SEXUALITY AFTER STROKE WITH HEMIPLEGIA. II
II. With Special Regard to Partnership Adjustment and to Fulfillment

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Abstract. Aspects of sexual function, partnership responsiveness and fulfillment after stroke were, together with sexually performance orientated and stigmatic attitudes, investigated in 51 subjects. Erectile and orgasmic spectactorship were frequent after stroke and were in the males significantly associated. Retarded ejaculation occurred for no man before but for 15% after the stroke. Marked decrease in different kind of reinforcing behavior were followed by disinterestment and up to and about half the subjects felt that sexual partnership responsiveness had deteriorated. After the stroke the commonly occurring reduction in general sexual satisfaction was significantly associated with symptoms of increased sexual dysfunction, disturbed partnership responsiveness and reduced sexual fulfillment. The high prevalence of sexual dissatisfaction in stroke victims appears mostly to be psychogenic. Important precipitating factors are performance orientation and sexual stigmatisation. Moreover, lack of sexual information and counselling may contribute to deterioration of partnership sexuality.

Key words: Sexuality, stroke, hemiplegia, coping, marital roles

The present investigation is the second part of a study of sexual life in 51 hemiplegic or hemiparetic former stroke victims. It was previously (20a) found that onset or increase of erectile and orgasmic incompetence were common sequelae of stroke and that these sexual dysfunctions were more common in males than in females who, on the other hand had a higher degree of organic incompetence than the males before the stroke. Frequency of sexual intercourse and durations of excitation caressings (foreplay), and of total sex-play were drastically reduced if not abolished in the majority of males and females. The neocortical–hypothalamic–pituitary–gonadal axis functioned normally in the males, and the site of the brain lesion was not associated with any of the investigated parameters of sexual function. Furthermore, decreases in the subjects’ ‘partnership drive’ were associated with several parameters of sexual dysfunction. These results suggest that psychological rather than organic factors contributed towards precipitation of the sexual dysfunction. This suggestion is supported by the findings that dependence upon spouse in self-care ADL outweighs signs of physical disability per se for predicting resumption of frequency of sexual intercourse after stroke (21).

This study was designed to explore further aspects of sexual function, responsiveness and fulfillment in the same stroke victims and to relate the findings to prevalence of performance orientated attitudes and to sexually stigmatic tendencies.

Materials
A consecutive series of 51 single stroke (25) subjects with hemiplegic or hemiparetic who were referred to the Department of Physical Medicine and Rehabilitation, University Hospital, Umeå, after discharge from the acute hospital wards. Thirty-nine were males (mean age 54.9 years) and twelve were females (mean age 50.12). All were married and had been at home for at least two months prior to the investigation. All were sexually active (including coitus) until the time of the vascular catastrophe. Mean interval between stroke and investigation was 14 months (range 3–68). Fifteen subjects were still in the process of rehabilitation; none were undergoing treatment for psychiatric illness. The criteria for selection of subjects have been presented in detail elsewhere (20a).

Methods
Subjects volunteered to participate in a structured interview containing questions about their sexual life. The interviews were conducted under undisturbed conditions and were performed by one investigator. Each interview lasted approximately 90 min.

This investigation focussed on aspects of sexual function, sexual fulfillment and partnership responsiveness (cf. Table I). For the functional parameters A, 1–8 questions were also asked about degree of liking and degree of satisfaction with frequency. All items were related to the stroke as subjects were asked about their experiences before and after the stroke.

Subjects were, moreover, asked if they could give
reasons for reduced sexual pleasure, if such reduction occurred. They were also asked if they had been given opportunity for or had themselves sought sexual counseling after the stroke.

Attitudes of sexual performance orientation (five items) and of sexual stigmatization towards the disabled (three items) were explored in 39 unselected subjects through the statements presented in Table III. For each item, a score of one was given for a stigmatic or a performance oriented attitude and a score of zero when the answer did not indicate such attitude. Thus, ad hoc indices ranging between 0-5 (performance orientation) and between 0-6 (stigma) could be constructed.

Statistical methods. For analyses of associations between pairs of variables simple cross-tabulations were performed. The sample size did not permit use of multiple regression methods. The chosen level of significance was p<0.05. In general, parameters concerning fulfilment, responsiveness and sexual function were dichotomized into no change vs. change. For cross-tabulations performance orientation and sexual stigma indices were dichotomized into little or no such attitudes (0-1 and 0-2 for performance orientation and stigma, respectively), intermediate amount of such attitudes (2-3 and 3-5, respectively) and pronounced performance orientation or stigmatization (4-5 and 6-9, respectively). For separate analyses in males and females the indices were due to small sample size dichotomized (performance orientation: 0-2 vs. 3-5; stigmatism: 0-4 vs. 5-9).

RESULTS

Only for one single (female) subject increase had occurred in one aspect (general caressings). For all other subjects no improvement of any aspect of sexual life was registered after stroke.

Sexual function. In general all caressive expressions (Fig. 1, also cf. Table I) became rarer after the stroke, especially for the male hemiplegics. This impoverishment of non-verbal communication was for each parameter accompanied by decrease in the level of satisfaction with frequency (x2 between 19.90 and 43.37, 1 df). However all, but one, had unaltered wishes (i.e. liking) for every single of these activities.

Among the males relatively few often or occasionally were orgasmic and/or erectile spectators before the stroke (Fig. 2). The majority were so after stroke—if they at all achieved orgasm or erection. In contrast, pre-stroke about 60% of the female hemiplegics were frequent or occasional orgasmic spectators and one was normorgastic. Post-stroke significantly fewer females than males had increased level of spectating (x2 = 3.54; 1 df), but three females were now anorgasmic.

Whereas no males felt they had ejaculatory disturbances before stroke, six (15%) complained of retarded and one of premature ejaculation after the stroke. At this time also two subjects, one male and one female, were dyspareunic. None of the females reported vaginalism. Erectile and orgasmic spectating were also significantly associated (x2 = 10.03; 1 df). This may indicate that, at least in the males, several sexual dysfunctions often occurred simultaneously. Cross-tabulations with the data obtained in the previous investigation (cf. Introduction) demonstrated that this was, indeed, the case.

The explanations provided by subjects for reduced sexual enjoyment during intercourse are presented in Table II. For the males, erectile problems dominated followed by fatigue, which was the main female cause of pleasure reduction. Other reasons given included fear of release, reduced sensibility and orgasmic problems. No subject felt that spasticity or decreased mobility and only two felt that extrapalinal pain had led to reduced sexual enjoyment.

Partnership responsiveness. Males and females rated pre-stroke sexual communication and responsiveness alike (Fig. 3). After the stroke verbal and especially non-verbal responsiveness was experienced as reduced. Thus, about half of the subjects felt that they were less responsive to partner's sexual initiative and about 50% of the males, but one-third of the females found the partner less responsive to sexual initiatives and less emotionally engaged than pre-stroke.

<table>
<thead>
<tr>
<th>x2</th>
<th>Sex life in general</th>
</tr>
</thead>
<tbody>
<tr>
<td>7.18</td>
<td>General caressings (toucing, hugging)</td>
</tr>
<tr>
<td>12.43</td>
<td>Deep kissing</td>
</tr>
<tr>
<td>6.98</td>
<td>Oral caressings S's breast</td>
</tr>
<tr>
<td>16.92</td>
<td>Oral caressings P's breast</td>
</tr>
<tr>
<td>12.31</td>
<td>Manual (oral) caressings of S's genitals by P</td>
</tr>
<tr>
<td>16.92</td>
<td>Manual (oral) caressings of P's genitals by S</td>
</tr>
<tr>
<td>13.62</td>
<td>Orgasmic spectating</td>
</tr>
<tr>
<td>4.39</td>
<td>Erectile spectating (males only)</td>
</tr>
<tr>
<td>4.27</td>
<td>Ejaculatory problems (males only)</td>
</tr>
</tbody>
</table>

Table II. Given reasons for restriction of full sexual enjoyment in 39 males and 12 females with hemiplegia due to stroke.

Some subjects gave more than one reason. n denotes number of subjects.
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Attitudes of sexual performance orientation (five items) and of sexual stigmatization towards the disabled (nine items) were explored in 39 (unselected) subjects through the statements presented in Table I. For each item, a score of one was given for a stigmatic or a performance oriented attitude and a score of zero when the answer did not indicate such attitude. Thus, ad hoc indices ranging between 0-5 (performance orientation) and between 0-35 (stigma) could be constructed.

Table I. Associations (x^2) between no change/change in parameters of sexual function, fulfilment and responsiveness after stroke with hemiplegia by no change/change in sex life in general

| P denotes partner, S denotes respondent, 51 subjects included |

<table>
<thead>
<tr>
<th>X^2</th>
<th>Sex life in general</th>
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<tr>
<td></td>
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</tr>
<tr>
<td></td>
<td>A. Function</td>
</tr>
<tr>
<td></td>
<td>1. General careings (talking, hugging) 7.38</td>
</tr>
<tr>
<td></td>
<td>2. Deep kissing 12.61</td>
</tr>
<tr>
<td></td>
<td>3. S careers S's breast 6.98</td>
</tr>
<tr>
<td></td>
<td>4. S careers P's breast 16.92</td>
</tr>
<tr>
<td></td>
<td>B. Manual (Manual) 6 careers of S's genitalia by P 12.31 (NS)</td>
</tr>
<tr>
<td></td>
<td>8. Orgastic spectator 13.62</td>
</tr>
<tr>
<td></td>
<td>9. Erotic spectator/male (males only) 4.39</td>
</tr>
<tr>
<td></td>
<td>10. Ejaculatory problems (males only) 4.27</td>
</tr>
<tr>
<td></td>
<td>B. Fulfilment</td>
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<tr>
<td></td>
<td>1. Sex life in general 9.31</td>
</tr>
<tr>
<td></td>
<td>2. Foreplay duration 17.61</td>
</tr>
<tr>
<td></td>
<td>3. Sex-play, duration 22.96</td>
</tr>
<tr>
<td></td>
<td>4. Intercourse, frequency 23.51</td>
</tr>
<tr>
<td></td>
<td>5. Interourse, as such 3.94</td>
</tr>
<tr>
<td></td>
<td>C. Responsiveness</td>
</tr>
<tr>
<td></td>
<td>1. Mutual verbal communication on sexuality 7.27</td>
</tr>
<tr>
<td></td>
<td>2. S's reaction to P's sexual initiatives 13.09</td>
</tr>
<tr>
<td></td>
<td>3. P's reaction to S's sexual initiatives 15.24</td>
</tr>
<tr>
<td></td>
<td>4. P's emotional involvement during sex activities 18.14</td>
</tr>
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<td></td>
<td></td>
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<tr>
<td></td>
<td>D. P's shown interest in mutual sexuality 9.04</td>
</tr>
<tr>
<td></td>
<td>With one of degree of freedom x^2&gt;.05 for x^2&gt;6.64; p&lt;.001 for x^2&gt;10.83. Only y^2&gt;2.70 included.</td>
</tr>
<tr>
<td></td>
<td>+ Stigmatism: yes/no.</td>
</tr>
</tbody>
</table>

Table II. Given reasons for restriction of full sexual enjoyment in 39 males and 12 females with hemiplegia due to stroke

| Male and female subjects gave more than one reason. n denotes number of subjects |

<table>
<thead>
<tr>
<th>Male and Female Subjects</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td>Fatigue</td>
</tr>
<tr>
<td>Fear</td>
</tr>
<tr>
<td>Fear</td>
</tr>
<tr>
<td>Hemihypertension</td>
</tr>
<tr>
<td>Reduced genital sensation</td>
</tr>
<tr>
<td>Orgastic problems</td>
</tr>
<tr>
<td>Ejaculatory problems</td>
</tr>
<tr>
<td>Erectile problems</td>
</tr>
</tbody>
</table>

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Fulfilment. Marked reduction in levels of sexual fulfilment (Fig. 4, also cf. Table I) occurred for the males and some reductions occurred for the females after the stroke. In fact, while 54% of the males and 50% of the females felt satisfied with all of these five aspects of sexual life before the stroke only 8% and 33% of males and females, respective-ly, felt so when interviewed. Table I illustrates that reduction in general sexual satisfaction was significantly associated with changes in nearly all other investigated details of sexual function, responsiveness and fulfilment.

Performance orientation and stigmatization. Table III shows that for the unselected sub-sample of 39 subjects, performance orientation was very common and between 33-63% of stroke victims gave answers suggestive of stigmation to each stigmaitem. Whereas 26% had less than three such atti-
spouseness and function. Sexual stigmatization was significantly associated with experiences of decreases in general sexual satisfaction (χ²: 4.92; 1 df) and in satisfaction with frequency of intercourse (χ²: 5.07; 1 df), with decreased own responsiveness to partner's initiative (χ²: 10.71; 1 df) and with increased frequency of erectile apathy (males: χ²: 4.84; 1 df). Performance orientation was significantly associated with decrease in satisfaction with intercourse (χ²: 6.65; 1 df) and for the males with increase in frequency of erectile and organic spectating (χ²: 8.15 and 2.92, respectively; 1 df).

Table III. Mean per cent affirmative answers to statements included in indices of sexual stigmatism (9 items) and performance orientation (5 items) in 30 males (♂) and 12 females (♀) with hemiplegia due to stroke

<table>
<thead>
<tr>
<th>Item</th>
<th>All</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sexual stigmatism</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disabled males can never fully satisfy their partner sexually</td>
<td>12</td>
<td>5</td>
<td>44</td>
</tr>
<tr>
<td>Disabled females can never fully satisfy their partner sexually</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Males who are interested in disabled females are insecure of their masculinity</td>
<td>21</td>
<td>5</td>
<td>67</td>
</tr>
<tr>
<td>Females who marry disabled males want to avoid competition for spouse</td>
<td>19</td>
<td>4</td>
<td>59</td>
</tr>
<tr>
<td>Females who are attracted to disabled males want to dominate male sexually</td>
<td>16</td>
<td>4</td>
<td>51</td>
</tr>
<tr>
<td>Disabled individuals are less interested in sex than are the able-bodied</td>
<td>14</td>
<td>3</td>
<td>44</td>
</tr>
<tr>
<td>Individuals who are physically incapable of intercourse have little or no thought of sex</td>
<td>11</td>
<td>3</td>
<td>36</td>
</tr>
<tr>
<td>The healthiest way for the disabled to deal with diminished sexual capacity is to change their other goals</td>
<td>19</td>
<td>6</td>
<td>64</td>
</tr>
<tr>
<td>A disabled individual's partner should not initiate sex</td>
<td>9</td>
<td>4</td>
<td>33</td>
</tr>
<tr>
<td>Performance orientation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Confidence in sexual techniques guarantees better sexual life</td>
<td>23</td>
<td>2</td>
<td>64</td>
</tr>
<tr>
<td>Orgasm cannot be achieved from non-genital areas</td>
<td>20</td>
<td>7</td>
<td>69</td>
</tr>
<tr>
<td>Erection is necessary for male sexual satisfaction</td>
<td>28</td>
<td>7</td>
<td>90</td>
</tr>
<tr>
<td>Orgasm is always the goal of sexuality</td>
<td>23</td>
<td>7</td>
<td>77</td>
</tr>
<tr>
<td>Partners' simultaneous orgasms are important</td>
<td>20</td>
<td>3</td>
<td>59</td>
</tr>
</tbody>
</table>

Finally, when the subjects were asked if staff had offered counselling on sexual matters after the stroke only one answered in the affirmative. Moreover, only two subjects had, themselves, sought such advice.

**DISCUSSION**

The profound negative influence of stroke with hemiplegia on the established partnership sexuality is illustrated by experiences of decline in mutual verbal and non-verbal sexual responsiveness. A common loss of interest and closeness is also symbolized by the marked decrease in frequency of caressing and touching without intentions of having sex. Furthermore, and to an even greater extent, frequency of intimate caressing, which is often regarded as sexual overtures, "foreplay", was reduced. It might be hypothesized that these changes reflect lowered libido, which Kallioniemi et al. (10) and Goddess et al. (8) feel occurs after stroke. It is, though, important to stress that the subjects' wishes (liking) for continuation of intimate body contact were unaltered. If libido is defined as the subconscious sexual drive based upon primitive wishes and upon sexual impulses (cf. 6) it appears unlikely that libido is decreased after stroke. However, we can only speculate in the explanation for this decrease in sexual partnership drive which might be classified as avoidance behavior. Firstly, changes in own responsiveness may serve to legitimate subjects' previous sexual dysfunction, which was more common in females than in males. Secondly, changes may reflect frustration over onset of increase of sexual dysfunctions post-stroke (cf. 20a). Thirdly, changes may be a result of stigmatization. These suggestions are supported by the fact that 64% of the subjects felt that "the healthiest way for the disabled to deal with decreased sexual capacity is to choose other goals" (cf. Table III). Fourthly, the non-disabled partner may factually endeavor to avoid or may be ambivalent towards mutual sexuality (cf. below). As Kaplan (12) pointed out, sexual avoidance is a sign of fear of sex not of decreased desire. It is necessary to separate these states as avoidance may present a barrier to therapy.

The finding that only about 50% were satisfied with intercourse and sex-life in general (cf. Fig. 4) before stroke is in agreement with other reports (23, 26). The significantly greater decline in these aspects of sexual satisfaction after stroke in males than in females may be due to the previously described (also cf. 20a) pre-stroke latent and expected (13, 24) high female rates of organic dysfunctions; latent because they are, generally, not accompanied by correspondingly low levels of contentment. This partial female self denial rights of sexuality is most likely a result of sociocultural requirements. Thus it appears that Swedish females silently accept rather than focus sexual dysfunctions; an assumption which is further discussed in and appears substantiated by our report on students of health care professions (7).

The fact that several sexual dysfunctions tended to appear simultaneously is in agreement with other findings (16). There appears, though, to be no available "normative" data on occurrence of erectile and organic spectating. The significant associations for performance orientation and sexual stigmatization with male increases in spectating support the suggestion of Masters & Johnson (14) and Sarrel & Sarrel (19) that spectating is a sequel of performance anxiety. The passive dysfuctional role as spectator is not only confined to the sexual sphere but occurs in other parts of life after stroke. Thus, leisure time is also characterized by passive discontentment (20). The change from being a participant to a psycho-
sponsiveness and function. Sexual stigmatism was significantly associated with experiences of decreases in general sexual satisfaction (χ²: 4.92; 1 df) and in satisfaction with frequency of intercourse (χ²: 1.07; 1 df), with decreased own responsivenes to partner’s initiative (χ²: 10.71; 1 df) and with increased frequency of erectile problems (males: χ²: 8.84; 1 df). Performance orientation was significantly associated with decrease in satisfaction with intercourse (χ²: 6.65; 1 df) and for the males with increase in frequency of erectile and orgasmic spectating (χ²: 8.15 and 2.92, respectively; 1 df).

Table III. Mean per cent affirmative answers to statements included in indices of sexual stigmatism (9 items) and performance orientation (5 items) in 30 males (3) and 9 females (3) with hemiplegia due to stroke

<table>
<thead>
<tr>
<th>Item</th>
<th>Males</th>
<th>Females</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Satisfied with own sexual performance</td>
<td>85.5</td>
<td>71.4</td>
<td>80.7</td>
</tr>
<tr>
<td>2. Satisfied with partner’s sexual performance</td>
<td>72.4</td>
<td>78.6</td>
<td>75.5</td>
</tr>
<tr>
<td>3. Satisfied with own orgasmic function</td>
<td>71.4</td>
<td>77.8</td>
<td>74.6</td>
</tr>
<tr>
<td>4. Satisfied with partner’s orgasmic function</td>
<td>69.4</td>
<td>74.4</td>
<td>71.9</td>
</tr>
<tr>
<td>5. Satisfied with own erectile function</td>
<td>67.4</td>
<td>71.4</td>
<td>69.4</td>
</tr>
<tr>
<td>6. Satisfied with partner’s erectile function</td>
<td>65.5</td>
<td>71.4</td>
<td>68.5</td>
</tr>
<tr>
<td>7. Satisfied with own sexual desire</td>
<td>63.7</td>
<td>71.4</td>
<td>67.5</td>
</tr>
<tr>
<td>8. Satisfied with partner’s sexual desire</td>
<td>61.4</td>
<td>71.4</td>
<td>66.4</td>
</tr>
<tr>
<td>9. Satisfied with own sexual pleasure</td>
<td>59.4</td>
<td>67.8</td>
<td>63.6</td>
</tr>
</tbody>
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We can only speculate in the explanation for this decrease in sexual partnership drive which might be classified as avoidance behavior. Firstly, changes in own responsiveness may serve to legitimate subjects’ previous sexual dysfunction, which was more common in females than in males. Secondly, changes may reflect frustration over onset of increase of sexual dysfunctions post-stroke (cf. 20a). Thirdly, changes may be a result of stigmatism. These suggestions are supported by the fact that 64% of the subjects felt that “the best way for the disabled to deal with decreased sexual capacity is to choose other goals” (cf. Table III). Fourthly, the non-disabled partner may factually endeavor to avoid or may be ambivalent towards mutual sexuality (cf. below). As Kaplan (12) pointed out, sexual avoidance is a sign of fear of sex not of decreased desire. It is necessary to separate these states as avoidance may present a barrier to therapy.

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The passive dysphasic role as spectator is not only confined to the sexual sphere but occurs in other parts of life after stroke. Thus, leisure time is also characterized by passive discontentment (20).

The change from being a participator to a psycho-
Many subjects, particularly females, felt that the decrease in sexual enjoyment was due to fatigue which may be a symptom of reactive depression that commonly occurs after stroke (5, 20). The high rate of fatigue in the females may furthermore serve to legitimate post-stroke avoidance of pre-stroke unrewarding sexual intercourse. An attempt to explain the emergence of ejaculatory retardation in 15% of the males shall also be offered. Kaplan (11) suggested that retarded ejaculation represents fear and/or inhibition of erection. Moreover, the “role shift hypothesis” may provide an explanation for the sexual deprivation of hemiplegic males in that both fear of being still more dependent—or die; fear of intercourse with the caretaker/mother and aggression (wishes to punish the female who “is in power”) may precipitate this sexual dysfunction.

Extremely few patients were offered or asked for sexual counselling. There may be many reasons accounting for this apparent defeatism. During the early phases denial (cf. 5) may block search for information. Furthermore, the patients’ depression and/or stigmatization may lead to passivity and sexual taboos may inhibit even the simplest question on sexual matters. It is worth noting that the only subject in this investigation who actually had a stroke during intercourse, a fact well known by staff, neither approached nor was approached by the medical or paramedical staff at the departments of internal medicine or rehabilitation to discuss sexual matters. Since this subject and his spouse dreaded intercourse during intercourse, his sexual life deteriorated.

It is felt that medical and paramedical staff members must actively deal with the sexual maladjustment of the disabled as has been maintained by other authors working in the field of sexuality and disability (1, 3, 4). This may, though, not be as easy a fair amount (about 3%) of staff may be sexual stigmatizers towards the disabled (7). Therefore, sexual education should be incorporated in the curriculum of medical and paramedical future staff members.

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logically maladjusted spectator resembles that re-
ported by Power (17) in male subjects with multiple
schizoid traits. Although the present investigation
was not designed to analyse the reactions and behaviour
of the spouse it must be pointed out that when a
subject is critically ill or becomes permanently dis-
abled, the partner is generally also in a crisis (15,
22).

Evidently performance oriented—mechanistic—
sexual attitudes were accompanied by sexual stigm-
atisation. It is suggested that the negative influence of
such attitudes on several aspects of sexual fulfil-
ment, responsiveness and function reflects the
vulnerability of the performance oriented sub-
jects. These apparently have great difficulties in
coming to terms with major changes in their habitual
life style. In other words, not being able to perform
according to own expectations leads to reduced
self-esteem (stigmatism) and in turn, or concurrently,
to, frustrated sexual spectatoring. Role expecta-
tions and role changes govern both the disabled and
his or her partner’s adjustment to the new life situa-
tion (2, 17). The fact that dependence upon spouse
in self-care ADL is a main predictor for resumption
of sexual intercourse after stroke overriding the
dependency per se (21) suggests that changes towards
undesired sexual passivity and spectatoring are
caused largely by changes in marital roles. In this
context, Racy (18) emphasized that sexual and
interpersonal aspects of a partnership are so inter-
woven that changes within one aspect leads to
changes in the other.

A major explanation of the marital maladjust-
ment, in particular that of the hemiplegic males,
may be that reduced somatic and perhaps mental
capacity, loss of occupation and fear of relapse
render the subject a ready victim to adopt mal-
adaptive defence mechanisms with stigmatized loss
of self-esteem and fixation in a dependent sick role
(20). The same precipitating factors may cause the
non-disabled spouse to turn custodial, with tenden-
cies to infantilize the disabled partner. Thus, the
spouse identifies with and is identified by the hemi-
plegic as the caretaker (a mother figure). These new
partnership roles may create ambivalence towards
mutual sexuality as illustrated by reduced partner-
ship responsiveness and sexual communication ac-
companied by unaltered libido. In support of this
explanation Jääskö & Fugl-Meyer (9) found that
after stroke the partner’s custodial attitudes lead to
lower frequency of intercourse.

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