Sexual Problems in Paraplegics

DR. UPINDERPAL SINGH[1], DR. S.K. VARMA[2]
Rehabilitation and Artificial Limbs, All India Institute of Medical Sciences, New Delhi

The importance of sexual problems in paraplegics is discussed. A brief is given about management of a patient with this problem. Sexual problems of 20 male paraplegic patients were studied. 70% talked freely about their problems. 70% reported erections. 40% could perform intercourse after counselling. Ejaculation was present in one case. Orgasm was experienced by 20% cases. Sex play was gratifying in 75% cases, irrespective of the type of play.

INTRODUCTION

While in the United States one is discussing sex openly even in a group; or watching a film in the congenial atmosphere of a hospital, on a couple with one of its partners a quadriplegic below C_6 perform a sex act; or talking on homosexuality without any reservations; it becomes hard to accept that a paraplegic in India won't like to talk about it because he has other priorities. For a common man in India, sex is a taboo to talk about, sin to perform other than for procreation and 'dirty' in the general sense. It has been on the neglect even in the advanced countries with permissiveness in sex. An American with paraplegia was quoted saying: "It would have helped if some sort of sex was possible. It would have given me something to fall back on". An Indian feels exactly the same way. The only difference being that he won't say it openly. There is a vacuum of literature on sexuality in Indian paraplegics. It is true that we in India can't go about it as our allies in the west. Even the health professionals, leave aside anybody else, are indifferent or hesitant.

If one really dramatises the situation or is hesitant to talk about sexual matters to a patient, the patient never confides in or even if he does, he has only a very superficial involvement. The basic pre-requisite being absolute privacy in the clinic or the hospital room. If sex is talked as a matter of fact we talk of any other problem to a patient of paraplegia like asking about bladder, bowel and sex in the same go, the patient is never shocked at the sudden question and speaks out his heart if the rapport has already been made. An eye to eye contact with the patient is important to put him into confidence. One should not wait for other things to be discussed first and leave the sex matters to a later session. Of course separate sessions with the partners too are required to discuss out the individual problems. If discussion about this is also made on the first meeting the patient does feel that he is really being looked after wholly and completely from all aspects. Anxiety about one's sexual performance is one of the biggest preoccupations or fears. If one is conversant with his problems and expectations and then learns to perform with one's limitations, it allays most of the anxieties and fears and one participates better in the rehabilitation program.

[1]Lecturer.
[2]Professor and Head of the Department.

MATERIAL AND METHOD

We have used the same clinical approach to our patients as above. In this study we are presenting some of the sexual aspects of our patients with paraplegia. We chose 20 males for this study with the segmental level of the cord lesion ranging from C_6 to L_4 (Table I).

Table I. Distribution of level of lesion

Cord level		No. of patients
Cervical	Incomplete	1
Dorsal	Incomplete	4
	Complete	6
Lumbar	Incomplete	2
	Complete	7
Total		20

The duration ranged from 3 months to 4 years. The age distribution is given in Table II. 19 out of 20 were married.

Table II. Age distribution of patients

Age (in years)	No. of patients	%age
Below 20	1	5
20-30	12	60
30-40	4	20
Above 40	3	15
Total	20	

OBSERVATIONS AND DISCUSSION

14 patients talked freely about their problems themselves once the topic was started and 4 confided when probed. A 25 years old patient could not shed his hesitation and one 22 years old said that he never thought about it, as he was unmarried. It can be explained otherwise also that in India even if one has premarital sexual relations or experiences one does not come out with it (see Table III).

Table III. Frankness in talking

	No. of patients	%age
Freely	14	70
After probing	4	20
Refused to talk	1	5
No feelings	1	5
Total	20	

Of all 20 patients 14 reported erections. Psychogenic erection was present in only one patient with incomplete dorsal lesion. In the rest of the 13 patients it was reflex. According to the site of lesion, 10 out of 11 of cervicodorsal spine, 4 out of 9 of lumbar spine (L_1—2 patients, L_2 incomplete—1 patient and L_4—1 patient) had erections. No patient had tried to have a sex play other than for caressing or kissing for various reasons. Most of the patients felt half a man without the powers of having sex, loss of bladder and bowel control and loss of muscle strength. Most of the patients thought that they never thought of having sex for the fear that it may damage their cord further.

All the patients were given counselling according to the deficits and the sexual faculties left. Wherever possible both individual counselling and conjoint counselling with the partner was arranged. Conjoint counselling was possible only in 7 cases. The importance was laid on the inter-personal relations and respect for the partner's needs in the matter. A free discussion was allowed on the sex play; e.g. preparation for love play, care of bladder & bowel for it. Full treatise was given on the positions of each and the aggressiveness of the partner. But intercourse was not emphasised too strongly. It was limited to the patients attaining erections. The partners were advised on how to maintain the erection. Out of 14 patients, who could attain erections, 8 could have intercourse, which was satisfactory

in 5 patients, 2 did not feel like having it. In one patient partner's cooperation was lacking. One case had a mechanical barrier due to flexor and adductor spasm of the hips. Only one patient had urinary incontinence. Performance of 2 patients could not be known for want of further sessions. The main problems for failure of intercourse were due to loss of erections and lack of cooperation from the partner. Ejaculation was present in only one patient having an incomplete lesion at D_{12} level (see Table IV).

Table IV. Performance

	No. of patients	%age
Erections	14	70
Intercourse possible	8	40
—Satisfactory	5	25
—Unsatisfactory	3	15

Orgasm was experienced by 4 patients with incomplete dorsal (2) and lumbar (2) lesions. It was a mixed feeling of pain, heaviness in the head, flushings and a feeling of pleasure more so because of the fact that they were capable of manhood in this respect, and they were able to satisfy their partners to some extent. 2 patients with dorsal complete lesions experienced autonomic hyper-reflexia.

In all the patients, extra genital sex play and the less conventional methods were advocated specially in those patients who could not attain erections. The over all results of sex play were gratifying in 15 out of 20 patients, irrespective of the type of sex play. The rating as put by the patients was : good in 11 out of 20, average in 3 patients and 3 patients did not comment (see Table V).

Table V. Patients reaction to sex play

Reaction	No. of patients	%age
Gratifying	15	75
good	11	55
Okay	3	15
No comment	3	15
Patient lost to follow up	3	15

In general all the patients once they had sexual counselling started feeling better morally, became more active in the exercise regime, showed better cooperation with the staff and better acceptability of disability with a new will to live. Looking at the needs of the patients and the boost it gives to the patient's morale, it is quite evident that how important sexuality is.

CONCLUSION

The problem of sexuality in paraplegics is global, the only difference in India being in its expression. Having sex does not mean having intercourse; understanding this itself widens the scope of sexuality. Clear policies are to be made in the Rehabilitation departments to deal with the sexual problems. The staff should be trained to deal with it in an open fashion without avoiding words, ideas, concepts, activities and myths. The patient should be encouraged to talk to anyone he feels comfortable with.

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