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Addressing Sexuality in Occupational Therapy

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This CE Article was developed in collaboration with **AOTA's Physical Disabilities Special Interest Section.**

ABSTRACT

Sexuality is an activity of daily living that plays an important part in an individual's life. Research has shown that sexuality and concerns with sexual participation after a disability can impact an individual's quality of life and self-esteem. As health care professionals, occupational therapy practitioners are well equipped to address sexual participation and sexuality with clients to maximize engagement and satisfaction. This article will explore the role of occupational therapy in addressing client concerns with sexual participation and sexuality while utilizing the Permission–Limited Information–Specific Suggestions–Intensive Therapy (PLISSIT) model (Annon, 1976).

LEARNING OBJECTIVES

After reading this article, you should be able to:

1. Identify treatment methods used to address sexuality and sexual participation
2. Identify and apply intervention appropriately based on the PLISSIT model
3. Identify the difference between the PLISSIT model and the Ex-PLISSIT model
4. Recognize the impact of the lived body experience on the effectiveness of treatment
5. Identify the components of the concept of therapeutic use of self that contribute to effective interventions

INTRODUCTION

Sexuality and sexual participation are common concerns for individuals with disability and chronic illnesses (Haboubi & Lincoln, 2003). Sexual participation and sexuality can be sources of "comfort, pleasure, and intimacy" for all individuals, including those with disability and chronic illness (McInnes, 2003, p. 264). Sexuality is an essential part of the whole person and can play a part in how we identify ourselves (Stuart & Sundeen, 1979). According to Hughes (2000), quality of life can be affected by disruptions to a person's sexual relationship. Sexual relationships contribute significantly to the quality of life of almost everyone (Filiberti et al., 1994). Occupational therapy entails client-centered and occupation-based interventions that maximize engagement and participation in meaningful activities of daily living (ADLs). The effects of an illness or disability on the ability to participate in sexual activity can be addressed with occupational therapy intervention. This article will focus on an evidence-based effective method of approaching sexuality with clients.

MULTI-FACETED CONCERNS

Many factors can affect the outcome of an intervention when addressing sexuality. Therapeutic use of self and the understanding of the lived body experience can improve the effectiveness of interventions addressing sexuality (Taylor, 2008). Both of these concepts stem from the Model of Human Occupation (MOHO; (Kielhofner, 2008), which is a theory of occupational practice that, without explicitly mentioning sexuality, supports the practice of occupational therapy clinicians in addressing sexuality with clients, when a client reports sexuality as being a meaningful activity. This article will review therapeutic use of self, the lived body experience, and common barriers encountered by clients that can affect their sexuality and sexual participation. Interventions discussed in the article will include the Ex-PLISSIT model (Taylor & Davis, 2006).

ADDRESSING SEXUALITY IN HEALTH CARE

Sexuality is a state of mind that represents how individuals feel about themselves, how they relate to others from the same and opposite gender, how relationships are established, and how they express themselves (American Occupational Therapy Association [AOTA], 2013). Understanding the complexity of sexuality is integral to addressing it with clients. *Sexual activity* is defined as "engaging in activities that result in sexual satisfaction and/or meet relational or reproductive needs" (AOTA, 2014, p. S19).

Studies have shown that patients wait for health care professionals to approach sexuality first (Taylor & Davis, 2006). A study conducted by Haboubi and Lincoln (2003) of health care professionals found that physical therapists and occupational therapists were less likely than nurses and physicians to have previous training, comfort, and preparation in discussing sexuality with patients. The same study found that therapists were least likely to be nominated by the staff to address and discuss sexual issues with patients.

Sexual activity has been identified as an ADL in the *Occupational Therapy Practice Framework: Domain and Process, 3rd Edition* (*Framework*; AOTA, 2014). However, as noted, sexuality has not traditionally been actively addressed by health care professionals and should be addressed by occupational therapy practitioners (Magnan, Reynolds, & Galvin, 2005).

THERAPEUTIC USE OF SELF

Therapeutic use of self has been identified by occupational therapy practitioners as a key determinant of success with clients (Taylor, 2008). Taylor defined therapeutic use of self as an intentional interaction with a client in a caring, respectful, and therapeutic manner (as cited in Hattjar, 2012b). As described by Taylor (2008), therapeutic use of self is multidimensional and includes an interpersonal skill base that the occupational therapy practitioner brings to the relationship. Therapeutic communication includes using verbal and nonverbal skills and therapeutic listening, being assertive, providing clients with direction and feedback, and responding to client feedback (Taylor, 2008). Communication is essential for any successful interpersonal relation. Therapeutic use of self utilizes therapeutic communication along with narrative and clinical reasoning to guide the client to discover meaning and build hope during the intervention process and to provide client-centered care (Taylor, 2008).

Body Language

Body language is a component of the therapeutic use of self and can affect how a client reacts to the clinician. Self-awareness of body language and how the topic of sexuality is approached can determine how a client responds to intervention (Lappa, 2012). Certain non-verbal communication—including closed-off body language, such as crossing arms across the chest or sitting too close—can deter a client from opening up and having a successful relationship with the practitioner. As always with practitioner–client interactions, paying attention to a client's body language provides insight into how the client is feeling. A gesture or posture (e.g., folded arms, looking away) may raise a flag to you that the client is not comfortable with a particular question or line or questioning and no longer wants to continue the conversation.

LIVED BODY EXPERIENCE

As described by Kielhofner (2008), the *lived body experience* is "the experience of being and knowing the world through a particular body" (p. 70). The lived body consists of two components, the mind and the body. The lived body is who we are and how we react to certain situations based on our experiences (Kielhofner, 2008).

The Intentional Relationship Model helps us to understand vital components of the client–therapist relationship (Taylor, 2008). The first and most important principle is critical self-awareness, which allows the therapist to understand the client's personal tendencies and personality style (Taylor, 2008). As mentioned by Taylor and Davis (2006), there is an impact of stereotypes when addressing sexuality with clients. When clinicians reflect on their own attitudes and how these attitudes may impact client care, they are better able to provide effective care without judgement and perceived disapproval from the client (Taylor & Davis, 2006). Carter, Moss, and Weyman (1998) identified some examples of useful questions a clinician can ask themselves to aide in reflection (as cited in Taylor & Davis, 2006):

- When did a client last disclose to me that they were in a same-sex relationship?
- Which consultations make me feel awkward or embarrassed?
- When did any client last express concerns to me of a psychosexual nature?

IMPACT OF DISABILITY AND ILLNESS ON SEXUALITY

The World Health Organization (2006) has defined sexuality as "a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence" (as cited by Esmail Knox, & Scott, 2010). As stated by Hattjar (2012a, p. 3), "many occupations are taken away by chronic illness, injury, or disability, sex and sexual activity [that] might [otherwise] provide one way of feeling 'normal' or connected with another person."

Sexual Response Cycle

Chronic illnesses can cause disruptions to the sexual response cycle, as described by Hughes (2000). The sexual response cycle has four phases:

- *Libido*, or sexual desire, is the urge to engage in sexual activity and is the most complex of the four phases. Libido is most difficult to evaluate and treat because it is least understood medically.
- *Arousal*, or excitement, causes increases in physical factors, such as heart rate, respiratory rate, blood pressure, and pelvic blood volume.
- *Orgasm* is the climax of sexual pleasure.
- *Resolution* is the recovery phase, including the rupturing of vaginal capillaries and normalizing of vitals.

When a disability interferes with sexual functioning, it can change the sexual response cycle, causing sexual dysfunction. Identifying which phase or phases has been disrupted will make intervention more client-centered and effective.

Illness and Sexuality

Hughes (2000) articulately described the systemic influences of cancer on sexuality; however, most of those influences are com-

monly experienced as a result of other illnesses as well. Physical changes that can affect sexuality include hormonal imbalances, muscle atrophy, central nervous system changes, fatigue and pain, shortness of breath, abnormal blood values, nausea, vomiting, and dry mouth (Doherty, Byrne, Murphy, & McGee, 2011).

Surgical changes can cause disfigurement or alter sensation. Physical changes may lead to body image dissatisfaction that affects quality of life and psychosocial adjustment (Connell, Coates, & Wood, 2014). Hormonal changes can cause a decrease in sexual desire, sterility, vaginal atrophy, vaginal dryness, irritation, and itching. For men, hormonal, surgical, and radiotherapy changes can cause erectile dysfunction (University of Texas MD Anderson Cancer Center [UTMDACC], 2012)

Pain and fatigue have been shown to affect a client's mood, quality of life, and the ability to perform specific ADLs, including sexual activities (Hughes, 2000). Psychological factors resulting from illness that can affect sexuality include and are not limited to poor body image, lowered self-esteem, changes in mood, lost sense of personal control over bodily functions, attitudes toward diagnoses and prognoses, gender role definitions, changes in personality, and fear (Hawkins et al., 2009).

Depression, both related and unrelated to illness, is a known cause of decreased libido. Anxiety and depression can affect relationship factors, such as decreased intimacy, relationship changes, fear of rejection, poor communication, role strain and change, performance anxiety, increased dependence on the partner, fear of abandonment, and financial stressors (Linkie, 2012).

CLIENT-CENTERED CARE

Occupational therapy is motivated by a drive to provide client-centered and occupation-based interventions to all clients. Many occupational therapists use MOHO to illuminate the reasons behind client-centered and occupation-based interventions. MOHO describes a client's volition or motivation to engage in any occupation as influenced simultaneously by their personal causation, values, and interests (Kielhofner, 2008). *Personal causation* comprises a sense of personal capacity (i.e., one's abilities) and self-efficacy (i.e., sense of effectiveness in using personal capacities).

Values include acquired beliefs and commitments that are derived from culture and can shape how people experience impairments and ultimately how their values may change (Kielhofner, 2008).

Interests are the things that a person finds enjoyable and satisfactory. Enjoyment in certain occupations evokes a strong feeling of attraction and leads to personal satisfaction. Two notable examples provided by Kielhofner (2008) include "bodily pleasure associated with physical exertion and fellowship with others" (p. 44).

Sexual practices can vary widely, and a client may not hold the same views as the clinician. Sexual orientation, gender identity, and type of marital relationship are unique to each individual. It is this author's recommendation that conducting a simple preliminary assessment to identify personal factors will assist the clinician in conducting client-centered treatment interventions. A simple assessment can be a set of questions that are asked after the client has expressed concerns with their sexuality (McKee & Schover, 2001). It may not be necessary to ask pointed questions, depending on what the client has identified as concerns:

- Your patient with prostate cancer reports, "I have lost an interest in having sex, and I feel like my partner resents me for it. I know he is still interested, but I seem to never be in the mood."
- Your elderly client who is recovering from a total hip replacement reports, "There is a special gentleman at the retirement home, and I was wondering when I will be able to be intimate with him again. Do you know when that can be?"
- Your patient with multiple sclerosis is a stay-at-home mom with a partner. She experiences constant fatigue and impaired thermoregulation. She mentions, "I struggle to do all the housework and take care of our two kids but somehow manage to get it all done. After the long days I have no interest or energy left for my partner. I know she feels neglected but I am not sure what else I can do."

In these examples, the clients eluded to their values, relationship statuses, and sexual practices.

PLISSIT AND EX-PLISSIT INTERVENTIONS

The PLISSIT model is used by health care practitioners to guide interventions related to client sexuality and sexual health care needs (Taylor & Davis, 2006). The PLISSIT model was developed by Annon (1976) and is an acronym that signifies four levels of intervention: Permission, Limited Information, Specific Suggestions, and Intensive Therapy. The Ex-PLISSIT was developed by Taylor and Davis (2006). The Ex-PLISSIT model is a not linear like the original, but cyclical in nature, with additions of reflection and review. The addition of reflection and review allows the clinician to increase self-awareness by challenging assumptions (Taylor & Davis, 2006). The Ex-PLISSIT model also states that all intervention levels should begin with permission-giving.

Permission

Permission is providing affirmation to clients that their concerns with sexuality are in fact appropriate and can be addressed by a health care professional. Providing permission during your therapy session is a safe way to let clients

know that occupational therapy is an appropriate setting in which to bring up their concerns (Hattjar, 2012a). Permission should be explicit and not vague, to avoid any confusion. Permission allows clients to feel comfortable voicing their concerns about sexuality. Permission can be provided as a handout on the role of occupational therapy and sexuality, an explicit question during the occupational therapy evaluation, or a mention of sexuality while explaining that the role of occupational therapy can all be permission-level intervention. For example:

- "During occupational therapy, we focus on increasing your safety and independence during your daily activities, such as bathing, dressing, toileting, grooming, and sexual activity."
- "Many clients with spinal cord injury report changes in their sexuality and intimacy. If you have any questions or concerns in that area, please let me know and we can explore them together."

According to Taylor and Davis (2006), it is not enough to just leave an informational pamphlet or educational resource. Discussion on an individual basis is important in distinguishing between those who wish to discuss their sexuality needs and those who do not (Taylor & Davis, 2006).

Permission will assist in building rapport with clients, and they will remember they can come to you with their concerns or questions. Providing permission to discuss sexuality also permits clients to decline to do so (Taylor & Davis, 2006).

Limited Information

Clinicians at this stage are a source of information for their clients. *Limited information* includes information related to the impact of illness on sexuality and sexual function (Taylor & Davis, 2006). It is important at this stage to clarify any misinformation the client may have and only provide factual information that can be easily understood. Avoid long booklets and websites that may be overwhelming. Important and relevant information can be highlighted and streamlined to avoid over simulation. Ensure that the information given is not too general or based on assumptions (Taylor & Davis, 2006). Offering too much information can deter clients from approaching the topic again; it can also make it difficult for them to process and implement information successfully.

Most clients will be curious about the changes to their bodies and when, if ever, they will be able to resume normal sexual activities. Practitioners can provide clients with basic information on their illness and how it can affect their sexuality. Providing clients with written/visual information that highlights what may be pertinent to them will give them a chance to look it over privately and return to you with any questions or further details. Some clients may want to go over the information with you, but they may not ask you upfront. Asking open-ended questions and listening to their needs will result in more positive outcomes (Taylor & Davis, 2006).

Specific Suggestions

The *specific suggestions* stage requires a problem-solving approach to address a particular issue (Hattjar, 2012a). Specific suggestions need to be tailored to address specific needs and will require further assessment into the nature of the particular problem. Lappa (2012) identified an intimacy assessment that can be used as an adjunct to the initial occupational therapy evaluation. The *intimacy assessment* is a compilation of questions that address client concerns with sexuality that is initiated by either the client or the occupational therapist (Lappa, 2012).

Information gathered from the intimacy assessment can be used to guide intervention during the specific suggestions stage. Interventions can include compensatory strategies and modifications as well as restorative interventions, when appropriate. For example, an occupational therapist may provide modifications to a client's positioning equipment and alterations to his or her environment to maintain hip flexion after a total hip arthroplasty. Teaching energy conservation strategies and planning daily activities are both great specific suggestions you can work on with your clients. Pleasure devices may be introduced; however, the inventory of such devices is vast and can be overwhelming. It is advised by this author to provide appropriate options for the client based on his or her needs, minimizing confusion. Pleasure devices can be explored in the clinic in a non-threatening environment, with the clinician present to limit anxiety. If that is not an option, practitioners can explore pleasure devices online with clients while filtering out inappropriate options. Pleasure devices can be very useful to increase arousal and orgasm as well as participation in certain positions. Many clients may wish to focus on body image, makeup, and clothing at this stage (Taylor & Davis, 2006)

Intensive Therapy

Intensive therapy is the most advanced stage of the PLISSIT model. Although occupational therapy practitioners may be able to effectively provide intensive therapy for sexuality, few have an adequate amount of training to do so, and clients should be referred to other professionals when appropriate (Hattjar, 2012a), such as neuropsychologists, sex therapists, or psychosexual counselors. Intensive therapy may involve couples counseling, changes to medication, or surgical interventions. Building experience requires practice and will increase your comfort. If the client's needs are functional and physical in nature, occupational therapy practitioners should address them at this level. Examples of intensive therapy appropriately

provided by occupational therapists include role playing to improve communication skills or to increase comfort during certain situations. Practitioners can also assist in increasing independence with adaptive equipment or positioning devices (Friedman, 2006).

Reflection and Review

The Ex-PLISSIT model incorporates reflection and review after all stages of intervention (Taylor & Davis, 2006). When review occurs at every stage, it allows more opportunity for the clinician to provide further Permission, enabling clients to discuss their concerns at any time and in as much detail as they wish. Reflection allows clinicians to identify their attitudes and how these attitudes might affect how they provide treatment. Reflection is another way for clinicians to embody and understand the lived body experience.

TREATMENT APPROACHES

There are three common types of treatment approaches that can be used when addressing sexuality (AOTA, 2013): health promotion, remediation, and modification. Each of these methods can be used at all levels of intervention, as outlined by the PLISSIT model.

Health Promotion

Health promotion involves providing education to at-risk populations (e.g., safe sex practices for clients who are at a high risk for sexually transmitted diseases or unwanted pregnancies). Health promotion can be provided through a pamphlet or flyer in a clinic waiting room that identifies occupational therapists as a resource for concerns regarding sexuality and sexual participation. Other examples include:

- Programs promoting safe sex practices for teenagers with or without disability or illness (AOTA, 2013).
- Programs promoting safe sex practices and use of condoms at an assisted living facility.

Remediation

Remediation requires the restoration of "skills such as range of motion, strength, endurance, effective communication, and social engagement as part of meeting sexual needs" (AOTA, 2013). Clinicians can work on the individual client factors that are required to engage in sexual activity or increase satisfaction with their sexuality. Some examples include:

- Increasing strength and range of motion after carpal tunnel surgery so a client can fully weight bear during sex without pain or loss of sensation
- Focusing on increasing endurance to maximize sexual participation
- Practicing asking people out to reduce anxiety during social events

Modification

Modification includes "changing the environment or routine to allow for sexual activity" and satisfaction (AOTA, 2013). Positioning and adaptive techniques and tools are included in this type of intervention. Some examples include:

- Lubrication to reverse the adverse effects of vaginal dryness
- Positioning devices to maximize safety and promote independence with maintaining positions
- Promoting energy conservation techniques to compensate for chronic fatigue
- Information on using personal pleasure devices to engage in self-pleasure
- Modified positions to compensate for activity limitations or restrictions
- Promoting intimacy in place of sexual intercourse

ADDRESSING SEXUALITY DURING ILLNESS OR INJURY

This section explores the various effects of a few common chronic illnesses on sexuality and how to address them. Each condition is presented as a case example, including assessment and intervention.

Most chronic and traumatic illnesses have some impact on clients' sexuality; however, the severity will vary. More resources are available to address issues with some conditions than others; however, no two clients will present in the same way.

Spinal cord injury

Spinal cord injury has been one of the most heavily examined conditions relative to sexuality (Paralyzed Veterans of America, 2011). A full guide on sexuality and spinal cord injury was published by the Paralyzed Veterans of American in 2011 titled *Sexuality and Reproductive Health in Adults With Spinal Cord Injury: What You Should Know*. The level of spinal cord injury plays a significant role in the types of concerns a client will have regarding sexuality and sexual function.

Clients with spinal cord injury commonly experience a temporary loss of sexual desire, loss of genital sensation, and ability to be sexually aroused. In addition, women often experience a temporary inability to experience orgasm, and men temporarily lose the ability to ejaculate and/or they experience erectile dysfunction (Paralyzed Veterans of America, 2011).

Overall level of injury will determine sexual functioning but does not limit exploration of sexuality and intimacy. Higher-level spinal cord injuries require more assistance, adaptive equipment, or compensation to maintain intimacy. Loss of sensation and motor function of the genitals will impact "normal" sexual function. Significant others may experience a role change, from spouses to caregivers, in turn impacting their ability to maintain intimacy.

Male clients may not experience any genital sensation; however, they may be able to maintain a reflexive erection that can allow them to remain sexually active. Thoracic-level spinal cord injuries affect core strength and balance, so clients may benefit from positioning aides and equipment to assist with thrusting motions and maintaining positions. Clients may also have limited control of their bowl and bladder functions and will need to be able to compensate to avoid accidents during sexual and intimate relations. All clients will benefit from adaptation to increase function and satisfaction with sexual and intimate relations (Hattjar, 2012b).

Case Example: James, Sacral Spinal Cord Injury

James Wheeler was a 28-year-old married male with two children who had experienced a traumatic spinal cord injury after a skiing accident the previous year. James sustained a complete S2-level injury and was admitted to an acute inpatient rehabilitation hospital to increase his safety and independence prior to returning home to his wife and children.

James had been a police officer prior to his injury and enjoyed outdoor activities. He was planning to return to the police department to do office duty after he recovered. He lived in a one-story home with a walk-in shower and was planning on having his car modified with hand controls.

James expressed his concerns with being able to resume his role as a husband. He reported that he sometimes experienced erections when he was adhering to his bowel and bladder program or during showers, and he was curious if he would be able to resume sexual activity. He was unsure whether he would be able to keep his wife sexually happy and satisfied and whether they would be able to have more children.

An occupational therapy intervention provided for James was based on the PLISSIT levels of intervention.

- **Permission:**
  - James had already expressed an interest in addressing his sexuality. His occupational therapist considered ways to provide permission, considering that James might be interested but still fear the outcomes of the conversations or feel shameful.
  - The occupational therapist validated James' concerns and reassured him that many individuals share the same or similar concerns after a spinal cord injury.
- **Limited intervention:**
  The occupational therapist provided a simplified explanation of how James' spinal cord injury had affected his sexual participation and performance, to help James consider the unknown variables. The therapist provided online resources on what to expect regarding sexuality and spinal cord injury through spinal cord associations, remembering to avoid using complicated medial jargon and also filtering resources to avoid providing so much information that it would become overwhelming.
- **Specific strategies:**
  The therapist asked James whether his wife had an interest in being involved and whether either of them had any specific questions. Including the client's significant other in the conversation is up to the client. It is important to recommend opening up the conversation, but it is equally important not to push clients if they are not comfortable with this approach. James' wife did want to be involved, and as if often the case, she wondered what could hurt James and what would be too much. This was an important conversation, because partners may be hesitant to re-engage in sexual activity, which the client may take to mean that they are no longer sexually attractive.

  Based on their discussion, the occupational therapist suggested positions and equipment to accommodate James' function. As with other ADLs, the therapist followed up to see what did and did not work, and offered additional modifications.
- **Intensive therapy:**
  The occupational therapist did not have additional training so was not qualified to provide intensive therapy. The therapist therefore provided James and his wife with a referral to a counselor who could provide intensive services as necessary.

CONCLUSION

Sexuality and sexual participation are areas of practice that are easy to overlook. Occupational therapists are particularly qualified to address and treat impairments of sexuality and sexual participation with clients. Sexuality is an activity of daily living and is a very important part of an individual's quality of life. Sexuality embodies the psychological and physical well-being of our clients and can be expertly addressed and treated by occupational therapy practitioners. The aim of this article was to provide enough relevant and precise information to occupational therapy practitioners to increase their comfort and confidence with addressing sexuality in practice. There is a continued need for research and program development that can validate the benefits of utilizing occupational therapy interventions to treat concerns with sexuality and sexual participation. Expertise and experience will come with practice. The first step is to open the door.

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Final Exam

Article Code CEA0517

Addressing Sexuality in Occupational Therapy

To receive CE credit, exam must be completed by March 31, 2019.

Learning Level: Intermediate
Target Audience: Occupational Therapists and Occupational Therapy Assistants
Content Focus: Domain of OT: Activity of Daily Living: Process: Intervention

1. **Which statement best describes the *specific suggestions* level of intervention?**
   A. Providing modifications and adaptive strategies
   B. Providing reassurance of feelings regarding sexuality
   C. Role playing effective communication strategies
   D. Providing an informational pamphlet to be reviewed independently
2. **What concept illustrates the perception of self-control and can impact engagement in sexuality?**
   A. Self-worth
   B. Self-efficacy
   C. Personal causation
   D. Personal imagery

3. **Which of the following are *not* external barriers to engagement and satisfaction in sexuality?**
   A. Disablism
   B. Practitioner discomfort
   C. Client hesitance
   D. Lack of treatment time

4. **Why are occupational therapy practitioners particularly able to address sexuality with clients?**
   A. They are creative and easy to talk to.
   B. They treat the whole person and value holistic interventions.
   C. They report comfort and knowledge in treating sexuality.
   D. They understand the importance of engagement in activities of daily living.

5. **Sexual participation and sexuality can be sources of all of the following except:**
   A. Satisfaction
   B. Comfort
   C. Pleasure
   D. Intimacy

6. **Which of the following is the most appropriate next step when you do not know how to and are not comfortable with addressing your client's concerns?**
   A. Make an educated presumption
   B. Refer your patient to someone who is better equipped
   C. Provide your client with ample reading materials
   D. Focus on other areas of concern

7. **Your client wants to know how to relieve back pain during sexual intercourse. At which level of intervention would you provide your client with alternative positions and positioning equipment?**
   A. Permission
   B. Limited Information
   C. Specific Suggestion
   D. Intensive Therapy

8. **Prior to approaching sexuality with clients, occupational therapists are advised to do which of the following?**
   A. Review therapeutic use of self.
   B. Increase proficiency in medical terminology of the reproductive system.
   C. Conduct a self-assessment.
   D. Complete at least three to four case studies to increase comfort.

9. **Based on the AOTA Fact Sheet *Sexuality and the Role of Occupational Therapy*, sexuality is defined as which of the following?**
   A. Physical function
   B. State of mind
   C. Emotional state
   D. State of well-being

10. **Therapeutic use of self is essential when addressing sexuality with clients for all of the following reasons except?**
    A. It allows the practitioner to develop and manage the therapeutic relationship
    B. It includes the use of therapeutic listening, which assists in increasing understanding of client experiences
    C. It provides more control to the practitioner, limiting inappropriate conversations
    D. It builds the therapeutic relationship and rapport with the client

11. **Which of the following is not one of the types of interventions recommended in the AOTA Fact Sheet on sexuality?**
    A. Health promotion
    B. Compensation
    C. Remediation
    D. Modification

12. **A program for parents of adolescents with developmental delay that provides things to look out for as the child reaches puberty and recommended actions to take is an example of which type of intervention?**
    A. Health promotion
    B. Risk reduction
    C. Remediation
    D. Modification