



ADOLESCENTS WITH BRAIN INJURY: ISSUES OF SEXUALITY

Sexuality can be a difficult issue for adults; it becomes even more difficult to deal with when adolescents have incurred a brain injury. Many therapists shy away from this often emotional and certainly controversial subject. However, kids have a strong need to learn the skills they require to deal with the problems they will encounter. Addressing sexual behaviour or questions of sexuality is not meant to usurp parental values or control. Parents should be involved with all aspects of therapy, including education of changes in behaviour. As therapists, health care providers and parents, we must approach sexuality at age-appropriate levels, through individual and group counselling, sex education, and/or behaviour modification.

Often, the focus of staff concern is impulsive actions and the inability to monitor oneself, resulting in inappropriate sexual behaviour. For those dealing with the person who is sexually acting out, it is important to orient the individual toward appropriate behaviours, always remembering that the person is a sexually functioning individual. With children and adolescents, one must discriminate between acting out behaviours and typical development and acceptable experimentation.

Frequently, “sexual” behaviours start early in recovery. It may be that while still functioning at a low level a person may begin to touch or rub him or herself. The person may not discriminate between being alone in his room or in the middle of the therapy area. Before we label the action as “inappropriate behaviour” we should check for rashes or catheter problems. If the touching is self-stimulation then we should view this action as a developmental stage. Just as a young child learns that touch is pleasurable, we also teach when and where this action is appropriate. Keep in mind that lower level patients may be less aware of their surroundings.

It is important to help staff understand that we do not assign consequences for such behaviour, but we do need to provide redirection. Redirection may include handing the patient something to hold, engaging him in an activity, giving verbal or physical directions where to put his hands. If the actions are happening while the patient is alone in his room, all that is necessary is to close the door and give a little private time. Individual dignity and respect are required at every level of recovery. Staff need to talk openly with parents and assure them that this behaviour is acceptable. Parents may need help to feel comfortable when handling situations that may be embarrassing to them.

Grabbing may occur. Again, we must be careful how we label the behaviour. For example, touching a nurse on the buttocks may initially be intended as a way of getting attention. Reaction to this behaviour will help determine if it continues or is extinguished. Ignoring the behaviour or redirecting without reaction will teach what is appropriate. Laughing, getting angry or becoming excited will encourage more of the same. It is important not to confuse attention-seeking behaviour with “sexual” behaviour.

When a person is at a higher level of cognitive functioning, disinhibited behaviour becomes even more difficult not only to deal with but to understand. It is here that I would like to distinguish between disinhibited behaviour and impulsive behaviour. Disinhibited refers to reacting or behaving without regard to society’s everyday norms or inhibitions. Impulsivity is the inability to monitor ourselves or think through the sequence before acting upon an idea or thought. A higher functioning adolescent may display disinhibition by masturbating in a public area, attempting to touch others inappropriately, or using sexually explicit language to describe a person, a situation or to express desires. One can obviously be disinhibited and impulsive at the same time. These behaviours, while we label them “sexually inappropriate,” are important to understand and put into the larger context of the individual’s overall behaviour pattern. Applying basic concepts of behaviour modification will help to extinguish inappropriate behaviours and reshape others. Again, helping staff and parents understand why these socially unacceptable behaviours occur is central to how they react or treat the person and therefore key to making changes.

Approaches to take when dealing with disinhibited and/or impulsive behaviour include ignoring the behaviour (especially if it is attention seeking), redirecting the person to another activity, directing the individual to a private area. Remember that there is a reason for the behaviour. The situation may be a male speaking inappropriately to a female, perhaps even touching inappropriately. The action may even take the form of sexually aggressive behaviour. It is not enough to simply redirect in this instance but to learn of the person’s goal and teach the appropriate behaviour. The person’s goal may have been as simple as wanting to talk to the female. Teaching, coaching, and practicing the desired communication skills takes time but pays off in the end. To assume only that the person was simply aggressive or inappropriate will not help to change the behaviour. Learning alternative behaviours will bring about change. To teach alternative behaviours we cannot be judgmental and we must, to the best of our ability, learn the goal of the person and work within that framework.

Adolescents with mild brain injury, perhaps several years’ post-injury, often return to a healthcare setting due to behaviour problems and issues including sexuality. It is not unusual for parents and guardians to report promiscuity, aggressive sexual behaviour, or that their child has been in a sexually dangerous position. These adolescents are unable to read subtle cues from individuals or the environment and have not developed the coping and negotiating skills demonstrated by their peers. A very simple example is a girl strategizing how she will get out of kissing a date goodnight. Without much planning, most girls negotiate this scenario. However, even this simple situation requires higher executive functions such as sequencing and problem solving. More intense situations, such as deciding to engage in intercourse, become more difficult for adolescents without brain injuries, and certainly are complex for those with a brain injury. It is not as easy as just saying “no” for there are many steps and decisions to be made before being able to give a firm negative response. Learning how to make decisions about where to go, whom to be alone with, identifying a potentially “hot” situation, and how to exit, are steps that must be taught. This pattern is the same for boys as it is for girls.

Sex education as provided in U. S. public schools is not sufficient to teach adolescents with a brain injury how to handle sexuality. Facilities treating adolescents cannot shy away from this topic. It is first important to ensure that the kids have their facts straight about anatomy and birth control. Do not assume that because individuals are sexually active that they know and understand about sex. I am always amazed by the statements made by some kids. Despite the emphasis and exposure of “sex” on television and in print, I hear statements such as “An orgasm

is something that happens when you give birth.” Even with the recent focus on the importance of use of condoms, kids still do not always understand birth control.

Using gender specific groups that are ongoing in nature helps to set the stage for discussion of this intimate topic. An example is a girls’ group that is open to different issues but also has a facilitator (social worker, psychologist, counsellor) introducing different topics. The goal of the group is to learn problem-solving techniques and to develop self-esteem through a better understanding of self and by using successful strategies. Such groups work well using cycles of a three-part series on sexuality. The first part deals with anatomy, intercourse and looks at the responsibilities of sexual activity and methods of decision making. The third session focuses on AIDS, sexually transmitted diseases and how the knowledge of such diseases influences decision-making. Discussions about sexuality are not limited to these three sessions but it is important to schedule specific times for such discussions so that the issues do not slip through the cracks.

Repetition and overlearning are often important tools in the rehabilitation of a person who has sustained a brain injury. Particularly with issues of sexuality, the therapist and the parents must develop strategies to use these methods without being condescending to the adolescent or boring him or her. Role-playing can be helpful to practice situations that may occur. Remember to use visual and auditory learning, emphasizing the method that the individual responds to best. For parents, it is important to be open and direct. However, do not ask your children to share with you and then punish them for doing so. If they come to you, help them problem solve and work through the issues: you want to help them set a pattern for their behaviour and have carryover in learning. Discuss birth control and acceptable levels of activity with your children. The “What’s Happening to My Body? Book for Girls” or the “What’s Happening to My Body? Book for Boys” by Lynda Madras are excellent reference books. If you are uncomfortable discussing sexuality or know that you cannot handle current behaviours look to another relative or adult friend that may assist. If this is not possible, find professionals in your community to whom you can turn.

All people are sexual. After a brain injury, an adolescent’s sexual behaviour may change. No matter what the behaviour, we must understand why it occurs. If the behaviour is not appropriate, we must teach an alternative behaviour when possible. We must let children grow and learn to take on responsibilities that are within their ability. Professionals and parents together must assist adolescents with brain injury to cope with their changing bodies and their own sexuality.

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