International Encyclopedia of Rehabilitation

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This publication of the Center for International Rehabilitation Research Information and Exchange is supported by funds received from the National Institute on Disability and Rehabilitation Research of the U.S. Department of Education under grant number H133A050008. The opinions contained in this publication are those of the authors and do not necessarily reflect those of CIRRIE or the Department of Education.

Sexuality and the Role of the Rehabilitation Professional

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Introduction

Sexuality is a fundamental aspect of health and well being for all individuals, but is often a difficult and sensitive subject to discuss, even in the most intimate relationships. It becomes even more difficult to address in a setting such as a hospital or health care facility where interactions are more formal. It is important that health professionals are knowledgeable and comfortable with the topic in order to adequately deal with issues concerning sexuality. However, in health care settings most professionals feel ill equipped to discuss sexual concerns with clients and patients. Many feel that they lack competence to provide sexual health care and are unsure of their roles in providing this kind of care (Anderson 1992, Conine 1984). Despite an increase in training and education surrounding sexual health services, it remains an area of discomfort for most health service providers, including rehabilitation professionals. In a rehabilitation setting, it is unclear which professionals should be primarily responsible for ensuring the sexual health of the client is addressed in an appropriate and timely manner. Determining who is responsible for addressing sexual health issues will ensure that the patient's needs are being met and the professionals themselves have the appropriate training and/or resources in place to deal with the topic. The World Health Organization (2006) maintains that sexuality is an important aspect of holistic well-being, and that sexual health requires, "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" (2006 p6). The job of rehabilitation professionals, is to increase the function of our clients in every domain of physical and mental health, well-being, and quality of life; including sexuality therefore, it appears logical that

rehabilitation professionals are not only equipped to deal with sexuality issues at this level, but it is imperative to also include sexual concerns in best practice protocols and curricula.

The best method for addressing sexual issues has not yet been established and will likely differ depending on the client's circumstances however; there are tools and techniques available that have been proven effective in the past. In order to better address issues surrounding sexuality, it is important that the rehabilitation professional take the time to reflect on his/her own biases and beliefs regarding sexuality. Rehabilitation professionals also need to be able to communicate openly and effectively, have knowledge of sexual theory and practices, as well as tools to assist with the evaluation and treatment process. Removing personal biases and developing strategies to deal with sexuality issues will allow for the rehabilitation professional to create a supportive and safe environment to assist the client with their needs. In a rehabilitation setting, professionals acknowledge the importance of active participation of a patient in the process of increasing function. In keeping with this philosophy, this document will use the term client to represent any individual, couple, or group receiving rehabilitation services.

Sexuality: Terms

In order to incorporate considerations for sexual well-being in daily practice, it is important to understand the definitions of sexuality, sexual health, and sexual rights. The following definitions were published in the technical consultation on sexual health by the World Health Organization (2006 p5).

"**Sexuality** is a central aspect of being human throughout life and encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction. Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviours, practices, roles and relationships. While sexuality can include all of these dimensions, not all of them are always experienced or expressed. Sexuality is influenced by the interaction of biological, psychological, social, economic, political, cultural, ethical, legal, historical, religious and spiritual factors."

"**Sexual health** is a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires 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. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled."

"**Sexual rights** embrace human rights that are already recognized in national laws, international human rights documents and other consensus statements. They include the right of all persons, free of coercion, discrimination and violence, to:

- the highest attainable standard of sexual health, including access to sexual and reproductive health care services;
- seek, receive and impart information related to sexuality;
- sexuality education;
- respect for bodily integrity;

- choose their partner;
- decide to be sexually active or not;
- consensual sexual relations;
- consensual marriage;
- decide whether or not, and when, to have children; and
- pursue a satisfying, safe and pleasurable sexual life.

The responsible exercise of human rights requires that all persons respect the rights of others."

Whose Role is it?

In a rehabilitation setting, many professionals are part of an interdisciplinary team working together toward a common goal with the client. The question then is who is responsible for dealing with sexuality? Cole (1991) suggests an approach to sexuality that has three main assumptions. The first is that sexuality is a valid health issue that should be addressed in all clinical settings. Secondly, the individual who addresses sexuality should have an adequate understanding of his or her own sexuality to reduce the likelihood that personal views on sexuality will be imposed upon the client. Lastly, sexuality should be dealt with in the same manner as other important issues in health care. These assumptions suggest that an interdisciplinary approach to sexual health would be ideal. For example, the doctor may ask about family planning and sexual activity, or discuss when it is safe to resume sexual activity, and risks for sexually transmitted infections. The nurse might talk about the self-care of reproductive organs after a surgery, or teach self-catheterizing to a client with a spinal cord injury. The physiotherapist might work with some of the physical limitations for example strengthening the pelvic floor, and the occupational therapist might look at ways to adapt sexual positioning and explore assistive technology as an aid to sexual functioning. In some cases, there may only be one professional working with the client for example, when working in an outpatient, rural, or private practice setting. In other cases, one professional may have more experience in sexual health, or they may be most comfortable with the client, or have a strong rapport with the client and see them most frequently. Regardless of who ultimately addresses sexual health with the client, it is imperative that the process includes input from various health professionals and team members (which may also include the client's sexual partner(s), family members, etc) and be sensitive to the client's unique needs, concerns and desires.

When asked about sexuality and sexual issues, Gianotten et al (2006) found that 73% of patients, 59% of patient partners, and 67% of rehabilitation professionals thought that sexuality was an important issue to be addressed. They found that 93% of physicians, psychologists, and social workers felt that sexuality fell within their domain of practice, whereas 87% of nurses felt that this was their role, and only 48% of physical therapists, speech language pathologists, and occupational therapists felt it was within their discipline. The theme from these findings is that although rehabilitation professionals feel that sexuality is important to address with patients, the training they have received is not sufficient enough to allow them to feel equipped to handle these issues. More specific training in the area of sexuality is necessary in order to be confident in their abilities to address clients' sexual concerns.

Training and Education

Based on the literature, it appears that many health professionals feel ill equipped to address sexual health concerns with their clients (Couldrick, 1999, Weerakoon et al 2004). Simply acquiring more knowledge about sexual behaviours, reproduction, sexual dysfunction and disease is not sufficient in providing comprehensive sexual rehabilitation services. Professionals should discuss and review personal values and attitudes regarding sexuality and practice skills in communication and unbiased counselling (Fifeld and Esmail 2000). The World Health Organization (1975) suggests that the following components be included in sexuality curriculum for all health disciplines:

- Sexual values: both past and present, and the influence of religion and culture
- Communication skills: sexual language and taking a sexual history
- Reproductive Anatomy and physiology: sexual response and sexual dysfunction
- Sexual lifestyles: role of sex in relationships and sexual orientation
- Effects of illness and injury on sexuality: sexually transmitted infection, sexual assault and abuse, changes in relationships and body image
- Role of the health professional: a sexual advocate, educator, and counsellor
- Resources: specialized sexual health services for referral.

It is recommended that all health professionals attend training sessions or conferences focussed on sexuality to expand knowledge, network with local experts in the field, as well as challenge personal beliefs and approaches to sexuality in a clinical setting.

Becoming Comfortable with Sexuality

It is important that the therapist understand his or her own personal biases and professional limitations when dealing with sexual health through reflection of personal values and beliefs regarding sexuality. What topics create feelings of unease or embarrassment? What sexual orientation is preferred? What brings sexual pleasure? What would it mean to have sexual ability impaired by illness or disability? Health professionals and clients may encounter people in their health care team who do not share similar sexual values and beliefs. It is not necessary to change ideals regarding sexuality; however, it is important to be understanding, and open minded towards the concerns and values of others. Awareness of personal biases is essential in determining various topics and areas one is not comfortable with so that a referral can be made to another professional or care team that can meet the needs of the client. Sexual practices which can potentially cause harm to the clients themselves or to others will likely require the assistance of other professionals and knowing where to find assistance in these situations is essential. Of course, any information released during client interactions that fall outside of the law need to be reported. A working understanding of the DSM IV and the criminal code will assist in determining which behaviors are atypical but appropriate, and those that are inappropriate (American Psychiatric Association 1994, Dailey 1988, Rodrigues 1989, Rozovsky and Rozovsky 1982).

To begin this process, consider available resources within the health region or seek out other professionals who may know more about sexuality, such as a sex therapist. There are likely to be courses and societies who deal directly with sexuality that may be helpful in assisting the

expansion of personal comfort and understanding. Researching professional development opportunities in this area is likely to prove beneficial in clinical practice.

Approaching Sexual Health Concerns

Approaching sexual health concerns can be daunting, and this section is focused on helping the rehabilitation professional feel more confident. Having a plan or strategy for bringing up the topic of sexuality with the client early in the therapy and intervention process is imperative. A sexual history is an important addition to an initial intake interview; whether the client shares anything intimate with the professional this early in the process is unlikely. However, introducing the topic early on in the process will pave the way for later discussion and ultimately, assessment and intervention strategies, as rapport and trust is established.

P-LI-SS-IT

One tool that has proven useful in approaching sexuality is the P-LI-SS-IT model (Annon 1976). Although dated, the P-LI-SS-IT model, developed by Annon (1976) is still commonly used to determine the level of participation a professional should have with clients, and is a key model for approaching sexuality with a client. There are four stages in the model, including: permission, limited information, specific suggestions, and intensive therapy.

Permission

Once the professional and the client have had a few initial therapy sessions and an intake interview, it can be determined whether the client is currently active sexually with one or more partners, and the kinds of relationships the client is involved in. At this point the professional should ask for permission to discuss issues regarding sexuality, as well as give the client permission to bring these issues up at any time. It is also important to gain direct permission to discuss any sexual concerns with the client's partner(s). Indirect permission may also be obtained through active participation by the partner at each level of education and care throughout the therapy process (Anderson 1992, Urey Viar and Henggeler 1987). Many levels of permission are given and received at this stage. This stage is also helpful in educating the client about sexuality as an important aspect of well-being and that disability or impairment is not necessarily a limiting factor of expressing oneself sexually. Although many rehabilitation professionals may not feel confident discussing sexuality, most have adequate skills to provide this level of service (Fifield and Esmail 2000).

Limited Information

In this stage the etiology, pathology and possible complications specific to the client's disability should be addressed with the client. Attention to sexual functioning and any contraindications of sexual engagement or levels of physical fitness required for sexual acts should be a focus (Dicker-Friedman 1997). It would be beneficial to include the client's partner in this stage to allow the couple to ask any specific questions if permission is granted by the client to do so. This may ease any fears the partner may have about hurting the client and dispel myths regarding sexuality and disability (Esmail, Esmail and Munro 2001). The main role of the health professional at this stage is educating the client. Providing basic sexual information to the client is beneficial for most clients, and most health professionals are well equipped in this educator role (Fifield and Esmail 2000).

Specific Suggestions

Through the permission and limited information stage, the client may identify specific issues that need to be addressed as part of the formal intervention plan. This would take place in the specific suggestion phase. Before progressing to this level, the professional should take a complete sexual history of the client and any significant or current partner(s). The professional can then decide whether the client requires more in-depth intervention offered by the specific suggestion stage. The history will also ensure that any specific suggestions offered will be appropriate and specifically tailored for the client and partner(s) (Dicker-Friedman 1997). Specific suggestions may vary in content and purpose, some of which may include: adapted sexual positioning, assistive devices, and altered techniques. This stage is most appropriate for the discussion of sexual boundaries and roles acceptable to the client and his or her partner. This level of intervention also encompasses assisting the client to redefine their personal definition of sexuality, which often requires attidudinal changes and a broadening of views that includes any activity that is stimulating and pleasureable for the client as well as the partner (Rolland 1994, David, Gur and Rozin 1977). This stage of the P-LI-SS-IT model may require the professional to have greater understanding and experience in the area of sexuality and the impact of disability or illness (Dicker-Friedman 1997). Although some professionals may not feel qualified to provide this level of service, the intervention they provide should be in line with the scope of practice for their own particualr profession.

Intensive Therapy

If more intensive therapy is required beyond specific suggestions, it may be outside of most rehabilitation professionals' knowledge and abilities. Once the client's need for sexual intervention is assessed and considered alongside the scope and comfort level of the professional, one needs to determine who is most capable of dealing with the client's concerns. The client may require intensive counseling or medical intervention and should be referred for specialized services (Thorn-Gray and Kern 1983, Dicker-Friedman 1997). This may include referral to a Gynecologist, Urologist, Psychologist, or certified Sex Therapist. An essential consideration during this stage is to be aware of one's professional limitations and up-to-date knowledge of resources available to meet the client's needs. This level of therapy is required by few clients.

Taking a Sexual History

A valuable tool in obtaining information about sexuality and sexual health concerns is through taking a sexual history. Regardless of the specific profession, a sexual history should be addressed in the same manner as routine assessments and history taking, and should be a regular component of the intake process. However, discretion must be used due to the sensitive nature of the topic; addressing sexuality during the intake process may not be an ideal time for all clients. Taking a sexual history is essential for successful counselling and assists in differentiating between sexual dysfunctions that began before or after the injury (Garner and Allen 1988).

Lefebvre (1997) outlines six main goals of communication within the health care setting. They include: establishing rapport, determining the client's medical and interpersonal history, assessing the role and nature of the client's relationships, identifying the changes that have occurred since the illness or injury, determining how these changes are understood and how they are affecting quality of life, and communicating in a way that encourages discussion and client

questions. An important consideration is that not everyone will tell the truth about their sexual history or concerns the first time they are ask (Lefebvre 1997). Therefore, re-addressing sexual concerns throughout interactions may be necessary with many clients.

Some guidelines for sexual history taking are provided by Pomeroy, Slax, and Wheeler (1982). These guidelines provide a framework for any interview regarding sexuality and are organized into three categories: building relationship with the client, considering the format of the interview, and forming the content of the questions.

Building Relationship

The client should feel like an equal during the interactions. Helping the client feel comfortable talking about their concerns may be achieved through normalizing their concerns. The client should be educated about the frequency and variety of sexual health concerns in the general population, and understand that asking about sexuality is a routine part of the assessment and interviewing process. The client should be encouraged to discuss topics openly and honestly.

Format of the Interview

The interview should begin with the least sensitive topics and moving into more sensitive areas. Asking more than one question at a time should be avoided, and very little, if any, of the interview should be recorded. Lefebvre (1997) suggests the professional use bridge statements to incorporate sensitive or difficult topics into the sexual history or interview. These are statements that begin with general inquiry and move to more specific details. They reduce discomfort both for the professional and the client, glean valuable information, and make the more difficult topics seem like a natural progression in the conversation. Essentially, the goal of using bridge statements is to "minimize awkwardness and maximize permission seeking" (Lefebvre 1997 p27). Some examples of bridge statements provided by Lefebvre (1997 p27) are:

- Has anyone talked to you about how your injury [illness] can affect your ability to have sex [or a sexual relationship?]
- Since your injury [illness], has your relationship with your [spouse, partner, lover, significant other] changed? Has there been any change in your physical relationship?
- How has your [arthritis, multiple sclerosis, amputation] changed the kinds of things you and your [spouse, partner, lover] do together? Does he or she treat you any differently now? How has your sexual relationship been affected? What was it like before [onset or first diagnosis]?
- How has your libido [your desire for sex, your interest in sex] changed? How has it affected the way you feel sexually about your partner?
- Were you romantically involved with anyone when you were injured? [A "yes" gets this probe:] Were you sexually involved?

A comprehensive sexual history should cover the following topics (Lefebvre 1997):

1. Demographic and subjective information: age, gender, education, work history, social history, salient relationships

2. Principle complaint: specifics about injury, impairment, disability. When, where, what, and why? How does the client perceive the problem? What do they know about it, what are their goals?
3. Previous history: what information given is important for the professional?
4. General history: explore important historical life events and issues including experiences with the health care system and significant stressors in the client's personal life
5. Essential issues: assess any history of abuse, including physical, psychological, sexual, and substance both in the client's family or personally.
6. Sex-Specific issues: ask about sexual abuse, sexually transmitted infections, family planning, unplanned pregnancies, body image, sexual concerns, and sexual consequences of major life changes. Try to determine how much knowledge and education the client has about these issues.
7. Family and friends: consider all social relationships and the reaction others have to the client's condition and how it has affected spousal, parental, romantic, and working relationships.
8. Expectations: review the client's primary issues and complaints. Determine where sexual concerns are on their priority list.

Questions and Content

Despite the sensitive nature of many topics, and the potential for discomfort on behalf of both the client and the professional, it is important to be direct in questioning and avoid the use of euphemisms. Ask questions in such a way that assumes your client has already experienced the behavior. For example, rather than asking "have you ever…" frame the questions to ask, "when was the first time you…" This way of asking questions often encourages the client to respond more readily (Fifield and Esmail, 2000). Ask open ended questions that allow clients to tell their experiences. Validate their concerns with verbal and physical language and educate the client throughout the interview process (2000). It is also recommended that the professional avoid suggesting answers and allow for appropriate periods of silence, use appropriate works, and avoid jargon. Also, rephrasing information given by the client to verify understanding and to check for inconsistencies is important. The discussion should end with a brief recap of the purpose of the interview, the confidentiality of all shared details, and should leave the client with the opportunity to contact the professional in the future and ask any additional questions (Pomeroy, Slax, and Wheeler 1982).

Assessments

Once a sexual history is collected, the professional can move into targeting specific areas of concern with the client. A valuable way to do this is with sexual health specific assessments. Although standardized assessments and questionnaires are a useful tool in rehabilitation, they may not be suitable for all patients. In some cases a semi-structured interview or professional discussion about sexual concerns may be more valuable and appropriate. It is important to consider the level of rapport with the patient and the unique issues of each individual before choosing an assessment, evaluation tool, interview, or discussion when approaching sexual health. Ensure that the population the assessment was created for is also appropriate for the gender, age, culture, and health concern specific to the client. Also, a review of the psychometric properties of the assessment is essential in ensuring the validity and reliability of

the results of the assessment, and will assist in the professional interpretation of outcomes. See Table #1 for a brief list of some available tools designed specifically for sexual health and function.

Table #1: Assessment tools

Assessment	Source
The Female Sexual Distress Scale	Derogatis LR, Rosen R, Leiblum S, Burnett A, Heiman J. 2002. The female sexual distress scale (FSDS): initial validation of a standardized scale for assessment of sexually related personal distress in women. Journal of Sex and Marital Therapy. 28(4):317-330.
The Female Sexual Function Index	Rosen R, Brown C, Heiman J, Leiblum S, Meston C, Shabsigh R, Ferguson D, D'Agostino Jr R. 2000. The female sexual function index (FSFI): A multidimensional self-report instrument for the assessment of female sexual function. Journal of Sex & Marital Therapy 26:191–208.
Sexual Interest and Desire Inventory – Female (SIDI-F)	Sills T, Wunderlich G, Pyke R, Segraves, RT, Leiblum S, Clayton A, Cotton D, Evans K. 2005. The sexual interest and desire inventory—female (SIDI-F): Item response analyses of data from women diagnosed with hypoactive sexual desire disorder. The Journal of Sexual Medicine 2(6):801-818.
Changes in Sexual Functioning Questionnaire	Clayton AH, McGarvey EL, Clavet GJ. 1997. Th**e** changes in sexual functioning questionnaire (CSFQ): development, reliability, and validity. Psychopharmacological Bulletin 33(4):731-745. *Spanish Version:* Bobes J, Gonzalez MP, Rico-Villandemoros F, Bascaran MT, Sarasa P, Clayton A. 2000. Validation of the spanish version of the changes in sexual functioning questionnaire (CSFQ)." Journal of sex and marital therapy 26(2):119-131.
Sexual Quality of Life-Female	Symonds T, Boolell M, Quirk F. 2005. Development of a questionnaire on sexual quality of life in women. Journal of sex and marital therapy 31(5):385-397.
Menopausal Sexual Index Questionnaire	Rosen RC, Lobo RA, Block BA, Yang H, Zipfel LM. 2004. Menopausal sexual interest questionnaire (MSIQ): A unidimensional scale for the assessment of sexual interest in postmenopausal women. Journal of Sex & Marital Therapy 30(4):235-250.
Female Sexuality Questionnaire	McCoy NL. 2002. The McCoy female sexuality questionnaire. Quality of Life Research 9 (Supplement 1):739-745.
Personal Experiences Questionnaire	Dennerstein L, Anderson-Hunt M, Dudley E. 2002. Evaluation of a short scale to assess female sexual functioning. Journal of sex and marital therapy 28(5):389-39.
Compulsive Sexual Behaviour Inventory	Coleman E, Miner M, Ohlerking F, Raymond N. 2001. Compulsive sexual behavior inventory: A preliminary study of reliability and validity. Journal of Sex and Marital Therapy 27(4):325-332.
Arizona Sexual Experience Scale	McGahuey CA, Gelenberg AJ, Laukes CA, Moreno FA, Delgado PL, McKnight KM, Manber R. 2000. The arizona sexual experience scale (ASEX): reliability and validity. Journal of sex and marital therapy 26(1):25-40.
Golombok Rust Inventory of Sexual Satisfaction	Rust J, Golombok S. 1986. The GRISS: A psychometric instrument for the assessment of sexual dysfunction. Archives of Sexual Behavior 15(2):157-165.
Sexual Interaction System Scale	Woody JD, D' Souza HJ. 1994. The sexual interaction system scale: a new inventory for assessing sexual dysfunction and sexual distress. Journal of sex and marital therapy 20(3):210-228.
Reiss Premarital Sexual Permissiveness (PSP) Scale (Revised version)	Sprecher S, McKinney K, Walsh R, Anderson C. (1988). A revision of the Reiss premarital sexual permissiveness scale. Journal of Marriage and the Family 50(3):821-828.

Sexual Records

There are very few standardized forms used for recording and filing sexual health information in any health discipline. To promote the inclusion of sexual history taking and interventions

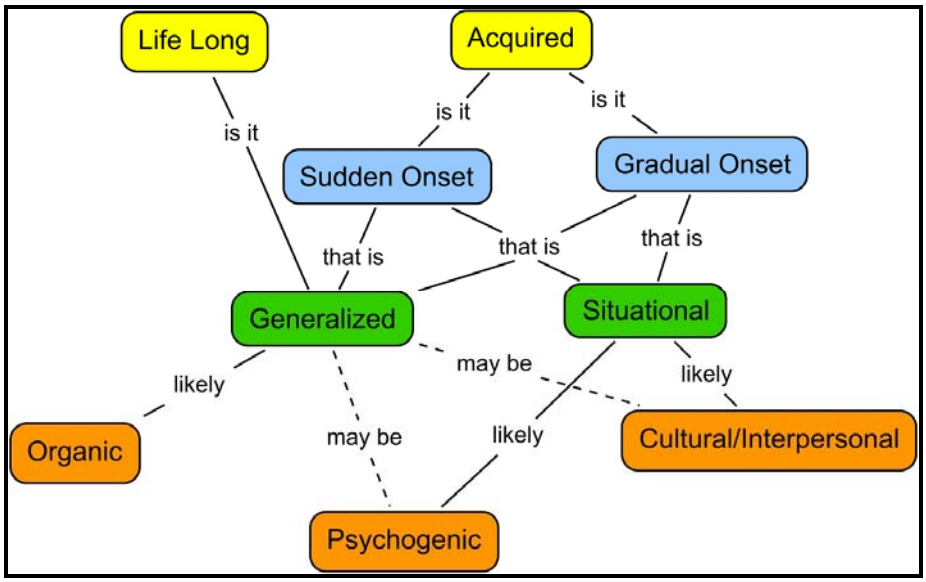
focused on sexuality, professionals and or departments should develop a form to be included. This may also validate sexual health as an integral part of health services in the department and increase the frequency of addressing sexual health concerns (Fifield and Fifield 1988).

Sexual Dysfunction and Treatment Strategies

Through taking a sexual history, interviewing the client, and doing some preliminary assessments, the professional will likely have an adequate understanding of the who, what, when, why, and how of the client's concern(s). Each disability, dysfunction, or illness will affect individuals differently. It is necessary that the professional understand what kinds of dysfunctions may be experienced by a client, and more importantly that that symptoms and experiences with the dysfunction will be unique to each client. This section will address some common dysfunctions for men and women, the possible causes, and some potential treatment strategies (Fifield and Esmail 2000).

There are three main categories of sexual dysfunction: organic, psychogenic, and cultural/interpersonal (Fifield and Esmail 2000). Organic dysfunctions include any physical trauma, illness, developmental difference, drug use, or hormone changes. These causes should be explored before looking into any other possible causes. Psychogenic dysfunctions may result from low self esteem, low confidence, conflicting personal values, history of abuse, anxiety, or a lack of sexual information. The above two are the more common causes of sexual dysfunction. The third reason for dysfunction is cultural and interpersonal issues. These are problems that may stem from sexually repressive societal values, feelings or beliefs of the individual/couple, and a lack of sexual experience or information. In evaluation of a client's sexual concern, one should look at the course of the problem to determine whether it is an ongoing or chronic issue, if it is recent and consistent, or it is dependent on the context or situation; such as with a specific partner, or in a specific place. Dysfunction may also be primary or secondary, meaning that it has always been present, or it occurs periodically (Fifield and Esmail 2000).

The diagram below illustrates the course of the problem, and is useful when evaluating the cause and course of sexual dysfunction.



Female Sexual Disorders (American Psychiatric Association 2000)

Arousal Disorders: inadequate excitement and vaginal lubrication

This may be caused by diabetes, low levels of estrogen, some neurological disorders such as spinal cord injury, excessive anxiety or stress, use of substances such as medications, alcohol, and narcotics, or negative experiences such as abuse. Arousal disorders may be treated by medical intervention for physical causes, sexual counselling aimed at reducing performance anxiety, and relationship counselling including any significant others or partners.

Orgasmic Disorders (anorgasimic/pre-orgasmic): the difficulty or inability to achieve orgasm

Orgasmic disorders may be caused by guilt or anxiety related to sexual pleasure, or insufficient clitoral stimulation. This dysfunction is often dependent on the situation, for example, a client may experience orgasm during masturbation, but not during intercourse. Possible treatment options could be counselling and education to counteract a negative attitude toward sexual activity, encouraging self exploration and massage, educating the client and significant others or partners on the female sexual response, and education or counselling on alternative sexual options and use of devices such as vibrators.

Dyspareunia: Painful intercourse or penetration of the vagina

The most common cause of dyspareunia is inadequate vaginal lubrication. This could also be caused by vaginal infections or sexually transmitted infections, pelvic inflammatory disease, endometriosis, among other diseases. This can be treated with medical intervention for physical causes, use of artificial water soluble lubricants, counselling for any psychological causes such as low self esteem or anxiety, and education on sexual techniques for both the client and significant others or partners such as increase foreplay.

Vaginismus: Involuntary contractions of the pelvic muscles surrounding the outer third of the vaginal barrel.

This is commonly caused by a fear of vaginal penetration and is often related to a history of assault or abuse. It can be treated through the use of graduated plastic vaginal dilators, encouraging sexual activities with the client in control, intercourse with the client on top, and counselling focussed on previous assault or abuse.

Male Sexual Disorders (American Psychiatric Association 2000)

Erectile Disorder: The inability to achieve or maintain and erection sufficient in firmness to penetrate

Approximately half of the people who experience erectile dysfunction have psychological issues that are causing the problem. Other common causes are diabetes, (50% of males who have diabetes experience some form of erectile dysfunction), stress and fatigue, low levels of testosterone, vascular or circulatory problems, general physical illness, substance use or abuse including medications, alcohol, and narcotics, anxiety related to sexual performance, or a neurological disorder such as spinal cord injury. Possible treatment strategies are: medical intervention for physical causes including medication, penile rings, vacuum pumps, urethral suppositories, and surgical insertion of flexible or inflatable rods in the body of the penis. Also, psychotherapy focused on decreasing anxiety to allow for regular sexual response may prove useful. This may include sensate focus among other techniques.

Premature Ejaculation: The inability for voluntary delay of ejaculation

There are a number of psychological causes for this dysfunction; such as, masturbating in secret as a means of immediate gratification, or first sexual experience in less than ideal situations. Physical causes such as neurological disorders should also be investigated as possible causes. The goal of treatment for premature ejaculation is to train the man to focus his sensations. Focussing teaches him to anticipate when an orgasm is going to occur and gain control over the timing of ejaculation. There are two main methods for focussing: the stop-go technique, and the squeeze technique.

Ejaculatory Incompetence: The inability to ejaculate after penetration despite adequate erection and arousal.

The disorder is primarily caused by psychological issues such as anxiety about penetration and ejaculation. Treatment may focus on the psychological reasons for the ejaculatory incompetence. A behavioural approach such as sensate focus is often useful.

Dyspareunia: Recurrent or persistent genital pain occurring before, during, or after penetration.

This is a rare sexual dysfunction and is usually associated with organic conditions such as herpes, prostatitis, or Peyronie's disease. Treatment strategies should focus on medical intervention to address the underlying organic causes.

When dealing with concerns around sexuality no matter what the issues or the dysfunction the rehabilitation professional must focus on the following four areas:

1. *Changing attitudes*

Many clients or couples may have limited views about sexual or physical relationships. This may be presented in how a couple thinks sex should be done and or when it should be done. Disability changes many aspects of life, and the way that partners engage in sexual activity is also very likely to change, therefore requiring an adjustment in client attitudes.

2. *Providing information*

Information about different techniques, positions, and devices that can improve a client's sexual experience is an important focus. Educating the client is essential.

3. *Giving permission*

As reviewed in the P-LI-SS-IT model, giving and receiving permission with your client and his or her partner(s) is necessary. Permission may also be required between the client and his or her partner to try new positions or techniques when exploring sexuality when considering a disability or illness.

4. *Reducing anxiety.*

Educating the client about options regarding sex and intimate relationships and providing them with resources, appropriate intervention and alternatives will assist in reducing the anxiety resulting from resuming sexual activity after injury or illness. Many clients may be unsure of their sexual potential and ability to perform sexually and will need to be reassured.

Through intervention and treatment, sexual dysfunction can be managed and or corrected. In brief, the objectives for a person with a disability and his or her partner should be to:

- Increase awareness of his/her own and partner's body sensations
- Learn to enjoy their own and other's body
- Develop greater satisfaction in physical experience together
- Enhance intimacy – both emotionally and physically
- Increase ability to talk openly about sexual thoughts and feelings
- Develop trust so they can talk openly about other options for sexual behaviours

Considering Couples

When sexuality is addressed by health care professional the client tends to be the focus of the intervention however, an individual often forgotten is the partner (Rolland 1994, Esmail, Esmail, Munro 2001). The literature on sexuality and disability suggests that intimate relationships are profoundly affected by disability (Esmail, Esmail and Munro 2001). In fact, sex has been reported as the most serious problem in relationships with one partner who has a disability (Kreuter Sullivan Dahllof and Siosteen 1998). In a study by Sadoughi, Leshner, and Fine (1971) most people who had a disability experienced a decline in frequency of sexual activity, the majority of whom had to change the way they participated in sexual activity. These changes also resulted in decreased sexual satisfaction and interest, coupled with most partners desiring an increase in satisfaction. Some cited reasons for the impact of disability on sexuality are the perceived and actual physical limitations causing fear and discomfort when participating in sexual activities (Sadoughi Leshner and Find 1971, Cohen Wallston and Wallston 1976). Disability may also increase stress in partner relationships which affects roles and personal boundaries (Rolland 1994, Feigin 1998, Kester et al 1988). Furthermore, it has been reported that the non-disabled partner may experience adverse health consequences, especially increased stress levels, due to having a partner with a spinal cord injury (Kester et al 1988).

As suggested by the literature, it appears that many sexual concerns are likely to require education and intervention for both the client and his or her sexual partners. Therefore, it may be useful to consider all individuals who make up the sexual partnership as the 'client', or recipient of services. When clients initially attempt to resume sexual relationships after an illness or disability they are likely to be anxious and unsure. In effort to decrease this anxiety the client and any partners can be encouraged to start with cuddling, petting, and masturbation before resuming intercourse (Garner and Allen 1988). Suggesting that clients seek out private times for exploration of their body and discussion about changes or feelings about their body may help in developing an understanding of their personal sexual anatomy and response. Using a sexual awareness program may be useful to aide this process (Fifield and Esmail 2000).

Strategies for addressing sexuality and disability in couple relationships are not common in the literature; however, there are some general strategies that have been found to be effective (Esmail, Esmail and Munro 2001). They include: mutual responsibility, education, facilitating communication between partners, facilitating attitude and behaviour change, and prescription or provision of aids, prosthesis, and resources. Counseling and therapy have also been effective tools for assisting couples in dealing with the stress and changes resulting from disability (Bernardo 1981). Again, it is important to understand that each disability will present differently based on the individual, and will have unique effects on couple relationships that will require various methods of education, counseling and intervention. For a more detailed discussion of the role of rehabilitation professions in the treatment of couple's sexuality as related to disability, readers are directed to the article by Esmail, Esmail, and Munro (2001).

Conclusion

The role of the rehabilitation professional in addressing sexuality has been a growing topic as more people acknowledge sexuality as an integral part of holistic well-being, and as central to being human (WHO 2006). Rehabilitation professionals must have an understanding of the physical and psychological aspects of sexuality and function in order to provide the best services possible to clients. An essential step in the process of service provision is understanding one's own values and beliefs regarding sexuality. Being open-minded and non-judgmental of both the professional's and the client's sexual behaviors aides in building rapport for an effective professional relationship. Discussing sexual concerns with a client is every professional's responsibility when providing health care services aimed at the whole person. Ability to take a comprehensive sexual history, knowing ones personal and professional limitations in providing sexual interventions, knowledge of appropriate assessments and common sexual dysfunctions are all the responsibility of the rehabilitation professional. In summary, understanding one's self, understanding the client, and understanding the dysfunction or disability are essential roles of the professional when considering sexual interventions. Ultimately, the most important professional role is addressing the topic of sexuality with every client in clinical practice.

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