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The ADL of Sexuality: A Guide for Occupational Therapists for Elderly Clients

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The ADL of Sexuality: A Guide for Occupational Therapists for Elderly Clients

by

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Approval Page

This Scholarly Project Paper, submitted by Autumn Edmundson and Amber Lafrenz in partial fulfillment of the requirement for the Degree of Master’s of Occupational Therapy from the University of North Dakota, has been read by the Faculty Advisor under whom the work has been done and is hereby approved.

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ABSTRACT

Purpose: The purpose of this scholarly project was to develop a guide that would address the assessments, treatment/interventions, and discharge planning process regarding sexual health/sexuality with an elderly client. Through the use of the guide and accompanying resources it is assumed that occupational therapists will have an increased level of comfort, knowledge, and competence. This is important as Coulombis and Miller (1994) study indicated that occupational therapists that received formal education (academically or clinical practice) addressed sexuality in the elderly 27.8% more than occupational therapists who did not have any educational experience.

Methodology: An in depth literature review was conducted using scholarly texts, scholarly search engines (SCOPUS, PubMed, CINAHL, Medline Plus, PsychInfo, Google), the American Occupational Therapy Association website, as well as AOTA’s publications such as the American Journal of Occupational Therapy, OT Practice, the Occupational Therapy Code of Ethics, Occupational Therapy Practice Framework: Domain and Process. Additional items, which were not available through the previously listed sources, were obtained through Interlibrary Loan at the Harley French Library of Health Sciences. Efforts were made to locate the original source of essential information in order to limit the use of secondary sources in this project. The project itself was guided by using the Model of Human Occupation, Malcolm Knowle’s Theory of Andragogy, and the BETTER model©.

Results: The result of this scholarly project is the development of The ADL of Sexuality: A Guide for Occupational Therapists for Elderly Clients, which illustrates many aspects of the therapeutic process to address the ADL of sexuality with the elderly client using one source. The completed Guide will be made available at the Harley French Library of Health Sciences for educational use, including faculty and upcoming health professionals. It is also suggested this Guide be made available to practicing occupational therapists to serve as a resource regarding sexual health/sexuality in the elderly.

Conclusions: The ADL of Sexuality: A Guide for Occupational Therapists for Elderly Clients provides many benefits to the occupational therapy profession. These benefits include methods to increase the comfort level and understanding of addressing sexuality as an important ADL. It provides an opportunity for occupational therapists to learn how to address sexuality in an elderly client using a holistic, client-centered approach. It is hoped that this Guide will increase the frequency of addressing sexual health/sexuality in the elderly, as well as enhancing their satisfaction with occupational therapy services.
CHAPTER I
INTRODUCTION

Sexual health/sexuality in the elderly is an issue that has been neglected by healthcare professionals, including occupational therapists, which has had negative health implications. Miller, Adams, Henry, and Silverman's 1993 study, found even after the elderly initiated expressing concerns about sexual health, occupational therapists were inconsistent with follow-up of their concerns. Redelman (2008) and Sharpe (2004) found that one reason healthcare professionals avoid addressing sexual health needs is due to the lack of comfort and pre-professional education they receive. Sharpe (2004) identified a lack of healthcare education concerning sexual health issues as the most significant sexual challenge the elderly population face.

Due to this lack of education and comfort in addressing sexual health/sexuality in the elderly, The ADL of Sexuality: A Guide for Occupational Therapists for Elderly Clients, was developed. Its goal is to decrease the prevalence of these factors in the profession of occupational therapy. It targets both pre-professional and professional occupational therapists. Indirectly, the elderly population will benefit from this resource via a more appropriate, effective, and comprehensive occupational therapy approach.

This Guide is designed to increase comfort and competency in addressing sexual health/sexuality with the elderly client, while serving as a guide for the therapeutic process. It has four sections: assessment, treatment/interventions, discharge planning,
and resources. In order to guide the therapeutic process, via these four sections, a strong theoretical base is important.

A theory or a theoretical model is what shapes the practice of a profession. It helps clinicians understand the occupational problems faced by a client and how to address the needs of that client. Three theories/models were chosen in the design of The ADL of Sexuality: A Guide for Occupational Therapists for Elderly Clients:


3. BETTER model© (Mick, Hughes, & Cohen, 2004): provides a detailed approach that is used to address sexual health/sexuality in clients in order to ensure holistic care, which is beneficial for both the client and the occupational therapist.

Each theory/model plays a role in the development of a comprehensive and integrative approach to meet the needs of the elderly in regards to sexual health/sexuality.

Throughout the scholarly project, several terms have been used to discuss sexuality/sexual health in the elderly and the role of the occupational therapist. In the following is a list of terms and definitions that may enhance the reader’s ability to understand the information presented, as some terms may be unfamiliar or have multiple meanings.
Terms and Definitions:


2. AIDS- “the most advanced stages of infection with the human immunodeficiency virus” (AIDS, 2009, ¶2).

3. Anal Sex- “most often refers to the sex act involving insertion of the penis into the anus” (Wikipedia, 2009, ¶2).


5. Competence- “therapist’s duty and responsibility to practice competently and to be knowledgeable about ongoing developments and practice and develop the research evidence to support these developments” (Taylor, 2008, p. 12).

   - For the purposes of this project, elderly will be defined as 65 and older.

7. Emotional Intimacy- “the need and ability to experience emotional closeness to another human being” (Mattiasson & Hemberg, 1998, p. 528).

8. Gerontics- “of or pertaining to the last phase in the life cycle of an organism or in the life history of a species” (Gerontic, 2009, ¶1).

9. Holistic- concerned with wholes or with complete systems rather than with the analysis of, treatment of, or dissection into parts” (Merriam-Webster, 2009, ¶1).
10. Human Immunodeficiency Virus (HIV)- “a virus that kills or damages cells of the body's immune system” (AIDS, 2009, ¶2).

11. Masturbation- “erotic stimulation especially of one's own genital organs commonly resulting in orgasm and achieved by manual or other bodily contact exclusive of sexual intercourse, by instrumental manipulation, occasionally by sexual fantasies, or by various combinations of these agencies” (Merriam-Webster, 2009, ¶1).

12. Oral sex- “is sexual activity involving the stimulation of the genitalia by the use of the mouth, tongue, teeth, or throat” (Wikipedia, 2009, ¶1)

13. Penile-vaginal intercourse- “heterosexual intercourse involving penetration of the vagina by the penis” (Merriam-Webster, 2009, ¶1).

14. Physical intimacy- “the need and ability to experience closeness to another human being either through bodily contact or sexuality” (Mattiasson & Hemberg, 1998, p. 528).

15. Quality of life- “ability to enjoy life based on personal goals, values, and beliefs” (Wilmoth, 2007, p. 508).

16. Safe Sex- “a term used to describe sexual activities that minimize the risk of spreading sexually transmitted diseases” (Ortiz, 2007, p. 648).

17. Sexual Activities- “actions taken to obtain release of sexual tension alone or with another to achieve sexual satisfaction” (Wilmoth, 2007, p. 508).

18. Sexual Behaviors- “the multiple ways one verbally and nonverbally communicates sexual feelings and attitudes to others” (Wilmoth, 2007, p. 508).


21. Sexual Functioning- “The physiologic components of sexuality, including human sexual anatomy, the sexual response cycle, neuroendocrine functioning, and life-cycle changes in sexual physiology; often affected by pathophysiologic and structural changes to the body and by pharmacologic treatments” (Wilmoth, 2007, p. 508).


23. Sexual Health- “the integration of somatic, emotional, intellectual and social aspects of sexual being in ways that are positively enriching, and that enhances personality, communication and love” (WHO, 2001, p. 7).

24. Sexual Identity- the process of continuing discovering who we are as individual in regards to sexuality (Sharpe, 2004).

25. Sexuality- “part of being human; present from birth through death. All that makes us man or woman; perceptions about one’s body; the need to touch and connect with others, in both intimate and social settings; interest and ability to engage in sexual behaviors; communication of one’s feelings and need to others; and the ability to engage in satisfying sexual behaviors” (Wilmoth, 2007, p. 508).
26. Sexually Transmitted Diseases (STD's)- “infections that you can get from having sex with someone who has the infection” (Sexually Transmitted Diseases, 2009, ¶1).

The scholarly project will be presented in the remaining four chapters. Chapter II is a review of the literature focusing on sexual health/sexuality in the elderly and the role of occupational therapy. Chapter III describes the methodology used to design and develop *The ADL of Sexuality: A Guide for Occupational Therapists for Elderly Clients*. Chapter IV includes an introduction to the product, as well as the project in its entirety. Lastly, Chapter V summarizes the purpose, key information found throughout the development of this product, as well as recommendation for implementation.
CHAPTER II
LITERATURE REVIEW

Introduction

Sexuality has been acknowledged as an important component of the quality of life for individuals in general, but it has not been easy to either encourage or respond to older people’s expressions of sexual interest, attitudes, activity and satisfaction (Low, Lui, Lee, Thompson, & Chau, 2005). This basic human need is consistent in its presence in an individual’s developmental life span, starting at birth and ending at death, which is not affected by age, physical appearance, health, or functional ability (Hajjar & Kamel, 2004; Redelman, 2008). Therefore, sexuality is not a need that is eliminated in the aging process. Multiple studies have proven that although sexuality varies in frequency, intensity, and mode of expression, the elderly are not different from the younger population, regarding the need for sexuality and engagement (Bonder & Wagner 2001; Geiss et al., 2003; Ginsberg, Pomerantz, & Kramer-Feely, 2005; Hajjar & Kamel, 2004; McNicoll, 2008; Olivi, Santana, & Mattias, 2008; Rheaume & Mitty, 2008; Sharpe, 2003, 2004). Levy (1994) states that each developmental stage of sexuality has its own properties for sexual development, such as the belief that expression may be with others or alone through various behaviors (as cited in Sharpe, 2004).

According to the AOTA Framework (2008), sexuality is considered an important activity of daily living (ADL). Although considered an ADL, sexuality is often neglected
in the medical field due to lack of comfort discussing the subject (Bonder & Wagner, 2001; Clover, 2006; Olivi et al., 2008; Redelman, 2008; Sharpe, 2003, 2004). Hattjar, Parker, and Lappa (2008) stated, “...The ADL of sexual activity does not receive the same weight or level of worth as more usually addressed ADL’s of dressing, bathing, and grooming...” (p. CE-1). The challenge for healthcare professionals to address sexuality becomes even more complex when sexuality is in reference to the elderly population.

For the purpose of this scholarly project, the term elderly will be defined as an individual aged 65 or older.

The literature review will present information regarding the following: 1) human sexuality and aging providing statistics and definitions of the terminology related to sexuality awareness; 2) issues concerning the elderly; 3) healthcare professionals; 4) sexual health and; 5) the role of occupational therapy (OT). The literature review will culminate with the presentation of a proposed program consisting of information, resources, and strategies to assist the healthcare professional, primarily the OT, to understand sexuality from older peoples’ perspectives and how their sexual health needs and concerns can be addressed by those caring for them.

**HUMAN SEXUALITY AND AGING**

**Definition of Sexuality**

In a survey of 3005 Americans, aged 57-85, it was discovered that the majority of older adults consider sexuality to be an important part of their life (Lindau et al., 2007). Sharpe (2003) described sexuality as “…a quality of being human, a powerful and purposeful aspect of human nature and important dimension of humanness” (p. 420). Fogel and Lauver (1990) indicate that sexuality includes intimate feelings of individuality
and the need for emotional closeness with another individual. Ginsberg, Pomerantz, and Kramer-Freely (2005) defined this emotional closeness as warmth that is produced from emotionality.

Intimacy includes two components; emotional and physical intimacy. Mattiasson and Hemberg (1998) found emotional intimacy to be a basic human need, which can hinder mental health, development, and maturity if not experienced. Physical intimacy, concerning bodily contact or sexuality, is also considered a fundamental need varying according to an individual’s needs (Mattiason & Hemberg, 1998).

Sexuality is an individualized concept, having different meanings for each person, which may differ in various stages of a person’s life (Redelman, 2008). It is shaped by each individual’s unique environment based upon psychological, social and physiologic factors, which help build an individual’s sexual self-identity (Kessel 2001; Sharpe, 2003).

The concept of sexual self-identity is linked to self-worth and can negatively affect an individual’s self-image, social relationships, or mental health, if not expressed (Hajjar & Kamel, 2004). Redelman (2008) supports these findings, indicating that one’s sexual preference is a combination of feelings, values, beliefs, and experiences.

Sexuality extends beyond the aspect of expressing with another. The concept of expressing oneself, as a sexual being, on a personal level, is a critical component of who we are, while sex is the action of intercourse (Redelman, 2008).

Expression of Sexuality

Bonder and Wagner (2001) identified sexual activity to be a valuable and pleasurable aspect of the elderly populations’ lives. McNicoll (2008) referred to sex and physical/emotional intimacy as ‘lifelong needs,’ and Rheaume and Mitty (2008),
identified sexual contact and closeness as desires that ‘can endure a lifetime.’ In addition to sexuality being a lifelong need, Robinson and Molzhan (2007) stated that it is a significant predictor of quality of life in the elderly population. Elderly people who are satisfied with the sexual activity in their lives are significantly more satisfied with both personal relationships and overall quality of life (Robinson & Molzhan, 2007).

Sexuality consists of sexual behaviors and desires, which must be defined to appreciate the distinction (Sharpe, 2004):

1. Sexual behaviors consist of both nonverbal and verbal expressions of sexuality. The term includes genital and nongenital acts, which may occur by oneself or with others. The term is broader than sexual acts alone, including behaviors such as seduction and courtship or more concrete behaviors such as touching and caressing (Ginsberg et al., 2005; Sharpe, 2003). Bonder and Wagner (2001) identified caressing, fondling, and deeply looking into another’s eyes as often being more important than the act of sexual intercourse or experiencing an orgasm. Mattiasson and Hemberg (1998) explained that touch, is a form of nonverbal communication, that communicates empathy, which when expressed appropriately, can lead to an increase in a persons’ self-identity, self-esteem, and well-being.

2. Schwartz and Rutter (1998) termed sexual desire, which is affected by physiologic, sociocultural factors, as the motivation that drives an individual to participate in sexual acts (as cited in Sharpe, 2003). This built upon Poorman’s (1988) definition, stating sexuality is what stimulates an individual’s sexual activity (as cited in Sharpe, 2003). This stimulation can vary widely, due to individuality, therefore causing the term to be vague in nature.

Sexual behaviors and sexual desires are integrated into sexuality through; notions, beliefs, facts, fantasies, rituals, attitudes, feelings, values, rights regarding gender identity and roles, sexual acts and orientation, pleasure, intimacy, celibacy, and reproduction (Bonder & Wagner, 2001; Rheaume & Mitty, 2008). Redelman (2008) found that people who are not physically sexually active are still capable of maintaining sexual activity through sexual dreams, feeling, and fantasies.
Differences in sexual expression have been noted among varying genders and marital status. Research indicates men are more sexually active than women (Bonder & Wagner, 2001; Lindau et al., 2007). This is often attributed to less women being involved in marital or other intimate relationships in late life; there is also a lower frequency of masturbation among older women when compared to older men (Lindau et al., 2007). Even when not sexually active, 98% of women acknowledged sexual activity as beneficial to overall health (Lindau, Leitsch, Lundberg, & Jerome, 2006, p. 749).

Although there appears to be an increase in quality of life with continued sexual activity in older adults, many may experience a decline in sexual activity, though the literature on the subject varies. Sources indicated that the frequency of sexual experience decreased with an increase in age (Bonder & Wagner, 2001; Zeiss & Kasl-Godley, 2001). Reasons for decline in sexual activity are attributed to several factors including sexual dysfunction, physical limitations, lack of privacy, and lacking of a partner (Hajjar & Kamel, 2004; McNicoll, 2008; Rheaume & Mitty, 2008). Ginsberg et al. (2005, p. 477) found that at least 60% of the elderly population were not sexually active as a result of lacking a partner. Another factor affecting the frequency of sexual activity may be a lack of education about aging and possible sexual changes, which will be discussed in more detail later. Therefore, in order to account for these factors in sexual expression, a holistic approach by the health care profession is needed (Mick, Hughes, & Cohen, 2004; Sharpe, 2003).

Holistically is defined as “concerned with wholes or with complete systems rather than with the analysis of, treatment of, or dissection into parts” (Merriam-Webster, 2009, p1). In order to holistically address sexuality with the elderly, it is important to
understand the physiological changes as one continues through the sexual development stages.

**Physiological Changes**

In order to understand the role of physiology within sexuality, one should understand the sexual response cycle and how it changes in middle and late adulthood. According to Sharpe (2004), the sexual response cycle consists of four phases: drive (desire), arousal, release (orgasm), and resolution (the refractory period). In both genders, drive remains consistent throughout the life span, although studies have proven frequency or activity may decrease (Sharpe, 2004).

Sharpe (2004) attributes arousal, to be the sexual response phase cycle most affected as an individual ages. Specifically, in relation to women during arousal, the decrease and eventual cessation of estrogen production, during menopause, may cause atrophy of urogenital tissues, decrease in genital vasocongestion, and lubrication (Sharpe, 2004). Both genders however, may need greater amounts of direct stimulation of the genitals due to lengthened arousal time (McNicoll, 2008; Sharpe, 2004).

Release is the phase least affected, however, there are changes that occur. As men age, it takes longer for an orgasm to occur, requiring direct sustained stimulation. Women, tend to be less rhythmic and coordinated in orgasmic contractions of the uterus and vagina, in addition to experiencing pain (Sharpe, 2004). Women, who were multiorgasmic before aging, will continue to be in late life (Sharpe, 2004).

The resolution phase, predominately affects men. As men age, the time between the ability to have another orgasm gets longer (Sharpe, 2004). Women experience a longer resolution duration due to decreased cervical dilation (McNicoll, 2008; Sharpe,
The sexual response cycle and the associated changes occur with both sexes/genders. There are also gender specific physiological changes that occur as one continues to progress through the aging process.

**Men**

Men have numerous physiological changes that are specific to their gender as they age. The changes concerning seminal fluid include a decrease in volume and ejaculation force; however, although reduced in number, the sperm remains fertile, as men do not undergo physiological climacteric (Bonder & Wagner, 2001; Hajjar & Kamel, 2004; Rheaume & Mitty, 2008; Sharpe, 2004). The erection needed to produce these fluids is smaller and less firm (Bonder & Wagner, 2001; Hajjar & Kamel, 2004; Rheaume & Mitty, 2008; Sharpe, 2003, 2004). In addition, it takes longer to get an erection, maintain it, and achieve subsequent ones. (Bonder & Wagner, 2001; Hajjar & Kamel, 2004; Rheaume & Mitty, 2008; Sharpe, 2003, 2004). Men experience a gradual decrease in the production of testosterone as they age (Bonder & Wagner, 2001; Hajjar & Kamel, 2004; Rheaume & Mitty, 2008; Sharpe, 2004). Many physical appearances take place such as senescence (i.e. thin and graying pubic hair), a decrease in size and firmness of the testicles, increased prostate size, and a decrease in production of preejaculatory fluid (Bonder & Wagner, 2001; Hajjar & Kamel, 2004; Rheaume & Mitty, 2008; Sharpe, 2004).

Men may also experience erectile dysfunction, the inability to have and maintain an erection. This sexual dysfunction is not considered part of the normal aging process, and usually results from medications or other medical conditions (Bonder & Wagner, 2001; Sharpe, 2004). Emotions can also affect erectile functioning (Sharpe, 2004). For
example, men may experience ‘Widower’s Syndrome’ which is the difficulty to achieve erection, after the death of their spouse, because they feel guilty pursuing another sexual relationship (Rheaume & Mitty, 2008; Sharpe, 2004).

Women

Women experience many of their physiological changes concerning sexuality during menopause (Ginsberg et al., 2005). With the onset of menopause, libido decreases (McNicoll, 2008). Hormonal changes occur, resulting in a decrease in production of estrogen levels. A decrease in estrogen leads to decreased clitoris size during arousal, decreased vaginal lubrication, stress incontinence, and graying and thinning of pubic hair (Bonder & Wagner, 2001; Sharpe, 2004).

Women also experience many vaginal changes during the aging process. The vagina changes in shape and flexibility, such as shortening and narrowing of the wall (McNicoll, 2008; Sharpe, 2004). The vagina also has less acidity, increasing the risk of vaginal infections (Sharpe, 2004). Moreover, the lack of vaginal lubrication production may also cause vaginal dryness and dyspareunia (pain with intercourse) (McNicoll, 2008). Although there are many physiologic changes that occur, research has found women who remain sexually active have fewer problems with maintaining their sexual activity and genital health (Beers & Berkow, 2000; Leiblum, Bachmann, Kemmann, Colburn, & Swartzman, 1983, as cited in Ryan, Berkowitz, Barbieri, & Dunaif, 1999). In addition to the normal implications of physiological changes with aging, medical issues may also negatively influence the sexual functioning of the elderly population.
Common Medical Diagnoses Affecting Sexuality

Lindau et al. (2007) recognized physical health as a stronger predictor of sexual functioning than age alone; thus, a decrease in physical health can lead to a decrease in sexual functioning. Poor health of the male in the relationship is the most common reason for sexual inactivity among elderly couples (Lindau et al., 2007). There is an abundance of literature about health issues and the sexual functioning of males; however, there is little literature about the impact of health on women although they may experience similar issues.

There are numerous medical diagnoses that can affect the sexuality of an individual. For the purpose of this literature review, the focus will be on six common medical issues: 1) diabetes mellitus; 2) cerebral vascular accidents (CVA); 3) cardiovascular disease (CVD); 4) psychological health; (5) sexually transmitted diseases (STDs) and; 6) the relationship of medication and sexuality.

**Diabetes:** According to National Diabetes Information Clearinghouse (2008), diabetes is a condition that approximately 23.6 million men and women are diagnosed with, in the United States. Ginsberg (2006) and Bonder and Wagner (2001) identified diabetes as a common cause of erectile dysfunction in men. More than half of all men diagnosed with diabetes identified decreasing firmness of erections as the first sign of the disease (Reinisch, 1991). Women also appear to be affected by the disease with a significant decrease in production of vaginal secretions (Ginsberg, 2006). This decreased production of vaginal fluid is often a cause of pain or discomfort during sexual intercourse (McNicoll, 2008).
**Cerebral Vascular Accident (CVA):** CVA, also known as a stroke, can cause sexual problems in both men and women. Ginsberg (2006) reported that people who have sustained a CVA often have decreased libido and diminished orgasms. In addition, people who have a history of a CVA were fearful of participating in sexual activity because they believed it may cause another (Ginsberg, 2006). Research indicates that CVA’s may cause erectile dysfunction in men and a decrease in vaginal lubrication in women (Monga & Osterman, 1995). They may also have difficulty participating in sexual activity due to one-sided weakness (Ginsberg, 2006). A CVA may additionally cause increased muscle tone, which may inhibit sexual activity, due deceased range of motion.

**Cardiovascular Disease (CVD):** CVD is also a common cause of sexual dysfunction in the elderly population (Bonder & Wagner, 2001). The American Heart Association (AHA, 2009) reports that 80,000,000 (one out of three) American adults have one or more types of cardiovascular disease. This population is comprised of 38,100,100 individuals who are over the age of 60 (AHA, 2009).

Individuals with cardiovascular disease have an increased risk for arteriosclerosis. Bonder and Wagner (2001) identified arteriosclerosis as a frequent cause of erectile dysfunction, created by a decrease in blood flow to the penis. Coronary bypass surgery, a treatment option for people with cardiac disease, is also a common cause of erectile dysfunction. Research indicates that at least 50% of men, who have had coronary bypass surgery for cardiac disease, now experience symptoms of erectile dysfunction (Bonder & Wagner, 2001, p. 225).
**Psychological Health:** Psychological issues are also a factor that impact sexual functioning. McNicoll (2008) identified poor body image, change in masculinity/femininity, fear of rejection, performance anxiety, and fear of isolation as psychological factors that may have a negative impact on sexual functioning. In addition, Bonder and Wagner (2001) identified both anxiety and depression as diagnoses that can create negative effects on sexual arousal and functioning.

**Sexually Transmitted Diseases:** Contrary to popular belief, sexually transmitted diseases and human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS) are prevalent diagnoses in the elderly population. According to the Center for Disease Control and Prevention (CDC), people over the age of 50 accounted for approximately 10% of new HIV infections in 2006 (Center for Disease Control and Prevention (CDC), 2008, p. 7). In 2007, the CDC estimated a total of 7,172 new HIV/AIDS cases diagnosed in adults over the age of 50 (CDC, 2008, p. 12). Furthermore, there are approximately 72,270 people living in the United States who have been diagnosed with the disease after turning 50 (Goodroad, 2003, p. 19).

HIV/AIDS is not the only STD the elderly population is susceptible to contracting. Olivi, Santana, and Mathias (2008) identified syphilis, gonorrhea, herpes, human papillomavirus (HPV), and hepatitis as other commonly contracted STD’s among the elderly population. Ginsberg (2006) expressed concern about the incidence of STD’s in this population by stating, “as people live longer, a greater percentage of the geriatric population will be diagnosed with sexually transmitted diseases” (p. 1031).

There are various reasons for the high prevalence of STD’s and HIV/AIDS in the elderly, which includes: 1) lack of formative education; 2) low risk perception for
contraction; 3) lack of protection; 4) physiological changes. Each of these contributing factors will be discussed in following points:

1. **Lack of Formative Education:** Rheuame and Mitty (2008) reported that the elderly population lacked formative sexual education during elementary school, high school, and college years. Olivi et al. (2008) discussed the nature of sexual education with the elderly population, in a healthcare setting, as one that revolves around sexual performance and dysfunction rather than sexual health promotion and STD and HIV/AIDS prevention. This lack of knowledge in turn leads to a decrease in perception of the risk for contracting HIV/AIDS (Olivi et al., 2008).

2. **Low Risk Perception:** A study by Falvo and Norman (2004) revealed over 70% of older adults surveyed did not perceive themselves at risk for contracting HIV/AIDS. Goodroad's (2003) research supported the perception that many older adults do not perceive themselves to be at risk for contracting sexually transmitted diseases although they are engaging in sexual activity considered high-risk. Ward, Disch, Levy, and Schensul (2004) discovered people, between the ages of 50-61, were 4.4 times more likely to perceive themselves as susceptible to contracting HIV/AIDS than people between the ages of 62-93 (2004, p. 581). This indicates that the elderly have a low risk perception.

   Gender was also found to be a contributing factor in risk perception. Ward et al. (2004) found males to be nearly two times as likely as females to perceive themselves at high-risk for the disease. While gender and age affected risk perception, sexual behavior was not considered a significant factor in the elderly populations' perception of contracting sexually transmitted diseases (Ward et al., 2004). This decreased risk perception has directly resulted in the decreased perception to practice preventative measures. Olivi et al. (2008) indicates that increasing the awareness of the prevalence of STD’s/AIDS in individuals over the age of 50, is the only way to approach prevention.

3. **Lack of Protection:** Bonder and Wagner (2001) identified a lack of protection during sexual activity as one reason for the high occurrence of sexually transmitted diseases in the elderly population. A study conducted by Lindau et al. (2006) revealed only 28% of sexually active, elderly women used condoms during their most recent sexual experience. Olivi et al. (2008) found similar results, indicating that 78.5% of men and 86.5% of female participants over the age of 50 did not engage in condom use during their last sexual encounter. The limited use of condoms among the elderly is stated to be a direct result of viewing contraceptives for pregnancy prevention rather than STD’s/AIDS prevention (Olivi et al., 2008).
4. **Physiological Changes:** In addition to a lack of education resulting in low risk perception and decreased use of contraceptives, physiological changes also put the elderly population at an increased risk for contracting HIV/AIDS and other sexually transmitted diseases (CDC, 2008; Goodroad, 2003). Catania et al. (1989) stated both decreased lubrication and vaginal wall thinning many post-menopausal women experience have been shown to increase the risk for HIV/AIDS. Although physiological changes are not preventable, lack of education about sexually transmitted diseases and HIV/AIDS are preventable factors that have a role in rate of transmission of these diseases.

Many common medical issues are addressed with pharmaceutical drugs. Pharmaceutical drugs may produce side effects that influence sexuality rather than being a direct result of the diagnoses.

**Medications:** Pharmaceutical drugs are often used to decrease the effects of illnesses and disease but they also have an impact on sexuality. Prescription medications, used to treat these illnesses, may cause adverse affects on sexuality (Bonder & Wagner, 2001). McNicoll (2008) identified decreased libido, erectile dysfunction, inability to reach an orgasm, and leakage of urine as common negative implications that medications have on sexual functioning.

McNicoll (2008) also identified antihypertensives, narcotics, diurectics, antipsychotics, and antidepressants as common medications that may cause these problems. Changing these medications might cause a drastic improvement of sexual functioning in the elderly population (McNicoll, 2008). After reviewing several medical diagnoses and the impact of pharmaceutical drugs that may affect an individual’s sexuality, one can understand the role of various education levels in relation to sexuality. The literature review presents various factors that can impact an individual’s sexual health; normal aging, medical diagnoses and/or medication. There remains a primary
factor that could be underlying all of the other factors; myths and stereotypes surrounding the topic within the United States.

**Myths and Stereotypes**

Although research proves the elderly engage in sexual expression, the general American society perception continues to demonstrate negative attitudes and beliefs towards sexuality in the elderly. Numerous myths and stereotypes in American society have negatively affected perceptions of sexuality in the elderly (Bonder & Wagner, 2001; Sharpe, 2004). These perceptions extend into the healthcare system as well as amongst the elderly population itself (Clover, 2006; Hajjar & Kamel, 2004).

Robert Butler, the first director of the National Institute on Aging, first developed the term ageism to describe this process of the systematic stereotyping and discrimination of the elderly (Palmore, 1999 as cited in Sharpe, 2004). Ageism, in modern western society, includes the following views of the elderly in regards to sexuality: limited in ability, weak, asexual and decreased attractiveness and appearance (Bonder & Wagner, 2001; Ginsberg, 2006; Kessel, 2001; Papaharitou et al., 2008; Sharpe, 2004). In addition to these falsehoods, there are groups of elderly who are marginalized: those in institutions such as nursing homes and those who are gay, lesbian, transsexual, and bisexual. Sharpe (2004) suggests that the feelings and expectations that are produced from ageism have a greater negative impact on sexuality than the actual physiological changes.

**Limited Ability, Weak and Asexual**

A common perception held by the majority of the population in western society, is that the elderly do not have, or even should not have sex, thereby upholding a lifestyle of
being asexual (Bonder & Wagner, 2001). The ideas that attribute to the notion of the elderly being too old to engage in sexual activities include not having sexual desire, and being weak or susceptible to injury (Bonder & Wagner, 2001; Ginsberg, 2006).

However, the idea of the elderly to be asexual, due to aging is far from reality. Sharpe (2004) iterates that sexuality and sexual development is a continuous process that includes the steps of recognizing, accepting, and expressing one’s sexual being, and as one goes through the process of aging and experience individual change, their sexuality too changes. Therefore, sexual development does not stop because one reaches physical maturity, but is part of the normal developmental process of aging (Sharpe, 2003).

Furthermore, to ensure progression of sexual development, there are new drugs that are available to enhance and maintain the sex lives of the elderly (Bonder & Wagner, 2001).

Although there are new drugs available, limited use has been established as only 10% of men and 7% of women who needed the help for enhanced sexual satisfaction, ever received it (Bonder & Wagner, 2001). Out of those who had, 62% of men and 59% women, reported enhanced satisfaction levels (Bonder & Wagner, 2001). It can make one wonder to what extent the beliefs of ageism are even held within the elderly population itself and if that plays a role in accessing these medical avenues. The question could also be, due to ageism, are elderly clients hesitant to raise the issue with their physician? Ageism in American society extends beyond the aspect of sexual development and medications, and expands into the physical appearance of the elderly (Hatch, 2005).
Attractiveness and Appearance

The ongoing process of aging has been recognized by American society to be a negative experience. As one ages, they are thought to become unattractive in their appearance, further making them feel sexually unattractive and undesirable (Bonder & Wagner, 2001; Ginsberg, 2006; Sharpe, 2003, 2004). This upholds the societal view that sexuality is prerogative of youth, and the elderly who defy this norm are perverse or ill (Ginsberg, 2006; Sharpe, 2004). However, the AARP study, as noted by Bonder & Wagner (2001), found that age does not decrease the number of elderly who viewed their partner as romantic or physically attractive. While this aspect is valid, Clover (2006) indicates the homosexual population is under further scrutiny when it concerns physical attractiveness in the aging process. This notion is due to the idea that homosexual males within society are believed to place high emphasis on physical appearance such as physical attractiveness. This iterates the sensitivity that needs to be elicited when working with marginalized groups concerning sexuality in the elderly, as their needs differ from their peers.

Marginalized Groups

There are particular populations within the elderly where sexual expression is even more stigmatized, such as those who identify as homosexual and those in institutionalized care. Hajjar and Kamel (2004) found that in institutionalized care, staff and family members were likely to have negative attitudes about sexual behaviors expressed by residents, when limited information concerning geriatric sexual education was present. In regards to being sexually active, the elderly are thought to be involved in only heterosexual relationships (Watson, 2004). Homophobia or discomfort in dealing
with homosexual clients has been identified among a variety of healthcare workers and a significant number of homosexual men have reported experiences of discrimination (Clover, 2006). Therefore, homosexual men and women avoid routine health care, perceiving health services as unfriendly places and are at great sexual health risks including HIV/AIDS (Clover, 2006).

Many myths and stereotypes exist within the healthcare system concerning elderly sexuality. Healthcare professionals believe sexuality, to be one of the first functions to cease with age (Papaharitou et al., 2008; Trudel, Turgeon, & Piche, 2000). Overall, myths and stereotypes have contributed to the limited research about sexuality in the elderly, which is a direct correlation to lack of healthcare involvement and education of healthcare professionals.

**Health Care Professionals**

As stated prior, the information available to professionals is limited and general (Hattjar, Parker, & Lappa, 2008; Olivi et al., 2008). This contributes to a lack of education, training and preparation, at the academic level on the issue of sexuality, for the medical and allied healthcare students prior to entrance in their professional field (Sharpe, 2004). Sharpe (2003) discovered sexual health education for healthcare professionals to be particularly poor in the United States.

**Academic Preparation**

Sharpe (2004) identified lack of healthcare education concerning sexual health issues, as the most significant sexual challenge the elderly population face, and further attributed this to lack of available academic resources. Sharpe (2003) states the United States lacks a framework dedicated to sexual development. Moreover, the progress that
has occurred has been solely focused on sexual changes in adolescence not adulthood, which Sharpe (2003) attributes to the limited understanding of basic sexual terminology. Fogel and Lauver (1990) discovered patients who were educated about age related sexual changes had little or no difficulty adjusting to these changes, therefore proving the importance of educating the health care professional at the collegiate level.

Specifically, a study by Miller, Adams, Henry, & Silverman (1993) aimed at occupational therapists, found that their knowledge levels were insufficient to ensure competent intervention, and that overall intervention levels were low. This indicates the need for implementation of academic preparation when addressing sexuality. This is supported by Couloumbis and Miller in their 1994 study, who found that therapists, that received information during the education or clinical practice regarding sexuality in the elderly, had a 27.8% higher intervention level than therapist who did not.

**Clinical Implications**

Healthcare professionals’ attitudes, values, and beliefs were also identified as contributing factors to the lack of healthcare involvement with sexuality in the elderly population (Bonder & Wagner, 2001; Bouman et al., 2007; Clover, 2006; Redelman, 2008; Sharpe, 2003). Sharpe (2003) identified sexuality in late life to be a challenge due to the lack of information and knowledge. Intertwined with the lack of information and knowledge, may be the hesitancy to ask the elderly questions about sexuality and negative attitudes towards sexuality in the elderly (Sharpe, 2003). These attitudes, values, and beliefs further illustrate the concept of ageism in American society and healthcare. Weir (2004) supports this statement, indicating, “Ageism in health care is an important and current practical issue” (p. 62).
Limited preparation for healthcare professionals correlates to a lack of identification of sexual behaviors, lack of patient education about sexually transmitted diseases, and a lack of education about the importance of preventative measures at routine doctors’ visits (Olivi et al., 2008). In a study by Lindau et al. (2007) it was discovered only 38% of men and 22% of women had reported discussing sexuality with their primary physician since age 50. This statistic is concerning, considering the most common reason for sexual inactivity among elderly couples is the physical health of the male partner (Lindau et al., 2007, p. 769). An even more alarming study, by Miller et al. (1993) found that even when patient’s initiated their sexual concerns, therapists responded inconsistently. Which brings to question, is this inconsistency related to therapist’s attitudes, their lack of knowledge, or both? Whatever the cause may be, Weir (2004) states that education at any stage, can help alleviate the phenomena of ageism. Overall, this lack of healthcare involvement has contributed to an increase in STD’s/AIDS in the elderly population (Olivi et al., 2008; Sharpe, 2004).

One important aspect not often addressed in the elderly is HIV testing. According to Lindau et al. (2006) only 2/55 women age 58 and older, reported being offered a HIV test at their last doctors visit. Of the women offered HIV testing, married women were found to be more likely to discuss sexuality issues with their physician (Lindau et al., 2006). Clover (2006) reports the elderly population is often overlooked by healthcare professionals in regard to sexual health. This action increases the exclusion that the elderly receive in HIV service provision (Clover, 2006). Clover (2006) suggests that the older homosexual population is at a greater risk for HIV and sexual health problems, due to this lack of healthcare involvement and homophobia.
Although the lack of education for healthcare professionals is a significant factor in the lack of healthcare involvement with sexuality in the elderly population, other studies have identified several additional reasons for this deficit. Bonder and Wagner (2001) and Redelman (2008) identified the perception of more important physical health concerns and time constraints to address sexual health issues as reasons for the lack of healthcare involvement. Lastly, Redelman (2008) identified that healthcare professionals often assume sexual health issues are the responsibility of another healthcare professional, leading to few healthcare professionals directly addressing the issues. This is concerning, as the World Health Organization, first noted this lack of health care responsibility in 1975, and recognized it as an issue for the healthcare community to address. Here we are, almost 35 years later and very little has been accomplished in addressing sexual health.

**Sexual Health**

The World Health Organization first coined the term “Sexual Health” in 1975 as the “…integration of the somatic, emotional, intellectual and social aspect of sexual being, in ways that are positively enriching and that enhance personality, communication, and love” (p. 6). Rheaume and Mitty (2008) revised the definition stating it is “…a state of sexual well-being that includes a positive approach to a sexual relationship and anticipation of a pleasurable experience without fear, shame, violence, and coercion” (p. 342). Therefore, sexual health is perceived to be an aspect of treating an individual holistically.

A review of the literature supports the importance of addressing sexuality and sexual health in the elderly population. It is a critical component in the elderly
population’s health care just as it is for anyone else along the developmental continuum. Therefore, this needs to be addressed through educating the healthcare professional and the elderly client.

**Education**

Rheaume and Mitty (2008) identified that the elderly population lacked formative sexual education during elementary school, high school, and college years, resulting in the current knowledge deficit that exists. Specifically, in the United States educational programs concerning sexual health promotion, such as STD’s and HIV/AIDS prevention, have been directed toward younger, higher risk populations (Goodroad, 2003). This gap in education has decreased the practice of preventative methods in older adults when engaging in sexual activity. However, studies prove the elderly’s ability to learn new information regarding sexual health.

In Falvo and Norman’s (2004) study, individuals age 60 and over, participated in an educational workshop about HIV/AIDS and safe sex practices. Specific topics included in the workshop were prophylactic use, modes of disease transmission, explanation of high-risk behaviors, and the importance of HIV/AIDS testing. The results indicated that older adults benefit from receiving education about HIV/AIDS. After participating in the workshop, participants demonstrated a significant increase in awareness of the disease (Falvo & Norman, 2004). After the participants completed a post-test three months after the educational workshop, the individuals were shown to have maintained the significant increase in awareness. Falvo and Norman’s 2004 study findings are specifically important to Occupational Therapy, as the profession can play a large role in client education to address sexuality in the elderly population.
ROLE OF OCCUPATIONAL THERAPY

Introduction

The American Occupational Therapy Association (AOTA) has established the need to approach clients holistically, further moving toward client-centered care. AOTA recognizes the importance of sexual health, and has incorporated it into the occupational therapy professional practice framework. According to the Occupational Therapy Practice Framework: Domain and Process (2nd Ed), sexuality is an area of occupation, moreover, an ADL. Under this Occupational Therapy Framework, sexual activity is defined as “…engaging in activities that result in sexual satisfaction” (American Occupational Therapy Association, AOTA, 2008, p. 631).

Gerontics, is a specialty area in occupational therapy, focusing on the promotion of health and wellness and the prevention and rehabilitation of disabilities for older adults (Stevens-Ratchford, 1996). The AOTA established the goal of gerontic occupational therapy to be “…helping older adults to continue or resume their participation in everyday living at the highest quality of living and the greatest sense of well-being” (Stevens-Ratchford, 1996, p. 308). The gerontic occupational therapist has an extended therapist role. They are the individual’s clinician and consultant as she or he provides advice, raises concern, suggests and weighs alternatives, and guides the problem solving process (Stevens-Ratchford, 1996). Therefore, addressing the elderly’s concerns requires a certain level of competency, especially in the area of sexuality.

An occupational therapist possesses the knowledge in the following areas; 1) medical science; 2) human physiology, anatomy, kinesiology; 3) psychology; and 4) gerontics. Each of these will be discussed in more detail in the following:
1. Competency in medical science includes knowledge and education of the human body systems regarding disease, disability, and comprehensive rehabilitation. Specifically these include chronic illness, neurological and orthopedic conditions, general medicine and surgery, and sensory disabilities across the lifespan. Having an understanding of bodily systems is important when working with the elderly in sexuality and the aging process.

2. Human anatomy and physiology includes detailed information regarding the skeletal system, muscles, vasculature, and the peripheral nervous system. While kinesiology provides a detailed study of musculature acting on the extremities and truck, including theory and techniques of musculoskeletal evaluation with analysis of normal and pathological human motion. Having an understanding of physical structures of the body an occupational therapist can understand the elderly’s performance capabilities and limitations related to sexuality.

3. Psychology focuses on the psychosocial development and interruptions to development in the maturing adult with emphasis on OT evaluation, treatment planning and implementation, and treatment outcomes. Having an understanding of psychology allows an occupational therapist to incorporate concepts of the elderly’s psychosocial well-being (i.e. self-identity, self-esteem, and interpersonal skills) into the therapeutic process.

4. Education about gerontics includes observation and experience in facilities supervised by registered occupational therapists, qualified health professionals and university faculty with integration and synthesizes of the theoretical knowledge concerning physical function/dysfunction with clinical practice. Having an understanding of geriatric practice provides hands-on experience and education about the targeted population.

This educational background prepares the occupational therapist to provide skilled professional contributions to the health care community, and furthermore the elderly, when sexuality is concerned. In addition, the domain of OT lies in the knowledge of human performance and how disease and other physical limitations can effect engagement in occupations such as sexuality. This distinguishes OT as a profession that can provide services to assist the elderly in resuming sexual satisfaction and preserving quality of life. Through the areas of physical, mental, and social performance, OT promotes health and well-being.
The problem is that sexual health in the elderly is an issue that is and has been neglected by occupational therapists, which has had negative health implications. Miller, Adams, Henry, & Silverman’s (1993) study found even after the elderly initiated expressing concerns about sexual health, occupational therapists were inconsistent with follow-up of their concerns. Redelman (2008) and Sharpe (2004) indicate this is due to a lack of comfort and pre-professional education.

Limited preparation for healthcare professionals, including occupational therapists, correlates to three primary factors: 1) lack of identification of sexual behaviors; 2) lack of patient education about sexually transmitted diseases; and 3) a lack of education about the importance of preventative measures routine doctors’ visits (Olivi et al., 2008). Olivi et al. (2008) attributed these factors to an increase in the prevalence of STD’s and HIV/AIDS in this population. Sharpe (2004) identified lack of healthcare education concerning sexual health issues as the most significant sexual challenge the elderly population face.

**Summary**

There are several significant reasons to address the sexual health of the elderly. The review of the literature identified barriers that negatively impact sexual health in the elderly population, which includes but is not limited to:

1. A lack of or limited information for healthcare professionals (Hattjar et al., 2008; Olivi et al., 2008);

2. A lack of education, training and preparation, at the academic level on the issue of sexuality, for the medical and allied healthcare students prior to entrance in their professional field (Sharpe, 2004).

3. Lack of accessible information, education, and training for the elderly population and U.S. Population in general regarding sexually transmitted diseases (STD’s), human immunodeficiency virus/acquired
immunodeficiency syndrome (HIV/AIDS) and overall sexual well-being (Hattjar et al., 2008; Olivi et al., 2008). Specifically, in the United States educational programs concerning sexual health promotion, such as sexually transmitted diseases (STD’s) and human immunodeficiency virus/acquired immunodeficiency syndrome (AIDS) prevention, have been directed toward younger, higher risk populations (Goodroad, 2003). This gap in education has decreased the practice of preventative methods in older adults when engaging in sexual activity. In turn, this has contributed to an increase in the prevalence of STD’s and HIV/AIDS in this population (Olivi et al., 2008; Sharpe, 2004) and;

4. Myths and stereotypes concerning sexuality in the elderly. Clover (2006) indicates healthcare professionals often neglect the sexual needs of the elderly population due to negative myths and stereotypes. The influence of negative myths and stereotypes has not only impacted the practicing healthcare profession, but also the academic institutions that prepare these professionals for interaction with clients (Sharpe, 2004). Clover (2006) reinforced this finding as his study indicated that sexuality was poorly discussed with healthcare professionals, which was a result of neglecting the subject at the academic level. Several outcomes have resulted from these negative biases including a rise in poor sexual health among the elderly, lack of resources for healthcare professionals and consumers, and overall incompetence in addressing sexuality in the elderly (knowledge, assessments, interventions, discharge planning, and referrals).

It is important to address sexual health in the elderly as the population is composed of 37.9 million people and is projected to increase to 72.1 million by 2030; therefore, if not adequately addressed further negative effects will arise concerning their sexual health (Administration on Aging, 2008). Robinson & Molzahn’s (2007) study provided evidence that sexual activity was a strong predictor of quality of life, further emphasizing the value of addressing sexuality in the elderly. Specific to occupational therapy is that as longevity increases and the baby boomers enter the elderly population, a greater need for sexuality awareness for OT practitioners will be created in geriatric practice (Sharpe, 2004). Therefore, the proposed manual presented in the following will increase knowledge and comfort in order to improve occupational therapists role in sexuality in the elderly.
The ADL of Sexuality: A Guide for Occupational Therapists for Elderly Clients

Purpose/Rationale

The purpose of this product is to provide current and future occupational therapists with a guide to client-centered practice in order to address sexual health/sexuality with the elderly population. The ultimate goal is to ensure that the elderly are receiving holistic care and the healthcare professionals addressing all of their needs. Sexual health/sexuality is one issue that should not be neglected due to the discomfort of the clinician. The only time it should not be addressed is if the client requests.

The ADL of Sexuality: A Guide for Occupational Therapists for Elderly Clients is based on a review of the literature in regard to:

1. human sexuality and aging,
2. sexual health,
3. sexuality awareness,
4. issues concerning involvement of healthcare professionals, and
5. the role of occupational therapy.

It will add to the number of resources for occupational therapy therapeutic interventions concerning sexual health/sexuality with the client who is elderly.

Use and Target Audience

The product is intended to be used by occupational therapists as well as other healthcare professionals, to gain knowledge, comfort, and competency in addressing the important ADL of sexuality/sexual health.
Theoretical/Model Framework

Theory or a theoretical model is what shapes the practice of a profession. It helps clinicians understand the occupational problems faced by a client and how to address the needs of that client. Three theories/models that were chosen in the design of *The ADL of Sexuality: A Guide for Occupational Therapists for Elderly Clients:*

3. The BETTER model©: provides a detailed approach that is used to address sexuality in clients in order to ensure holistic care, which is beneficial for both the client and the clinician.

Each theory/model plays a role in the development of a comprehensive and integrative approach to meet the needs of the elderly in regard to sexual health/sexuality. Each of these will be presented in more detail within the following section.

*Model of Human Occupation (MOHO)*

The guiding principle of MOHO involves the “...individuals’ participation and adaptation in life occupations” (Kielhofner, 2009, p. 149). It is ultimately concerned with the extent to which individuals can participate in life occupations. MOHO is comprised of three interrelated components: 1) volition; 2) habituation; and 3) performance capacity, which are impacted by the individual’s environment (Kielhofner, 2009). Each component of MOHO is unique to each person but applicable across a population segment.
1. **Volition:** is the motivation for engaging in an occupation. What motivates individuals to engage in activities of his/her choice that are meaningful and he/she receives satisfaction when engaged? In regard to this project, the primary motivation is the fundamental need for intimacy (Mattiasson & Hemberg, 1998). This fundamental need is supported by numerous research studies that have indicated the elderly continue to engage in sexual expression (Bonder & Wagner, 2001; Geiss et al., 2003; Ginsberg et al., 2005; Hajjar & Kamel, 2004; McNicoll, 2008; Olivi et al., 2008; Rheume & Mitty, 2008; Sharpe, 2003, 2004).

2. **Habituation:** is the process by which occupation is organized into patterns or routines, apparent in an individual’s everyday life. These patterns or routines can include aspects of sexual expression such as kissing, hugging, and the act of intercourse. These behaviors can be classified into habits and roles. Habits are repeated behaviors that occur within the environment automatically. The loss of habits regarding sexual expression in the elderly, have been identified to decrease mental health, development, and maturity (Mattiasson & Hemberg, 1998). Roles assist in establishing self-identity and the responsibilities that are associated with his/her identity. Roles can include being a spouse, partner, and companion. Sharpe (2004) indicated the importance of engaging in roles to increase life satisfaction throughout the life span.

*The ADL of Sexuality: A Guide for Occupational Therapists for Elderly Clients* addresses habituation by considering the elderly clients habits and roles in sexual health/sexuality. These habits and roles can be identified using sexual
health/sexuality assessments provided in this Guide; thereby, allowing occupational therapists to shape the therapeutic process according to the elderly client’s everyday life. This Guide has examples of client education for learning how to modify habits and roles.

3. **Performance capacity**: refers to the physical and mental abilities that underlie skilled occupational performance. MOHO illustrates the importance of a person’s experience of his/her performance and how limitations or impairments may alter his/her experience. Performance capacity is addressed in this Guide by examining elderly client’s physical and mental abilities and how limitations may be impacting sexual expression. This is completed through assessments using semi-structured interview, formalized assessments and instruments. The results from these can then guide intervention/treatment of the individual according to his/her performance capacity.

The final aspect is considering how motivation, habituation, and performance capacity are influenced by the client’s environment in order for the individual to engage in occupation. The environment includes the following contexts: physical, social, cultural, economic, and political. Sharpe (2004) supported this by identifying physiological and societal contexts as factors that influence sexual health/sexuality in the elderly. Sharpe further states societal and peer attitudes shape what is acceptable behavior in the elderly; therefore, either supporting or ignoring the individual’s need for sexual expression.
**Andragogy**

The second theory is Malcolm Knowle’s Theory of Andragogy (1975). This is integrated in this *Guide* to facilitate the adult learning process of the occupational therapist, which will directly affect the clients who are elderly. This approach has five basic assumptions:

1. **Self-concept:** As an individual matures, they move away from being a dependent learner to a self-directed learner. This *Guide* is designed to provide occupational therapists with educational information and resources that can be utilized in the professional setting with the elderly. Furthermore, this product can serve as a guide for the therapeutic process as it is composed of current literature and practices that address sexual health/sexuality in the elderly. The expectations are that the occupational therapists will continue to learn and expand upon the resources that are presented in this *Guide*, fulfilling the assumption of independent learning.

2. **Experience:** Adult’s use past experiences to assist in the learning process. Through self-assessment of these experiences, you can identify beliefs, attitudes, and values regarding sexuality in the elderly. Through recognition, these can be used to challenge and further remove biases/prejudices occupational therapists may have in order to meet the needs of the client.

3. **Readiness:** An individual’s readiness to learn is associated with the development of tasks to fulfill social roles in adulthood. This product is based on the belief that occupational therapists are ready to learn and gain a greater understanding and knowledge of sexual health/sexuality. In addition, it allows
the opportunity to learn new skills that will increase competency and fulfill
the role of a holistic occupational therapist.

4. **Orientation:** Immediate application of new knowledge when problem solving
is important in adult learners. The portion of the guide concerning the
assessment process includes specific questions that can be used for
interviewing clients and guidelines that can be incorporated into the
therapeutic approach. Additionally, this *Guide* contains
treatment/interventions that can be incorporated into immediate practice based
on specific client needs.

5. **Motivation:** Internal factors motivate adults to learn. Occupational therapists
are driven to provide quality, holistic care. This *Guide* is based on the belief
that the occupational therapists are motivated to learn how to address sexual
health/sexuality for clients who are elderly. This *Guide* provides specific
information as well as resources to address this topic with the elderly;
however, motivation is needed to gather additional resources to meet each
facilities needs.

Overall, these factors contribute to the development of new knowledge or
expanding upon current and past clinical knowledge in an adult learner who is the OT.
Lastly, this theory fosters the practice of directly linking subject matter to the learner’s
work, which is evidenced by occupational therapists using this *Guide* in his/her
therapeutic practices concerning sexual health/sexuality for the elderly.
The BETTER model© (Mick, Hughes, & Cohen, 2004) is a detailed therapeutic approach that is used to address sexual health/sexuality in clients in order to ensure holistic care. The BETTER model© incorporates a six-step process for approach to sexual health/sexuality.

1. Bring up issues of sexuality/sexual function/sexual health
2. Explain that sexual health/sexuality is integral to quality of life and important to discuss
3. Tell clients that resources are available and provide assistance to obtain those needed
4. Timing is crucial; discussions should be facilitated as the client/partner desires
5. Educate the client/partner about potential/expected changes in sexuality, sexual function, and overall sexual health
6. Record discussions, assessments, interventions, and outcomes in the client’s health care records.

The BETTER model© serves as the foundation for the occupational therapists approach to address sexual health/sexuality in the elderly. This approach is used in combination with this Guide’s suggestions for assessment, treatment/intervention, and discharge planning. Although the BETTER model© was originally created for the profession of oncology nursing, it illustrates several components that are essential in the occupational therapy domain. These components are the elements of quality of life and the holistic approach of the client, which leads to client-centered care. The BETTER model© also was incorporated due to its strong emphasis on educating the client, which
is necessary due to the lack of education and resources regarding sexual health/sexuality in the elderly. It is for these reasons that the BETTER model© was chosen over other models to address sexual health/sexuality.

Organization of the Guide

This Guide is divided into four sections: 1) assessment; 2) treatment/interventions; 3) discharge planning; and 4) additional resources for therapist’s knowledge. A brief introduction to these sections is provided below:

I. Assessment

The assessment section of the product has two portions; self-assessment and client assessment. These two portions combined, ensure that an accurate and comprehensive sexual history is collected; therefore, enhancing occupational therapists understanding of the client’s overall sexual health/sexuality.

- The first portion, self-assessment, includes guidelines for therapeutic self-assessment for approaching sexual health/sexuality. It is important for occupational therapists to reflect upon his/her attitudes and knowledge in order to have an increased level of comfort and decreased conflicting attitudes. This self-assessment is based on the second assumption of the Knowle’s Theory, where the OT recognizes the importance of incorporating his/her own personal and clinical experiences that conflict and/or support the intervention needs of the client.

- The second portion, client assessment, includes descriptions of:

  i. The BETTER model©,

  ii. Schover method©,
iii. Additional interview questions, and;

iv. Formal assessments:

These can all be used by OT’s to obtain information about the client regarding his/her volition, habituation, and performance capacity pertaining to sexual health/sexuality (the three components of MOHO).

This section is based upon the first assumption within Knowle’s Theory, which is self-concept. Self-concept states the learner is self-directed. The assumption is that occupational therapists will complete additional research in order to formulate a comprehensive assessment approach that meets each client’s sexual health/sexuality needs. The ability of occupational therapists to do this demonstrates self-directed learning.

II. Treatment/Interventions

The treatment and interventions section of the product assists the occupational therapist in designing client-centered treatment. Components include: 1) information regarding sexual health/sexuality; 2) preparatory techniques for sexual activity; and 3) modification and compensatory techniques for sexual expression.

This section incorporates the BETTER model© by having the OT incorporate the six-step process throughout treatment/interventions. This model specifically illustrates client education by ensuring therapists have the knowledge and resources to distribute/incorporate into the treatment/intervention process.

The components of MOHO that are represented in the treatment/intervention section include volition, habituation, and performance
capacity. The unique value of sexual health/sexuality is incorporated in this Guide by providing various treatment/intervention ideas for the occupational therapist to use with clients. Habits and routines regarding sexual health/sexuality are reflected in this Guide through treatment/interventions ideas that match the client's lifestyle needs. Lastly, the individual's performance capacity is reflected by providing recommendations for treatment/intervention ideas regarding specific diagnoses.

As stated prior, Knowle's Theory is incorporated in this Guide through self-directed learning. Occupational therapists need to be self-directed learners by obtaining additional resources for treatment/intervention ideas that are not provided. The information in this Guide is not all-inclusive and only reflects a limited amount of treatment/intervention ideas for certain health issues.

III. Discharge Planning

This section of the product includes information to assist the occupational therapist during the discharge planning process. There is a list of resources that can be distributed to the client if additional services are necessary. The BETTER model© is incorporated by illustrating step five, which demonstrates providing education through additional resources for the client. Knowle's Theory is reflected in this section by the self-directed learning and motivation required to locate additional resources as well as utilizing the resources provided. This Guide emphasizes the importance of referring to other professionals when addressing sexual health/sexuality that is out of the occupational therapists area of expertise.
IV. Resources

This section of the product includes information to assist the occupational therapist in learning more about how to address sexual health/sexuality in the elderly. It includes various charts regarding diagnoses, medications, psychosocial factors, lubrications, and sexual positioning for CVA. This section also includes lists and descriptions of different positioning techniques for sexual expression such as oral sex, anal sex, penile-vaginal intercourse, masturbation, tips for avoiding pain during sexual intercourse, as well as a list of ideas for alternate expressions of sexual expression that does not require sexual intercourse. Lastly, a list of terms and definitions that relate to sexual health/sexuality is included.

This section of the guide was developed using three assumptions of Knowles Theory including: 1) self-concept; 2) readiness; and 3) motivation. Self-concept is reflected in the resource section, as it is not all encompassing and will require the occupational therapist to complete additional research. The therapist needs to be ready to learn about sexual health/sexuality through additional research in order to fulfill their professional role. Furthermore, this process will reflect the occupational therapists’ motivation to complete additional research.

The product is included in its entirety in Chapter IV, while Chapter III will present the methodology used to design the product.
CHAPTER III

METHODOLOGY

In the development of *The ADL of Sexuality: A Guide for Occupational Therapists for Elderly Clients*, it was important to look at the process from the beginning to the end. Through reflecting on the authors' experience as occupational therapy students, it was felt that there was limited academic preparation and exposure to addressing the sexual health/sexuality needs of the elderly. This was an issue as sexuality is part of the professional domain representing an activity of daily living in the occupational therapy scope of practice. The lack of exposure in addressing the ADL of sexuality was further reinforced while completing the required level I fieldworks in physical disabilities and psychosocial setting, as it was not addressed with clients. Through reviewing abstracts of previously completed scholarly projects, it was noticed that this issue has never been addressed for this population; therefore, it was chosen to be addressed for the scholarly project.

An in-depth literature review was conducted using scholarly texts, scholarly search engines (SCOPUS, PubMed, CINAHL, Medline Plus, PsychInfo, Google), the American Occupational Therapy Association website, as well as AOTA's publications such as the American Journal of Occupational Therapy, OT Practice, the Occupational Therapy Code of Ethics, Occupational Therapy Practice Framework: Domain and Process. Additional items, which were not available through the previously listed sources, were obtained through Interlibrary Loan at the Harley French Library of Health.
Sciences. Efforts were made to locate the original source of essential information in order to limit the use of secondary sources in this project.

The review of literature began with 20 scholarly articles that provided the basis of the project components of Chapter II. The literature was then compiled into categories for the development of Chapter II. These categories included: human sexuality and aging, role of occupational therapy, academic preparation of healthcare professionals regarding sexual health/sexuality, the lack of healthcare involvement in addressing sexual health/sexuality in the elderly, and myths/stereotypes surrounding the population and the concept of sexual health/sexuality.

Throughout the development of the literature review, information that would be pertinent to the development of the product was set aside for future use. During this time, identification of frame of references and theories, both within occupational therapy and external to the profession, was completed. This was used to as a guide for development of the assessment and intervention sections of The ADL of Sexuality: A Guide for Occupational Therapists for Elderly Clients. The literature review, conducted for theories and frames of references, extended beyond the profession of OT, making it important to include how:

- occupational therapy’s role was illustrated
- client-centered care was being incorporated
- the product is user friendly for occupational therapists of all experience levels of practice, as well as other healthcare professionals
This led to the selection of the Model of Human Occupation, Malcolm Knowle’s Theory of Andragogy, and the BETTER model©. Based upon the information obtained, the focus then turned to developing the product.

The product was developed by completing additional research and combining it with the information that was previously set aside from the literature review. The information was further categorized, through the identification of the following sections: assessment, treatment/intervention, discharge summary, and resources. These sections were selected as they are the main aspects of the therapeutic process addressed during the provision of occupational therapy services. After identification of the product sections, information addressing the role of occupational therapy was incorporated in order to integrate these sections for the therapeutic process.

During the development of the treatment/intervention section, final editing was completed on the literature review. With the literature review finalized, sole focus was then placed on finalizing the product, including completion of discharge planning and resource sections as well as additional editing. This led to the completion of *The ADL of Sexuality: A Guide for Occupational Therapists for Elderly Clients*, which was developed based on the Model of Human Occupation, Malcolm Knowle’s Theory of Andragogy, and the BETTER model©. This project guides occupational therapists in addressing sexual health/sexuality in the elderly by increasing the comfort and competency of the occupational therapist. Competency is established based on the Occupational Therapy Code of Ethics. This guide is presented in Chapter IV in its entirety.
CHAPTER IV

PRODUCT

The purpose of *The ADL of Sexuality: A Guide for Occupational Therapists for Elderly Clients*, is to provide future and current occupational therapists with a resource to guide the therapeutic process in addressing the sexual health/sexuality needs of the elderly. The implementation and utilization of this *Guide* will increase the frequency and effectiveness of addressing the sexual health/sexuality concerns of the elderly. It may also decrease the negative health implications that have arisen such as STD’s. It can also be used to inform other healthcare professionals and students about the unique services OT can provide within the area of sexual health/sexuality.

The guide, in its entirety, is presented in the product section of this chapter. It is composed of four main sections:

1. **Assessment**: The assessment section includes a self-assessment for the occupational therapist as well as assessments to be used with the client.
2. **Treatment/Intervention**: The section regarding treatment/intervention includes suggestions to use during OT therapy sessions concerning seven commonly encountered issues affecting the elderly’s sexual health/sexuality.
3. **Discharge Planning**: The discharge planning section includes lists of resources for the occupational therapist and client to use in order to locate more information based on his/her need.
4. Resources: The resource section includes additional information for the occupational therapist to refer to as needed.

The product is designed using the Model of Human Occupation (MOHO), the BETTER model©, and Malcolm Knowle’s Theory of Andragogy. MOHO incorporates the client’s volition, habituation, and performance capacities regarding his/her sexual health/sexuality. The BETTER model© incorporates a detailed therapeutic approach that is used to address sexual health/sexuality in clients in order to ensure holistic-care using a six-step process.

Lastly, The ADL of Sexuality: A Guide for Occupational Therapists for Elderly Clients was developed by using Malcolm Knowles Theory of Andragogy, in order to facilitate adult learning in occupational therapists. The ADL of Sexuality: A Guide for Occupational Therapists for Elderly Clients, is presented in its entirety in the following section.
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III. Treatment/Intervention pg. 51

IV. Discharge Planning pg. 71

V. Resources pg. 76

VI. References pg. 98
Introduction

This guide is important to the profession of occupational therapy and the general healthcare profession. It is designed to serve as a guide for the therapeutic process of addressing the ADL of sexual health/sexuality with the elderly. It provides foundational knowledge regarding the issues of sexual health and sexuality for the healthcare professional, specifically the occupational therapist. Sexual health/sexuality is often neglected in the process of assessment and intervention with the elderly, which has contributed to negative trends. These trends include a rise in sexually transmitted diseases (STD’s) and human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS), as well as the needs not being served for elderly clients. The hope of this guide is to increase occupational therapists involvement in addressing the sexual health/sexuality of the elderly by enhancing their initial comfort, competency, and knowledge regarding the therapeutic process.

Purpose/Rationale

The purpose of this product is to provide current and future occupational therapists with a guide to client-centered practice in order to address sexual health/sexuality with the elderly population. The ultimate goal is to ensure that the elderly are receiving holistic care and the healthcare professionals addressing all of their needs. Sexual health/sexuality is one issue that should not be neglected due to the discomfort of the clinician. The only time it should not be addressed is if the client requests.

The ADL of Sexuality: A Guide for Occupational Therapists for Elderly Clients

is based on a review of the literature in regard to:

1. human sexuality and aging,
2. sexual health,
3. sexuality awareness,
4. issues concerning involvement of healthcare professionals; and
5. the role of occupational therapy

This Guide will add to the number of resources for occupational therapy therapeutic interventions concerning sexual health/sexuality with the client who is elderly.
Use and Target Audience

The product is intended to be used by occupational therapists as well as other healthcare professionals, to gain comfort, knowledge, and competency in addressing the important ADL of sexual health/sexuality.

Theoretical/Model Framework

Theory or a theoretical model is what shapes the practice of a profession. It helps clinicians understand the occupational problems faced by a client and how to address the needs of that client. Three theories/models that were chosen in the design of The ADL of Sexuality: A Guide for Occupational Therapists for Elderly Clients:

3. The BETTER model© (Mick, Hughes, & Cohen, 2004): provides a detailed approach that is used to address sexuality in clients in order to ensure holistic care, which is beneficial for both the client and the clinician.

Each theory/model plays a role in the development of a comprehensive and integrative approach to meet the needs of the elderly in regard to sexual health/sexuality. Each of these will be presented in more detail within the following section.

Model of Human Occupation (MOHO)

The guiding principle of MOHO involves the “…individuals’ participation and adaptation in life occupations” (Kielhofner, 2009, p. 149). It is ultimately concerned with the extent to which individuals can participate in life occupations. MOHO is comprised of three interrelated components: 1) volition; 2) habituation; and 3) performance capacity, which are impacted by the individual’s environment (Kielhofner, 2009). Each component of MOHO is unique to each person but applicable across a population segment.

1. **Volition:** is the motivation for engaging in an occupation. What motivates individuals to engage in activities of his/her choice that are meaningful and he/she receive satisfaction when engaged? In regard to this project, the primary motivation is the fundamental need for intimacy (Mattiasson & Hemberg, 1998). This fundamental need is supported by numerous research studies that have indicated the elderly continue to engage in sexual expression (Bonder &
2. **Habituation:** is the process by which occupation is organized into patterns or routines, apparent in an individual’s everyday life. These patterns or routines can include aspects of sexual expression such as kissing, hugging, and the act of intercourse. These behaviors can be classified into habits and roles. Habits are repeated behaviors that occur within the environment automatically. The loss of habits regarding sexual expression in the elderly, have been identified to decrease mental health, development, and maturity (Mattiasson & Hemberg, 1998). Roles assist in establishing self-identity and the responsibilities that are associated with his/her identity. Roles can include being a spouse, partner, and companion. Sharpe (2004) indicated the importance of engaging in roles to increase life satisfaction throughout the life span.

The *ADL of Sexuality: A Guide for Occupational Therapists for Elderly Clients* addresses habituation by considering the elderly clients habits and roles in sexuality/sexual health. These habits and roles can be identified using sexual health/sexuality assessments provided in this *Guide*; thereby, allowing occupational therapists to shape the therapeutic process according to the elderly client’s everyday life. This *Guide* has examples of client education for learning how to modify habits and roles.

3. **Performance capacity:** refers to the physical and mental abilities that underlie skilled occupational performance. MOHO illustrates the importance of a person’s experience of his/her performance and how limitations or impairments may alter his/her experience. Performance capacity is addressed in this *Guide* by examining elderly client’s physical and mental abilities and how limitations may be impacting sexual expression. This is completed through assessments using semi-structured interview, formalized assessments and instruments. The results from these can then guide intervention/treatment of the individual according to his/her performance capacity.

The final aspect is considering how motivation, habituation, and performance capacity are influenced by the client’s environment in order for the individual to engage in occupation. The environment includes the following contexts: physical, social, cultural, economic, and political. Sharpe (2004) supported this by identifying physiological and societal contexts as factors that influence sexual health/sexuality in the elderly. Sharpe further states societal and peer attitudes shape what is acceptable behavior in the elderly; therefore, either supporting or ignoring the individual’s need for sexual expression.
Andragogy

The second theory is Malcolm Knowle’s Theory of Andragogy (1975). This is integrated in this Guide to facilitate the adult learning process of the occupational therapist, which will directly affect the clients who are elderly. This approach has five basic assumptions:

1. **Self-concept:** As an individual matures, they move away from being a dependent learner to a self-directed learner. This Guide is designed to provide you with educational information and resources that can be utilized in the professional setting with the elderly. Furthermore, this product can serve as a guide for the therapeutic process as it is composed of current literature and practices that address sexual health/sexuality in the elderly. The expectations are that you will continue to learn and expand upon the resources that are presented in this Guide, fulfilling the assumption of independent learning.

2. **Experience:** Adult’s use past experiences to assist in the learning process. Through self-assessment of these experiences, you can identify beliefs, attitudes, and values regarding sexual health/sexuality in the elderly. Through recognition, these can be used to challenge and further remove biases/prejudices you may have in order to meet the needs of the client.

3. **Readiness:** An individual’s readiness to learn is associated with the development of tasks to fulfill social roles in adulthood. This product is based on the belief that you are ready to learn and gain a greater understanding and knowledge of sexual health/sexuality. In addition, it allows the opportunity to learn new skills that will increase competency and fulfill the role of a holistic occupational therapist.

4. **Orientation:** Immediate application of new knowledge when problem solving is important in adult learners. This section of the guide concerning the assessment process includes specific questions that can be used for interviewing clients and guidelines that can be incorporated into the therapeutic approach. Additionally, this Guide contains treatment/interventions that can be incorporated into immediate practice based on specific client needs.

5. **Motivation:** Internal factors motivate adults to learn. Occupational therapists are driven to provide quality, holistic care. This Guide is based on the belief that you are motivated to learn how to address sexual health/sexuality for your clients who are elderly. This Guide provides specific information as well as resources to address this topic with the elderly; however, motivation is needed to gather additional resources to meet your facilities needs.
Overall, these factors contribute to the development of new knowledge or expanding upon current and past clinical knowledge in an adult learner who is the OT. Lastly, this theory fosters the practice of directly linking subject matter to the learner’s work, which is evidenced by occupational therapists using this guide in his/her therapeutic practices concerning sexual health/sexuality for the elderly.

**BETTER model©**

The BETTER model© (Mick, Hughes, & Cohen, 2004) is a detailed therapeutic approach that is used to address sexual health/sexuality in clients in order to ensure holistic care. The BETTER model© incorporates a six-step process for approach to sexual health/sexuality.

1. Bring up issues of issues of sexuality/sexual function/sexual health
2. Explain that sexual health/sexuality is integral to quality of life and important to discuss
3. Tell clients that resources are available and provide assistance to obtain those needed
4. Timing is crucial; discussions should be facilitated as the client/partner desires
5. Educate the client/partner about potential/expected changes in sexuality, sexual function, and overall sexual health
6. Record discussions, assessments, interventions, and outcomes in the client’s health care records.

The BETTER model© serves as the foundation for the occupational therapist’s approach to address sexual health/sexuality in the elderly. This approach is used in combination with this Guide’s suggestions for assessment, treatment/intervention, and discharge planning. Although the BETTER model© was originally created for the profession of oncology nursing, it illustrates several components that are essential in the occupational therapy domain. These components are the elements of quality of life and the holistic approach of the client, which leads to client-centered care. The BETTER model© also was incorporated due to its strong emphasis on educating the client, which is necessary due to the lack of education and resources regarding sexual health/sexuality in the elderly. It is for these reasons that the BETTER model© was chosen over other models addressing sexual health/sexuality.
Organization of the Guide

This Guide is divided into four sections: 1) assessment; 2) treatment/interventions; 3) discharge planning; and 4) additional resources for therapist’s knowledge. A brief introduction to these sections is provided on pages 8-10:

Assessment

The assessment section of the product has two portions; self-assessment and client assessment. These two portions combined, ensure that an accurate and comprehensive sexual history is collected; therefore, enhancing your understanding of the client’s overall sexual health/sexuality.

1. The first portion, self-assessment, includes guidelines for therapeutic self-assessment for approaching sexual health/sexuality. It is important for you to reflect upon your attitudes and knowledge in order to have an increased level of comfort and decreased conflicting attitudes. This self-assessment is based on the second assumption of the Knowle’s Theory, where the OT recognizes the importance of incorporating his/her own personal and clinical experiences that conflict and/or support the intervention needs of the client.

2. The second portion, client assessment, includes descriptions of:

- The BETTER model©,
- Schover method©,
- Additional interview questions, and;
- Formal assessments

Can all be used by OT’s to obtain information about the client regarding his/her volition, habituation, and performance capacity pertaining to sexual health/sexuality (the three components of MOHO).

This section is based upon the first assumption of Knowle’s Theory of self-concept that states the learner is self-directed. The assumption is that you will complete additional research in order to formulate a comprehensive assessment approach that meets your client’s sexual health/sexuality needs. The ability of you to do this demonstrates self-directed learning.
Treatment/Interventions

The treatment and interventions section of the product assists the occupational therapist in designing client-centered treatment. Components include: 1) information regarding sexual health/sexuality; 2) preparatory techniques for sexual activity; and 3) modification and compensatory techniques for sexual expression.

This section incorporates the BETTER model© by having the OT incorporate the six-step process throughout treatment/interventions. This model specifically illustrates client education by ensuring therapists have the knowledge and resources to distribute/incorporate into the treatment/intervention process.

The components of MOHO that are represented in the treatment/intervention section include volition, habituation, and performance capacity. The unique value of sexual health/sexuality is incorporated in the guide by providing various treatment/intervention ideas for the occupational therapist to use with clients. Habits and routines regarding sexual health/sexuality are reflected in this Guide through treatment/interventions ideas that match the client’s lifestyle needs. Lastly, the individual’s performance capacity is reflected by providing recommendations for treatment/intervention ideas regarding specific diagnoses.

As stated prior, Knowle’s Theory is incorporated in this Guide through self-directed learning. Occupational therapists need to be self-directed learners by obtaining additional resources for treatment/intervention ideas that are not provided. The information in this Guide is not all-inclusive and only reflects a limited amount of treatment/intervention ideas for certain health issues.

Discharge Planning

This section of the product includes information to assist the occupational therapist during the discharge planning process. There is a list of resources that can be distributed to the client if additional services are necessary. The BETTER model© is incorporated by illustrating step five, which demonstrates providing education through additional resources for the client.

Knowle’s Theory is reflected in this section the self-directed learning and motivation required to locate additional resources as well as utilizing the resources provided. This
**Guide** emphasizes the importance of referring to other professionals when addressing sexuality that is out of your area of expertise.

**Resources**

This section of the product includes information to assist the occupational therapist in learning more about how to address sexual health/sexuality in the elderly. It includes various charts regarding diagnoses, medications, psychosocial factors, lubrications, and sexual positioning for CVA. This section also includes lists and descriptions of different positioning techniques for sexual expression such as oral sex, anal sex, penile-vaginal intercourse, masturbation, tips for avoiding pain during for sexual intercourse, as well as a list of ideas for alternate expressions of sexual expression that does not require sexual intercourse. Lastly, a list of terms and definitions that relate to sexual health/sexuality is included.

This section of the guide was developed using three assumptions of the Knowles Theory including: 1) self-concept; 2) readiness; and 3) motivation. Self-concept is reflected in the resource section, as it is not all encompassing and will require the therapist to complete additional research. The therapist needs to be ready to learn about sexual health/sexuality through additional research in order to fulfill their professional role. Furthermore, this process will reflect the occupational therapists’ motivation to complete additional research.
Assessment
Introduction

The assessment section of the product has two portions, therapeutic self-assessment and client assessment. These two sections combined ensure that an accurate and comprehensive sexual history is collected; therefore, enhancing the therapists understanding of the client’s overall sexual health/sexuality.

Section I: Therapeutic Self-assessment

The first portion includes guidelines for you to engage in therapeutic self-assessment toward understanding and addressing sexual health/sexuality. Your therapeutic self-assessment is accomplished through self-reflection, which is the process of evaluating your performance, beliefs, attitudes, habits, and experiences. It is necessary to gain a deeper understanding of your culture, personal/cultural biases, experiences, and beliefs that may affect future actions with your clients and openness to learning.

It is important to reflect upon your attitudes honestly as research has shown that these extend into the healthcare system (Hajjar & Kamel, 2004). The importance of your ability to use self-reflection in regard to your professional clinical performance, beliefs, attitudes, habits, experiences, and knowledge is demonstrated by Miller, Adams, Henry, & Silverman’s 1993 study. Miller et al. (1993) found that even after the elderly client initiated expressing concerns about sexual health, occupational therapists were inconsistent with follow-up of the concerns. This inconsistency reflects how therapist attitudes and lack of knowledge can interfere with addressing client’s needs concerning sexual health/sexuality.

This Guide facilitates self-assessment to measure your comfort, competency, and knowledge of sexual health/sexuality in order to recognize your attitudes and knowledge level regarding sexual health/sexuality. Only through honest self-assessment can you recognize any attitudes and limited areas of knowledge that could become potential barriers to effectively treating your clients. By reading and learning through this Guide, you have already started the self-reflection process by recognizing that you need to either increase your competency, knowledge, or comfort in addressing sexual health/sexuality in the elderly.
Section II: Client Assessment

The second portion provides descriptions of specific assessments, instruments, and interview questions to use during assessment. This portion is based upon the first assumption of the Knowle’s Theory of self-concept, which states that the adult learner is self-directed. Being a self-directed learner includes having initiative and motivation to research information regarding sexual health/sexuality, best practice for occupational therapy, and sharing this information with other professionals. Self-directed learning is applied as assessments and their components are listed; however, you are required to complete additional research in order to obtain a comprehensive assessment process that meets your client’s needs. This is important for your own professional growth as well as for quality of care for clients.
Self-Assessment
Self-Assessment

Purpose of Self-Assessment

Research has proven that in order to effectively address the topics of sexuality and sexual health with your clients, it is vital to understand your own values, beliefs, and attitudes. This understanding will allow you to eliminate these factors from influencing the therapeutic process negatively (Krebs, 2007). For example, a therapist who has strong beliefs that an elderly person should not or does not engage in sexual activity may stop a client from talking about his/her concerns. You may not even be aware you are doing this. Avoiding questions about sexual health/sexuality and/or not even raising the issue are both ways a therapist’s values, beliefs, and attitudes can negatively affect the therapeutic process. Therapists can sometimes forget that this is really the client’s therapy and is based on what the client needs, not what the occupational therapist thinks he/she may need or what the OT is comfortable talking about.

The self-assessment guidelines and questions are designed to evaluate your knowledge and attitudes regarding sexual health/sexuality and deepen your understanding and use of therapeutic-use-of-self. Therapeutic-use-of-self is described by AOTA (2008) as an “occupational therapy practitioner’s planned use of his or her personality, insights, perceptions, and judgments as part of the therapeutic process” (p. 653). If done honestly, self-assessments can help you become more comfortable and confident in discussing sexual health/sexuality. In turn, this helps your client, because you become more comfortable addressing sexual health/sexuality with elderly clients.

The following portion includes activities for self-assessment in order to identify areas to improve occupational therapists competency. The portion for self-assessment focuses on these areas: knowledge, attitudes, values, beliefs, and therapeutic-use-of-self. When engaging in the self-assessment process, you will want to use a notebook specifically for recording your answers to questions that are posed throughout this section. This will serve as your Professional Development Journal, in which you can reflect on these answers and develop goals to improve your deficits. A suggested outline for your Professional Development Journal is located on page 17-25 with personal and professional development activity suggestions included.
A Guide to Self-Assessment for Professionals

Instructions:

The expectation is that as a professional you will complete this self-assessment honestly in order to gain a deeper understanding of yourself. This understanding can make you self-aware of your needs regarding the topic of sexual health/sexuality and help to further develop therapeutic-use-of-self. This self-assessment should be completed before interacting with clients and addressing concerns about sexual health/sexuality. Please record and reflect upon answers in your professional development journal as discussed on page 17-25.
**Professional Development Journal Guide**

It is important to document your thoughts, questions and challenges so you can focus on the areas you need to improve on and also measure your growth in comfort, knowledge, and competency.

Frequent self-assessments can be used to measure knowledge, which can identify strengths and areas of growth to ensure a competent therapist. This can be accomplished by using a SWOT (Strengths, Weaknesses, Opportunities, and Threats) analysis. Below is a guideline with examples to help you identify your own.

<table>
<thead>
<tr>
<th><strong>SWOT Self-assessment</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Strengths</strong> (i.e. Having clinical experience interacting with clients)</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td><strong>Weaknesses</strong> (i.e. Having limited experience addressing sexual health/sexuality with clients)</td>
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<td></td>
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</tbody>
</table>
Another way an occupational therapist can complete self-assessments is through identifying interpersonal traits such as interpersonal strengths, abilities, and challenges. Please see the following example.

<table>
<thead>
<tr>
<th>Interpersonal Trait Self-assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Interpersonal Strengths</strong></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>(i.e. Having the ability to naturally be empathetic)</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td><strong>Interpersonal Abilities</strong></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>(i.e. Having the ability to be assertive, although it takes more effort)</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td><strong>Interpersonal Challenges</strong></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>(i.e. Having difficulty being open about sexual concerns)</td>
</tr>
</tbody>
</table>
Read and answer the following questions:

It is important to decrease your anxiety, if there is any, so you can become more comfortable and confident in addressing concerns of sexual health/sexuality. This process is called desensitization, which is used to increase the level of comfort regarding sensitive issues. Some examples of how this process might work include discussions about sexual health/sexuality with trusted colleagues and/or attending a continuing education seminar/educational courses about sexual health/sexuality. This process allows the professional to become more comfortable with addressing with sexual health/sexuality. This also allows you to further develop therapeutic-use-of-self and enhance your interpersonal skills regarding verbal and nonverbal communication when discussing sexual health/sexuality with clients.

In order to assess your comfort level when addressing sexual health/sexuality it is important to identify feelings or behaviors that you may have. Some questions to consider and record, when assessing your comfort level, include:

1. How comfortable do you feel discussing sexual matters?

2. What sexual terms can you comfortably use to describe sexual fantasies, interests, arousal, orgasm, and behaviors?
3. Have you ever noticed your physical tension, body position, eye contact, and facial expressions when discussing or listening to specific sexual content?

4. What is your comfort level in dealing with the ADL of sexuality/sexual health?

**Tip**
Involve others (co-workers) in a discussion about this topic. This can further your comfort as well as your colleagues. It helps build team understanding and approach which is a step closer to ensuring holistic intervention.
What is your attitude regarding the ADL of sexuality and sexual health?

Read and answer the following questions:

It is important to know your attitudes towards sexual health/sexuality, especially in relation to the elderly. This is important as it influences how you conduct assessment and treatment for your clients regarding his/her sexual health/sexuality needs. Positive attitudes toward sexual health/sexuality are important to communicate to clients. In order to gain a greater understanding of your attitudes and how they may affect your clinical practice, reflect upon the following questions and record your responses.

1. Define sexuality:

2. Define sexual health:

3. List three values you have about sexuality and sexual health:

4. Could these values (if conflicting) affect the way you would work with clients if they have sexual health issues, questions or concerns?
5. Do you consider sexuality and sexual health to be an integral component of quality of life and overall health?

6. Do clients deserve the opportunity to discuss their sexual concerns with a qualified occupational therapist in your clinic?

7. Do you feel sexual health/sexuality assessments should occur at the time of initial client interactions, throughout treatment, and during follow-up?

8. List any areas regarding sexual health/sexuality, which are unacceptable or difficult for you to discuss; for example:
   - Is masturbation acceptable for both males and females?
   - Should oral sex be a method of sexual expression?
   - Should homosexuality be a method of sexual expression?
   - Should I provide treatment/intervention suggestions such as alternate means of sexual positioning for a client that is homosexual?
9. What can you do to overcome your attitudes if a client requested services regarding sexual expression that you feel it is unacceptable?

If you discover through completing the self-assessment and reflection that you may lack comfort, knowledge, competence and/or have any negative attitudes with addressing sexual health/sexuality in the elderly, additional action is necessary. This additional action may include seeking a therapist to discuss your attitudes, beliefs, perceptions and discomfort. You could also discuss these with fellow colleagues.

It is important to highlight the Occupational Therapy Code of Ethics as not addressing the sexual health/sexuality needs of a client could be a violation. Principle 1 states “occupational therapy personnel shall demonstrate a concern for the well-being of the recipients of their services (beneficence)” (AOTA, 2000, p. 614). Specifically section 1 A states:

Occupational therapy personnel shall provide services in a fair and equitable manner. They shall recognize and appreciate the cultural components of economics, geography, race, ethnicity, religious and political factors, marital status, sexual orientation, and disability of all recipients of the services. (AOTA, 2000, p. 614)

It is important to remember that sexual health/sexuality is an essential ADL.

**Tip**

Involve others (co-workers) in a discussion about this topic. This can further your comfort as well as your colleagues. It helps build team understanding and approach which is a step closer to ensuring holistic intervention.
Read and answer the following questions:

In order to assist clients in addressing the ADL of sexual health/sexuality, a knowledge base about normal sexual functioning and the possible changes regarding the aging process is important to have. Self-assessment can be used to measure knowledge regarding sexual health/sexuality. To help you begin assessing your knowledge, a list of questions is provided below. Reflect upon the questions and record your responses. It is important to keep in mind this is a beginners list and there are additional questions that can be incorporated to assess your knowledge.

1. Did you know appropriately educated occupational therapists are well qualified to conduct sexual assessments, provide options for interventions/treatments, and referrals as needed?

2. Does your facility have models and evaluations to assess and treat client’s sexual health/sexuality? If not, do you know how/where to locate these in order to implement at your facility?

3. Are you familiar with your facilities models and evaluations that are used to assess and treat clients’ sexual health/sexuality? Do you know how/where to locate these?
4. Did you know sexual assessments should occur at the time of initial client assessment, throughout treatment and during follow-up?

5. Out of the following which is needed to complete a comprehensive assessment: sensitivity, caring, knowledge, skill, and/or timing or all of these?

6. List five physiological changes that occur in the elderly as part of the “normal” aging process.

7. Do you know various compensation techniques to recommend during treatment for clients with specific physical limitations?
Summary

Through answering these questions and engaging in reflection and/or discussion, you discover that you have limited knowledge or lack a feeling of competency to address the concerns of sexual health/sexuality for your elderly clients, additional action is necessary. This additional action may include seeking continuing education involving sexual health/sexuality and the role of an occupational therapist. This can be achieved through formal (attend continuing education training) or informal (obtaining continuing education information from other colleagues) educational opportunities. This is important as not having knowledge to meet your client’s issues related to sexuality can be a violation of Principle 4 of the Occupational Therapy Code of Ethics (American Journal of Occupational Therapy, 2000). Principle 4 states, “Occupational therapy personnel shall achieve and continually maintain high standards of competence (duties)” (AOTA, 2000, p. 615).

Specifically section 4 C states:
Occupational therapy practitioners shall take responsibility for maintaining and documenting competence by participating in professional development and educational activities. (AOTA, 2000, p. 615)

Specifically section 4 D states:
Occupational therapy practitioners shall critically examine and keep current with emerging knowledge relevant to their practice so they may perform their duties on the basis of accurate information. (AOTA, 2000, p. 615)

Specifically section 4 G states:
Occupational therapy practitioners shall refer to or consult with other service providers whenever such a referral or consultation would be helpful to the care of the recipient of the service. The referral or consultation process should be done in collaboration with the recipient of the service. (AOTA, 2000, p. 615)

Now that you have completed the previously discussed self-assessments and have identified your strengths and weaknesses you are ready to begin learning about the process of completing an evaluation of the ADL sexual health/sexuality with your client who is elderly.
Client Assessment
Strategies and Guidelines

Before addressing the sexual health/sexuality issues of a client, there are specific strategies and guidelines to understand and follow prior to interacting with clients. Strategies and guidelines were included in this *Guide*, as many entry-level, experienced, and expert therapists have little practice discussing sexual health/sexuality particularly in the elderly population.

Strategies and guidelines are important as they serve as a resource to guide you on how to set up the physical and social environment, which will increase a client’s comfort when discussing sexual health/sexuality. Secondly, strategies and guidelines help you develop an approach, which may enhance the process of establishing rapport with your client.

Each strategy and guideline, that is included in this *Guide*, should be used to ensure a physical and social environment that is comfortable for the client. Once you gain experience using these strategies and guidelines, they will become more natural and effortless, when completing sexual assessments with clients.
Instructions: Read and consider the following guidelines for use during the assessment.

**Ensure Privacy**

When discussing sexuality it is important to ensure the client’s privacy. This can be accomplished by locating a private area and closing the doors. If this is not possible, and no other measures are feasible, draw the curtain in the treatment area and speak in a soft tone.

**Ensure Confidentiality**

Meet privately with the patient first and if requested, by the client, then include the partner in the therapeutic process. Reassure the client and his or her partner that the conversation is and will be kept confidential.

**Address Sexual Concerns Early and Throughout Treatment**

Initiate discussion early in the therapeutic process, specifically in the assessment. This implies that sexual health/sexuality is an important component of good health. Asking the client about his or her sexual health/sexuality as part of the clinical assessment and throughout the therapeutic process legitimizes and normalizes the subject. The assessment proceeds from less sensitive to more sensitive issues and the occupational therapist needs to continually clarify responses to assure accurate understanding of both verbal and nonverbal communication.

The client’s current sexual practices, cultural and religious beliefs, relationships, communication patterns, and general intimacy issues should be incorporated into the discussion. This will help the client and occupational therapist establish client-centered
goals. Lastly, use sexual terminology before expecting the client to apply them and discuss them in language the client will understand.

**Establish Client Centered Goals**

It is important to remember that all not all clients experience sexual satisfaction in the same manner. A client may not have a partner, or want one. Sexuality may not be a part of his/her concept of quality of life. Thus, it is important to include clients in setting goals.

**Avoid Overreaction**

Listen to the client with genuine interest, which conveys acceptance. Present a positive, relaxed attitude and do not let facial expressions reveal shock or surprise. Lastly, do not allow personal bias to interfere with the therapeutic process.

**Refer Patients for Complex Problems**

Know your professional scope of practice, and if complex problems arise, utilize referral sources when appropriate.

**Interpersonal Skills**

Occupational therapists have numerous client interactions during the therapeutic process. Therefore, considerations should focus on communication (style and context), environment, socioculture beliefs and values, content and timing when addressing sexuality in the elderly.

Assessing a Client's Sexual Health/Sexuality

Sexual health/sexuality is composed of numerous aspects including various physical, psychological, and sociocultural factors (Krebs, 2007). The information you gather from the assessment process correlates with each component of MOHO which is unique to each person.

1. **Volition**: is the motivation for engaging in an occupation. What motivates individuals to engage in activities of their choice that is meaningful and they receive satisfaction when engaged? In regard to this project, the primary motivation is the fundamental need for intimacy (Mattiasson & Hemberg, 1998). This fundamental need is supported by numerous research studies that have indicated the elderly continue to engage in sexual expression (Bonder & Wagner, 2001; Geiss et al., 2003; Ginsberg et al., 2005; Hajjar & Kamel, 2004; McNicoll, 2008; Olivi et al., 2008; Rheaume & Mitty, 2008; Sharpe, 2003, 2004).

2. **Habituation**: The ADL of Sexuality: A Guide for Occupational Therapists for Elderly Clients addresses habituation by considering the elderly clients habits and roles in sexual health/sexuality. These habits and roles can be identified using sexuality assessments provided in this Guide; thereby, allowing occupational therapists to shape the therapeutic process according to the elderly clients everyday life. This Guide has examples of client education for learning how to modify habits and roles.

3. **Performance capacity**: refers to the physical and mental abilities that underlie skilled occupational performance. MOHO illustrates the importance of a person’s experience of his/her performance and how limitations or impairments may alter his/her experience. Performance capacity is addressed in this Guide by examining elderly client’s physical and mental abilities and how limitations may be impacting sexual expression. This is completed through assessments using semi-structured interview, formalized assessments and instruments. The results from these can then guide intervention/treatment of the individual according to his/her performance capacity.
Assessment Methods

There are several methods that an occupational therapist can use to gather accurate, detailed information regarding sexual health/sexuality in the elderly. In order to complete an accurate and comprehensive sexual health/sexuality assessment, a variety of models, interview questions, and evaluation instruments should be utilized (Krebs, 2007).

In this section, the BETTER model© and the Schover method© are discussed in greater depth and are the primary suggested methods. A list of formal instruments and additional questions are also included if you wish to expand or formalize this practice area. The BETTER model© and Schover method© are presented with examples so you can see their applicability to your practice.

The assessments are arranged in the order that they should be approached during the process (as described on page 32-47) to help reinforce the appropriate sequence of the evaluation process:

1. Begin with the BETTER model©: The main thing you want to do here is to provide the opportunity for the client to talk about his/her concerns or issues with the ADL: sexuality/sexual health.

2. If clients are not comfortable discussing sexual health/sexuality, provide the client with educational handouts and assure them that they can discuss his/her concerns at a later date if desired (steps 3-6 in the BETTER model©, as explained on page 7). Therefore, at this time you would not begin using the Schover method©, additional questions, or formal instruments.

3. Once the client has identified that his/her sexual health/sexuality are areas he/she wishes to address during therapy, you can then progress to using the Schover method©.

4. If you feel you need more objective measures to assess values, beliefs, habits, routines, and physical/mental abilities then formal instruments can also be used during the assessment process.

5. The additional questions provided should be used if you failed to obtain comprehensive information during the initial assessment. These are also used to continually monitor the client’s concerns and progress throughout the therapeutic process.
Step I: The BETTER model©

Although many in the healthcare profession are most familiar using the PLISSIT model© to approach the issue of sexuality, this manual will only present the BETTER model©. Based on a review of the literature and taking into consideration the potential outcomes and MOHO, the authors feel the BETTER model© is preferred for several reasons:

1. The BETTER model© has a strong emphasis regarding client education. It iterates the importance of providing client education that is specific to the client’s needs (diagnoses/medical condition/concerns). This relates much stronger to MOHO’s components of volition, habitation and performance capacity. These components focus on identifying the motivation for continued engagement in an ADL that is meaningful, satisfying, and a preferred habit and role. The client has an interest in learning how to be able to continue to perform an ADL that he/she finds important.

2. Client education is important, as this population has lacked receiving sexual health education and resources from the healthcare system. The rise in STD’s and HIV/AIDS rates in the elderly population has been attributed to limited education and resources (Olivi et al., 2007). Primary prevention is the main method for reducing the prevalence of these diseases and needs to focus on the identification of risk factors and behaviors that can contribute to the development of STD’s and HIV/AIDS (Adalman & Daly, 2001). Unlike the PLISSIT model© which suggests providing basic and general client education, but does not provide an occupational therapist with clear suggestions and guidelines.

3. The BETTER model© emphasizes the importance of documenting the client’s concerns and sexual health/sexuality goals through a written report and plan. This allows for other healthcare professionals to track whether or not sexual health/sexuality concerns have been addressed with the client. This is important as Redelmen (2008) identified that healthcare professionals often assume sexual health/sexuality concerns are the responsibility of another healthcare professional, leading to few healthcare professionals directly addressing the concerns. While the PLISSIT model© does not specifically address documenting these concerns as a part of the assessment and intervention documentation process.
4. Both the BETTER and the PLISSIT model© can be utilized by occupational therapists. The BETTER model© is composed of a six-step process, all of which occupational therapists are qualified to address with a client. This six-step process includes:

   a. Bring up the topic,
   b. Explain,
   c. Tell,
   d. Time,
   e. Educate and;
   f. Record

However, the PLISSIT model© only has four steps, three of which an occupational therapist is qualified to address. These three steps include:

   a. Permission,
   b. Limited Information, and;
   c. Specific Suggestions

Although the BETTER model© was originally created for the profession of oncology nursing, it illustrates several components that are essential in occupational therapy practice. These components are the elements of quality of life and the holistic approach of the client, which leads to client-center care.
Instructions:

The following information will provide you with additional knowledge about the BETTER model©. Once you have an understanding of the basic concepts you can further develop the approach by reinforcing the application through practice and role-playing with another colleague. Lastly, consider using the BETTER model© as your approach for assessing sexual health/sexuality in clients and consider establishing this model as a part of your occupational therapy department’s protocol.

The following is an example of how an occupational therapist would use the BETTER model© to address sexual health/sexuality in an elderly woman who has arthritis.


   **Bring up the topic:**

   *Therapist States:* “Clients who have arthritis may have questions about how their disease and treatment will affect his/her sexuality.”

   *Therapists Asks:* “What questions do you have at this time?” or “Do you have any questions at this time?”

2. Explain that for many, sexuality can be integral to how individuals define their quality of life and an important to discuss if she or he wants (Mick, Hughes, & Cohen, 2004, p. 85).

   **Explain:**

   *Therapist States:* “I know this may feel like a very personal question, but part of my job as an occupational therapist includes making sure that I am looking at all areas of your life. I also want to make sure that you feel you can continue to enjoy and participate, in all the areas of your life that you want, to the largest amount possible. Some of the areas I consider important in a person’s life include things such as sleep, feelings, and sexual health/sexuality. I will answer any questions that you may have or work on any concerns/problems or issues that you want in our occupational therapy sessions.”
3. Tell clients that resources are available and provide assistance to obtain those needed (Mick, Hughes, & Cohen, 2004, p. 85).

**Tell:**

_Therapist States:_ “I understand that you have several questions about the pain in your body during and after sexual activity. I can give you some ideas and strategies that may decrease the pain you feel in your body during therapy sessions. These can be used before, during, and after participating in sexual activity.”

4. Timing is crucial; discussions should be facilitated as the client/partner desires. If the timing does not feel appropriate during the initial assessment with the client due to whatever factors there may be, let the client know that it is okay, and that you will bring up sexual health/sexuality again later if any questions, issues, or concerns come up. (Mick, Hughes, & Cohen, 2004, p. 85).

**Timing:**

_Therapist States:_ “I understand that you may not wish to talk about this right now as you have had a lot of information given to you today. This is completely fine, as I understand the first day can be overwhelming. We can discuss this later, when you are ready and want more information.”


**Educate:**

_Therapist States:_ “I understand that you still do not have any questions or concerns, but just in case you do later, here are some materials regarding sexual health and sexuality in arthritis, in addition to a couple of helpful websites ..... I also wanted to make sure you are taking care of your sexual health by going for yearly check-ups such as the PAP and breast exams. I know you may be wondering why this important for you to do, but it is our facilities procedure regarding sexual health promotion. Our facility addresses sexual health promotion because the United States has seen an increase in STD’s and HIV/AIDS among individuals.

Or
If the client has already expressed and development sexual goals for treatment you can educate him/her on the ideas/strategies more in depth, in addition to still giving him/her educational materials and resources as this step entails giving written materials, as well as verbal instructions. There are also audio or video tapes that can be utilized as educational materials, depending on the client’s learning needs.

Therapist States: “I will be giving you information during therapy sessions. We will talk about and practice the information here so you can take it home and use it as you wish.”


Record:
This step is self-explanatory, as the documentation process is familiar to an occupational therapist. The materials, conversation, and methods practiced and incorporated into the therapeutic process, such as treatment/intervention should be documented if they were beneficial to the client, or helped the client achieve his/her sexual goals.

Remember
- If clients are not comfortable discussing sexuality, provide the client with educational handouts and assure them that they can discuss their concerns at a later date if they desire (steps 3-6 in the BETTER model©).
- Therefore, at this time you would not begin using the Schover method©, additional questions, or formal instruments.
- Once the client has identified that his/her sexual health/sexuality are areas they wish to address in therapy then you can move onto using Schover method©.
Step II: The Schover method© (1998)

Semi-structured interviews provide a method of obtaining comprehensive information through asking direct and open-ended questions (Krebs, 2007; Sharpe, 2004). Direct questions compose the basic foundation for the assessment by initiating sexual health/sexuality discussion with the client. Open-ended questions allow for expansion of information obtained regarding past and present sexual history. Open-ended questions facilitate attainment of more comprehensive information that results in an in depth understanding of a client’s sexual concerns (Krebs, 2007).

This Guide uses the Schover method© to obtain a more in depth understanding of the client’s volition, habituation, and performance capacities. The Shover method© will help you obtain information about the client’s values, beliefs, habits, routines and physical/mental abilities. It uses three core components that allow you to gain a comprehensive background of the client’s sexual history:

1. evaluate past and present,
2. evaluate current and;
3. identify, sexual goals and desires as well as knowledge needed in order to continue to engage in sexual expression

Unlike other semi-structured interviews, the third component of the Schover method© contains information for identifying a client’s sexual goals, desires, knowledge, and current abilities which occupational therapy addresses during the therapeutic process. Goals and desires represent the component of volition in MOHO, while current abilities represent the performance capacity component of MOHO.

Instructions:

In the next three tables, the three core components of the Schover method© are displayed. Sample questions have been included to assist you in formulating questions that can be incorporated into each component of the Schover method©. These can be used to facilitate gathering information while interviewing clients.

You are going to want to formulate your own additional questions for each component. Formulating your own questions enhances your clinical skills for gathering
information and ensures client-centeredness as each questions will reflect a client volition, habituation, and performance capacity. By forming your own questions, you are incorporating your interview style (wording you are familiar with), which may increase your comfort and confidence during the interview.

<table>
<thead>
<tr>
<th>Core Component</th>
<th>Sample Questions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Evaluate past and present</strong></td>
<td></td>
</tr>
<tr>
<td>Sexual activities</td>
<td>How would you describe your sexual health? (values, habits)</td>
</tr>
<tr>
<td></td>
<td>What sexual activities did you previously engage in? (values, habits, performance capacity)</td>
</tr>
<tr>
<td></td>
<td>What sexual activities do you currently engage in? (values, habits, performance capacity)</td>
</tr>
<tr>
<td>Sexual functioning</td>
<td>Have you ever had problems or concerns in the past with sexual functioning? (habits, performance capacity)</td>
</tr>
<tr>
<td></td>
<td>Are you currently having any problems or concerns with sexual functioning? (performance capacity)</td>
</tr>
<tr>
<td>Sexual relationships</td>
<td>What did your past sexual relationships consist of? (values, habits, performance capacity)</td>
</tr>
<tr>
<td></td>
<td>What do your current sexual relationships consist of? (values, habits, performance capacity)</td>
</tr>
</tbody>
</table>

Through evaluating these areas you are able to assess your client’s values, beliefs, and motivation related to sexuality. For example:

- These can be illustrated through the types of sexual expression client’s engage in, the types of relationships the client expresses intimacy in, and the frequency the client engages in sexual expression. This reflects MOHO’s component of volition.
- Habituation, another component of MOHO, is assessed through obtaining information such as frequency of sexual expression or the types of sexual expression the client uses routinely.
- Lastly, performance capacity is addressed by asking questions about sexual functioning from the past and present. These performance capacities are representative of MOHO as they include both physical and psychological.
<table>
<thead>
<tr>
<th>Core Component</th>
<th>Sample Questions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Evaluate current</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Disease or disability</strong></td>
<td>Does your current disease or disability impact your sexuality? (Performance capacity)</td>
</tr>
<tr>
<td><strong>Treatment</strong></td>
<td>Has treatment interfered with your routine sexual expression? (habits, performance capacity)</td>
</tr>
<tr>
<td><strong>Comorbidities</strong></td>
<td>Are there other diseases or illnesses that may be attributing to these problems? (performance capacity)</td>
</tr>
<tr>
<td><strong>Psychological status</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Coping skills</strong></td>
<td>How do you feel about your current sexual functioning? (values and beliefs)</td>
</tr>
<tr>
<td></td>
<td>How have you been dealing with the changes in your life regarding sexuality since the disability or disease? (habits)</td>
</tr>
</tbody>
</table>

Through evaluating these areas you are able to assess your client’s values, beliefs, and motivation resulting from their current disease/disability. For example:

- The value of sexual expression may have decreased due to symptoms interfering with the enjoyment of the activities. This reflects MOHO’s component of volition.

- Habituation, another component of MOHO, is assessed through obtaining information such as whether or not the current disease has affected frequency of sexual expression or the types of sexual expression.

- Lastly, performance capacity is addressed by asking questions about the disease and how it may be affecting sexual functioning. These performance capacities are representative of MOHO as they may be both physical and psychological.
<table>
<thead>
<tr>
<th>Core Component</th>
<th>Sample Questions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Identify</td>
<td></td>
</tr>
<tr>
<td>Sexual goals</td>
<td>Do you have any goals regarding your sexual health? (values, habits)</td>
</tr>
<tr>
<td></td>
<td>Do you have any goals regarding your sexual functioning? If so, what are they? (values, performance capacity)</td>
</tr>
<tr>
<td>Sexual desires</td>
<td>Do you have any sexual desires? (values, habits)</td>
</tr>
<tr>
<td>Sexual knowledge</td>
<td>Do you know alternate positioning for continued engagement in sexual intercourse? (values, habits, performance capacity)</td>
</tr>
</tbody>
</table>

- By identifying the client’s goals, desires, and knowledge, volition is represented as you use the client’s values, beliefs, and motivation to develop them.
- In addition, these will be reflective of the client’s preferred habits and routines as well as their current physical and mental abilities. These demonstrate MOHO’s components of habituation and performance capacity.
Introduction:

As stated prior, if you feel you need more objective measures to assess values, beliefs, habits, routines, and physical/mental abilities then formal instruments can also be used during the assessment process. This may be important as the previous assessments are models and questions that are based on subjective information that the client provides.

Formal assessments (instruments) can include a variety of questionnaires, inventories, or surveys that assess sexuality. Instruments are intended to compliment the sexual assessment by facilitating a complete, accurate assessment; however, these are not intended as the only means of assessment (Krebs, 2007). These instruments are designed to measure multiple aspects of sexuality such as beliefs, values, function, and satisfaction (Krebs, 2007), which represents how MOHO can be applied to a formal assessment.

Knowle’s Theory is also reflected in this portion as an occupational therapist needs to demonstrate self-concept, readiness, and motivation to learn. This is necessary as the formal assessment section in the manual only contains a brief list and description of instruments. This limited information, will make it necessary for you to complete additional research, select the most appropriate instrument for your facilities use, and familiarize yourself with the instruments prior to implementing in practice.

In this section is a list of possible instruments to incorporate into practice at your facility. These instruments were selected as they were recognized in literature to be reliable and valid measures of sexual health/sexuality (Krebs, 2007). For more detailed information regarding the instrument description (including validity and reliability for specific diagnoses) and its standardized form, you will need to independently research these. It may be helpful to choose an instrument for your facility that is applicable for a broad and diverse population as it will be more cost effective. Other considerations for selecting formal instruments for your facility include the literacy level and time needed to complete the assessment.
Resource:
For additional instruments and information regarding sexuality the following book is recommended: Handbook of Sexuality – Related Measures by Clive M. Davis, William L. Yarber, Robert Bauserman, George Schreer, & Sandra L. Davis

<table>
<thead>
<tr>
<th>Name of Instrument</th>
<th>Description</th>
<th>Test Items</th>
</tr>
</thead>
<tbody>
<tr>
<td>Changes in Sexual Functioning Questionnaire (CFSQ)</td>
<td>A structured interview questionnaire designed to measure illness, medication, and related changes affecting sexual functioning.</td>
<td>▪ Females – 35 items</td>
</tr>
<tr>
<td></td>
<td></td>
<td>▪ Males – 36 items</td>
</tr>
<tr>
<td>Derogatis Interview for Sexual Functioning (DISF)</td>
<td>An interview designed to measure quality of sexual functioning.</td>
<td>▪ 25 items</td>
</tr>
<tr>
<td>Derogitis Sexual Functioning Inventory (DSFI)</td>
<td>An inventory designed to measure components that are considered important for successful sexual functioning (such as drive, body image, satisfaction) and well-being.</td>
<td>▪ 254 items</td>
</tr>
<tr>
<td>Sexual History Form (SHF)</td>
<td>A questionnaire designed to evaluate the frequency of sexual activity, sexual function related to desire, arousal, orgasm, pain, and overall sexual satisfaction.</td>
<td>▪ 46 items</td>
</tr>
<tr>
<td>Watts Sexual Function Questionnaire (WSFQ)</td>
<td>A self-assessment designed to measure sexual experience by evaluating desire, arousal, orgasm, and satisfaction.</td>
<td>▪ 17 items</td>
</tr>
<tr>
<td>Golombuk-Rust Inventory of Sexual Satisfaction (GRISS)</td>
<td>An inventory designed to measure the presence and severity of sexual problems.</td>
<td>▪ 28 items</td>
</tr>
</tbody>
</table>
### Instruments for Men Only

<table>
<thead>
<tr>
<th>Name of Instrument</th>
<th>Description</th>
<th>Test Items</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brief Sexual Functioning Inventory (BMSFI):</td>
<td>A short screening tool designed to assess sexual function.</td>
<td>11 items</td>
</tr>
<tr>
<td>Center for Marital and Sexual Health Sexual Function Questionnaire (CMSH-CFQ):</td>
<td>A questionnaire designed to measure psychosocial and physical dimensions of erectile dysfunction.</td>
<td>Baseline of 17 items, Follow-up of 23 items</td>
</tr>
<tr>
<td>International Index of Erectile Dysfunction (IIEF):</td>
<td>A measure designed to assess sexual function through the evaluating the areas of erectile function, orgasmic function, sexual desire, intercourse, and satisfaction.</td>
<td>15 items</td>
</tr>
<tr>
<td>Male Sexual Health Questionnaire (MSHQ):</td>
<td>A measure designed to assess sexual function and satisfaction.</td>
<td>5 items</td>
</tr>
<tr>
<td>Sexual Health Inventory for Men (SHIM):</td>
<td>A brief measure designed to screen and diagnose (including severity) erectile dysfunction.</td>
<td>5 items</td>
</tr>
<tr>
<td>Sexual Function Index (SFI):</td>
<td>A measure designed to assess sexual satisfaction and function for those who may have diseases/disabilities.</td>
<td>11 items</td>
</tr>
</tbody>
</table>

### Instruments for Women Only

<table>
<thead>
<tr>
<th>Name of Instrument</th>
<th>Description</th>
<th>Test Items</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brief Index of Sexual Functioning for Women (BISF-W)</td>
<td>A self-report instrument designed to assess the current level of sexual functioning and satisfaction.</td>
<td>22 items</td>
</tr>
<tr>
<td>Female Sexual Function Index (FSFI)</td>
<td>A questionnaire designed to measure sexual functioning in women in areas such as sexual arousal, orgasm, satisfaction, and pain.</td>
<td>19 items</td>
</tr>
<tr>
<td>Self-Perception of Female Sexuality (SPFS):</td>
<td>An instrument designed to assess sexual attitudes, sexual behavior, and sexual response.</td>
<td>123 items</td>
</tr>
<tr>
<td>Wilmoth Sexual Behaviors Questionnaire-Females (WSBQ-F):</td>
<td>A questionnaire designed to measure the frequency of sexual behavior by assessing 6 areas including communication, techniques, sexual response, body scar, self-touch, and relationship quality/masturbation.</td>
<td>54 items</td>
</tr>
</tbody>
</table>
Step 4: Additional Questions (if desired)

The following questions further broaden the discussion between the client and occupational therapist during the semi-structured interview. Questions also can be incorporated continuously throughout the therapeutic process, as the client may have new experiences or concerns regarding sexual health/sexuality (Shell, 2007). After a review of the literature, regarding sexual health assessments, questions on pages 46-47 were selected for gathering more in depth information that may not be obtained through the Schover method©. There are several uses for this section:

1. If you failed to obtain comprehensive information during the initial assessment you could consider using these additional questions.

2. You can use the questions to monitor the client’s concerns and progress throughout the therapeutic process. This is important to do as you want therapy to be beneficial to the client and knowing what is/is not effective will help you modify your treatment/interventions accordingly.

3. The Schover method© does not include questions for initial facilitation of the assessment and some of the questions are applicable for that purpose.

4. These questions may be considered for the first step of the BETTER model©, which brings up the topic of sexual health/sexuality.

5. Additional questions can assist in identifying a client’s sexual goals, desires, knowledge, and current abilities, which may not have been obtained comprehensively during the use of the Schover method©.
Instructions:

The following is a sample list of questions that can be used to facilitate discussion of sexuality during the interview process such as step 1 in the BETTER model© and initiating the Schover method©.

Some of these questions are asking more personal information; therefore, require more established rapport between the therapist and the client. The questions are grouped from least sensitive to most sensitive, with the most sensitive needing more established rapport with the client than the less sensitive.

It is not necessary to use all of the questions if the information was previously obtained or if you have developed more effective questions. However, implementing questions that ensure the client is comfortable discussing sexuality is recommended.

Questions for initiating:

• Do you have any concerns or worries about your sexual performance?
• May I ask you some questions about your love and sex life?
• People often have questions they would like to ask about sex. Do you have some questions about sexual activity that you would like to ask me?
• A person may experience sexual difficulties at some point in life. Do you have any trouble or problems that you want to tell me about?

Questions to use once the client has identified he/she has concerns:

• What would you consider a satisfactory sex life?
• How long has it been since you participated in sexual activity?
• Is there anything about your sex life that you wish were different?
• Having sex means different things to different people. For some people it means having sexual intercourse and to others it means holding hands. What different types of activities do you participate in?
• As people age, they sometimes have pain or discomfort during sexual intercourse. Does this ever happen to you?
• Do you feel you have enough privacy for sexual activities that you want to participate in?
Questions to use once the client has identified concerns and rapport has been established:

- Some people have changes in their body from aging, illness, or surgery. Have any of these affected how you feel about your body? What about your partner?
- Have you had an increase or decrease in thoughts about sex?
- Does your religion affect how you feel about sexuality in any way?
- Some people use lubricating gels or liquids when participating in sex because he/she feels pain or it provides more pleasure. Do you use any of these? What kind do you use?
- How easy or difficult is it for you to talk about your sexual behavior with your partner? With me right now? How about your doctor?

Questions to use for monitoring the therapeutic process:

- Do you feel suggestions have been helpful?
- Do you have additional concerns at this time?
- Is what we are practicing in treatment working at home?

Hillman, 2000, p. 31-2

Next Step

Based on the information you obtain from the assessment process, continue onto the development of goals for the client within occupational therapy.
Goal
Development
Introduction:

The purpose of goal writing is to determine the issues that will be addressed during the therapeutic process. This will be completed using a client-centered approach and the information previously obtained during the client assessment process. This ensures the client's perspective is used to develop long and short-term goals, by incorporating the client's volition, habituation, and performance capacity. The following are provided below to guide your goal development using the theoretical framework of MOHO.

1. **Volition:** is the motivation for engaging in an occupation. What motivates individuals to engage in activities of their choice that is meaningful and they receive satisfaction when engaged? In regard to this project, the primary motivation is the fundamental need for intimacy (Mattiasson & Hemberg, 1998). This would include using the client’s values and beliefs regarding sexuality such as participating in sexual intercourse as his/her way of showing his/her partner affection.

2. **Habituation:** consider the clients habits and roles in sexuality. These habits and roles can be identified using sexuality assessments provided in the guide; thereby, allowing occupational therapists to shape the therapeutic process according to the clients everyday life. Habituation would be incorporated into the goal by demonstrating the client’s preferred habits and routines, such as preferred sexual positions and time of day to engage in sexual intercourse.

3. **Performance capacity:** MOHO illustrates the importance of a person’s experience of their performance and how limitations or impairments may alter their experience. Performance capacity is addressed in this guide by examining client’s physical and mental abilities and how limitations may be impacting sexual expression. Performance capacity would be implemented into goal development by recognizing the physical and mental abilities that would be needed in order for him/her to participate in sexual intercourse.
### Possible Goal Areas

<table>
<thead>
<tr>
<th>Issue</th>
<th>Sample Goal</th>
<th>Relationship to Theory</th>
</tr>
</thead>
</table>
| **Pain**                      | 1. Client will identify a more appropriate time for sexual expression (morning, after a warm shower) to minimize joint pain.  
                                  2. The clients partner will learn a relaxing massage (foreplay) to reduce pain, spasms and/or anxiety to increase pleasure in sexual expression. | Habituation, Volition, Habituation       |
| **Joint Limitations**         | 1. Client will express understanding of side lying positions.  
                                  2. Client will demonstrate strategic placement of cushions or pillows to enhance the experience for both partners. | Performance Capacity, Performance Capacity |
| **Endurance**                 | 1. Client will demonstrate and increase in overall strength to improve function and endurance during sexual relations.  
                                  2. Client will demonstrate an understanding of energy conservation by stating two techniques he/she can incorporate into sexual expression. | Performance Capacity, Performance Capacity, Habituation |
| **Body Image**                | 1. Client will demonstrate effective communication with his/her partner to discuss body image concerns.  
                                  2. Client will learn and implement sexual positions that may be more flattering for his/her body. | Volition, Performance Capacity, Performance Capacity, Habituation |
| **Muscular Impairments**      | 1. Client will demonstrate an understanding of alternate sexual positions by verbally describing one position.  
                                  2. Client will demonstrate an understanding of techniques to decrease spasticity in order to engage in sexual expression. | Performance Capacity, Habituation, Performance Capacity, Habituation |
| **STD and HIV/AIDS**          | 1. Client will demonstrate the ability to identify 3 risk factors associated with STD and HIV/AIDS.  
                                  2. Client will verbally identify 2 ways to prevent the contraction of STD and HIV/AIDS. | Performance Capacity, Performance Capacity, Volition |
Treatment/Intervention
Introduction

The treatment and interventions portion of the product assists the occupational therapist in designing client-centered treatment. Components include: 1) information regarding sexual health; 2) preparatory techniques for sexual activity; 3) modification and compensatory techniques for sexual expression. This information will be related to commonly encountered issues impacting the sexual health of the elderly. These include muscular impairments, joint limitations, pain, body image, erectile dysfunction, endurance, and sexually transmitted diseases (STD’s) and human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS).

This section provides an occupational therapist with information regarding treatment/interventions that can be incorporated into the therapy session in order to educate the client. Using MOHO’s components of volition, habituation, and performance capacity, the client and occupational therapist can select treatment/intervention ideas that best suit the client’s needs and preferences.

This guide only contains seven sections regarding commonly encountered issues impacting sexual health of the elderly; therefore, it is necessary for the occupational therapist to research other diagnoses and their symptoms that influence sexual functioning. Although there are only seven sections of health issues presented, many of these issues limiting sexual expression are prevalent across numerous diagnoses. Therefore, you can incorporate some of the treatment/intervention ideas provided with new treatment/intervention ideas. Treatment/intervention ideas such as communication and alternate forms of sexual expression can be used for any sexual health issue. Lastly, after giving the client recommendations or suggestions for treatment/intervention make sure to have the client practice these at home. After the client has practiced these recommendations or suggestions on his/her own time, have him/her report to you on whether or not these are helpful for meeting his/her needs. This incorporates monitoring during the therapeutic process as well as may help determine when it is necessary to make an outside referral to sex therapists or counselors, marriage counselors, physicians, psychiatrists, and psychologists.
Muscular Impairments

For the purposes of this product muscular impairments are described as factors affecting normal musculature such as weakness, spasticity (muscle tightness), and flaccidity (muscle limpness), which impact a person’s ability to engage in sexual expression. These can be caused by diagnoses such as cerebral vascular accident (CVA), multiple sclerosis, chronic fatigue syndrome, or other illnesses associated with generalized muscle weakness. Muscle weakness is attributed to factors other than disease/illness. For example, the elderly experience a decrease in musculature due to the normal aging process.

These factors can affect the way a person participates in sexual expression in various ways. Examples of how different types of muscular impairments affect sexual expression are provided below:

1. **Weakness**: may affect how long a person can sustain a sexual position
2. **Spasticity**: may affect what types of sexual position a person can perform
3. **Flaccidity**: may affect if person is able to support their body weight during sexual expression

Although each of these can impact the sexual expression of the client, there are many suggestions which can be recommended to the client so they can continue to engage in sexual expression. The following section provides a sample list of treatment/intervention ideas for each type of muscular impairment described above (weakness, spasticity, and flaccidity). In addition, located within the resource section of this manual (page 78) is a table specifically addressing sexual positioning for people who have had a CVA according to the area of the brain that was affected.
Weakness

- Adaptive sexual positioning for sexual expression:
  - Using objects such as pillows, blankets, towels, or chairs to support and maintain body positioning in areas that the client has muscle weakness.
    - Example: Place a pillow under the client’s lower back while lying in supine in order to support the back muscles and elevate the pelvis. This reduces the amount of back and abdominal muscles being utilized during this position as well as lower extremity muscles.
    - Example: Have the client sit in a chair with their back and legs supported (recliner) during masturbation to reduce the amount of strength required to maintain positions.
  - Teaching and demonstrating alternate body positions that may require less muscle strength to achieve or maintain body positions.
    - Example: Have the client with muscle weakness lie in supine during sexual intercourse using the missionary position.
    - Example: If both the client and the client’s partner experience muscle weakness, recommend they complete side-lying facing each other during sexual intercourse.

- Alternate forms of sexual expression:
  - Educate the client about forms of intimacy other than sexual intercourse.
    - Example: Educate the client that there are multiple forms of intimacy that can be satisfying such as hugging, kissing, touching, and masturbation, that do not require as much physical strength as sexual intercourse.
    - Educate the client about the importance of communication with their partner to find alternate forms of intimacy, which will satisfy both partners’ needs.

- Scheduling:
  - Educate the client about choosing times of the day where muscle strength is at its peak.
Example: Ask the client when he/she feels they have the most muscle strength. If the client has more strength in the morning, suggest he/she perform sexual activities during that time.
Spasticity

- Adaptive sexual positioning for sexual expression:
  - Using techniques prior or during sexual activity that may decrease tone.
    - Example: Educate the client about the affects of weight bearing on the affected extremity to decrease spasticity prior to engaging in sexual expression.
    - Example: If a client experiences spasticity in their left upper extremity, have them place a wrist weight on that extremity in order to decrease tone.
  - Teaching and demonstrating alternate body positions that may inhibit spasticity.
    - Example: Have the client with muscle spasticity lie on his/her affected side to decrease spasticity.
  - Teaching and demonstrating alternate body positions that the client may achieve and maintain although they have spasticity.
    - Example: Have the client with spasticity lie in supine during sexual intercourse using the missionary position.

- Alternate forms of sexual expression:
  - Educate the client about forms of intimacy other than sexual intercourse.
    - Example: Educate the client that there are multiple forms of intimacy that can be satisfying such as hugging, kissing, and touching that do not elicit spasticity as sexual intercourse.
    - Educate the client about the importance of communication with his/her partner to find alternate forms of intimacy which will satisfy both partners’ needs.
Flaccidity

- Adaptive sexual positioning for sexual expression:
  - Using objects such as pillows, blankets, towels, or chairs to support and maintain body positioning in areas that the client has muscle flaccidity.
    - Example: Place a pillow under the client’s upper extremity to support proper positioning during sexual intercourse. This is especially important to address for client’s who may have shoulder subluxation.
    - Example: Suggest the client sit in a chair with their back and legs supported (recliner) during masturbation to provide support for the musculature that is flaccid.
  - Teaching and demonstrating alternate body positions that the client may be able to perform although they experience flaccidity.
    - Example: Have the client with muscle flaccidity lie on the affected side. This allows the client to use their non-affected side to caress his/her partner and provides proprioceptive input that will facilitate neurons in the brain.
- Alternate forms of sexual expression:
  - Educate the client about forms of intimacy other than sexual intercourse.
    - Example: Educate the client that there are multiple forms of intimacy that can be satisfying such as hugging, kissing, touching, and masturbation, that do not require as much involvement of the affected extremity as sexual intercourse.
    - Educate the client about the importance of communication with his/her partner to find alternate forms of intimacy, which will satisfy both partners’ needs.
Joint Limitations

For the purposes of this product joint limitations are described as factors affecting normal joint movement or range of motion, which impact a person’s ability to engage in sexual expression. These can be caused by specific diagnoses arthritis and obesity or post-operative limitations such as total hip/knee replacements, and rotator cuff repairs. These can affect the way a person participates in sexual expression in various ways. Methods of addressing joint limitations are described below in three sections including preparatory methods, compensatory techniques, and alternate forms of sexual expression.

Preparatory Methods

- Preparatory methods are described as methods or techniques that prepare the client for sexual expression.
  - For Example: Take a warm shower or bath to increase blood flow to the joints in order gain increased range of motion.
  - For Example: Positioning objects or devices that prevent the patient from completing movements that may be against their post-operative precautions, such as putting on a shoulder brace in order to participate in sexual activity that requires standing.

Compensatory Techniques

- Compensatory techniques are described as methods or techniques revise the current context or activity to support sexual expression.
  - Teaching and demonstrating alternate body positions that the client may be able to perform although they experience joint limitations.
    - For example: Educate the client that has had a total hip arthroplasty (depending upon type of surgical procedure and protocol) about alternate positions.
  - Using objects such as splints, towels, blankets, or chairs remind the client they have precautions to follow while engaging in sexual expression.
    - Example: Recommend the client to place bubble wrap on the floor while participating in sexual expression in standing position. The bubble wrap
serves to remind the client to maintain their weight bearing precautions. If the client places weight on the bubble wrap, they will hear it pop and take the weight off that extremity.

**Alternate Forms of Sexual Expression**

- Educate the client about forms of intimacy other than sexual intercourse.
  - Example: Educate the client that there are multiple forms of intimacy that can be satisfying such as hugging, kissing, touching, and masturbation, that do not require as much involvement of the affected joints as sexual intercourse.
  - Educate the client about the importance of communication with his/her partner to find alternate forms of intimacy, which will satisfy both partners' needs.
Pain

Pain is a feeling that varies in intensity and duration and may be experienced in varying parts of an individual’s body. Pain is an individualized concept and each individual experiences uniquely. For the purposes of this product, pain will be addressed for people with joint/muscular and vaginal dyspareunia and dryness during sexual expression.

**Joint/Muscular Pain**

- Methods of decreasing pain prior, during, and after sexual activity:
  - Warm baths/showers
    - Warm baths/showers before and after sexual activity to decrease pain by facilitating blood flow.
  - Pain medication peaks
    - For example: Educate the client on taking pain medications to peak during sexual activity that is associated with the most pain such as during or after.
  - Changes in timing of sexual activity
    - For example: Assist the client in determining when they have the least amount of pain. Once this has been established, suggest the client engage in sexual expression such as masturbation, during the times when he/she has the least amount of pain.
    - People with Osteoarthritis often experience less pain in the morning.
    - People with Rheumatoid Arthritis often experience less pain in the afternoon and evening.
  - Stretching
    - For example: Educate the client about the importance of stretching before and after sexual activities in order to prevent muscular pain.
  - Alternate Sexual Positions
    - For example: Educate the client about alternate positions that can be used for sexual expression that do not lead to pain
    - For example: Educate the client that they may need to stop and change sexual positions during sexual activity.
Alternate Forms of Sexual Expression
- For Example: Educate the client that there are multiple forms of intimacy that can be satisfying such as hugging, kissing, touching, and masturbation, that do not require as much involvement of the affected joints as sexual intercourse.
- For Example: Educate the client about the importance of communication with his/her partner to find alternate forms of intimacy, which will satisfy both partners’ needs.

Progressive Muscle Relaxation
- For example: Educate the client about progressive muscle relaxation to decrease pain prior to engaging in the sexual activity.

Vaginal Dyspareunia (vaginal pain) and Dryness

Vaginal Dyspareunia is the term used to explain vaginal pain. Vaginal dyspareunia is often associated with vaginal dryness as the lack of lubrication causes friction against female genitalia. Treatment/interventions an occupational therapist can address during therapy include:
- Progressive Muscle Relaxation
  - Educate the client about progressive muscle relaxation of the vaginal/pelvic musculature.
    - For Example: Instruct a client how to perform Kegel exercises
- Vaginal Lubricants/Moisturizers
  - Educate the client about appropriate vaginal lubricants to use. Please refer to the table on page 79 in the resources section of this manual for a list and descriptions of appropriate vaginal lubricants.
  - Educate the client about inappropriate vaginal lubricants such as vasoline and scented hand lotions as these may affect the pH level of the vagina (changes in the pH level of the vagina can lead to vaginal infections).
• Referral
  o Refer to a gynecologist if over the counter topical lubricants and moisturizers are ineffective in relieving vaginal pain.
    - The gynecologist may evaluate the client further to determine the source of the pain.
      • The gynecologist may prescribe medications such as vaginal estrogen cream or birth control as low doses of estrogen can improve vaginal lubrication, which can decrease pain.
      • The gynecologist may prescribe topical lidocaine, which is applied to the vaginal area to relieve pain.
Body Image

Body image is described as an individual’s opinion of his/her physical appearance, which is attained through self-reflection and reflection of other’s reactions to his/her body. Body image is based on an individual’s self-confidence and self-esteem and can influence sexual expression. The elderly may experience a decrease in positive body image due to factors such as aging skin (increase of wrinkles, loses elasticity), graying hair, muscle atrophy, and bladder/bladder problems. This section is separated into two sections of treatment/intervention ideas. The first can section can be applied to all body image concerns, while the second section provides additional suggestions for that bowel/bladder problems. These lists are not all inclusive as there are numerous factors that may impact body image. Therefore, it is important to communicate with your client to determine what his/her specific concerns regarding his/her body image.

**Body Image**

- Alternate Sexual Positioning
  - For Example: Suggesting the client engage in sexual activities in positions that may be more flattering to an individual’s body such as missionary position for someone who may be self-conscious of the loose skin.

- Communication
  - For Example: Educate the client about the importance of communication with their partner to find alternate forms of intimacy, which will address his/her body image concerns. Communication can also assist the client and his/her partner in discussing what they find attractive in each other beyond physical appearance.

- Alternate Forms of Sexual Expression
  - For Example: Educate the client that there are multiple forms of intimacy that can be satisfying such as hugging, kissing, touching, and masturbation, that do not require an individual to present their body without clothing. This may cause the individual to feel more comfortable expressing his/her sexuality with his/her partner.
## Bowel/Bladder Problems

- **Bowel**
  - Educate the client about having a routine for bowel elimination. This is important as distended bowel can be uncomfortable during sexual intercourse and may cause incontinence.

- **Bladder**
  - Educate the client about the importance of emptying his/her bladder prior to engaging in sexual activity. This will decrease the probability that he/she will become incontinent during sexual activity.
  - Educate the client to drink a glass of water after sexual intercourse to help decrease urinary tract infections. Drinking water will increase the likelihood of urination, which in turn helps clean bacteria out of the genitalia area. This is important as bacteria accumulate in the genitalia area during sexual activity.
  - Educate the client on how to perform Kegel exercises in order to strengthen pelvic floor muscles. These exercises may decrease the probability that he/she will become incontinent during sexual activity.
  - If a female client has a catheter and still wants to engage in sexual activity, instruct her to tape the catheter out of the way before engaging in sexual activity.
Erectile Dysfunction

Erectile dysfunction is associated with many different diseases/diagnoses including diabetes, cardiovascular disease, cerebral vascular accident, renal failure, and chronic obstructive pulmonary disease. Medications that are used to treat various diseases/diagnoses may also cause erectile dysfunction.

Occupational therapists are not qualified to diagnose or treat erectile dysfunction. It is important to note if erectile dysfunction has not been diagnosed previously by a medical doctor, you should not use the formal instruments for that purpose. The formal instruments that are used with erectile dysfunction should be directed towards finding how erectile dysfunction is influencing a man’s sexual health/sexuality concerning volition, habituation, and performance capacity. Lastly, you cannot prescribe any medications or medical treatment; however, you can make recommendations to compensate for erectile dysfunction. Recommendations for erectile dysfunction include:

- Educating the client about alternate forms of sexual expression.
  - For Example: Educate the client that there are multiple forms of intimacy that can be satisfying such as hugging, kissing, touching, and masturbation, that do not require an erection.
  - For Example: Educate the client about the importance of communication with his/her partner to find alternate forms of intimacy, which will satisfy both partners’ needs.

If the client needs additional consultation or help beyond competency, refer to necessary healthcare professionals.
Endurance

Endurance is described in this manual as an individual’s ability to sustain participation in an activity. Endurance can be affected by a variety of diseases/diagnoses such as chronic obstructive pulmonary disease, obesity, cardiovascular disease, multiple sclerosis, and chronic fatigue syndrome. There are preparatory and compensatory techniques to address endurance for sexual activity listed below. This list is not all inclusive and you may need to complete additional research to locate suggestions for clients with specific needs.

Preparatory Techniques

- Temperature
  - Educate the client on the importance of managing environment temperature. Extreme hot/cold temperatures increase fatigue, which decreases endurance.
    - For example: If the client is exposed to extreme heat, recommend he/she uses a fan, air conditioning, or cooling vest.
    - For example: If a client has multiple sclerosis recommend he/she avoid hot tubs, hot showers, and activities in extreme hot temperatures prior to engaging in sexual activities.

Compensatory Techniques

- Adapting Sexual Intercourse
  - For Example: Suggest the client and his/her partner adjust the speed at which sexual activity is being performed (slowing down thrusts can decrease the energy required to engage in intercourse)
  - For Example: Suggest the client and his/her partner, incorporate a smoother rhythm as it requires less energy to maintain and perform during intercourse.
  - For Example: Suggest the client and his/her partner, stop and rest during sexual intercourse as needed.
• Alternate Sexual Positioning
  o For Example: Suggesting the client engage in sexual activities in positions that may require less energy, such as lying in supine during intercourse using the missionary position.
  o For Example: If a client finds breathing difficult (which will decrease endurance as the body is receiving limited oxygen), suggest the client and his/her partner sit in a chair facing one another with feet flat on the floor to engage in sexual activities.

• Communication
  o For Example: Educate the client about the importance of communication with his/her partner to explore what each other’s sexual needs are.

• Alternate Forms of Sexual Expression
  o Educate the client that there are multiple forms of intimacy that can be satisfying such as hugging, kissing, touching, and masturbation, that do not require as much energy as sexual intercourse.
    ▪ For Example: Masturbation and oral sex cause less cardiac stress and energy expenditure than sexual intercourse.
STD’s and HIV/AIDS

Contrary to popular belief, sexually transmitted diseases (STD’s) and human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS) are prevalent diagnoses in the elderly population. According to the Center for Disease Control and Prevention, people over the age of 50 accounted for approximately 10% of new HIV infections in 2006 (Center for Disease Control and Prevention (CDC), 2008, p. 7).

There are various reasons for the high prevalence of STD’s and HIV/AIDS in the elderly. These include:

1. lack of education
2. low risk perception
3. lack of protection
4. physiological changes

Each of these reasons can be addressed through primary prevention using client education as the treatment/intervention. Information for client education about STD’s and HIV/AIDS is provided below.

**Client Education**

- Educate the client about why they should be concerned with STD’s and HIV/AIDS at their age, as many individuals will not be aware of the growing concern regarding his/her sexual health. Furthermore, Olivi, Santana, Mathias (2008) indicated that the only way to approach prevention for STD’s/AIDS in individuals over the age of 50, is to increase the awareness of the prevalence. Lastly, this will help establish therapeutic rapport with the client too.

  - In 2003, approximately 72,270 people over the age of 50 had been diagnosed with AIDS in the United States (Goodroad, 2003).
  - This is a continued problem as the CDC estimates there are 7,000 new diagnoses of AIDS each year in people over the age of 50 (CDC, 2008).
The elderly are at higher risk for contracting STD’s and HIV/AIDS due to physiological changes. Changes such as decreased lubrication and vaginal wall thinning decrease a female’s ability to avoid infection (CDC, 2008). The elderly often engage in sexual activities that are considered high risk for STD and HIV/AIDS infection as they do not perceive themselves at risk and do not practice preventative methods (Goodroad, 2003). This was further proven as 70% of elderly participants believed that they were not at all or only slightly vulnerable to contracting HIV/AIDS (Falvo & Norman, 2004).

- Educate the client about what are considered high-risk behaviors and how to avoid them.
  - For Example: High-risk behaviors include engaging in sexual activities without the use of a condom when the client is not in a monogamous relationship or when he/she is entering a new relationship.
  - For Example: Recommend both the client and the client’s partner complete STD and HIV/AIDS testing.

- Educate the client regarding the benefits and use condoms and diaphragms during sexual intercourse.
  - For Example: Condoms and diaphragms prevent contraction of STD and HIV/AIDS.
  - For Example: Condoms can provide lubrication and additional stimulation for sexual activity.
  - For Example: Using oil-based lubricants such as mineral oil or baby oil reduce the effectiveness of condoms and diaphragms for preventing STD’s and HIV/AIDS.
• Educate the client on resources that he/she may refer to for more information about STD’s and HIV/AIDS.
  o For Example: The client can use the resources to obtain information regarding types/descriptions, statistics of prevalence, ways of contraction, signs and symptoms, complications resulting from disease, and methods of prevention.
  o Internet websites that you may want to refer the client to in order to obtain information:
    ▪ www.cdc.gov
    ▪ www.mayoclinic.com
    ▪ www.nlm.nih.gov
DISCHARGE PLANNING
Introduction

This portion of the product includes information to assist the occupational therapist during the discharge process. There are two lists of resources within this section.

- The first list contains resources that are beneficial for the occupational therapist to use to enhance their professional practice.
- The second list contains resources that can be distributed to the client who wishes to learn more. By providing him/her with credible resources the client can actively participate in his/her own education. Clients may also have questions he/she does not want to discuss with you, and these resources provide a means of still meeting his/her needs. It is always recommended that if there are changes in the client’s sexual health he/she should contact their doctor right away as this could be a sign of something medical and/or medicine related.

In addition, some resources may be included in both sections as both the client and the occupational therapist may find them helpful. These lists are not specific to any geographical location, so if you plan to refer to other specialty healthcare professionals in your area you will need to research and comprise a list independently.
Occupational Therapist:

- American Association of Retired Person
  - http://www.aarp.org
- American Association of Sex Educators, Counselors, and Therapists (AASECT)
  - http://www.aasect.org
- American Heart Association
  - http://www.americanheart.org
- American Occupational Therapy Association
  - http://www.aota.org
- Arthritis
  - http://www.arthritis.org/resources/relationships/intimacy/experts/asp
- CancerBACUP
  - http://www.cancerbacup.org.uk
- Center for Disease Control and Prevention
  - http://www.cdc.gov
- Healthfinder
  - http://healthfinder.gov
- Mayo Clinic
  - http://www.mayoclinic.com
- Medicare
  - http://www.medicare.gov
- MedlinePlus
- National Board for Certification in Occupational Therapy
  - http://www.nbot.org
- National Cancer Institute
  - http://cancernet.nci.nih.gov
- National Council on Aging
  - http://ncoa.org
- National Institute on Aging
- National Institute of Diabetes and Digestive and Kidney Diseases
- Sex Over Sixty DVD
  - [https://www.sexoversixty.org/index.php](https://www.sexoversixty.org/index.php)
- Sexual Functioning Advisory Council of the American Foundation for Urologic Disease
  - [http://www.afud.org](http://www.afud.org)
- Sexuality Information and Education Council of the United States
  - [http://www.siecus.org](http://www.siecus.org)
- The Sexual Health Network: Sex Therapy, Expert Education
  - [http://www.sexualhealth.com](http://www.sexualhealth.com)
- Women’s Health America
  - [http://womenshealth.com](http://womenshealth.com)
- World Health Organization
  - [http://www.who.int/en](http://www.who.int/en)
Client Resources:

Instructions:
Here is a list of credible internet websites that can be used at your convenience after you have finished receiving occupational therapy services. These internet websites may provide you with information that you could use to improve your sexual health/sexuality. You may also use these internet websites, as a resource if you have questions or concerns regarding your sexual health/sexuality that you do not wish to discuss with your occupational therapist. However, if these internet websites are not helpful to you, please discuss your sexual health/sexuality concerns with your primary doctor. It is always recommended that if you have changes in your sexual health you should contact your doctor right away as this could be a sign of something medical and/or medicine related.

- American Association of Retired Person
  - http://www.aarp.org
- American Heart Association
  - http://www.americanheart.org
- Arthritis
  - http://www.arthritis.org/resources/relationships/intimacy/experts/asp
- CancerBACUP
  - http://www.cancerbacup.org.uk
- Center for Disease Control and Prevention
  - http://www.cdc.gov
- Healthfinder
  - http://healthfinder.gov
- Mayo Clinic
  - http://www.mayoclinic.com
- Sex Over Sixty DVD
  - https://www.sexoversixty.org/index.php
- Women’s Health America
  - http://womenshealth.com
Resources
Introduction

This section of the guide includes information to assist the occupational therapist in learning more about how to address sexuality in the elderly. It includes:

- Various charts regarding diagnoses, medications, and psychosocial factors, lubrications, sexual positioning for CVA.

- A list of terms and definitions that relate to sexual health/sexuality.

- Lists and descriptions of different positioning techniques for sexual expression such as oral sex, anal sex, penile-vaginal intercourse, and masturbation, as well as tips for avoiding pain during for sexual intercourse.
  
  o These lists and descriptions can be used by you, as an occupational therapist, as part of your client education, if you are unfamiliar with various positioning techniques.
  
  o This portion may also be used as an educational handout for the client, if he/she is unfamiliar with the various positioning techniques. The client may also use these resources to refer to when not in therapy, to ensure he/she is practicing these techniques correctly.

This section is not meant to be pornographic, however due to the limited information that individuals may have concerning sexual positioning and forms of expression, it was included in order to meet the client’s needs. In addition, it provides a resource to refer to while not having to obtain information through questionable internet sites that may be blocked at your facility. Lastly, it is important to ask if the client would want these provided to him/her, as some may be offended if you do not ask first.

- A list of ideas for alternate expressions of sexual expression has been included that does not require sexual intercourse that can be used as part of your client education, or provided to your client as an educational handout for different ideas.
While these resources have been included for you, it is not all encompassing. Therefore, you may have to complete additional research to find treatment/interventions ideas that meet your client’s needs regarding volition, habituation, and performance capacity. The action of you seeking additional information reflects Knowle’s Theory, while meeting your client’s needs integrates the components of the Model of Human Occupation.
### Positioning Techniques for People with CVA

The following table provides information regarding sexual positioning techniques for individuals with specific types of cerebral vascular accidents and associated problems.

<table>
<thead>
<tr>
<th>Area of Brain Affected</th>
<th>Associated Problems</th>
<th>Positioning Techniques</th>
</tr>
</thead>
<tbody>
<tr>
<td>Left Cerebrum</td>
<td>right sided weakness or paralysis and possible sensory impairment</td>
<td>lying on right side during sex to be able to caress with left hand; using vibrator to increase sensory stimulation, especially in erogenous zones</td>
</tr>
<tr>
<td>Right Cerebrum</td>
<td>left sided weakness or paralysis and possible sensory impairment</td>
<td>lying on left side during sex to be able to caress with right hand; using vibrator to increase sensory stimulation, especially in erogenous zones</td>
</tr>
<tr>
<td>Cerebellum</td>
<td>problems with balance/coordination, dizziness, and abnormal reflexes</td>
<td>missionary style with client on back to provide stability</td>
</tr>
<tr>
<td>Brain Stem</td>
<td>Weakness or paralysis in all limbs</td>
<td>missionary style with client on back to provide stability</td>
</tr>
</tbody>
</table>

Adopted from Miller, 2008
## Types of Vaginal Lubricants

The following tables contain information regarding vaginal lubricants and moisturizers, their characteristics, and instructions for the clients.

<table>
<thead>
<tr>
<th>Lubricant</th>
<th>Specific Characteristics</th>
<th>Instructions for Clients</th>
</tr>
</thead>
<tbody>
<tr>
<td>K-Y Jelly</td>
<td>Inexpensive, Water soluble</td>
<td>Needs to be applied each time before engaging in sexual intercourse.</td>
</tr>
<tr>
<td>Astroglide</td>
<td>Water soluble, pH balanced, water based, Petroleum free, Tubes prep-Packaged in single-dose syringes</td>
<td>Decreases the possibility of becoming pregnant as it interferes with sperm mobility.</td>
</tr>
<tr>
<td>Lubrin</td>
<td>Water soluble, Nonstaining Can be applied well before inter-course, Liquefies only inside the body</td>
<td>May cause the condom to slip off during sexual intercourse.</td>
</tr>
</tbody>
</table>

## Types of Vaginal Moisturizers

<table>
<thead>
<tr>
<th>Moisturizers</th>
<th>Specific Characteristics</th>
<th>Instructions for Clients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Replens</td>
<td>Bioadhesive ingredients that typically lasts up to 24 hours.</td>
<td>Apply every 3 days. This will form a moist coat on the vaginal wall, which may result in some residue. This may increase the risk of vaginal infections because it lowers the pH level of the vagina.</td>
</tr>
<tr>
<td>Moist Again Vaginal Moisturizing Gel</td>
<td>Specifically formulated to provide long-lasting relief of vaginal dryness and can be used daily. Fragrance and irritant free and does not contain petroleum or mineral oil, so it can be safe to use with a latex condom</td>
<td>Apply daily as needed to decrease vaginal dryness.</td>
</tr>
</tbody>
</table>

Adopted From Grandjean & Moran, 2007
Medications and Their Side Effects Affecting Sexuality

The following table contains the sexual side effects some medications.

<table>
<thead>
<tr>
<th>Type of Medication</th>
<th>Side Effect</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anti-Depressants</td>
<td></td>
</tr>
<tr>
<td>SSRI</td>
<td>decreased libido, delayed or no orgasm</td>
</tr>
<tr>
<td>Tricyclic</td>
<td>decreased libido &amp; increases erectile dysfunction</td>
</tr>
<tr>
<td>Trazadone</td>
<td>increased libido, anorgasmia, priapism</td>
</tr>
<tr>
<td>Citalopram</td>
<td>decreased libido</td>
</tr>
<tr>
<td>Venlafaxine</td>
<td>decreased libido</td>
</tr>
<tr>
<td>Anti-Cholinergics</td>
<td>decreased blood flow to the penis</td>
</tr>
<tr>
<td>Antipsychotics</td>
<td>decreased libido and ability to reach an orgasm, priapism</td>
</tr>
<tr>
<td>Diuretics</td>
<td>embarrassment with leakage of urine</td>
</tr>
<tr>
<td>Narcotics</td>
<td>erectile dysfunction, decreased libido</td>
</tr>
<tr>
<td>Cardiovascular</td>
<td></td>
</tr>
<tr>
<td>Benzodiazapines</td>
<td>increases erectile dysfunction</td>
</tr>
<tr>
<td>Beta-blockers</td>
<td>erectile and ejaculatory problems</td>
</tr>
<tr>
<td>Calcium Channel Blockers</td>
<td>erectile and ejaculatory problems</td>
</tr>
<tr>
<td>Digoxin</td>
<td>decreases libido</td>
</tr>
<tr>
<td>Thiazide diuretics</td>
<td>erectile and ejaculatory problems, decreases libido, decreased vaginal lubrication</td>
</tr>
</tbody>
</table>
### Factors Affecting Sexuality

The following table includes information about medical factors and how they affect, psychological and relationship factors regarding sexuality.

<table>
<thead>
<tr>
<th>Medical Factors</th>
<th>Psychological Factors</th>
<th>Relationship Factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disease or treatment symptoms and side effects</td>
<td>Fear of triggering new MI or CVA</td>
<td>Communication difficulties</td>
</tr>
<tr>
<td>Mobility limitations</td>
<td>Fear of causing hurt or harm</td>
<td>Lack of intimacy, trust</td>
</tr>
<tr>
<td>Alterations in physical sensations</td>
<td>Altered body image and self-esteem</td>
<td>Partner’s reaction to illness</td>
</tr>
<tr>
<td>Alterations in ability to ejaculate or reach orgasm</td>
<td>Fear of rejection by partner</td>
<td>Partner’s personal sexual dysfunction</td>
</tr>
<tr>
<td>Dyspnea or angina upon sexual stimulation</td>
<td>Preoccupation with disease or treatment</td>
<td>Cultural and societal beliefs</td>
</tr>
<tr>
<td>Altered body function/image</td>
<td>Limited coping skills</td>
<td>Lack of privacy (hospital, long-term care facility)</td>
</tr>
<tr>
<td>Comorbidities</td>
<td>Past physical, sexual, emotional abuse</td>
<td>Alterations in social, work, family, and/or marital role</td>
</tr>
<tr>
<td>Medications</td>
<td>Pre-existing patterns of sexual behavior, attitudes, and beliefs</td>
<td>Quality of partnered relationship</td>
</tr>
</tbody>
</table>

Adopted From Krebs, 2007
### Effects of Diagnoses on Sexuality

The following table contains specific diagnoses and how they may impact sexual functioning.

<table>
<thead>
<tr>
<th>Diagnoses</th>
<th>Potential Sexual Dysfunction</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cancer</td>
<td>↓ libido, problems with maintaining an erection/ejaculation, difficulty with arousal/lubrication, ↓ frequency of sexual activity, infertility, dyspareunia, ↓ sexual satisfaction, early menopause/ menopausal symptoms, self-image (from surgeries, incontinence)</td>
</tr>
<tr>
<td>COPD</td>
<td>↓ libido/arousal, erectile dysfunction, ↓ ability for sexual function caused by SOB and hypoxia, reduced frequency of sexual activity</td>
</tr>
<tr>
<td>CAD/MI</td>
<td>Fear of angina, new MI, erectile dysfunction, ↓ arousal, concomitant depression, ↓ sexual satisfaction</td>
</tr>
<tr>
<td>Diabetes Mellitus</td>
<td>↓ libido/arousal, erectile dysfunction, retrograde ejaculation, chronic vulvovaginal candidosis</td>
</tr>
<tr>
<td>Hypertension</td>
<td>Erectile dysfunction, ↓ arousal</td>
</tr>
<tr>
<td>Multiple Sclerosis</td>
<td>↓ libido, retrograde ejaculation, delayed or absent orgasm</td>
</tr>
<tr>
<td>Parkinson’s Disease</td>
<td>Libido may be ↑ due to dopaminergic medications but generally ↓ libido particularly in women, retrograde ejaculation</td>
</tr>
<tr>
<td>Renal Failure</td>
<td>↓ libido, erectile dysfunction, anovulation, amenorrhea</td>
</tr>
<tr>
<td>Spinal Cord Injury</td>
<td>Erectile dysfunction, ↓ lubrication, delayed/absent ejaculation, delayed/absent orgasm</td>
</tr>
<tr>
<td>Incontinence</td>
<td>Embarrassment</td>
</tr>
<tr>
<td>Diagnoses</td>
<td>Potential Sexual Dysfunction</td>
</tr>
<tr>
<td>-----------------------------------</td>
<td>---------------------------------------------------</td>
</tr>
<tr>
<td>Chronic pain syndromes</td>
<td>↓ libido</td>
</tr>
<tr>
<td>Depression</td>
<td>↓ libido</td>
</tr>
<tr>
<td>Pelvic surgeries</td>
<td>Incontinence, impotence</td>
</tr>
<tr>
<td>Chronic Foley Catheter Placement</td>
<td>Inhibits intimacy, obstruction of penetration</td>
</tr>
<tr>
<td>Vision and Hearing Loss</td>
<td>Reduced stimuli for sexual excitement</td>
</tr>
</tbody>
</table>

Adopted from Krebs, 2007 and McNicoll, 2008
Oral Sex Positions

The following is a list of oral sex positions with a brief description of body positioning regarding giver and receiver.

1. **Oral Sex Position: On Knees**
   - The receiving partner is standing, while the giving partner is kneeling in front of him/her. This position allows for visual benefits, as well as allowing both partners to use their hands. Furthermore, this position does not require much space, nor time to assume the position. However, this position can be straining on the giving partner’s neck and knees (may put a pillow under knees).

2. **Oral Sex Position: Between the Legs**
   - The receiving partner is lying supine with the giving partner further down between his/her legs. This position allows for multiple variations, such as the receiving partner bending his/her knees or placing his/her legs off the bed or on the shoulders of the giving partner. The receiving partner may also turn on his/her side, which places less strain on the giving partner’s neck.

3. **Oral Sex Position: Right Angle Approach**
   - The receiving partner is lying supine, while the giving partner head is positioned at a right angle with his/her partner’s genitals. Using this position switches the direction of stroking/licking from the normal up and down pattern, to side-to-side.

4. **Oral Sex Position: Face Sitting**
   - The receiving partner is located over the giving partner’s face while either positioned in a crouching position or with his/her shins on the bed. This position also allows the receiving partner to lean forward and support his/her upper body. This positioning technique is good for the giving partner if he/she has mobility restrictions or fatigues easy.

5. **Oral Sex Position: Edge of Seat**
   - The receiving partner is in a sitting position (either the edge of a chair, sofa, bed) with his/her bottom located at the edge. The giving partner is positioned in front of them (kneeling or sitting) with the ability to shift his/her body using whatever object the receiving partner is sitting on.
Anal Sex Positions

The following is a list of anal sex positions with a brief description of body positioning regarding the partner penetrating and partner being penetrated.

1. **Anal Sex Position: Rear Entry**
   - The partner being penetrated is on his/her hands and knees while the other partner is located behind on his/her knees. This position does not allow for face-to-face interaction.

2. **Anal Sex Position: Knees on Chest**
   - The partner being penetrated is lying supine with his/her legs up. Both partners are located close to the ground, which requires less energy expenditure and increased relaxation. Pillows can be placed under the partner’s back who is being penetrated for increased support.

3. **Anal Sex Position: Side-by-Side**
   - This position requires that both partners face the same way, while lying side-by-side. It may be beneficial for one partner to be located slightly above the other, in order to increase the angle for the partner to penetrate the other. This position is also beneficial, as many angles for penetration can be achieved without having to change positions.

4. **Anal Sex Position: Receiver on Top**
   - This position requires that the partner who is being penetrated sit on top of the other partner (sitting in his/her lap). The partner who is being penetrated has control of the speed, angle, and depth of penetration. This position is not optimal for those who find it difficult to relax his/her anus and sphincter muscles when sitting upright.
Penile-Vaginal Intercourse Positions

The following is a list of six penile-vaginal intercourse positions with a brief description of body positioning.

1. **Lying on Top of Each Other**
   - This position involves one partner lying on top of the other partner, either facing each other or facing the same way. This technique can include the missionary and woman on top position. Variations of this position include changing the angle of penetration through a partner’s physical orientation.

2. **Sitting Positions**
   - This position involves both partners to be in seated manner with one partner in or on the other partner’s lap. This position does not require a lot of ability to complete movement.

3. **Side-by-Side**
   - This position involves both partners lying on his/her side. The partners can either be face-to-face or facing the same direction. This position allows for support once in position, as pillows can be leaned against, which is good for those who fatigue easy.

4. **Hands and Knees**
   - This position involves one partner on his/her hands and knees, while the other partner is penetrating from behind. Variations to this position include changes in the angle of penetration or to the extent in which the partner being penetrated is elevated up or down.

5. **Standing Positions**
   - This position involves one or both partners standing. This position requires more energy to engage in for extended periods.
6. Using Additional Objects

- This position involves the use of some object or large prop to incorporate for support. Some common objects or props include edge of the bed, chairs, sofa, kitchen tables, counters, washing machines. The objects and props help support the partner’s weight, change the angle of penetration, and increase possible opportunities for movement.
Masturbation Positions and Tips

The following includes a list of masturbation positions with a brief description of proper body positioning and tips for enhancing masturbation, for both men and women.

1. Masturbation Position: Stretch and Relax
   - The individual is lying supine, with his/her upper and lower extremities resembling an “X” shape. Before initiating the act of masturbation, the individual should stretch in the “X” shape position for about 10-15 seconds to relax, and then try to maintain the shape throughout the duration of his/her masturbation session.

2. Masturbation Position: Knees Bent/Hips Open
   - The individual is lying supine with his/her feet flat on the surface (floor, bed, etc) with the knees bent. This position allows the individual to open and rock his/her hips as he/she progresses through the masturbation process. A variation to this position is to bring the knees close to the chest.

3. Masturbation Position: On Knees
   - The individual finds a position that is comfortable to him/her while being on his/her knees (may place pillow under knees). The individual then leans back resting on his/her calves or on his/her hands and knees (balance is harder with only support from one upper extremity).

4. Masturbation Position: Heels Over Head
   - The individual is lying supine, and brings his/her legs up so the legs are pointing at his/her head. This position allows the legs to be kept together or spread apart as well as the knees to be bent or straight. For more support for the back, place a pillow under the lower back.

   - The individual places half of his/her body on a flat surface while the other half is located at a different level, such as sitting upright with the upper torso on the bed, while the lower torso is laying flat.
6. Masturbation Position: Against the wall

- The individual is lying supine in bed or on the floor, with his/her bottom right by the wall, and the legs going straight on the wall (resembles the “bicycle” exercise position). A variation can include moving his/her bottom away from the wall, and resting his/her flat against the wall with knees bent.

7. Masturbation Position: Curling Up

- The individual is either curled up on his/her side, supine, or on his/her hands and knees, and entails the drawing one’s body in on itself.

**Tips for enhancing masturbation**

1. Setting the Mood

- It is important to relax to engage in masturbation. Some ideas to help an individual to relax include taking a bath, lighting candles, listening to music, ensure privacy, and remove the desired amount of clothing to make yourself aroused.

2. Imagination

- It is important to not only set the environmental mood, but also the mood in one’s brain. Some ideas to consider include using sexual fantasies, looking at adult magazines, reading erotic stories, or watching adult videos.

3. Exploring the Body

- It is important to know how different parts of your body are responsive to touch. Once an individual knows this, he/she can focus running his/her hands over these body parts during masturbation.

4. Touching

- There are numerous responsive areas for touch around an individual’s genitalia. It is important that an individual explore his/her areas to figure what arouses him/her.
5. **Experiment**
   - It is not only important to know what parts of one’s body is responsive to touch, but to also know what kind of touch to be using. It is recommended that individuals experiment with various types of touch such as pressure, speed, and motion.

6. **Stimulation Build Up**
   - An individual can progress through masturbation by building up arousal and then reducing stimulation, in order to experience many arousal stages.

7. **Breathing and Rocking**
   - An individual should take in deep breaths and rock his/her hips as one would in sexual intercourse.

8. **Getting Over the Top**
   - If an individual hand’s get tired, he/she can alternate hands, or females may try a vibrator. If he/she cannot quite reach an orgasm, alter breathing or focus on a fantasy, or perform extra stimulation.

9. **Other Considerations for Women**
   - Direct, sustained stimulation to the clitoris can be achieved through a vibrator easier than manual labor
   - Water helps to learn to masturbate. One can lie in the bath with legs spread apart and the shower hose situated between the legs providing direct stimulation to the clitoris. The water pressure, temperature, and pulsation can be easily varied.
   - Rubbing against an object may help with arousal (furniture, pillow, dildo)
Tips for Positioning to Decrease Pain

The following is a list of tips to decrease pain in order to engage in sexual expression.

1. Using Pillows
   - Placing pillows under areas that are causing pain such as the hips, buttocks, chest, and back may help reduce pain, and keep those parts from moving around during sexual intercourse (you can buy specific pillows made for this or use household ones).

2. Strengthening Pelvic Floor Muscles
   - Increasing pelvic floor muscles enhance sexual function. These muscle are components of the core support system, and therefore help stabilize body posture. Strengthening pelvic floor muscles require less contributions from back and abdomen muscles for sexual activity.

3. Watching one’s Hips
   - If an individual has lower back pain he/she should avoid a lot of thrusting from his/her hips and fast jerky movements.

4. Watching one’s Legs
   - Lifting legs can be straining to the lower back and lead to fatigue faster, therefore propping the legs up (using pillows or partner’s body) is recommended.

4. Finding Movements
   - Knowing what positions may cause pain in an individual’s body is important. Encourage the individual to pay attention to what kinds of movements he/she can do throughout the day that does not cause him/her pain. This can be noticed even during regular exercise. In addition, the individual should have an understanding of his/her condition, as well as what positions bring on symptoms and alleviate them.

5. Staying Aligned
   - Finding sexual positions that keep the neck and back are aligned as much as possible is beneficial for those who have back or neck pain.
6. Changing and Planning Positions

- Changing positions during sexual intercourse and planning ahead to use positions, which are less painful to the partner, as well as communicating with one's partner.
Ideas for Intimacy without Sexual Intercourse

The following is a list of suggestions for intimacy without the need for sexual intercourse.

1. Sexual Touch
   - Masturbation (solo or mutual)
   - Oral sex
   - Massage (using oils)
   - Using external stimulation (sex toys)
   - Taking baths or showers together
   - Hugging
     - Hugging with pelvic of both partners touching with arms wrapped around the partner’s lower back.
     - Hugging with one partner standing behind the other.
   - Kissing
     - With or without tongue
     - Areas of the body other than the lips

2. Sexual Intimacy through Talking
   - Talking sex to his/her partner (dirty talk)
   - Reading exotic stories to another

3. Additional Ideas
   - Writing love letters
   - Cooking
   - Activities such as pottery, in which partners can be close to each other
   - Sensuality using a partner’s senses (feathers being brushed across skin, smelling pleasurable aromas, drinking wine, eating foods or feeding another)
   - Dancing
List of Terms and Definitions


2. AIDS- “the most advanced stages of infection with the human immunodeficiency virus” (AIDS, 2009, ¶2).

3. Anal Sex- “most often refers to the sex act involving insertion of the penis into the anus” (Wikipedia, 2009, ¶2).


5. Competence- “therapist’s duty and responsibility to practice competently and to be knowledgeable about ongoing developments and practice and develop the research evidence to support these developments” (Taylor, 2008, p. 12).

   - For the purposes of this project, elderly will be defined as 65 and older.

7. Emotional Intimacy- “the need and ability to experience emotional closeness to another human being” (Mattiasson & Hemberg, 1998, p. 528).

8. Gerontics- “of or pertaining to the last phase in the life cycle of an organism or in the life history of a species” (Gerontic, 2009, ¶1).

9. Holistic- concerned with wholes or with complete systems rather than with the analysis of, treatment of, or dissection into parts” (Merriam-Webster, 2009, ¶1).

10. Human Immunodeficiency Virus (HIV)- “a virus that kills or damages cells of the body's immune system” (AIDS, 2009, ¶2).
11. Masturbation- "erotic stimulation especially of one's own genital organs commonly resulting in orgasm and achieved by manual or other bodily contact exclusive of sexual intercourse, by instrumental manipulation, occasionally by sexual fantasies, or by various combinations of these agencies" (Merriam-Webster, 2009, ¶1).

12. Oral sex- "is sexual activity involving the stimulation of the genitalia by the use of the mouth, tongue, teeth, or throat" (Wikipedia, 2009, ¶1)

13. Penile-vaginal intercourse- "heterosexual intercourse involving penetration of the vagina by the penis" (Merriam-Webster, 2009, ¶1).

14. Physical intimacy- "the need and ability to experience closeness to another human being either through bodily contact or sexuality" (Mattiasson & Hemberg, 1998, p. 528).

15. Quality of life- "ability to enjoy life based on personal goals, values, and beliefs" (Wilmoth, 2007, p. 508).

16. Safe Sex- "a term used to describe sexual activities that minimize the risk of spreading sexually transmitted diseases" (Ortiz, 2007, p. 648).

17. Sexual Activities- "actions taken to obtain release of sexual tension alone or with another to achieve sexual satisfaction" (Wilmoth, 2007, p. 508).

18. Sexual Behaviors- "the multiple ways one verbally and nonverbally communicates sexual feelings and attitudes to others" (Wilmoth, 2007, p. 508).


20. Sexual Dysfunction- "disturbances in the process of the sexual response cycle; can be cause by pain associated with intercourse" (Wilmoth, 2007, p. 508).
21. Sexual Functioning- “The physiologic components of sexuality, including human sexual anatomy, the sexual response cycle, neuroendocrine functioning, and life-cycle changes in sexual physiology; often affected by pathophysiologic and structural changes to the body and by pharmacologic treatments” (Wilmoth, 2007, p. 508).


23. Sexual Health- “the integration of somatic, emotional, intellectual and social aspects of sexual being in ways that are positively enriching, and that enhances personality, communication and love” (WHO, 2001, p. 7).

24. Sexual Identity- the process of continuing discovering who we are as individual in regards to sexuality (Sharpe, 2004).

25. Sexuality- “part of being human; present from birth through death. All that makes us man or woman; perceptions about one’s body; the need to touch and connect with others, in both intimate and social settings; interest and ability to engage in sexual behaviors; communication of one’s feelings and need to others; and the ability to engage in satisfying sexual behaviors” (Wilmoth, 2007, p. 508).

26. Sexually Transmitted Diseases (STD’s)- “infections that you can get from having sex with someone who has the infection” (Sexually Transmitted Diseases, 2009, ¶1).
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18-25.
CHAPTER V

SUMMARY

Sexual health/sexuality is an important issue for occupational therapists to address. Neglecting this issue could mean that occupational therapists fail to treat clients holistically and possibly violate the Occupational Therapy Code of Ethics. Through the review of literature, a need appeared for occupational therapists to develop competency and comfort in order to address sexual health/sexuality in the elderly. The purpose was to develop a resource that can guide occupational therapists during the therapeutic process of addressing the sexual health/sexuality needs of the elderly client. It is hoped that the resource will facilitate an increase in occupational therapists competency, comfort, and awareness of the role in addressing the sexual health/sexuality needs of the elderly. This increase in competence and comfort will hopefully increase the frequency that occupational therapists address the sexual health/sexuality concerns of the elderly. As well as increasing satisfaction with occupational therapy services.

The ADL of Sexuality: A Guide for Occupational Therapists for Elderly Clients, was created illustrating the therapeutic process of assessment, treatment/intervention, discharge planning, and resources. The product was designed based on the Model of Human Occupation (MOHO) (Kielhofner, 2009), Malcolm Knowle’s Theory of Andragogy (1975), and the BETTER model© (Mick, Hughes, & Cohen, 2004). MOHO incorporates the client’s volition, habituation, and performance capacities regarding his/her sexual health. Malcolm Knowle’s Theory of Andragogy was
used in order to assist the facilitation of adult learning in occupational therapists. Lastly, the BETTER model©, a six-step process, incorporates a detailed therapeutic approach that is used to address sexual health/sexuality in clients to ensure holistic-care. This Guide has numerous clinical benefits associated with the implementation of it.

Clinical Benefits

*The ADL of Sexuality: A Guide for Occupational Therapists for Elderly Clients:*

1. is written at a level that is easily understood and provides specific examples of how various aspects of each section can increase professional growth
2. is designed to be easy to use for all healthcare professionals
3. provides an overview of the therapeutic process in addressing sexual health/sexuality
4. is congruent with occupational therapy theories and models
5. is a resource that adds to the limited resources in occupational therapy

Not only does this manual have numerous clinical benefits, it may produce positive outcomes.

Outcomes

There are several ways to measure the outcomes of this product. Possible methods of measuring outcomes include:

1. Providing occupational therapists with self-assessments which he/she can use to document his/her comfort and competency for professional growth. This is already a primary section of the guide.
2. Through client satisfaction evaluations in clinical settings, one can see how increased competency and comfort in occupational therapists has influenced

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occupational therapy services. This can be completed through facility client satisfaction evaluations where clients are surveyed directly in questions related to OT’s involvement in addressing his/her sexual health/sexuality needs.

3. Through a review of documentation regarding occupational therapy services, one can track the frequency of OT addressing sexual health/sexuality in the elderly. This can be completed through specifically analyzing if short and long-term goals, as well as the initial evaluation address sexual health/sexuality of the client.

**Implementation**

The guide, *The ADL of Sexuality: A Guide for Occupational Therapists for Elderly Clients*, is suggested to be implemented into an accredited occupational therapy curriculum as a supplemental guide to current course material. It is also suggested this guide be made available to practicing occupational therapists to serve as a resource regarding sexual health/sexuality in the elderly.

**Implementation Challenges**

Despite numerous clinical benefits and measurability of outcomes, there are limitations in this scholarly project:

1. The natural resistance of healthcare professionals to address sexuality. This is validated by Redelman (2008) and Sharpe (2004) who found that healthcare professionals avoid addressing sexual health needs of clients.

2. The natural resistance to change, especially when it incorporates unfamiliar processes or subject matter. This project uses the BETTER model© to
address sexual health/sexuality in the assessment process; whereas, most healthcare professionals are familiar with using the PLISSIT model© to address sexuality. Sexual health/sexuality in itself is unfamiliar as many healthcare professionals have not had experience addressing sexual health/sexuality concerns. Sharpe (2003) identified sexuality to be a challenge due to the lack of information and knowledge provided in the pre-professional curriculum.

3. It may be difficult to implement into institutionalized settings (i.e. skilled nursing facilities) as policies and procedures may prohibit some forms of sexual expression.

**Improvements and Potential**

In the future, expanding on some of the content that is incorporated into this Guide would improve the overall quality by further making it comprehensive. One aspect of the guide that can be expanded is the treatment/intervention section. This can be enhanced by including more information regarding specific diagnoses, how the diagnoses impacts sexual health/sexuality, and specific treatment/intervention ideas that may be applicable for client-centered care. The second aspect of the guide that can be expanded on is the assessment section regarding formal instruments that are used to assess objective sexual functioning in clients. Specifically, research can be done to provide information regarding reliability, validity, and application for clinical use. This would decrease the need for occupational therapists to seek out additional information on personal time. Lastly, the discharge planning section could be enhanced by including a
comprehensive list of location specific referrals including other healthcare professionals with a description of his/her area of expertise regarding sexual health/sexuality.

By incorporating these improvements, one can further develop upon this scholarly project. Potential for future scholarly project may include conducting research on the effects of using this *Guide* in clinical practice by measuring outcomes, or further designing an evaluation outcome measurement instrument to coincide with the *Guide*. The outcome measurement may include conducting a pilot study that tracks occupational therapists that have incorporated the *Guide* into his/her practice. Another way the scholarly project can be further developed is completing a pilot study of the effects regarding integration of the *Guide* into the academic curriculum at an occupational therapy program. Lastly, a continuing education workshop can be designed using *The ADL of Sexuality: A Guide for Occupational Therapists for Elderly Clients*, as the course content.

**Conclusion**

By using this *Guide* in the clinical and academic settings, sexual health/sexuality in the elderly can be addressed by occupational therapists. When an occupational therapist or occupational therapy student uses this guide, it is the authors hope that increased comfort, knowledge, and competency will be demonstrated when addressing sexual health/sexuality with elderly clients. This in turn, will increase in the frequency of occupational therapists addressing sexual health/sexuality while increasing client satisfaction of services. Overall, this will increase the practice of addressing the ADL, sexuality, while meeting the client’s needs. Through this, occupational therapists will be
adhering to the Occupational Therapy Practice Framework: Domain and Process and the Occupational Therapy Code of Ethics, while demonstrating holistic, client-centered care.
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