Psychosexual Therapy and Spinal Cord Injuries – My personal and Professional Journey

Written by Michelle Donald PG Dip. PST
Psychosexual Therapist, Accredited Member of COSRT, Specialist in Spinal Cord

I became spinally injured in 1996 as a result of a motorbike accident, which left me paralysed from my waist at T12. It was in the spinal centre that I became aware of people asking about relationship and sexual issues very early after their injury. I was one of them and went home with an indwelling catheter in, feeling very unsexy. My partner and I took a long time to manage the adjustments. Whilst I was an in-patient we were able to talk to the psychologist at the spinal centre, once home it was very difficult to find specialist help and we started to find out just how much had changed for us as a couple.

As a result of my personal experience, I decided to train as a relationship counsellor and then specialise as a psychosexual therapist with the objective of helping people like myself.

My client group consists of both individuals and couples looking for help with various sexual dysfunctions affecting their relationships.

I work with both able and disabled clients but have developed a particular expertise with sexual and relationship issues that a spinal cord injury (SCI) may bring with it.

The Importance of Sexuality After An SCI

I feel it is necessary to emphasize how important sexuality is after a SCI; in that this aspect of the relationship shared by a couple, and the fears of singles, is often neglected, with the focus being on the physical dysfunction.

It is critical to the process of renewing the sexual experience that clients accept that their sexual experience is now going to be different. Some tasks that I give help to guide the couple in an exploration of alternative ways of being intimate and reaching sexual fulfilment, which don't necessarily rely on intercourse.

Clients do need to be very open about their sexual feelings and be willing to try new ideas or ways of behaving. I ask clients to do some reading and try exercises at home as part of their program. Providing me with feedback on their experiences allows me to design a personal program for a positive way forward.

In addition to working at Stoke Mandeville National Spinal Injuries Centre and the North West Regional Spinal Injuries Centre in Southport, I work with private clients. I also present workshops to health care professionals needing greater expertise and confidence to talk with their clients about sexual issues. Individually tailored workshops have been provided for many clients such as Active Assistance and Warrington Disability Partnership and Relate. I also speak and present at conferences.

If you are the client what is the process?

At some point after a SCI, you will have many questions and may feel the need to discuss sexual matters and relationship issues with a specialist such as myself.

As a psychosexual therapist I will assist you with the impact that your SCI has had on your sexual lives. I will help you deal with how you feel about yourselves sexually and how you feel about your intimate relationships. I will help you talk through how the SCI has impacted on your sexual experience.

A range of techniques will be spoken about to help you understand and reconnect with your sexuality. You may not be currently in a sexual relationship, but if you are it is more helpful to attend together.

We will discuss what is possible or not regarding your inability to get or maintain an erection or achieve an orgasm. We can discuss many issues including fear or anxiety about sex, loss of sexual desire and difficulty communicating with your partner.

Sometimes these problems can be addressed with just a little information or reassurance and one or two sessions is enough. Typically, people will need more time.

If you are in a relationship, you can both talk about your feelings and be involved in goal setting. You will both need to talk about your relationship, your sex lives, and the changes you have experienced. I understand how anxious people are about voicing how they feel about this. We then formulate a plan on the best way to proceed. You need to be as open about yourselves as possible and be willing to try new ideas or ways of behaving. You will be asked to do some reading and try some exercises at home and provide feedback on your experiences from which we can develop a positive way forward.

An example of an exercise that proves useful for many couples is body mapping. This exercise emphasises intimacy and sensual pleasure. For example, you may lie on a bed while your partner caresses parts of your body. For each area your partner touches, you describe how pleasurable it is on a

scale of one to ten. The process helps people rediscover their own bodies and their partner's bodies.

I have found this helpful as it enables clients to better understand what has changed for themselves and for their partner in knowing which areas can now be comfortably touched. Many partners become tentative about touching and are confused about where is more pleasurable or more painful. Body mapping facilitates communication and incorporates an element of fun!

Below are two examples of my client work. Minor changes have been made to protect the privacy of these clients.

Male in his 40's, recently spinally injured.

A 42-year-old man had fallen downstairs at his home and sustained a SCI from his navel down. He was admitted to the Spinal Injuries Centre and underwent five months of rehabilitation. As his injury is from his navel (T10), he cannot experience any sensations below this area so not only is he unable to feel he can now only sustain a reflex erection, as his psychogenic erection has been lost. That is, he can obtain an erection through local touch but cannot maintain it through thought or any visual stimuli, so he will not be able to maintain it long enough for penetration.

He was assessed and offered a medical treatment approach to his erectile dysfunction. Treatment seemed successful for the mechanics of his erectility as his erections are initially maintained. Subsequently it become apparent that both partners were struggling to cope with the idea that he could not feel and struggled to move as he once did. His wife felt hurt and became critical of her husband. This caused him to feel increasingly emasculated and a loss of desire developed in both partners. Sexual activity decreased and soon after the medication would no longer maintain his erections.

The psychosexual approach offered to this couple, included specifically tailored sex education and cognitive behavioural therapy to help with their reactions to changes in sexual functioning. They explored issues around masculinity, the meaning of erections, ejaculation, and the reliance on medication as experienced by both partners. It also addressed couple communication and issues of adjustment and loss.

Sex therapy approaches were used to allow this couple to become more comfortable and relaxed in each other's presence, to be naked and to begin touching again, to overcome awkwardness and performance anxiety. It offered specific strategies to increase arousal and help the couple to make decisions about the use of and choice of medication. It enabled exploration of sexuality in the absence of erections and sensations, along with techniques to overcome loss of spontaneity and anxiety.

Female in her 30's, spinally injured for four years.

A 32-year-old woman had been involved in a car accident four years ago. She had sustained a spinal cord injury from T4 (chest down). She felt very unhappy about the way she now looked, as she could not control her stomach muscles and had a 'pot belly'. Her legs had become thin and flat and she could not sit up straight. She worried about how she looked in her wheelchair as she had lost her self-esteem and now disliked her body.

She had issues with spasms causing problems with bladder leakage and now wears a catheter attached to a leg bag for urine drainage. She felt she was no longer a 'real' woman and in addition worried about being unattractive to her partner. This had led to marked avoidance behaviours such as of being naked, of touching herself, of being seen naked or touched by her partner.

As a consequence of her level of injury, she suffered from vaginal dryness, and she had also lost her breast and nipple sensation. As a consequence, the couple's relationship was deteriorating. The husband developed erectile dysfunction as he found it difficult to stay aroused due to his wife's apparent lack of interest, her changed body, and the increasing amount of conflict.