorder. The other two domains address 'enjoyment' and 'partner' issues.

# IV. Interventions

- **The PLISSIT model** (Annon 1975, 1976).
- **The Sexual Intervention Programme (SIP)** (Aloni and Katz, 2003).
- **Surrogate Therapy**

# PLISSIT Model (Annon)

- Provides a general framework for any sexual intervention programme for all people with disabilities.
- A practical model and uses a stepwise approach that can be implemented by different professionals with diverse knowledge and experience in the field of sexuality.
- Geared for special populations as it relates to physical, cognitive, emotional and behavioural problems.

# Intervention Level 1 - Permission

- Need to know one is ok and normal in their sexuality, and hear this from someone in position of authority.
- Providing information regarding sexual rehabilitation not sufficient for creating a permissive environment.
- Providing permission can be expected from every staff member.
- Achieve permission through staff training in how to deal with issues of sexuality as they arise in hospital or when the client goes home.

# Permission (Cont'd)

- Educate family and partners. Parents may provide ADL help, but this does not give them control over the private life of the client.
- Sex education and counselling to client, or conveyed indirectly through positive approach of staff and family.
- Modify the environment to facilitate appropriate sexual behaviour and encourage age appropriate sexual behaviour. For example: provide privacy; Arrange regular home visits; encourage time with friends; control family overprotection.

# Permission (Cont'd)

- Address issues of sexuality during the rehabilitation process is another way to legitimise sexual behaviour:
  - Passive permission for a provider less comfortable with their own sexuality. The professional waits for the survivor to address issues of sexuality or act in a sexual manner and only then address it in a positive way.
  - Active permission - approach sexual matters when the professional thinks it is the appropriate time.

# Intervention Level 2 – Limited Information

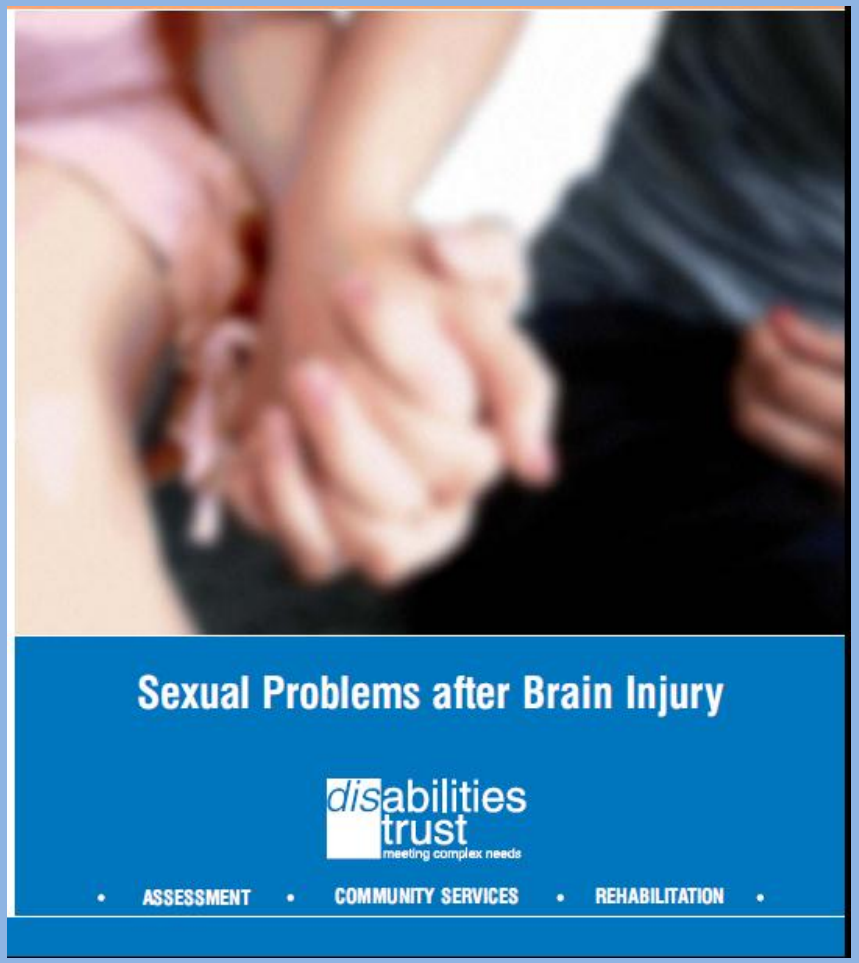
- Provide specific and factual information related to sexual concern.
- Information does not require specific knowledge about the personal sexual life of the person receiving the information.
- Provides foundation for reassessment of sexual values and beliefs, and possible behavioural changes.

# Limited Information (cont'd)

- Includes three facets: education, information and staff training.
- Educating all associated with the client regarding the effects of TBI on sexual function. The information can be provided through booklets, lectures, group work, or discussions on a personal basis.
- Another example - telling clients that medication might cause sexual dysfunction and, if it should occur, they should inform doctors so an alternative medication can be found.

# Example – BIRT Information Leaflet

- BIRT information leaflet for clients and families.
- Addresses issues such as prescribed drugs and their effects on sexual functioning, how physical problems can affect client's sexual life, communication problems.
- Free download from website.



# Intervention Level 3 – Specific Suggestions

- Counselling for clients and families, behavioural techniques, social skills training and the provision of safeguards.
- These could help client change behaviours to set or reach a goal.
- A sex history should be taken using the human sexual response stages as a guideline, and information regarding the client's social, intimate, relationships should be obtained.
- On the basis of the history, the provider can give specific suggestions to client regarding measures to be employed in the current situation.

# Specific Suggestions - Examples

- Specific behavioural strategies - increasing affectionate behaviours, relaxation, behavioural rehearsal and/or more sex specific strategies such as desensitisation, non-demand pleasuring, directed masturbation, Kegel exercises, non-demand stimulation, start-stop techniques, the squeeze technique and the quiet vagina exercise.
- Specific pharmaceutical strategies - medroxyprogesterone for hypersexuality following brain injury or carbamazepine for hypersexuality due to bi-temporal lobe injury.

# Intervention Level 4 – Therapeutic Interventions

- this stage initiated only when all presented interventions were attempted without achieving the desired response. People with severe TBI often will need all four levels of intervention.
- Intensive therapy can focus on social, dyadic, or sexual issues.
- This level of intervention should be provided by a qualified sex therapist, with an experience in rehabilitation.

# Therapeutic Interventions (cont'd)

- Individual treatment programme in which group therapy, psychotherapy, behavioural methods and sex therapy, including surrogate therapy and learning techniques, can be used.
- Married clients may need to focus on both sex therapy and intimacy skills.
- The younger clients and singles will have to concentrate mostly on social skills, social reintegration, and the opening of opportunities for an intimidate relationship in order to reach the point of having a partner for a sexual relationship.

# The Sexual Intervention Programme
## Aloni and Katz, 2003

- Based on information and experience accumulated by professionals working in rehabilitation and in sex therapy.
- Can be used at any stage following the injury.
- Involves 3 fronts: work with client, with family and with rehabilitation staff.

# SIP Main Goals

1. Provide information concerning sexual function and help process it in order to minimise stress and frustration.
2. Improve communication and social skills for single survivors, thus facilitating opportunities for intimacy relationship; improving sexual intimate skills for married clients.
3. Preserve and promote self esteem as basis for normal sexual functioning.
4. Adapt to cognitive and behavioural deficits following TBI.
5. Gradually develop from least intensive intervention method to more intensive ones.
6. Address sexual and intimacy problems of partners and family.
7. Early participation promotes better awareness of limitations.
8. Goals are different for single versus married survivors.

# SIP – Interventions with Clients

- Goals: Maintain and promote self-esteem and self-confidence; Maintain and promote social and intimacy skills; Provide relevant post-TBI sex education; Provide relevant post-TBI sex counselling and therapy; Encourage social reintegration; Encourage returning to sexual activity; Prevent traumatic social and intimate experiences.

# SIP – Interventions with Clients - techniques

- Group, individual and couple therapy to deal with anxiety, blame, shame, self-esteem, confidence and rejection.
- Relearn and teach communication skills, increase communication.
- Provide onsite feedback, model and rehearse target behaviour, role-play and practice social skills in the community.
- Peer-support and opportunities for peer interaction.
- Give guidelines, instruct and avoid demanding too much. Provide safeguards for preventing taking unnecessary risks and for preventing failure.
- Behaviour modification techniques and regulate the environment.
- Provide basic knowledge and relevant information about human sexuality.
- Provide privacy and possible options for intimate experience, such as self-pleasure and dyadic interaction. Teach and practice intimacy skills with a partner or with a surrogate partner. Utilise sensate focus and touching techniques individually and with the partner.
- Evaluate sexual function, suggest compensatory techniques for identified sexual dysfunction before and after the first home visit. Provide relaxation and desensitization techniques when appropriate.

# SIP – interventions with Partners

- Goals: Provide information to increase understanding of the limitations of client so as to prevent unrealistic expectations; Reinforce realistic demands; Minimise criticism and the partner's judgemental behaviour; Maintain self-esteem and self-confidence of the partner and the client; Promote coping skills and containing ability, encourage empathy, reduce anxiety, anger and guilt; Prevent widening of the gap between partners and promote an early return to intimate behaviour.
- Can be met in couple therapy or is group setting. Important to help partners feel they are not trapped in a relationship and that they have a choice to leave should they wish to do so. It is also important to prevent over-protection by the partner, and to maintain the dyadic roles as much as possible.

# SIP – interventions with Family (Parents)

- Goals: Increase awareness of the sexual and intimacy needs and limitations of the survivor with TBI; Promote and enhance coping skills and containing ability of family members; Encourage empathy towards the survivor; Reduce anxiety, anger and guilt feelings of family members; Allow the individuation process to continue and prevent over-protection; Support the family as a social interaction model that will encourage social reintegration.

# SIP – Interventions with Staff

- Goals: Increase staff knowledge regarding sexual issues after TBI; Increase staff awareness of their attitudes regarding sexuality of survivors; Teach professional social interaction as a model for the survivors; Teach mentoring skills, promote containing abilities; Promote a team approach.
- The goals are meant to improve staff awareness pertaining crucial role as a role model for the client, as well as improve their professional and personal skills to do so.

# SIP – Interventions with Staff (cont'd)

- This process requires working through their own attitudes regarding their sexuality and the sexuality of people after brain injury.
- The Sexual Awareness Reassessment Program (SAR) is recommended. It is intended for use with professionals who deal with sexual matters and is recommended by the American Association for Sex Educators, Counsellors and Therapists.

# Surrogate Therapy

- When client seeks help with sexual problems but does not have a partner, and finding a partner is difficult, it may be appropriate to work with a surrogate partner.
- Masters and Johnson (1970) - one cannot learn about sexuality in any practical way without actually experiencing intimate behaviour with a partner.
- Surrogate - “a member of a three way therapeutic team who acts as a partner for the dysfunctional patient in the therapy programme and participates in experimental exercises involving sensual and sexual touching as well as social and sexual skills training” (IPSA).
- Studies examining the efficacy of the method – Sommers, 1978; Dauw, 1983; Apfelbaum, 1980; Cole, 1982; Pearlman and Aloni, 1997. Small sample sizes, but trend for improvement for most people undergoing surrogate therapy.

# Surrogate Therapy (cont'd)

- Surrogate therapy a form of sex education, in which a substitute partner works under the supervision of a trained sex therapist with the patient on an experiential basis.
- The surrogate role offers an experience in shared physical intimacy, while working with a client's sexual self-concept and body responses. Allows modelling of sexual closeness and social skills; genital-genital contact may constitute a minor part of the therapy programme.
- Nooman (1995) - almost 90% of the surrogate's time is spent in non-sexual activities.
- Surrogate therapy identified with the behavioural approach to the treatment of sexual dysfunction. Inclusion of a surrogate allows for the implementation of most of the modes of behaviour therapy, such as experiential learning, repetitions, and in vivo learning, as well as monitoring of appropriate behaviour and immediate on-going feedback.

# Typical Surrogate Contract

1. The therapy process includes working with a primary therapist and a surrogate.
2. The process with the surrogate is explained and the roles of the participants clarified and limits defined.
3. Anonymity is required both for the survivor and the surrogate.
4. They do not approach each other under any circumstances in other situations besides the therapy.
5. The client agrees that there will be no sexual interaction with other people during the period of the therapy and if there is, they need to inform the therapy team.
6. The client and surrogate both undergo thorough medical examinations.

# V. Inpatient Setting– Inappropriate Sexual Behaviour

- Inappropriate sexual behaviour is one of the possible behavioural consequences of both progressive neurological conditions and acquired brain injury. Often overlooked in comparison to other challenging behaviours such as agitation and aggression, it can manifest itself in many different forms and with varying stimuli.
- The impact of inappropriate sexual behaviour on individuals and their carers, friends, family and fellow patients can be significant and pervasive, and in some cases, destructive.
- St Andrew's Sexual Behaviour Assessment (SASBA) scale allows continuous observation of inappropriate sexual behaviour within an in-patient setting where a high frequency of challenging behaviour is exhibited.

# ST ANDREW'S SEXUAL BEHAVIOUR ASSESSMENT SCALE (SASBA SCALE)

Knight, Alderman, Johnson, Green, Birkett-Swan & Yorston, 2008

SASBA
SEXUAL BEHAVIOUR ASSESSMENT
DEVELOPED BY ST ANDREW'S HEALTHCARE

## 1.BEHAVIOURS

| | Verbal Comments VC | Non Contact NC | Exposure E | Touching Others TO |
|---|---|---|---|---|
| 1 | Intimate personal comments of mild severity, e.g. "Have you got a girlfriend?", "I love you", "You're gorgeous" | Blowing kisses, kissing self or staring at another persons groin, female breasts or buttocks, or makes obscene gesture | Appears unaware that is exposing genitals, female breasts or buttocks in a public setting | Touches for a prolonged period (excess of 2 seconds) or strokes another person – does not include groin, female breasts or buttocks |
| 2 | Comments of a sexual nature, clearly not person directed, e.g. "I've got a big dick" | Touches own groin, female breasts or buttocks over or under clothes (no exposure) | Wearing no clothes in a public setting, clearly not person directed | Kissing another person |
| 3 | Descriptions of another persons groin, female breasts or buttocks clearly directed to another person e.g. "You have a nice bottom", "She's got lovely breasts" | Masturbates in a non shared setting where staff are present (e.g. begins when staff enter bedroom or in bath) | Intentionally exposes genitals, female breasts or buttocks to another person (appears to be a deliberate premeditated behaviour) | Lifting skirts, pinching or touching buttocks, sitting on other's knee |
| 4 | Explicit accounts of sexual intent, requests or activity e.g. "Show me your knickers", "I want to shag you" | Masturbates without genitals being exposed in a public setting, including ward shared areas (e.g. dining room) | Masturbates with genitals being clearly exposed in a public setting, including ward shared areas (e.g. patient's lounge) | Touching others groin, female breasts, or rubbing own genitals or female's breast against another person |

a) Masturbation = rubbing own genitals  b) Bedrooms and bathrooms are non public/non-shared environments
c) Attempts to touch which are only prevented by staff intervention, should be rated as if contact occurred.

## 2.ANTECEDENTS

**Set One**
**Contributing Factors (coded 1-3)**

1. Structured activity
2. Noisy environment
3. Had epileptic fit in last 24 hrs

**Set Two**
**Observed directly before behaviour(Coded 11-25)**

11. Given direct verbal prompt to comply with instruction
12. Given verbal guidance/advice to assist completion of task/activity
13. Given verbal/visual feedback about performance
14. Direct response to other clients verbal behaviour
15. Request specifically denied by other person
16. Any other verbal interaction
17. Physical guidance/facilitation to complete a task
18. Direct response to other clients physically aggressive behaviour when directed at them
19. Direct response to other clients physically aggressive behaviour when directed at another person
20. During restraint
21. Given item e.g. food/therapy materials
22. Purposeful behaviour is ignored or "played down" by person to whom it is directed at
23. Obviously agitated or distressed
24. No obvious antecedent
25. Other (please specify on the back of the recording form)

## 3. INTERVENTIONS

**Set One**
**Contributing Factors (coded 1-3)**

- **A** Behaviour ignored or "played down" completely
- **B** Talking to patient including prompts
- **C** Closer observation
- **D** Holding Patient (physical restraint)
- **E** Immediate medication given by mouth
- **F** Immediate medication given by injection
- **G** Isolation without seclusion
- **H** Seclusion
- **I** Activity distraction
- **J** Injury requires immediate medical treatment for patient
- **K** Injury requires immediate medical treatment for other
- **L** Special programme
- **M** Physical distraction (leading the patient away)
- **N** Other (please specify on the back of the recording form)

# SASBA Categories and Severity Levels

- Sexually inappropriate behaviour is divided into four content categories, within each 4 severity levels are defined:
- **Verbal Comments** – the client makes inappropriate intimate personal comments. This ranges in severity from mild severity (level 1), e.g. “Have you got a girlfriend?”, “I love you”, “You’re gorgeous”, to Comments of a sexual nature, clearly not person directed severity level 2), e.g. “I’ve got a big dick”, to Descriptions of another person’s groin, female breasts or buttocks clearly directed to another person (severity level 3) e.g. “You have a nice bottom”, “She’s got lovely breasts” , and finally explicit accounts of sexual intent, requests or activity e.g. “Show me your knickers”, I want to shag you” (severity level 4).

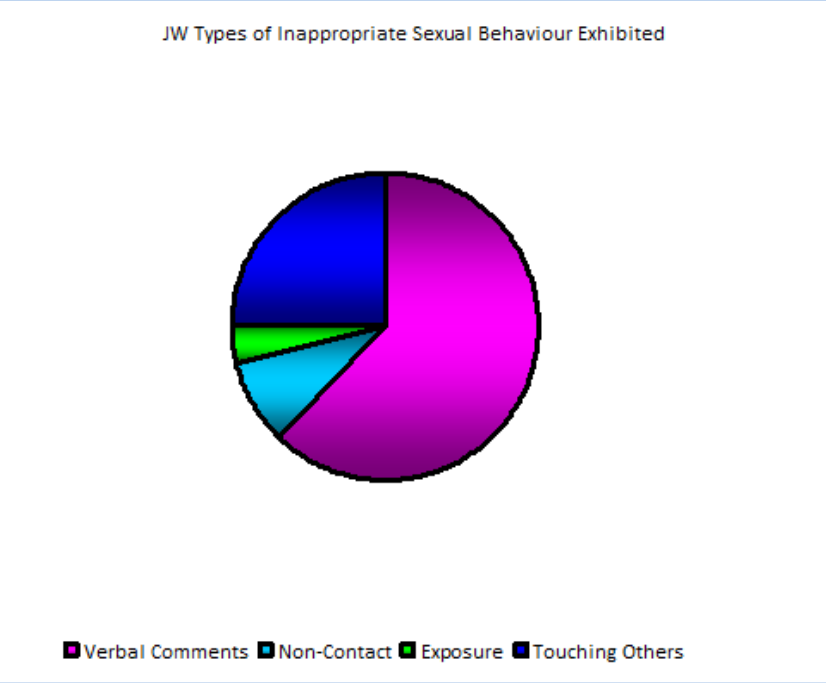
# SASBA Categories and Severity Levels

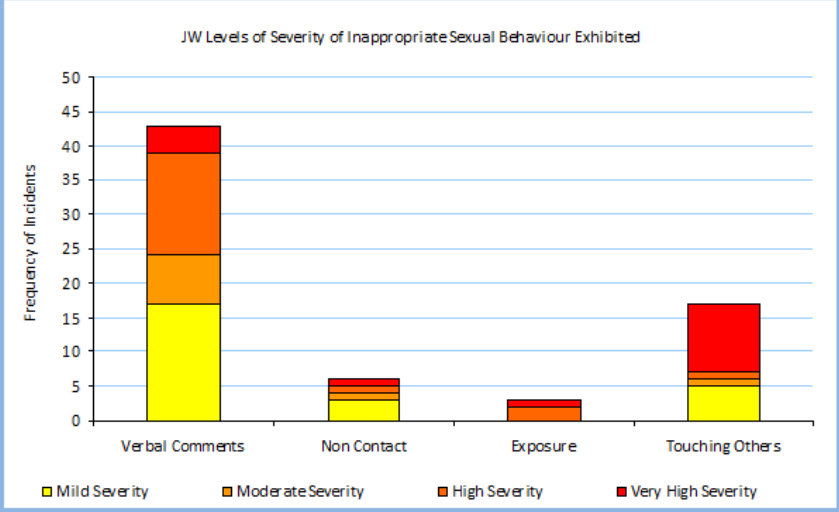
- **Non-Contact** – the client engages in non-contact inappropriate behaviour. Blowing kisses, kissing self or staring at another person's groin, female breasts or buttocks, or makes obscene gesture (severity level 1). Touches own groin, female breasts or buttocks over or under clothes (no exposure) (severity level 2). Masturbates in a non-shared setting where staff are present (e.g. begins when staff enter bedroom or in bath) (severity level 3). Masturbates without genitals being exposed in a public setting, including ward shared areas (e.g. dining room) (severity level 4).
- **Exposure** – the client exposes themselves inappropriately. Severity level 1: Appears unaware that is exposing genitals, female breasts or buttocks in a public setting. Severity level 2: Wearing no clothes in a public setting, clearly not person directed. Severity level 3: Intentionally exposes genitals, female breasts or buttocks to another person (appears to be a deliberate premeditated behaviour). Severity level 4: Masturbates with genitals being clearly exposed in a public setting, including ward shared areas (e.g. patient's lounge).
- **Touching Others** – clear as it sounds. Severity level 1: Touches for a prolonged period (excess of 2 seconds) or strokes another person – does not include groin, female breasts or buttocks. Severity level 2: Kissing another person. Severity level 3: Lifting skirts, pinching or touching buttocks, sitting on other's knee. Severity level 4: Touching others' groin, female breasts, or rubbing own genitals or female's breast against another person.

# SASBA in clinical use

- SASBA categories are based on ABC analysis.
- Staff record the **antecedent** to the behaviour: the client looks obviously agitated, the client  is disorientated, the client is sitting bored, a favourite member of the team just passed in the corridor, client came back from a home visit.
- Then they record the actual **behaviour** based on the four categories and severity levels.
- Finally, staff record how they've reacted to the behaviour (**consequence**).  For example, ignore the behaviour, the need to hold and restrain the client, take client to their room, need for sedating medication, etc.

As a clinical team, we look at numerous examples of sexual ABCs. We analyse the frequency of behaviour, the severity and the circumstances in which it happened. Then we devise intervention methods to decrease behaviour.



# Clinical Examples

- J touches women's breasts. It was identified that this happens when a situation is unpleasant for him and he wishes to terminate it. We suggested an alternative way to inform staff he would like to terminate a clinical session and this reduced number of inappropriate touching.
- K lacking is inhibition, takes off trousers and pants and masturbates in public spaces. It was found that he tends to do this more when wearing trainers as opposed to jeans or formal trousers. Solution - staff to allow him to go in trainers when in his room evening time, but not during the day.
- S masturbates in his room, door is shut, but he watches pornographic movies and the sound is too loud. Staff record and complain about this. Solution – staff education, a client should be allowed to pleasure himself in privacy of his own room. However, client was provided with headphones so noise isn't interrupting others.

# Summary

- Brain injury impacts on sexual behaviour. This is a multi-faceted change which can result from numerous injuries to the CNS, as well as affective, cognitive, social, behavioural and physical changes after the injury.
- Professionals should be aware of sexuality as one of the topics worth addressing when assessing the client's needs and those of the family.
- Be proactive in finding out about the client's pre-morbid and current sexual life. Use appropriate scales to elicit required information.
- Staff should be trained in lower levels of the PLISSIT model, so that permission and limited information are available in the rehabilitation facility.
- When clients and family are in need of greater intervention, be aware of higher levels of PLISSIT model, send to relevant professional, consider use of relevant therapies and in some cases surrogate therapy.
- In an inpatient setting, inappropriate sexual behaviour may arise. In that case, the SASBA can be used to map and diminish these behaviours.
- Sexuality is an integral part of our lives as normal, adult human beings – it should remain so, as much as possible, after an injury.