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A Website Designed to Equip Occupational Therapists with Information and Strategies for Holistically Addressing Sexual Activity with the Geriatric Population

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A Website Designed to Equip Occupational Therapists with Information and Strategies
for Holistically Addressing Sexual Activity with the Geriatric Population

by

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This scholarly project, submitted by, Amber Fernandez, MOTS and Ashleigh Mora, MOTS in partial fulfillment of the requirement for the Degree of Master 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

A Website Designed to Equip Occupational Therapists with Information and Strategies for Holistically Addressing Sexual Activity with the Geriatric Population

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As individuals age, they are likely to experience occupational deprivation. Occupational deprivation occurs in many forms. Many older adults experience occupational deprivation relating to the activity of daily living, sexual activity. Older adults experience many age-related changes, which impacts their ability to engage in sexual activity. Health care professionals have a responsibility to ensure older adults are able to engage in safe sexual practices. Yet, healthcare professionals, including occupational therapists, are not addressing this need with their clients in a routine manner. A literature review was conducted in order to gain a comprehensive understanding of all the barriers older adults experience when engaging in sexual activity. Research identified several barriers including age related changes; the ability to provide consent; sexually transmitted diseases; ageism; healthcare professionals' attitudes, knowledge, and perceptions; lack of sexual partner; depression and anxiety; and other

health related concerns in correlation to old age, such as arthritis, cancer, or dementia (Bauer, Haesler, & Fetherstonhaugh, 2016; Bauer et al., 2016; Benjamin Rose Institute on Aging, 2017; Freak-Poli et al., 2017; Ginsberg, 2006; Syme & Steele, 2016; & Tsatali & Tsolaki, 2014).

In order to address these concerns an educational website was developed for occupational therapists on the importance of addressing safe sexual practices with their older clients. The goal of this product is to provide support, education, and resources for occupational therapists, ultimately enabling them to holistically address their patients' needs and desires in relation to sexual activity.

CHAPTER ONE

Introduction

There is a societal belief that as individuals transition to older adults, the desire to engage in sexual activities lessens (Freak-Poli et al., 2017; Tsatali & Tsolaki, 2014). Conversely, people continue to have sexual desires in older adulthood (Freak-Poli et al., 2017; Tsatali & Tsolaki, 2014). Yet due to the societal belief, many health care professionals are not addressing sexual health with their clients (Bauer, Haesler, & Fetherstonhaugh, 2016). Moreover, many health care professionals avoid conversations regarding sex due to their own personal discomfort in discussing the topic with the geriatric population (Benjamin Rose Institute on Aging, 2017). It is essential that occupational therapists address sexuality with their older clients as there are many barriers preventing this population from engaging in this occupation, including age-related changes, sexually transmitted diseases, and ageism. To truly be working as a holistic health care provider, one must address all areas that are meaningful to a client (Finlay, 2001). According to Sakellariou and Algado (2006), occupational therapists must consider sexuality as an identity component of the individual and must include it in the intervention process. Not recognizing sexuality as an integral component to therapy may lead to less than optimal therapeutic outcomes (Sakellariou & Algado, 2006). Therefore, the students developed a website occupational therapists can use as a resource when addressing sexual activity with the geriatric population.

Occupational therapists have the skillsets and abilities to provide services to diverse populations across the lifespan. However, the topic of sexuality is one that practitioners rarely address in their practice (Bauer, Haesler, & Fetherstonhaugh, 2016). Rose and Hughes (2018) support the notion that excluding sex and sexuality from the therapy process could potentially hinder the client rehabilitation by not addressing vital components of their life. The lack of confidence reported by many occupational therapists derives from thinking they are not equipped with the skill or knowledge to address sexual activity issues (Rose & Hughes, 2018). Moreover, discomfort discussing the topic of sexuality may be a reason for not pursuing sexual health with older adults due to cultural stigma, lack of resources, or lack of self-confidence and competence on the issue (McGrath & Lynch, 2014). This scholarly project aims to provide educational components for occupational therapists to utilize while addressing sexuality with older adults. Research has shown that occupational therapists educated in the topic of addressing sexual activity provide more satisfactory services, as they can address their client's in a more holistic manner (Couldrick, 1999). The website provides education on therapeutic use of self, various assessment tools, approaches to appropriately address sexual dysfunction as a healthcare professional, as well as additional web-based resources occupational therapists can refer to. Additionally, the website can assist practitioners by providing a manner in which they can increase their knowledge on common trends and barriers for sexual activity in the older adult. Lastly, the website provides interactive components structured to enable practitioners to seek and offer advice through a community forum. The application of this product is contingent upon occupational

therapists' ability to access the website and be proactive in applying the information to their practice.

The importance of sexuality in the older adult has been thoroughly investigated and data from current research shows that increase in age does not affect older adults satisfaction and frequency of engagement in sexual activity (Ginsberg, Pomerantz, & Kramer-Feeley, 2005). Tsatali and Tsolaki (2014) explain that regardless of an individual's age, human beings continue to have sexual needs throughout the course of their lives. Moreover, not only do older individuals continue to have sexual needs, but Palacios-Cena et al. (2012) identify sexual engagement as a factor that affects quality of life and well-being. The Canadian Model of Occupational Performance and Engagement (CMOP-E) is a culturally sensitive, occupation-based model that was chosen to guide this product due to its emphasis on occupational therapists' ability to enable their clients to engage in meaningful occupations. One aspect of the CMOP-E that makes it unique to other models is that it considers the client's spirituality as a component that is central to the person. In addition to religious beliefs providing individuals with a sense of spirituality, the term can also be identified as what a person feels when doing certain activities and what gives the person meaning and determination in life (Polatajko, Townsend, and Craik, 2007). The CMOP-E was useful in directing the development of the product due to its emphasis on occupational therapists providing environments that were occupationally supportive. In addition, the CMOP-E highlights the importance of how engaging in meaningful activities, such as sexual activity, can enhance a person's overall health and well-being (Polatajko et al., 2007).

This scholarly project is concerned with enabling, or providing the means for, older adults to engage in sexual activity. As defined in the *Occupational Therapy Practice Framework: Domain and Process*, sexual activity encompasses activities that result in sexual satisfaction and/or meet relationship or reproductive needs (American Occupational Therapy Association, 2014). One's sexuality is defined as sexual activities they find meaningful and choose to engage in. For the purposes of this scholarly project, older adult was defined as individuals who are sixty-five years and older.

The following chapters address elements of the scholarly project and discuss the website designed to be a resource for occupational therapists when addressing sexual activity with the geriatric population. Chapter two reviews current and past literature, emphasizing the importance of addressing sexuality in health care, as well as describing the barriers older adults face when engaging in sexual activity. Following, chapter three is comprised of the complete system of methods utilized in developing the scholarly project. Chapter four includes the written version of the content offered on the website, including occupational therapy's role, models and assessment tools, strategies and resources, and barriers. Lastly, chapter five summarizes the scholarly project by addressing limitations and recommendations for further development. The complete list of references utilized to develop the product can be found following chapter five.

CHAPTER TWO

Literature Review

The Relevance of Sexual Intimacy in the Geriatric Population

According to MaCrae (2013), sexuality is defined as a state of mind, representing a person's feelings about themselves, what it is like to be female or male, and how they relate to people of their own gender and those of the opposite sex. Expression of sexuality occurs in the form of holding hands, flirting, touching, kissing, masturbating, and having sexual intercourse (MaCrae, 2013). "Physical intimacy is a profound human need that cannot be replaced by other relationships, such as friendships" (Lichtenberg, 2014); however, choosing to engage in sexual activities unprotected can result in sexually transmitted diseases. According to Wallace (2008), sexual health is a concern for all sexually active individuals, including older adults. With age, older adults face normal aging and pathological changes. These changes can impact sexual health. Addressing sexuality in a therapy setting can lead to increased self-esteem, promotion of companionship, restoration of function, healing and enhanced energy (Wallace, 2008). Although sexuality is a crucial and relevant part of aging, healthcare providers' preparedness to address related patient concerns is unclear (McGrath and Lynch, 2014).

The importance of participating in the occupation of sexual activity is often overlooked or underestimated when considering the older population. While Lindau et al. (2007) found that sexual activity decreased with time, the researchers also found that twenty-six percent of Americans between the ages of seventy-five and eighty-five

continued to engage in sexual activity. Tsatali and Tsolaki (2014) reported that as individuals age, they continue to require acceptance, tenderness, warmth, and safety. A study done completed by Kalra et al. in 2011 found 83.6% of men over the age of fifty were interested in sexual activity in the last month, with 53.3% reporting interest every day. Comparatively, 43.5% of females over the age of fifty expressed they had interest in engaging in sexual activity within the last month, with 30% of women reporting interest on a daily basis (Kalra, Subramanyam, & Pinto, 2011). Moreover, 83.4 % of the men and 43.4% of the women reported engaging in sexual activity within the last year (Kalra et al., 2011). In spite of the common belief that sexual needs reduce with age, human beings continue to have sexual needs throughout their lifetime (Freak-Poli et al., 2017; Tsatali & Tsolaki, 2014). The ability to engage in sexual expression has been identified as an integral factor in the individual's quality of life and well-being (Bauer, Haesler, & Fetherstonhaugh, 2016; Palacios Ceña et al., 2012). The most common sexual expression in the geriatric population has been identified as kissing, hugging, and sexual intercourse (Palacios Ceña et al., 2012).

While sexual desires and needs are still a part of older adults' lives, sexual function can be diminished or altered with age (Tsatali & Tsolaki, 2014). Common explanations for lack of sexual function include a lack of interest, widowhood, or physical illness (Palacios Ceña et al., 2012). Freak-Poli et al. (2017) identified the greatest barrier to maintaining sexual function while aging is in the pursuit of a sexual partner, and moreover, this barrier has a greater impact on women than men. Additionally, there is evidence proving depression and anxiety can significantly reduce an individual's desire to engage in sexual activities; therefore, a lack of interest in sexual

function may be indicative of a mood disorder (Tsatali & Tsolaki, 2014). Literature has shown that sexual activity and physical intimacy are more prevalent in older adults with partners and older men, while very few women without a partner were engaging in sexual activity (Freak-Poli et al., 2017). Individuals who were unhappy with their low level of sexual activity, reported sadness, lack of intimacy, and increased anxiety (Tsatali & Tsolaki, 2014). Women who were not engaging in sexual activities reported that it was due to a partner's illness and/or personal health issues, while men reported that their partner's willingness or lack thereof was the main factor for their continued or discontinued sexual function (Tsatali & Tsolaki, 2014).

Age-Related Changes

Throughout the aging process, there are a number of progressive age-related changes that can affect different aspects of a person's life. Ginsberg (2006) categorizes age-related changes into three main categories: physical, cultural, and psychological. Changes in any of these categories may affect how an individual expresses their sexuality, engages in sexual activities, and alters their sexual preferences. The physical changes humans experience may vary between individuals. According to Ferucci et al. (2016), between the ages of 60-70 years old, there is a more noticeable change in an individual's muscle strength and muscle mass. This muscle loss is then replaced with an increase in adipose tissue. Due to the decreasing strength and endurance, the combination of these factors interferes with a person's ability to move in a way that allows them to engage in certain sexual activities. This decrease in strength and endurance would then directly affect the individual's motor skills correlated with sexual activities. Depending on whether the individual was engaging in caressing, fondling, oral activity, or

intercourse activity, the hindered motor skill could negatively affect how that individual is able to engage in each activity. For example, a person's ability to lift their partner into different sexual positions, or endure throughout the entire sexual activity, would be negatively affected during intercourse activities. An additional gender-specific change seen in women is menopause. Although menopause usually occurs at an earlier age than the targeted population for this project, the symptoms that can occur during menopause may affect the individual's motivation for sexual activity. Sexual dysfunction and impaired cognition are among the symptoms seen during menopause in women (Ginsberg, 2006). Moreover, Ginsberg, Pomeroy, and Kramer-Feeley (2005) note the decrease in vaginal lubrication for women, and difficulty with sustaining an erection in men are factors that affect engagement in sexual activity in older individuals. Regardless of the physical changes previously noted, studies have shown that although the frequency of sexual activity and intimacy declines as a person ages, sexual satisfaction is not as affected (Ginsberg et al., 2005). This could be due to the fact that as individuals experience age-related changes, they then adapt how they choose to sexually express themselves in order to continue to maintain sexual satisfaction.

Finally, one other factor identified as the mediator of sexual behavior (Hartmans, Comijs, & Jonker, 2013), is the brain and what neurological and psychological changes occur as individuals age. In order for a person to exhibit sexual behaviors, they must initially become sexually aroused. Sexual arousal occurs from a series of messages sent throughout many different portions of the brain such as the parietal lobe, prefrontal cortex, hypothalamus, and amygdala (Hartmans, Comijs, & Jonker, 2013). Also, in addition to the arousal process, for a person to engage in sexual activity they must be able

to make decisions, have a sense of self and others, and be able to make judgments that all require executive functioning managed by the brain (Hartmans et al., 2013). Disease can affect how the brain functions as well as how the brain processes pain and illness.

Ginsberg (2006) notes the importance of understanding how any type of disease can generate fatigue or pain, and that psychological ailments such as anxiety and depression are also co-morbidities of aging. Age-related diseases that cause chronic pain may result in depression and a lack of interest in sexual activities and intimacy. Moreover, older individuals may experience anxiety during sexual activities due to not feeling adequate, an inability to perform, or in anticipation of any pain that may be associated with age-related physical changes (Ginsberg, 2006).

Cognitive changes that occur may negatively affect one's ability to process when to engage in sexual behaviors, and how to appropriately pursue them. Age-related changes in cognition can greatly affect a person's judgment, decision-making, sense of self and others, memory, abstract thinking, and all around executive functioning (Hartmans et al., 2013). Intact cognition allows a person to appropriately input, process, and produce a corresponding action, or what would be considered the output. This is made possible by an infinite number of neural connections that receive and pass on information to correct areas of the brain. In the later stages of aging, these neuronal connections begin to deteriorate, which cause interferences in shifting tasks, memory, and executive functioning (Carroll, 2018). Some of the gross anatomical changes that occur include a decrease in gray matter volume, decrease in white matter integrity, and an increase in neuron cell death (Carroll, 2018). In conclusion, like any other organ in the body, the brain relies on sufficient oxygen consumption to function correctly. As humans

age, there is a decrease in vascular functions which then decreases the blood flow throughout the cerebral region (Carroll, 2018).

Challenges Corresponding to Sexual Activity and the Geriatric Population

Ageism. Ageism, or being prejudiced against someone due to their age (World Health Organization, 2016), is relevant in today's society and it often shapes assumptions about older adults' abilities to be intimate (Bauer, Haesler, and Fetherstonhaugh, 2016). Bauer, Haesler, and Fetherstonhaugh (2016) identified the tendency for society to accept the stereotype that older individuals are sexless and undesirable. According to Hillman (2012), the predominant portrayal of older adults consists of depicting them as depressed, helpless, and sexless individuals. The younger generations focus on the arousal aspect and describe sexuality as individuals with hard, beautiful bodies. In popular ads and greeting cards, the geriatric population is portrayed as rigid, out of touch, and helpless. Those TV ads that do portray older adults' sexuality are only the ones selling products to treat erectile dysfunction (Hillman, 2012).

Societal ageism is also something that some older individuals experience, which causes them to feel anxious when engaging in or sharing their sexual experiences. Multiple research studies have noted how society views sexual behaviors among the older population as uncomfortable or inappropriate. Benbow and Beeston (2012); Doll (2013); and Taylor and Gosney (2011) all make note of how key societal views are of older individuals being asexual beings rather than sexual. The idea that this population no longer enjoys, needs, or pursues any type of sexual or intimate relationships has created a stigma which hinders this population from freely speaking to their medical advisors for advice or help with sexual problems (Taylor & Gosney, 2011). Apart from heterosexual

residents finding it uncomfortable to speak to their medical providers, an American survey found that 67% of doctors and nurses report that homosexual patients received substandard care and/or were at times denied care (Age Concern, 2002).

Sexually transmitted diseases. According to Benjamin Rose Institute on Aging (2017), older adults in today's society are engaging in sexual activity despite age-related changes. Medications, such as those designed for erectile dysfunction, have allowed individuals to continue to engage in sexual activities as they age. Moreover, there is a high divorce rate in the middle age range in America. Older adults are turning to online dating, which makes it difficult to know the sexual history of the individuals with whom they have engaged in sexual activity with. It has been found that older adults are less likely to perceive themselves at risk for contracting a sexually transmitted disease (STD). In today's education system, adolescents and teens are provided with educational courses regarding safe sex, however, this was not available during the time that the geriatric population were in school (Benjamin Rose Institute on Aging, 2017). STD prevention was developed after 1980, when the human immunodeficiency virus (HIV) and acquired immune deficiency syndrome (AIDS) were discovered (Benjamin Rose Institute on Aging, 2017). At this time, the majority of the current geriatric population were middle-aged and already married, therefore, they missed this crucial information during their formative education years. Older adults with STDs are more likely to receive the diagnosis too late, making it impossible to benefit from the current medications, which are capable of only treating the disease in its early stages. A reason for this late diagnosis is caused by an embarrassment to ask health care professionals to test for such diseases (Benjamin Rose Institute on Aging, 2017). Moreover, many STDs do not have

symptoms, so individuals do not realize they are infected until it becomes serious and potentially irreversible damage has already occurred (Benjamin Rose Institute on Aging, 2017).

According to Macdonald, Lorimer, Knussen, and Flowers (2016) there is a scarcity of condom use interventions for both middle-aged and older adults. In addition, there is not enough evidence to prove that those existent interventions are effective for this population (Macdonald et al., 2016). Because of this, there is an identified need for theory-based interventions targeting condom use among older adults to be evaluated and published (Macdonald et al., 2016). Beyond the need for interventions addressing sexual health for this population, it is also necessary to explore and understand how medical professional's knowledge, perspectives, and interactions have the ability to affect sexual health well-being in their older clients.

Health care professionals' attitudes, knowledge, and perceptions. Literature has shown that certain staff characteristics are positively correlated to knowledge and attitudes, including race, age, religion, and educational level, in regard to sexual activity in the geriatric population (Di Napoli, Breland, & Allen, 2013). According to Chen et al. (2017), those health care staff individuals with higher qualifications were found to have a better understanding of sexuality in older adults. Literature has shown that the majority of health care professionals working with older adults do not have accurate information regarding sexuality in older individuals. Yet, health care staff attitudes toward older adults engaging in sexual activity are permissive. Moreover, the majority of staff who work with the geriatric population are in support of education and additional training for staff and residents (Chen et al., 2017). Regardless of these reports, communication

between the geriatric population and health care professions about sexual issues or activity has been poor (Bauer et al., 2016). While some individuals prefer to keep their sex related questions to themselves, there is evidence showing a desire to be able to discuss sexual issues with healthcare professionals (Bauer et al., 2016). There are often barriers to facilitate discussions between health care professionals and clients regarding the matter of sexuality. Those include negative attitudes, clients' shame or embarrassment, and a feeling that the healthcare professional is not interested or cannot help in the matter (Bauer et al., 2016). Often, doctors also avoid these discussions due to their own personal discomfort in discussing sex with the geriatric population (Benjamin Rose Institute on Aging, 2017). Taylor and Gosney (2011), carried out a study showing that 78% of patients who were experiencing erectile dysfunction did not discuss it with their primary physician, even though it was affecting their overall satisfaction and quality of life. Additionally, the researchers found that there were a number of reasons health care professionals did not pursue addressing sexuality with their older patients (Taylor and Gosney, 2011).

According to Taylor and Gosney (2011), the information given from healthcare professionals during interviews revealed feeling undertrained, fearful of offending their patients, or they lacked the time to pursue the subject. Moreover, healthcare professionals may assume older adults are not engaging in sexual activity due to their age (Benjamin Rose Institute on Aging, 2017). In order to avoid addressing sexuality, Bauer et al. (2016) suggest the idea of normalizing sexual behavior in older adults, and they encourage the use of posters and pamphlets that display older adults in intimate and sexualized roles to promote an attitude of openness.

Researchers have identified a need for healthcare professionals to act in the following areas: to define the role of health professionals in identifying the decline in geriatric sexual interest and activity (Tsatali & Tsolaki, 2014); to proactively address sexuality and extend the knowledge about safe sex and sexual function to older adults (Freak-Poli et al., 2017); to develop and evaluate communication strategies in order to have discussions regarding sexuality and sexual health (Bauer et al., 2016); to address sexuality early and to incorporate the client's values, beliefs, and concerns (Sakellariou & Algado, 2006); to develop interventions to educate staff attitudes and knowledge regarding sexuality in the older adult (Di Napoli et al, 2013); and to ultimately ensure the older adult's need and desire for sexual fulfillment, and human intimacy is being met (Mahieu & Gastmans, 2012). Apart from these concrete expectations identified by past literature, there are more abstract components that will be evident in an aging population.

Cognitive deterioration and the ability to provide sexual consent. While older adults continue to engage in sexual activities, Syme and Steele (2016) have presented an ethical dilemma. Older adults experience normal age-related changes, especially, individuals who are living in long-term care settings. Many facilities lack policies and procedures in the area of sexual expression management and consent. One aspect of normal aging is a high cognitive decline. Therefore, the following question has become an ethical dilemma: are these older adults, who demonstrate a decline in cognition, capable of providing sexual consent? One example of this dilemma occurred at a nursing home. A male of normal cognition was found having sexual relations with a woman who had declining cognition. It was their right to engage in sexual activities, but the facility was unsure if the woman was capable of providing consent for such activities (Syme &

Steele, 2016). In addition to normal cognitive decline, there are also age-related diagnoses which significantly impact one's cognition.

Dementia is a disease of progressive cognitive deterioration that affects memory and reasoning capabilities; both of which, are necessary to determine whether or not to consent to sexual activity (Mahieu & Gastmans, 2012). A correlating issue faced by healthcare professionals is whether to aid in upholding an individual's sexual preferences prior to deterioration. Practitioners are asking the question, should individuals be permitted to make the decision about potential sexual partners during their cognitive deterioration (Cook, Schouten, Henrickson, & McDonald, 2017). For example, an individual may be faithful to one partner prior to cognitive deterioration, but during the process of declining memory and reasoning capabilities, he/she may be willing to engage in sexual activity with multiple partners. The level of cognitive impairment is often the determinant in whether or not to allow an individual to engage in sexual activity (Mahieu & Gastmans, 2012). Health care professionals must be cognizant of this fact, and be careful to not simply reduce the experience of declining cognition to a mere diagnosis, but rather consider the individual as one deserving of rights (Mahieu & Gastmans, 2012).

While age-related cognitive changes may negatively affect one's ability to engage in sexual behaviors as individuals grow older, a study conducted by Eloniemi-Sulkava et al. (2002) revealed that there may be positive changes that can occur as well. Eloniemi-Sulkava et al. (2002) gathered data from a survey that included 42 spousal caregivers of patients with dementia. The results from the survey showed that one-third of the patients increased expression of tenderness towards their caregiver and that one in ten of the

caregivers had experienced some positive change in their spouses' sexual behaviors (Eloniemi-Sulkava et al., 2002).

Occupational Therapy Role in Addressing Sexual Activity with the Older

Population

Within nursing home facilities, there are a number of medical professionals who work as a team to care for their residents. A common societal misconception regarding occupational therapists is that they are not always an essential part of this team or that they lack the knowledge or professional experience to contribute (Pollard & Sakellariou, 2007). However, occupational therapists can provide the necessary education and interventions that would benefit the resident, care team, and their families. The argument for occupational therapists' need to address their patient's sexual health is brought up in many different research studies. Eglseder, Webb, and Rennie's (2018) stance on the issue is that sexual expression contributes to a person's quality of life, and because sexuality is an area of occupation, or known as an activity of daily living, it is within the realm of the occupational therapist's work and important to address and treat. Moreover, Couldrick (2005) argues that occupational therapists should encourage and promote sexual expression with their clients. However, regardless of an occupational therapist's ability to address sexuality with their patients, the discomfort felt by many other clinicians regarding this subject inhibits them from addressing it with their patients (Rose & Hughes, 2018). Taylor and Gosney (2011) found that there were a number of reasons health care professionals did not pursue addressing sexuality with their older patients. The information received from healthcare professionals during interviews revealed that they did not discuss sexuality with their older patients, because they felt undertrained,

fearful of offending their patients, or that they lacked the time to pursue the subject (Taylor and Gosney, 2011).

Despite the discomfort felt towards the subject of sexuality, occupational therapists are equipped to provide beneficial interventions that can improve their clients' quality of life. Client-centered interventions may include teaching adaptive skills or safe sexual behaviors that will allow clients to engage in their sexual activities (Pollard & Sakellariou, 2007). Although client centered care is significant, if a person is reticent to engage in their preferred sexual activities due to company policies, it could then be more beneficial for occupational therapists to educate, advocate, and be involved in creating individualized plans. These plans would ensure that their patients are able to participate in all meaningful activities. Pollard and Sakellariou (2007) identify using a client-centered approach as "applying clinical reasoning skills from the client's personal-subjective vantage point and not within preset professional boundaries that do not necessarily correspond to client's wishes and needs" (p. 364). Nursing home policies regarding sexual activities can limit their residents' feelings of autonomy, and their ability to engage in activities that may improve their quality of life.

Occupational therapists may be able to positively impact this problem by educating health care professionals in nursing home facilities in a way that will make the subject of their residents' sexuality a more comfortable discussion, ultimately, creating a more individualistic approach when creating policies. A research study conducted by Doll (2013) included a survey that incorporated all nursing homes in the state of Kansas. The purpose of the study was to better grasp what types of sexual behaviors are seen in nursing home facilities, how the staff would respond when encountering said behaviors,

and what types of policies were in place and were used to guide the staff appropriately. Results from the survey showed that 68.9% of the participants would seek out a supervisor for help, 51.1% would attempt to help the resident, 41.1% would follow company policy, 32.2% would respond in disgust, 27.8% would ignore the behaviors, and 20% would panic (Doll, 2013). Results from this survey reveal how the responses of the nursing facility staff when encountering typical resident sexual behaviors varies vastly. Another study noted by Benbow and Beeston (2012) found that facility staff would disregard their residents' sexual needs due to personal discomfort.

Providing holistic care. The term holistic care has different meanings, depending upon the interpreter (Finlay, 2001). Therefore, while some health care professionals set out to deliver holistic services, they may not be providing true holistic care (Finlay, 2001). According to Sakellariou and Algado (2006), occupational therapists must consider sexuality as an identity component of the individual and must include it in the intervention process. Not recognizing sexuality as an integral component to therapy may lead to less than optimal therapeutic outcomes. Of even more concern, is those occupational therapists who do not address sexuality can be considered ageist, ultimately, reinforcing societal stigmas (Sakellariou & Algado, 2006). To address the person holistically, specifically in regard to sexuality, one may benefit from including ethical concepts such as empathy, responsibility, respect, and vulnerability (Mahieu & Gastmans, 2012). Moreover, respecting an individual's right to autonomy has been the prevailing factor in permitting sexual behavior in older adults residing in healthcare facilities (Cook, Schouten, Henrickson, & McDonald, 2017; Mahieu & Gastmans, 2012). According to Cook et al. (2017), health care professionals should ensure that each

individual's rights are being met while his/her well-being is also being evaluated. Unyielding policies may not have the person's best interest in mind, as it pertains to an individual's well-being. Instead, client-centered and flexible approaches are more desirable when determining an individual's autonomy for sexual activity (Cook et al., 2017).

Occupational therapists are equipped with the skill set to handle these concerns in a holistic manner and may apply problem-solving techniques within the realm of occupational therapy services (Sakellariou & Algado, 2006). Even when sexual concerns are not apparent, occupational therapists should make an effort to include it in the intervention process, even if only mentioning the importance of sexuality to the quality of life (Sakellariou & Algado, 2006). In addition, to prevent miscommunication, Bauer et al. (2016) suggests defining terminology and clarifying when broad terms or metaphoric language is used.

Sexual consent capacity. Lichtenberg and Strzepek created a model of a sexual consent capacity assessment for older adults in 1990. The approach assessed specific abilities associated with making sexual decisions (Lichtenberg & Strzepek, 1990). Syme and Steele (2016) conducted research on the sexual consent capacity and found there to be no other assessment tools created for assessing sexual consent, although, the addition of multiple guidelines has been suggested. Addressing contextual information and analyzing the level of risk were added to the assessment (Syme & Steele, 2016).

One additional approach was developed in 2008 by the American Bar Association/ American Psychological Association (ABA/APA). The ABA/APA created the Handbook of the Assessment of Older Adults with Diminished Capacity. This

assessment had considerable overlap with the original Lichtenberg and Strezepek model developed in 1990. However, this model expanded to include values, steps to enhance capacity, and more comprehensive neuropsychological testing components (Association/American Psychological Association, 2008).

Additionally, in 2016, an integrated model was proposed by Jennifer Hillman. This model combines aspects from both the ABA/APA and the original Lichtenberg and Strezepek model. The integrated model is the most detailed model of sexual consent assessment (Hillman, 2016). Therefore, utilizing an integrated model would be the most beneficial.

PLISSIT model. The PLISSIT Model is an assessment created by Jack Annon in 1976 (Palmisano, 2016). Wallace (2008) reports that the goal of the model is to gather data, which allows the patient to express sexuality safely, and to feel unrestrained by normal or pathologic issues. The first step is to ask for permission (P) to discuss the topic of sexual activity. After gaining permission, the administer asks a series of open-ended questions to understand the client's concerns regarding sexual health (Wallace, 2008). Next, the health care provider gives the client limited information (LI) regarding normal and pathological changes which may affect intercourse. Additionally, any misconceptions are addressed (Wallace, 2008). The third step is based upon the responses received from asking the open-ended questions. The health care provider offers specific suggestions (SS) to continue with sexual relations (Wallace, 2008). The last part of the model may not be necessary for all clients. However, a referral for intensive therapy (IT) may be necessary for older patients with sexual difficulties outside the range of normal aging, disease, or environmental factors (Wallace, 2008). This model may be used with older

adults in a variety of settings. The validity and reliability of the model are not available as of yet since there is little scientific material in the literature to assess the sexuality of older adults. Therefore, there is a need for further research on the topic of sexual health in older adults (Wallace, 2008). Teaching the PLISSIT model could be successfully utilized with a foundational understanding of the Canadian Model of Occupational Performance and Engagement model.

Guiding Model

The Canadian Model of Occupational Performance and Engagement (CMOP-E) was utilized to guide the product development of this scholarly project. The CMOP-E is described as a model that presents a dynamic relationship between the person, their environment, and occupations (Hurst, 2017). The person is considered to be made up of physical, affective and cognitive domains that influence components of a person's occupations which are regarded by the CMOP-E as self-care, productivity, and leisure (Hurst, 2017). Moreover, the CMOP-E identifies self-care occupations as activities that address personal care or functional mobility; productivity occupations as activities that include work, volunteering, additional hobbies, household management, and participating as a grandparent; and leisure occupations to be activities that provide enjoyment to the person, such as playing games or social participation (Kallidalen, Marcusson, Nagga, & Wressle, 2012). The environmental portion of the model is essential for presenting individuals with occupational opportunities. The physical, cultural, institutional, and social environments identified by the CMOP-E can influence both the person and the occupation. The influence the environment has on the person or occupation has a direct result on the individuals' occupational performance (Law & Laver-Fawcett, 2013).

The CMOP-E emphasizes a person's ability to engage in and perform meaningful occupations throughout the day and views this as a means of supporting well-being and health (Kalldalen et al., 2012). Krupa (2016) further identifies how the level of engagement can vary from person to person and through the clients identified level of engagement, individuals can fully experience how any given occupation can enhance their own health and well-being. Moreover, results from past research conclude that active participation in occupation has been found to be an important component of successful aging for older adults (Menec, 2003).

The CMOP-E has a clear client-centered approach that provides occupational therapists with strategies that can aid clients in identifying occupational performance issues. These identified performance issues can be utilized to create goals (Hurst, 2017). This approach allows the occupational therapist and the client to work on problematic issues collaboratively, in contrast to the practitioner making decisions without input from the client. The themes and approaches provided by the CMOP-E assisted the students in developing a website that would provide occupational therapists with the means to enable their clients to engage in meaningful occupations, specifically, sexual activity. Kalldalen et al. (2012) emphasizes the lack of research and understanding on how older adults perceive problems in their occupational performance that obstruct participation in meaningful activities. The CMOP-E provides enablement skills for occupational therapists to utilize in order to facilitate a conversation which allows the client to voice their opinions, ideas, and personal perceptions of their occupational performance. Furthermore, the enablement skills outlined by the CMOP-E can be used to assist occupational therapists in providing their clients with the means to engage in the

occupations they identify as meaningful, ultimately, positively enhancing their health and well-being (Krupa, 2012).

The CMOP-E was utilized to establish necessary the components developed for the website. CMOP-E concepts, including enabling the client to participate in occupations, engaging the client in meaningful occupations, empowering the client, supporting clients' sense of spirituality, and enhancing the client's health and well-being, were used to influence the development of the website. In conclusion, the CMOP-E was selected to support occupational therapists when addressing sexuality with the older adult by developing a website that would include educational elements, support, and the tools to provide client-centered and holistic care.

Summary

Past literature supports that there is a need and a place for occupational therapists to address sexual activity in practice (Eglseder & Webb, 2018). Occupational therapists are equipped with the knowledge and skills that can contribute to advocating for older adults needs, safety, and comfort in regard to their sexuality. The older adult population encounters many unique barriers that make it difficult to engage in sexual activity. The literature found on this subject supports the need for a more holistic and client-centered approach when addressing sexuality on the older adult. Incorporating models created for addressing sexual activity would assist occupational therapists when initially addressing the topic with their clients. Furthermore, occupational therapists would benefit in becoming more familiar with societal trends, needs, and intervention strategies that can be found in current research regarding sexuality in the older adult.

An additional asset occupational therapists possess is their ability to educate other disciplines on ways in which to appropriately approach, respond, and guide their actions, when considering the older adults' sexual needs or behaviors. Education, open discussion, and inclusion of holistic and person-centered policies and procedures would then assist facilities' to better assist their clients in participating in their desired sexual activities appropriately and safely (Doll, 2013). The implementation of creating holistic procedures would create a more client-centered environment. This would then require the healthcare staff to respond to each client's individual needs. Additionally, educating other disciplines may assist in eliminating the biases and stigma that surrounds sexuality in the older population. For example, there are instances where skilled nursing facility residents have been shamed and forced to neglect their sexual expression, as policies are created to protect other residents who may not be able to cognitively understand the consequences of their actions (Gordon, 2016). An occupational therapist may advocate for the resident's right to engage in sexual activity while also ensuring the other residents' safety, as well.

Information from the identified research literature supports that sexuality is human nature and should be pursued if it is meaningful to the person, regardless of their age. However, the ethical dilemma that then remains is, how does one decipher how, when, and if another person should be able to engage in sexual behavior or how can this subject be discussed and appropriately managed? An easily-accessible website dedicated to educating and supporting occupational therapists on addressing sexuality in the older adult. America heavily relies on technology and the use of digital marketing and sales more now than ever. The website would enable occupational therapists to develop a more

holistic and client-centered practice by providing pertinent information that can be implemented into all phases of the therapeutic process. The scholarly project will serve as a web-based resource for occupational therapists to access when seeking more information regarding sexuality in the older adult and how to support the older population in engaging in their meaningful activities. Occupational therapy can be a valuable asset toward igniting a more positive view on sexuality, by demonstrating open communication regarding the topic of sexuality and providing an inclusive environment for discussion and education.

CHAPTER THREE

Methodology

The purpose of this chapter is to provide a comprehensive overview of how the students obtained information for the development of the product. To begin, the idea for this project manifested after a preliminary literature review was completed in the second academic year of the occupational therapy program of University of North Dakota. The information from the preliminary literature review was then shared with occupational therapy program faculty, who verified the need to pursue this project by developing a product that would benefit future occupational therapists.

After solidifying the lack of current occupational therapy resources regarding addressing sexuality in the older adult, an assortment of online databases were utilized to conduct a literature review. The following databases were used to identify and obtain pertinent research articles that would be used to write the literature review: Google Scholar, CINAHL, SCOPUS, PubMed, Cambridge University Journals, American Occupational Therapy Association, and Gerontological Society of America. In order to identify relevant articles, search terms were narrowed down to “consent”, “older adults”, “cognitive decline”, “role of occupational therapist”, “sexuality as an activity of daily living”, “sexuality”, and “sexual behavior”. From this, information was gathered regarding how sexuality in the older adult is perceived in society, sexual health and cognition in the older adult, how occupational therapists can address sexuality, and what types tools are currently available to assess the cognitive abilities of older adults in

providing sexual consent. Apart from utilizing web-based information, a variety of theory, occupational therapy, and gerontological based books were used to obtain information.

From the literature, it was found that contrary to popular belief, older adults continue to engage in sexual activities. However, many healthcare professionals fail to address sexual health during routine evaluation and treatment, including occupational therapists. The literature presented several barriers to engaging in sexual activity as an older adult, including age-related changes, societal stigma, sexually transmitted diseases, lack of partner, health care professionals' attitudes, and perceptions regarding sexuality in the older adults. It was also found there are very few evaluation tools available for medical professionals to use when assessing the sexual consent ability in older adults. Moreover, no occupational therapy-based assessment tools developed for sexual consent and cognition in the older adult were identified during the research phase of this project. Occupational therapists often overlook addressing sexual activity during the treatment process with the older adult population, and the topic is rarely initiated by the patient due to discomfort and embarrassment (Taylor & Gosney, 2011). Moreover, occupational therapists have reported they lack the education, ability, or confidence to address sexual activity in the older adult (Eglseder, 2018). For these reasons, the Canadian Model of Occupational Performance and Engagement (CMOP-E) was determined to be appropriate for guiding the development of the product in order to provide tools, education, and strategies that will educate and assist practitioners to address sexual activity and enable the older adult in engaging in their meaningful activities.

This information was used to develop the website-based educational tool titled, “A website designed to equip occupational therapists with information and strategies for holistically addressing sexual activity with the geriatric population”. This product can be utilized by occupational therapists who are working with the geriatric population in a variety of settings. This product assists practitioners to understand their role and how they can effectively utilize their clinical knowledge to address sexuality with older adults. The website encompasses information regarding occupational therapy’s role in addressing sexuality with clients including general information regarding sexuality in the older adult, beneficial models and assessment tools, additional online resources, and a forum to reach out and discuss these concepts with other fellow occupational therapists.

An online website builder was determined to be the most efficient and effective manner to develop the scholarly project. When considering what online website builder to utilize, Courtney Leonis, a director of operations for Progressive Surgical Solutions, was consulted. Mrs. Leonis has significant experience in developing websites and suggested looking into the website builders, WordPress and Squarespace. Additionally, Troy Wood, software technician for Radius labs, was consulted; he also suggested WordPress as a potential website builder. An online search was conducted to review additional website designers, including Wix, Weebly, and Webnode. Based upon price, accessibility, and design, Weebly was selected to develop the website, “Sexuality in the Older Adult”. As certain components could not be provided from the website builder alone, outside sources were used to create the forum section and quizzes. In order to input the forum, the Website Toolbox application was used. This was accomplished through inputting the Website Toolbox applications’ HTML code into the Weebly site. Moreover,

the Dashboard add-on was used in order to create quizzes and fact sheets outside of the Weebly website designer.

Apart from building the components of the website, pictures were used to create a more aesthetically pleasing layout. The models used in the pictures were chosen to reflect the intended occupational therapy population. Informed consent was obtained from the individuals via written agreement (see Appendix A). The photography consent form was generated with assistance from the web-based application, FormSwift.

It was then determined there were many additional online resources which may be beneficial to occupational therapists when addressing sexuality with older adults. This included American Occupational Therapy Association (AOTA) fact sheet, *Sexuality and the Role of Occupational Therapy*; the National Institute on Aging webpage, *Sexuality in Later Life*; SAGE: Advocacy and Services for LGBT Elders website; healthyaging.org's website; the Centers for Disease Control and Prevention's (CDC) webpage, *Sexually Transmitted Diseases*; AARP's webpage, *STDs Keep Rising For Older Adults*; the World Health Organization (WHO) webpage, *Sexual Health in Older Women*; the American Health Association's website; and the Mayo Clinic webpage, *Senior Sex: Tips for Older Men*. An email was developed and sent to each organization, asking permission to provide a link to their websites on the scholarly project webpage, *Resources*. Permission was granted from the following organizations: AOTA, National Institute on Aging, SAGE, CDC, WHO, and the American Health Association.

The goal of this product was to provide a resource for occupational therapists to utilize when addressing sexual activity with the geriatric population. The online format provides ease of access. It is expected that by providing this information to occupational

therapists, they will feel better equipped to address the older adult population in a holistic and client centered manner. Chapter four contains a written format of the product, including the occupational therapy unique perspective of sexual activity, barriers older adult face when engaging in sexual activity, pertinent models and assessment tools, additional online resources, and a forum designed for practitioners to discuss these concepts with other fellow occupational therapists.

CHAPTER FOUR

Product

Introduction

A web based resource was developed to encompass information about occupational therapy's role in addressing sexuality with clients. This information includes general facts about sexual activity and the older adult, beneficial models and assessment tools, additional online resources, and a forum to reach out and discuss these concepts with fellow occupational therapists. This product assists practitioners in understanding their role and how they can effectively utilize their clinical knowledge to address sexuality with older adults. For the purposes of the scholarly project, the website was converted into a written document. As such, the headers of this written scholarly project correlate to the pages on the website. The website can be accessed through the following link: www.sexualityintheolderadult.net.

Home

Vision statement. Our vision is to create an environment in which individuals across the lifespan can engage in all occupations that contribute to their well-being and quality of life. We further envision a society that does not judge a person based on their age, but embraces each person for their unique client factors, including age-related changes.

Mission statement. Our mission is to provide education for occupational therapists on the importance of enabling older adults to safely engage in sexual activity.

The goal of the website is to provide support, education, and resources for occupational therapists, ultimately enabling them to holistically address their patients' needs and desires. Our goal is to promote awareness on the topic of sexual activity in the older adult and facilitate a safe environment for individuals to explore and connect with others.

Who we want to reach. This website is intended to be used by occupational therapists who are working directly with clients over the age of sixty-five and who are experiencing occupational deprivation due to sexual dysfunction. Moreover, we recognize the importance of sexual activity, specifically, how individuals may consider their sexual experiences to be meaningful and spiritual. This website has been formatted in a way that will assist occupational therapists enable and support older adults who wish to participate in sexual activity, ultimately enhancing their health and well-being. Information provided by the website may also assist occupational therapists in providing any involved family members with pertinent education that will assist them in supporting their loved one with engaging in sexual activity.

The Canadian model of occupational performance and engagement. The Canadian Model of Occupational Performance and Engagement (CMOP-E) was utilized to guide the development of this website. The CMOP-E emphasizes participation in meaningful occupations as a means to support a person's health and well-being (Krupa, 2016). Also, the CMOP-E recognizes individuals can continue to participate in occupations supporting health and well-being, regardless of any illnesses, disease, or life disruptions (Krupa, 2016). Other major components of the CMOP-E that supported the development of this website, was how the model views the person as a multi-faceted being and emphasizes spirituality. Krupa (2016) describes spirituality as the "essence of

the self, the sense of purpose and meaning, and the relationship of the self to larger society and the world" (Krupa, 2016, p. 218).

Why this is important. Sexual activity is an important occupation for many individuals, though it is rarely addressed during the therapeutic process with the older adult. However, engaging in sexual activity is often negatively impacted due to the number of barriers this population encounters as they age. For this reason, the need to actively address and be educated on how to approach and develop effective interventions for sexual activity in the older adult is imperative.

About the authors of the website. Amber Fernandez and Ashleigh Mora are Masters of Occupational Therapy students at the University of North Dakota. This website was developed to fulfill requirements for their scholarly project in the final year of the graduate program. The students were driven to create this product as they wanted to provide a tool for occupational therapists to utilize that would enable older adults to access and participate in all meaningful occupations, including sexual activity.

Occupational Therapy Perspective

Occupational therapy is a profession that has its own unique therapeutic process. Within the following webpages, you will learn how occupational therapy is equipped with the skills to address sexuality with clients, including occupational therapy scope of practice, therapeutic modes, enablement skills, approaches to intervention, and outcomes.

Scope of practice. *"With awareness and skill development, occupational therapists can affirm sexual identity, they can listen, and, with sometimes simple*

measures, they can address issues that fall within their professional role." -Lorna Couldrick

Occupational therapy is a profession that helps individuals of all ages participate and engage in the daily activities (known as occupations) they want or need to (American Occupational Therapy Association, 2018). The *Occupational Therapy Practice Framework: Domain and Process* identifies eight occupations practitioners can help clients engage in; one of these occupations is activities of daily living (American Occupational Therapy Association, 2014). Activities of daily living (ADLs) is defined as activities that are fundamental to one's basic survival and well-being (American Occupational Therapy Association, 2014). ADLs are comprised of nine areas, including sexual activity. Sexual activity encompasses "activities that result in sexual satisfaction and/or meets relational or reproductive needs" (American Occupational Therapy Association, 2014, p. S19). Therefore, the occupation of sexual activity falls within the scope of occupational therapy. However, the importance of participating in the occupation of sexual activity is often overlooked or underestimated when considering the older population. In spite of the common belief that sexual needs reduce with age, human beings continue to have sexual needs throughout their lifetime (Freak-Poli et al., 2017; Tsatali & Tsolaki, 2014). It is important for occupational therapists to address clients holistically. This includes addressing any sexual activity barriers or challenges individuals may be facing as they age. By reducing the impact of the barriers, an occupational therapist can enable clients to engage in all areas of occupations that are meaningful to them.

Enablement skills. After selecting the Canadian Model of Occupational Performance and Engagement, additional Canadian models were considered. The Canadian Model of Client Centered Enablement: Skills of Enabling (CMCE) provides therapeutic strategies for occupational therapists to utilize with clients. These therapeutic strategies are known as enablement skills and are designed to be used by the occupational therapist in order to provide their clients with the means to participate in their valued occupations, or to find ways to make a difference in their health or well-being (Krupa, 2016). Using enabling as an approach to the therapeutic process can positively impact the client’s sense of autonomy, ability to solve problems, cope with problems, and sense of self-efficacy (Krupa, 2016). The enabling skills encourage occupational therapists to develop a therapeutic process that will enable clients to engage in and perform their meaningful occupations. Krupa (2016) identifies several factors that support the use of enablement skills in practice. These skills allow the occupational therapist to practice with a diverse range of clients, develop a collaborative relationship with client, change environmental factors to support occupational performance, and present all the possibilities on how to perform occupation (Krupa, 2016). The CMCE enablement skills should be used to guide goal and intervention development in order to provide occupation-based and client-centered treatment plans that will facilitate engagement in meaningful occupations. The following is a list of enablement skills and their descriptions, as identified by Krupa (2016). The website developers have provided relevant examples which correlate with each skill listed.

Table 1 Summary of Enablement Skills and Examples

Skill	Description	Example
Adapt	Accommodate, adjust, “analyze	Occupational therapists break down sexual

	and break down” occupation into doable components, configure and reconfigure, confirm, cope, observe, tailor	activity tasks into smaller components for the client to accomplish. Moreover, the occupational therapist could assist the client in adjusting how the sexual activity is being performed by teaching adaptive positions.
Advocate	Challenge, champion, develop (guidelines, policy, positions, regulations, reports), generate critical perspectives, politically strategize, prompt power sharing and empowerment, enlighten, lobby, make visible, mobilize, promote, raise consciousness	Advocacy occurs when encouraging a person to speak for themselves or empowering them to take charge of a situation. A client may need assistance in saying "No" when sexual activity is not wanted, or they might need assistance in verbalizing their wants and needs regarding sexual desires. Occupational therapists may also review current policies which negatively affect their client and develop a plan to confront and change the policy to benefit the client’s health and well-being.
Coach	Encourage, guide, challenge, expand choices, hold accountable, see the big picture, listen, mentor, motivate, pose powerful questions, reflect, reframe, support	An occupational therapist might coach a client who is experiencing sexual dysfunction by offering alternative choices, assisting them on reflecting on what activities they are still capable of performing, or guiding them to seek out a specialist if needed.
Collaborate	Communicate, cooperate, encourage, facilitate, form alliances, mediate, negotiate, partner, resolve competing interests, tap motivation	The collaborate skill may be utilized with other medical professions. It is important to actively communicate with all medical professionals involved in the client's treatment in order to develop the best therapeutic plan. Collaboration with the client as well as with the family is important. The occupational therapist may be acting as a facilitator for conversation during meetings.
Consult	Advise, brainstorm options, confer, counsel, integrate, recommend, suggest, synthesize, and summarize	An occupational therapist may be a consultant regarding the positioning needs of a client who is experiencing age-related declines in physical ability, but would like to engage in sexual activity with their spouse.

Coordinate	Arrange, bring together, case coordinate/manage, develop and manage budgets, document, integrate, identify, interweave or weave together, allocate human, financial, space and material resources, lead, link, manage, network, orchestrate, organize, supervise, synthesize	In skilled nursing facilities, it is likely that an occupational therapist will be working with a healthcare team to determine what is best for the client. An occupational therapist may coordinate with the healthcare team and client's family to determine whether or not a client has the ability to provide consent to engage in sexual activities.
Design/Build	Conceive, construct, create, develop, devise, fabricate, formulate, envision, evaluate, manufacture, plan, prescribe, propose, redesign, rebuild, strategize, visualize	In some cases, a client may need specialized assistive technology to engage in sexual activity. Their occupational therapist may collaborate with a designer/builders to develop assistive technology that would allow the client to engage in sexual activity in a safe and healthy manner.
Educate	Demonstrate, enlighten, instruct, inform, facilitate learning through doing, notify, present just-right-challenge, prompt learning of skills, prompt rote and repetitive learning, prompt transformative learning, stimulate, teach, train, tutor	An occupational therapist must inform their clients of the potential for contracting sexually transmitted diseases while engaging in sexual activity. Additionally, the therapist will need to instruct their clients on strategies to prevent the transfer of sexually transmitted diseases through the use of condoms and safe sex practices.
Engage	Build trust, challenge normal expectations, develop readiness and confidence, do with/in parallel, draw into performance in tests or use of technology, engage in "doing", identify occupational issues and potential, involve, occupy, optimize potential, socially mobilize, spark visions of possibility and hope, stimulate creative expression through occupation, prompt optimal participation, tap potential	An occupational therapist will need to build trusting rapport with a client before expecting them to openly share about the dysfunction within their sexual lives. This enablement skill is crucial prior to discussing a client's sexual activity.
Specialize	Facilitate body function, apply hands on techniques (e.g., asset-based practice, cognitive approaches, driver rehabilitation,	Most occupational therapists have not specialized in sexual activity. Therefore, the occupational therapist would refer their client to a specialist in order to

	ergonomics, group therapy, psychosocial rehabilitation, sensory integration)	facilitate body function or apply hands on techniques in an attempt to reduce the impact of the sexual dysfunction they are experiencing.
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Approaches to intervention. Occupational therapists can utilize several different approaches when addressing sexual dysfunction with clients. The following are approaches to intervention from the *Occupational Therapy Practice Framework: Domain and Process* (American Occupational Therapy Association, 2014) along with corresponding examples.

Create, promote (health promotion). This type of approach can be utilized when the client is not assumed to be disabled (American Occupational Therapy Association, 2014). Occupational therapists will use this type of approach when the client expresses a problem that can be solved through education or additional information intended to enhance their sexual experience or prevent any negative occurrences.

Establish, restore (remediation, restoration). This type of approach will be utilized when the client has lost a skill due to an injury, or is need of establishing new skills in order to continue participating in sexual activity (American Occupational Therapy Association, 2014). Occupational therapists will use this type of approach to develop a restorative program for strength, movement, or other variables the client may be struggling with. An additional way this approach may be utilized is by assisting a client to establish a new skill, such as proper positioning that enables them to continue participation in desired sexual activities.

Maintain. This approach to intervention will be used with clients who have already regained functional performance and are in need of further maintenance to

continue participating in their preferred occupations (American Occupational Therapy Association, 2014). For example, a sexually active female client who is experiencing problems with vaginal dryness would be advised to use synthetic lubrication in order to engage in sexual intercourse. Without the lubrication, the client would not be able to optimally engage in sexual activities which would then affect her overall health and well-being by inhibiting her from meeting all of her occupational needs.

Modify (compensation, adaptation). This approach to intervention can be used to address clients with low cognitive abilities, mobility issues, or other diagnoses which would call for a modification to the task or environment in order to make participation more obtainable (American Occupational Therapy Association, 2014). A client who is wheelchair bound may need adaptive equipment in order to participate in sexual activities. They may also need the environment to be restructured in a manner that will enable them to move around effectively and engage in the activities they want to.

Prevent (disability prevention). This approach to intervention can be used directly with a single client or with a group of individuals. Occupational therapists using this approach would aim to decrease or eliminate the potential risks involved with engaging in sexual activity (American Occupational Therapy Association, 2014). Educational pamphlets, condom distribution, and/or focus groups on safe sex can all be beneficial in preventing sexually transmitted diseases and infections.

Outcomes. According to American Occupational Therapy Association (2014), occupational performance refers to how well a person, group, or population performs an activity, task, action, or occupation. Through occupational therapy, occupational performance can be improved or enhanced. Improving occupational performance is

necessary when there is a limitation in performance (American Occupational Therapy Association, 2014). For example, occupational therapists can reduce an individual's sexual fatigue by teaching them energy conservation techniques. This would allow the individual to continue to engage in sexual activities without feeling fatigued, which results in improved occupational performance. In order for occupational therapists to enhance occupational performance, they need to address the client's performance skills and patterns that have the potential to improve their existing performance in occupations (American Occupational Therapy Association, 2014). Older adults are at risk for developing depression and anxiety when confronted with age related challenges that affect sexual activity performance. Ginsberg (2006) explains that men and women can experience depression due to sexual dysfunction as a result of unpleasant sexual experiences related to age-related changes. An example of enhancing a person's occupational performance in sexual activities would be increasing their confidence and decreasing their anxieties surrounding sexual performance by identifying ways to compensate for the changes they are experiencing.

Prevention allows a client, group, or population to have equitable access, education, or information on how to prevent or reduce the risk of disease and injury (American Occupational Therapy Association, 2014). It is occupational therapy's role to promote a healthy lifestyle at all levels in society (American Occupational Therapy Association, 2014). For example, older populations are at a higher risk of contracting diseases, such as HIV/AIDS, due to a decreased immune system function (Ginsberg, 2006). Occupational therapists can implement programs targeting older adults which

educate on the topic of safe sex practices, essentially aiming to decrease the spread of sexually transmitted diseases.

According to American Occupational Therapy Association (2014), health and wellness refers to the physical, mental, and social well-being of the client. The term, health, encompasses a client's concept of themselves with regard to the social resources, personal resources, and physical capacities. When considered together, well-being is the dynamic process in which individuals develop a perception of their health and make decisions to achieve a more satisfying life (American Occupational Therapy Association, 2014). This outcome may be jeopardized if a client is unable to participate in sexual activity, due to lack of social resources. According to Palacios-Ceña et al. (2012), the leading cause of occupational deprivation of sexual activity in the geriatric population was lack of partner. Additionally, due to age-related changes, one may not have the physical capacities required to engage in sexual activities they once enjoyed. When considering their lack of social resources and physical capacities, one's self concept may decrease, resulting in an inability to meet the outcome, health, and wellness.

Quality of life is the ongoing assessment of one's satisfaction with their life, hope, self-concept, health, functions, and socioeconomic factors (American Occupational Therapy Association, 2014). The American Occupational Therapy Association (2014) defines the term self-concept as the beliefs and feelings one has regarding themselves. As discussed previously in health and wellness, an individual's self-concept may be damaged due to changes in physical capacities and lack of social interactions correlated with aging. Additionally, American Occupational Therapy Association (2014) defines health and functioning as one's self-care capabilities. As sexual activity is an activity of daily living

(American Occupational Therapy Association, 2014), one's inability to engage in the occupation may threaten their health and functioning. Lastly, socioeconomic factors include one's education (American Occupational Therapy Association, 2014). Education is relevant to one's quality of life in regard to sexual activity; this is especially true if an individual never received appropriate information regarding sexually transmitted diseases and other health concerns which correlate to participation in sexual activity. Together, these three components have the potential to restrict one's quality of life.

Participation refers to the engagement in meaningful occupations, essentially creating a feeling of personal satisfaction in correlation to the cultural expectations (American Occupational Therapy Association, 2014). Sexual activity is a meaningful occupation to many older adults (Kalra, Subramanyam, & Pinto, 2011; Palacios-Ceña et al., 2012; Tsatali & Tsolaki, 2014). An inability to partake in the occupation, would mean the individual would not meet the outcomes of participation and ultimately, would experience a loss of spirituality, as defined by the Canadian Model of Occupational Performance and Engagement.

The *Occupational Therapy Practice Framework: Domain and Process* (American Occupational Therapy Association, 2014) refers to role competence as an individual's capacity to fulfill the expectations of the roles they hold (American Occupational Therapy Association, 2014). For example, a man may feel an inability to meet his role competence of a husband if he is experiencing erectile dysfunction as a result of age-related changes (Ginsberg, 2006).

According to the *Occupational Therapy Practice Framework: Domain and Process* (American Occupational Therapy Association, 2014), well-being encompasses

an individual's satisfaction with their health, self-esteem, sense of belonging, security, and opportunities for self-determination, meaning, roles, and ability to help others (American Occupational Therapy Association, 2014). Well-being will be negatively impacted if an individual is dissatisfied with any of these components. For example, an older adult may experience a lack of well-being due to a decreased self-esteem about age-related changes affecting her physical appearance.

As stated by American Occupational Therapy Association (2014), Occupational Justice is an individual's ability to access and engage in the valued occupations accessible to others, including social inclusion and necessary resources for occupational participation correlating to personal, health, and societal needs. For instance, an older adult who recently moved to an assisted living facility may find she is unable to engage in the sexual activities she participated in when living in the community as a result of facility policy. This individual is experiencing occupational injustice.

Models

The following models can be utilized to facilitate conversation about sexual dysfunction and possible interventions with clients. The models can be utilized by occupational therapists as well as other medical professionals.

The PLISSIT Model.

About the Model. Jack Annon, a psychologist, developed the PLISSIT Model in 1976 (Annon, 1976). According to Annon (1976), the model was a tool he could utilize when addressing sexuality with clients. However, Annon realized with a few modifications, the model could be used by any health care professional. The model includes four levels, beginning with a basic level and progressing to more complex sexual

health concerns. The four levels are an acronym: Permission, Limited Information, Specific Suggestions, and Intensive Therapy (PLISSIT). The model also takes into consideration the health care professionals level of knowledge and comfort with the topic. When a client's needs exceed a practitioner's comfort, knowledge, or time, a referral to a specialist can be made (Annon, 1976).

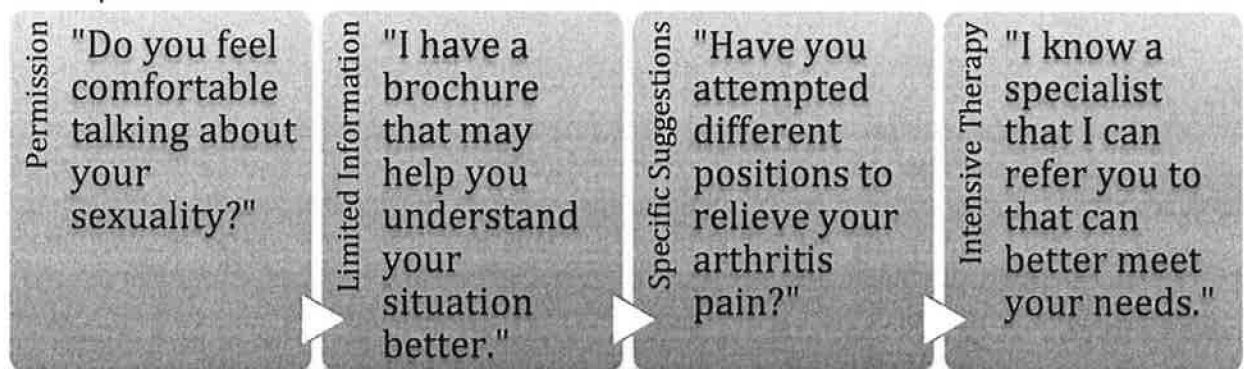


Figure 1 PLISSIT Model

Permission. According to Annon (1976), a client should first assent to discussing sexual activity with their occupational therapist. This can be achieved by simply asking permission to talk about sexual activity concerns a client may have during therapy. While some therapists find asking permission to be challenging, it is crucial for practitioners to take this step as it confirms the client's sexual activity concerns are a health care matter. Additionally, by validating the client's feelings, practitioners empower clients to take an active role in the advancement of their health and well-being. Moreover, a client may be concerned whether or not they can take part in certain sexual activities due to an illness, injury, or age-related changes. At this level, a therapist can reassure the patients that this action is appropriate to engage in, after considering their client factors and performance skills (Annon, 1976).

Limited Information. Next, Annon (1976) addresses what to do when a client is still unsure about engaging in sexual activity. An occupational therapist can offer limited information to provide a basic education regarding the matter. A practitioner must have a foundational knowledge regarding the topic in order to provide limited information. This level also includes answering client questions and resolving any misconceptions. Brochures or handouts with accurate information/resources is a beneficial way to provide clients with information at this level (Annon, 1976).

Specific Suggestions. According to Annon (1976), some clients will require specific suggestions regarding particular barriers they may be facing, such as positioning or anatomical changes in the body. To provide specific suggestions, a practitioner will require advanced knowledge of the identified health issue, and the necessary skills to assess a patient's distinct situation. Evaluation may include discussing patient concerns and experiences, collaborating to identify the specific issues, problem solving to find solutions, and selecting accommodating strategies. Using the information gathered from the assessment, a practitioner would develop a plan. At this point, referral to a sex specialist may be the best option for the client, dependent upon therapist's available time, knowledge, and comfort level with the sexual activity concern. Additionally, a therapist may refer the client to a different therapist who is more skilled in the area of sexual activity. If the concern is brought up and time is limited during the session, it may be more appropriate to schedule an additional appointment to allot enough time to address the concern (Annon, 1976).

Intensive Therapy. Some clients may require intensive therapy for specific sexual activity concerns. If this is the case, an occupational therapist would refer their client to a specialist (Annon, 1976).

Cons to using the PLISSIT model. Although the PLISSIT model provides a guideline for addressing sexuality with clients, Taylor and Davis (2007) emphasize some of the negative factors that may decrease the efficiency of using the PLISSIT model with clients. Annon (1976) suggests the first step of the model is to ask for permission to discuss the topic of sexuality during initial evaluations. However, Taylor and Davis (2007) argue that medical professionals should not only ask for permission during the initial evaluation, but also during every session or visit thereafter. Moreover, the PLISSIT model also suggests that the client will bring up the topic of sexuality on their own (Taylor & Davis, 2007). This can be detrimental during therapeutic sessions in that the topic of sexuality could inadvertently be forgotten and ignored. Apart from these two factors, Taylor and Davis (2007) also propose that the basic PLISSIT model does not incorporate a “review” component. Because the PLISSIT model does not involve a “review” component, Taylor and Davis (2007) then assert the client is not able to bring up any concerns regarding previously suggested interventions. The lack of review leaves clients without an opportunity to voice their concerns, ask for suggestions, or give the medical professional any feedback regarding the given intervention.

The extended PLISSIT model. According to Taylor and Davis (2007), the extended PLISSIT (ex-PLISSIT) Model stresses the importance of obtaining permission not only in the beginning of treatment as a step by itself, but also before each step in the PLISSIT model. For example, a therapist should obtain permission before offering

limited information and again before offering specific suggestions or referring a client to a specialist for intensive therapy. Asking permission between steps is also beneficial, as some steps require more information than others. For example, to offer limited information, a therapist only needs limited information regarding a client's sexual activity. However, when offering specific suggestions, more specific information is needed to provide suggestions that are relevant to the client's individual preferences (Taylor & Davis, 2007).

Additionally, Taylor and Davis (2007) identify the ex-PLISSIT Model differs from the original model in that the steps do not have to occur in sequential order of asking permission, giving limited information, offering specific suggestions, and lastly referring for intensive therapy. Instead, the ex-PLISSIT Model states a referral for intensive therapy can be offered at any time during the treatment. Occupational therapists should be aware of their strengths, as well as their weaknesses. Utilizing clinical reasoning skills, practitioners should decide whether or not intensive therapy would be the best option for the client moving forward (Taylor & Davis, 2007).

Lastly, Taylor and Davis (2007) present a continuous reflection and review process the ex-PLISSIT Model offers. This process aims to create self-awareness, dispute assumptions, and obtain a more comprehensive knowledge base. Using the original PLISSIT Model, a therapist may address one sexual concern. However, a client may have several or more may arise during the therapy process. The ex-PLISSIT Model allows for reviewing interventions to ensure all needs are being met. Additionally, the ex-PLISSIT Model requires that practitioners also review and reflect on their ability to provide treatment, including understanding their personal attitudes, beliefs, and opinions. This

model encourages team approaches, which are helpful in identifying and providing constructive feedback regarding underlying biases (Taylor & Davis, 2007).

When to refer. According to Taylor and Davis (2007), refer to a specialist when a client needs:

- Psychosexual therapy or relationship counseling
- Urology consultation
- Genito-urinary medicine
- Gynecology
- Continence advice (Taylor & Davis, 2007)
- Or when you, as a practitioner, do not feel competent or comfortable addressing the client's needs

The ALLOW model.

About the Model. According to Sadovasky (2003), the ALLOW acronym stands for a management plan which recognizes the need for health care professionals to address sexual dysfunction with their clients or patients. Additionally, the plan allows for healthcare professionals to refer to other specialists and/or disciplines, if they feel they are unable to adequately address the problem themselves. This management plan consists

of five stages.

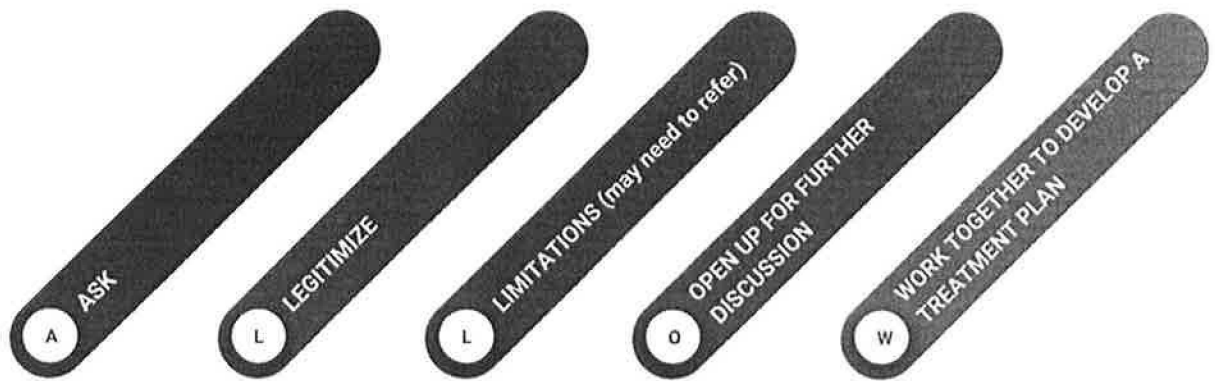


Figure 2 ALLOW model

Stages. During stage one, the health care professional asks their client/patient about their sexual activity in relation to their diagnosis, illness, or injury (Sadovasky, 2003). According to Sadovasky (2003), if a patient or client feels their concerns are being dismissed, it is likely they will not seek further assistance in the area. Stage two involves validating or legitimizing the client/patient's problems and emphasizing the sexual dysfunction they are experiencing is a significant problem (Sadovasky, 2003). During stage three, the health care professional must assess his or her own interest and ability (or limitations) to work with patients who report a sexual problem. Based on this self-evaluation, the clinician takes the next step. Next, stage four may require the health care professional to refer to an appropriate specialist or additional discipline to further evaluate and treat the patient's sexual problems. Though, if the health care professional feels qualified and comfortable moving forward, they may address the issue, which would require further analysis of underlying causes or problems through open discussion. Lastly, stage five requires that the healthcare professional works collaboratively with the client or patient to develop appropriate goal(s) and treatment plans (Sadovasky, 2003).

The BETTER model.

About the Model. The BETTER model was introduced as a structured approach for nurses when addressing sexual issues with clients in an oncology setting (Mick, Hughes, & Cohen, 2004). While this model was developed for this specific population and profession, the components of the model can be considered by all healthcare professions when addressing clients of varying disabilities. The model is comprised of six individual stages.

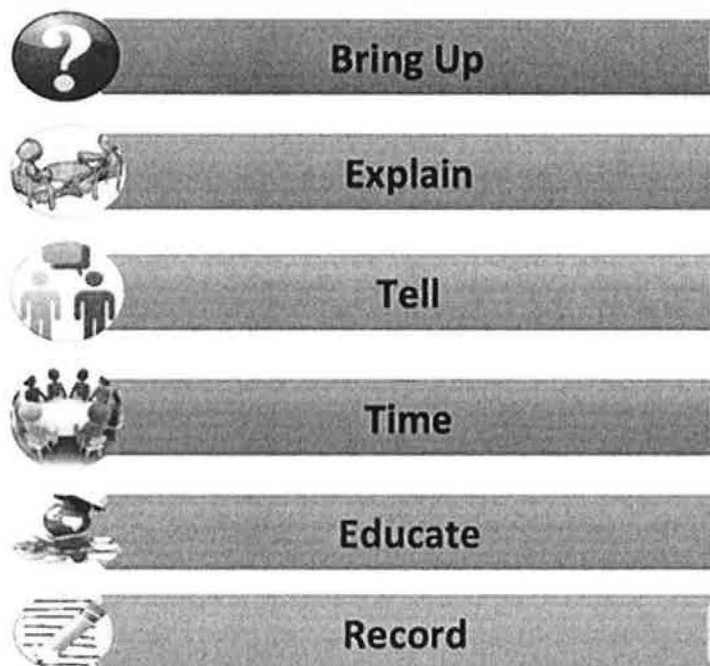


Figure 3 BETTER model

Components. Bring up: During this step, the healthcare professional brings up the topic of sexuality (Mick et al., 2004). While some clients may feel uncomfortable discussing this topic, bringing the topic up ensures the client knows the healthcare professional is willing to discuss this area, if they ever do want to express their concerns (Mick et al., 2004).

Explain. Explaining requires that a practitioner inform the client, that for many, sexuality is an important and meaningful aspect of their lives, and that the healthcare professionals are open to discussing these issues (Mick et al., 2004). This assists in normalizing the discussion and might help the consumer to feel less embarrassed or alone (Mick et al., 2004).

Tell. During this stage, healthcare providers inform their clients that if a solution cannot be provided immediately, then a referral will be made to another professional who can address the problem (Mick et al., 2004).

Time. Time encompasses client centered care, as the client determines whether or not they are ready to discuss aspects of their sexuality; if they are not, the topic can bring it up at a later point in services (Mick et al., 2004).

Educate. This step involves educating the clients about the potential side effects of the medications they are taking on the performance of sexual activity (Mick et al., 2004). Additionally, this step may be used for educating clients about positioning, assistive technology, sexually transmitted diseases, and other relevant topics.

Record. The assessment, treatment, and outcome should all be documented in the client's medical record. Integrating this information can validate the consumers' experiences and enhance their quality of life (Mick et al., 2004).

Assessment Tools

Prior to developing a treatment plan or interventions, it is imperative to assess and evaluate your client in order to identify what they need to participate in meaningful occupations. Deciding on the appropriate assessment can assist in developing a more client-centered therapeutic process. Occupational therapists have the skills to assess a

variety of client factors. This website was developed to equip occupational therapists with the tools and information needed to address sexuality and enable older client to engage in preferred sexual activities. For this reason, we have researched and identified assessments that are relevant to sexuality and older adults. Below you will find information on cognition and how it relates to sexual consent, potential assessments that can be used to assess ability to give sexual consent, and other assessments targeting sexual activity and satisfaction. The assessments provided are only a few of many that are available for assessing sexuality and other related topics.

Sexual consent capacity.

Sexual consent. According to Syme and Steele (2016), sexual consent, across most states, generally involves a person having the knowledge of making the decision, making the decision voluntarily and without coercion, and displaying a “reasoned understanding” on the risks and reward of their decision (p. 496).

Components of cognition. According to Syme and Steele (2016), cognition is composed of three elements:

- Executive Functioning/Higher Level Cognition
 - The Occupational Therapy Practice Framework define higher level cognition as judgement, formulation of concepts, metacognition, executive functions, praxis, cognitive flexibility, and insight (American Occupational Therapy Association, 2014). Syme and Steele (2016) define executive function as problem solving skills, planning, and judgement.
- Memory

- According to the American Occupational Therapy Association (2014), memory encompasses short term, long term, and working memory. Syme and Steele (2016) emphasize semantic memory, episodic memory, and procedural memory. Semantic memory includes all the knowledge obtained throughout a lifetime (Binder & Desai, 2011). Episodic memory is defined as the recollection of a past event (Tulving, 2002). Lastly, procedural memory refers to the memories related to the usual step-by-step way of doing things, such as riding a bike (GoodTherapy, LLC., 2015).

- Attention

- According to the occupational therapy paradigm, attention is described as the sustained shifting and divided attention, degree of concentration, and distractibility level (American Occupational Therapy Association, 2014).

The connection between sexual consent and cognitive functioning. The connection between sexual consent and cognition begins with a person's ability to make reasonable and appropriate judgements for themselves. Dye, Hare, and Hendy (2003) suggest a person should have adequate information relevant to the decision being made. In order for a person to give sexual consent, they must utilize their memory to recall what the experience of sexual activity was like in the past, and also to remember if they enjoy the specific activity. Individuals would then need the ability to use problem solving skills to decide if their decision will result in a negative or positive outcome. Dye et al. (2003) further explains how the ability to comprehend the consequences and risks of their decision is necessary when providing consent for sexual activity. The attention

component of cognition enables the individual to be self-aware of sexual behaviors that may occur. If someone is not able to attend, they will then not be able to appropriately consent to engage in sexual activity. All components of cognition are dynamically involved in a person's ability to provide consent (Dye et al., 2003). Therefore, all components of an individual's cognition should be assessed when considering their ability to consent to sexual activity. Lack of ability to consent may put individuals at a risk for physical or emotional injury.

Assessment Tools Available.

Sexual consent capacity assessment with older adults. The Sexual Consent Capacity Assessment with Older Adults (SCCAOA) was originally created by psychologists Peter Lichtenburg and Deborah Strezepek in 1990 as a tool that could be used in one of the first co-ed Alzheimer's care units (Syme & Steele, 2016). The SCCAOA was originally created to assess individuals in three different areas, all of which, are vital in providing sexual consent:

- Understanding the consequences of sexual activity
- Having a basic understanding of sexual knowledge
- Possessing safety skills

This assessment is meant to be conducted as an interview and led by a psychologist. The three criteria are assessed by asking questions pertaining to each of the three categories. The responses are then analyzed by the psychologist. The authors suggest other team members, such as occupational therapists, be incorporated in the assessing the findings in order to increase objectivity. Since it was created, founder Peter Lichtenburg has proposed modifications to the tool's criteria which includes:

voluntarism, safety, no exploitation, no abuse, the ability to communicate “no”, and a sense of social appropriateness (Syme & Steel, 2016). This tool should not be used as the sole determining factor of a person’s capability to consent to sexual activity, but instead should be utilized in congruence with other assessments in order to develop a more comprehensive understanding of the person and their ability to engage in safe sexual activities.

Below is a link that provides more information on this assessment tool.

<https://www.apa.org/pi/aging/programs/assessment/capacity-psychologist-handbook.pdf>

ABA/APA handbook of assessment of older adults with diminished capacity. The ABA/APA Handbook of Assessment of Older Adults with Diminished Capacity is closely related to the SCCAOA. This assessment considers the patient’s’ medical, cognitive, social, and psychological history. Apart from sexual consent considerations, this assessment also considers the individual’s sexual values, what they might consider to be potential risks regarding sexual engagement, as well as the functional capacity assessment (Syme & Steele, 2016). This assessment also differs from the SCCAOA in that it does not emphasize a team approach for assessing results (Syme & Steele, 2016).

Other Information. Apart from these two assessment tools, there is very little research available regarding this topic and we are unaware of any other assessment tools being developed to assess ability to consent to sexual activity.

Additional assessment tools.

Capacity assessment for sex (CAS). This tool was developed to assess individuals with learning disabilities and their capacity for engaging in sexual activity with other people (Dodd, 2011). The CAS is intended to determine if the individual has the capacity

to consent to sex. The CAS does not identify who specifically should be administering it, however, the assessment tool refers to “staff” as being the administrators of the tool within the instructional portion. The CAS offers professionals insight into how the individual comprehends the consequences of sexual activities (Dodd, 2011).

Sexual assessment tool (SexAT). This tool was designed to assist residential care facilities support their residents, both with and without dementia in expressing their sexuality (Bauer, Fetherstonough, Nay, Tarzia, & Beattie, 2013). The SexAT is intended to be administered by the managers of residential care facilities. The SexAT assesses the facilities policies, resident’s needs, staff education/training, any support and information available for residents or family, the actual physical environment, and safety and risk management (Bauer et al., 2013). The SexAT also offers solutions in developing facility interventions that will better serve their resident’s sexual needs and desires by evaluating what the facility is lacking, including the staffs’ understanding of their resident’s needs and corresponding behaviors, physical barriers, and additional resources (Bauer et al., 2013)

Activity index and meaningfulness of activity scale. This scale was developed by Nystrom and Gregory (1983) in order to examine the meaning and significance of activity and activity patterns among the geriatric population (Traulmann Boop, 2014). The activity index lists twenty-three activities older adults typically take part in, with areas for subjects to list additional activities not included in the list (Gregory, 1983). The meaningfulness of activity scale allows the individual to rate their enjoyability, autonomy, and competency in the activity (Gregory, 1983). However, this assessment

would only be applicable if the client or occupational therapist listed sexual activity in one of the designated “other” areas in the activity index.

Resources

General information for sexual health handout. The following five pages include a handout occupational therapists can use when addressing sexuality with their older clients. This handout was designed to address the “obtaining permission” portion of the PLISSIT Model. By providing clients with this handout and asking them to read it over and return with any questions regarding the material, a therapist has opened the doors for the client to grant them permission to discuss sex. Moreover, this handout can also be used as a tier one intervention. By placing this handout in a place where any older adult could pick it up and benefit from its contents, sexually transmitted diseases may be prevented and safe sex promoted, ultimately increasing quality of life of those interested.



Sex in Older Adulthood

If you are over the age of sixty-five, this handout is for you. According to Kalra, Sybramanyam, and Pinto (2011) having sex is a normal part of aging. Many adults over the age of 65 continue to have sex as they age (Kalra, Sybramanyam, & Pinto, 2011). In this handout, you will find information on the changes your body experiences as it ages; sexual transmitted diseases (sicknesses); and giving or getting consent (permission) before having

Reference

Kalra, G., Subramanyam, A., & Pinto, C. (2011). Sexuality: Desire, activity, and intimacy in the elderly. *Indian Journal of Psychiatry, 53*(4), 300-306. Doi: 10.4103/0019-5545.91902

Changes in your Body

According to Mayo Clinic Staff (2017), changes occur in the body as it ages. Some of these changes can be seen but many cannot. The following are changes experienced by older adults as they age:

Changes in men:

- Lower male hormones
- Longer time to get an erect penis
- Less firm erections
- Longer time to climax
- Soft penis

Changes in females:

- Lower female hormones
- Vaginal dryness
- Slower sexual arousal
- Emotional changes (such as stress)

It is common and normal to experience changes as you age. Many older adults can maintain a happy sex life even though these changes occur (Mayo Clinic Staff, 2017).

Reference

Mayo Clinic Staff. (2017). Know how to keep the fire burning as you age? Retrieved from <https://www.mayoclinic.org/healthy-lifestyle/sexual-health/in-depth/sexual-health/art-20046698>

Protection

The Mayo Foundation for Medical Education and Research (2017) defines sexually transmitted diseases (STDs) as sicknesses that are contracted by having sex with someone who already has the sickness. STDs are serious. Talk to your doctor if you are experiencing any of the following symptoms:

- Sores or bumps on body parts used during sex
- Pain or burning when peeing
- Discharge from the penis
- Unusual vaginal discharge
- Unusual vaginal bleeding
- Pain during sex
- Soft penis
- Small, sore, swollen areas in the body
- Lower stomach pain
- Fever
- Rash

(Mayo Foundation for Medical Education and Research, 2017).

Reference

Mayo Foundation for Medical Education and Research. (2017). Sexually transmitted diseases (STDs). Retrieved from <https://www.mayoclinic.org/diseases-conditions/sexually-transmitted-diseases/stds/symptoms-causes/syc-20351240>

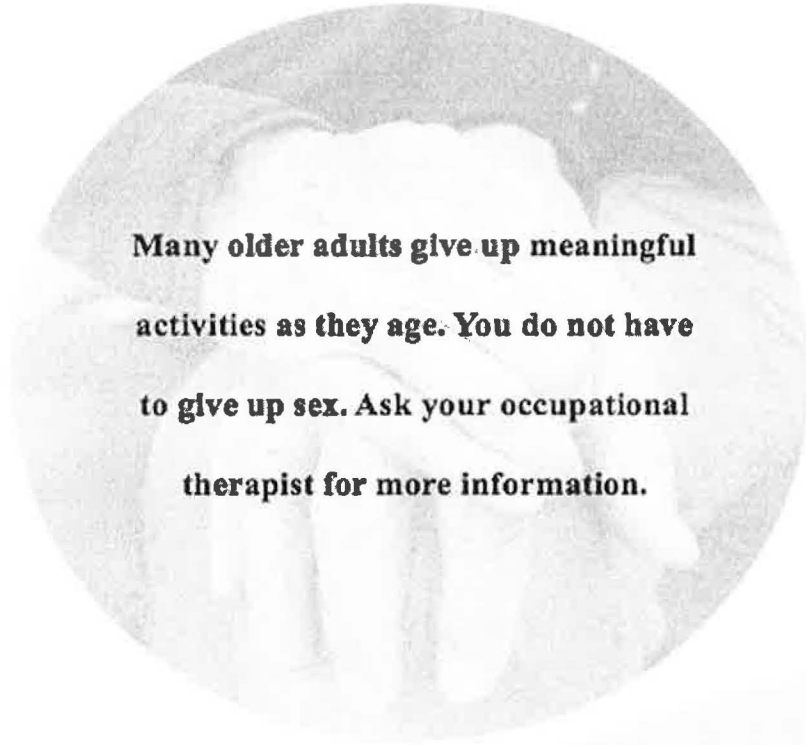
Consent

Planned Parenthood (2018) defines sexual consent (permission) as the agreement between people to have sex. Consent has five factors:

1. Consent should be freely given. It was not obtained by misleading, tricking, or pressuring; or while under the influence of drugs/alcohol.
2. Consent can be reversed. It can be taken back at any time.
3. Each person should be informed about what is going to happen. If someone says they will use a condom and they do not, they have not received consent.
4. Each sexual partner should want to have sex
5. When asking for consent, be precise. Just because consent has been received to kiss someone does not mean they have given consent for anything else (Planned Parenthood, 2018).

Reference

Planned Parenthood. (2018). What is sexual consent? Facts about rape & sexual assault Retrieved from: <https://www.plannedparenthood.org/learn/sex-and-relationships/sexual-consent>



Many older adults give up meaningful activities as they age. You do not have to give up sex. Ask your occupational therapist for more information.

ACCREDITATION

The Occupational Therapy Program is accredited by the Accreditation Council for Occupational Therapy education (ACOTE). All basic professional programs must comply with the *Standards for an Accredited Educational Program for the Occupational Therapist*, American Occupational Therapy Association, 2011 (4720 Montgomery Lane, PO Box 31220, Bethesda, Maryland 20824-1220) (Phone #301-652-2682). The UND Occupational Therapy Department and the UND Casper site was last awarded continuing accreditation during its on-site visit, in 2011.

AOTA's sexuality and the role of occupational therapy fact sheet. The American Occupational Therapy Association (2018) is the national professional association established in 1917 that represents the interests and concerns of occupational therapy practitioners and students. The association aims to improve the quality of occupational therapy services. AOTA has published a fact sheet titled, "Sexuality and the Role of Occupational Therapy" (American Occupational Therapy Association, 2018). This fact sheet was developed by MaCrae (2017) and describes the role occupational therapy holds in addressing sexuality with clients, in addition to providing appropriate intervention techniques. The following link will take you to AOTA's fact sheet.

Link: <https://www.aota.org/About-Occupational-Therapy/Professionals/RDP/Sexuality.aspx>

National institute on aging's sexuality in later life. The National Aging Institute's Web site (www.nia.nih.gov) is an institute of the NIH, a U.S. Federal Government agency that provides accurate, up-to-date information about aspects of aging research, information about clinical trials, educational materials and resources about aging for the general public, and information for researchers and health professionals. The following link will take you to their informative web page, Sexuality in Later Life, which includes information regarding age-related changes, causes of sexual problems, safe sex, correlating emotions, and steps individuals can take to advocate for a healthy and happy sex life (National Institute on Aging, 2017).

Link: <https://www.nia.nih.gov/health/sexuality-later-life>

SAGE's advocacy and services for LGBT elders. SAGE (2018) is a national advocacy and services organization that has been looking out for LGBT elders since

1978. They build welcoming communities and keep relevant issues in the national conversation to ensure a fulfilling future for all LGBT people (SAGE, 2018). The following link will take you to SAGE's homepage.

Link: <https://www.sageusa.org/what-we-do/>

The center for disease control and prevention's sexually transmitted diseases.

The Center for Disease Control and Prevention (2018) website is dedicated to offering information that will promote health and well-being. The website also offers tools, materials, current statistics, treatments, additional resources, and other pertinent information regarding thousands of topics. The following link will take you to one of the CDC's page which provides information on sexually transmitted diseases (STDs). There you will find information that can help you identify, prevent, and treat STDs (Center for Disease Control and Prevention, 2018).

Link: <https://www.cdc.gov/std/default.htm>

The world health organization's sexual health for women. The World Health Organization (2018) was created to offer information about current health trends and problems experienced by individuals across the world. The WHO works to support individuals by coordinating international health for the United Nations system (World Health Organization, 2018). The following link will direct you to Lusti-Narasimhan and Beard's (2013) webpage that provides information about sexually transmitted diseases and offers support for older adult females.

Link: <http://www.who.int/bulletin/volumes/91/9/13-119230/en/>

The American sexual health association's strategies to enhance and understand sexual health. The American Sexual Health Association (2018) is a website

designed to promote sexual health for individuals by advocating for policies and providing knowledge that will enhance healthy sexual relationships and prevent any potential risks from becoming negative outcomes. The following link will take you to their webpage which provides helpful information in understanding one's sexual health, and what strategies can be implemented to enhance one's sexual life.

Link: <http://www.ashasexualhealth.org/who-we-are/>

Barriers

There are many barriers to engaging in sexual activity as an older adult. Some of these barriers include age-related changes; providing consent; ageism; attitudes, knowledge, and perceptions of health care providers; sexually transmitted diseases; and more. The following pages are designed to shed light on those barriers; so, occupational therapists can be aware of these challenges and/or work with their clients to overcome them.

Age-related changes.

Physiological changes in the older adult. Age-related physical changes are factors that all humans will experience as they grow older. There are many identified physiological changes that are gender specific. There are also more commonly discussed physiological changes such as a decrease in sight/hearing or loss of muscle tone that directly affects movement, function, and performance in everyday tasks. Ginsberg (2006) identifies multiple gender-specific physiological changes that can negatively affect sexual function, performance, and satisfaction. Below are two tables identifying commonly seen age-related changes in men and women and how they may affect sexual activity. This information was compiled based on Ginsberg's (2006) article.

Physiological Changes in Men according to Ginsberg (2006):

Table 2 Physiological Changes in Men

Physiological Change	Effect on Sexual Function
Decrease in testosterone	Increased difficulty with obtaining and maintaining a sufficient erection
Increased need for stimulation to reach climax	Ability to become erect will become more difficult without excessive self-stimulation or stimulation from partner
Prolonged plateau phase	Need to transition from orgasm to ejaculate becomes less urgent
Weaker orgasm	Decrease in satisfaction in resolution phase
Reduction in amount of semen produced	Decrease in fertility

Physiological Changes in Women according to Ginsberg (2006):

Table 3 Physiological Changes in Women

Physiological Change	Effect on Sexual Function
Decrease in vaginal lubrication	Results in a need for an increase in stimulation to reach excitement stage
Bladder atrophy	Increased need and possibility to urinate while engaged in sexual activities
Thinning of vaginal mucosa	Increase pain with penetration due to dry or inflamed areas within the vagina
Decrease in estrogen levels	Affects vaginal lubrication, which can result in pain with sexual activity
Decrease in vaginal length and width	May affect sexual enjoyment
Loss of vulvar tissue	Can result in an increase in skin irritation, soreness, or dryness
Decrease in size of clitoris	Clitoral orgasm will become more difficult to achieve

Cognitive changes in the older adult. According to Harada, Natelson Love, and Triebel (2014), there are several structural changes that occur in the brain as individuals age. Consequently, many cognitive skills and abilities are affected. Below are two tables describing both the structural changes in the brain and the affected cognitive skills and abilities (Harada et al., 2014). Intact cognitive skills and abilities are critical when engaging in sexual activity in order to assess safety, seek help from healthcare professionals, choose a suitable partner, and provide verbal consent. The first table describes the structural changes that occur in the brain, including both grey and white matter.

Table 4 Structural Changes in the Brain with Description

Structural Changes in the Brain	Description
Decline of Grey Matter	Once someone turns twenty, their grey matter begins to diminish. This decline is most widespread in the frontal cortex. However, grey matter declines in the temporal cortex at a slower rate. This is believed to be caused by neuron death.
White Matter Changes	The integrity of white matter declines with age at a much higher rate than the decline of grey matter. The areas most affected by these changes are the precentral gyrus, gyrus rectus, and corpus callous.

According to Harada et al. (2013), certain skills and abilities are negatively impacted as a result of the decreased white matter and grey matter, including crystallized and fluid intelligence, processing speed, attention, memory, language, visuospatial abilities and construction, and executive functioning. The following table provides a description of these skills and examples of the deficits that may occur due to one or more of these changes (Harada et al., 2013).

Table 5 Declines Due to Structural Changes, Descriptions, and Examples

Declines due to Structural Changes	Description	Example
Crystallized and Fluid Intelligence	Skills, abilities, and knowledge that are over-learned, well practiced, and familiar	Decrease in vocabulary
Processing Speed	Speed at which cognitive tasks are performed	Taking a longer time to understand the symbols of letters to spell out a word
Attention	Ability to concentrate and focus of specific stimuli	Inability to engage in a conversation in a noisy environment
Memory	Ability to recall facts, events, or routines	Forgetting to take medicine before bed
Language	Vocabulary, visual confrontation naming, and verbal fluency	Unable to name a certain category (ex: animal names)
Visuospatial Abilities/Construction	Ability to put together individual parts to make a coherent whole	Unable to assemble a desk from a box of parts
Executive Functioning	Ability to self-monitor, plan, organize, reason, be mentally flexible, and problem solve.	Unable to use simple math skills, they were previously able to

Cognitive Deterioration and the Ability to Provide Sexual Consent. According to Gordon (2016), western societies emphasize the importance of self-determination, fundamental rights, and independence. Therefore, when it comes to sex, law abiding, individuals expect to participate whenever, and with whomever they choose (Gordon, 2016). While older adults continue to engage in sexual activities, Syme and Steele (2016) have presented an ethical dilemma. Older adults experience normal age-related changes, especially, individuals living in long term care settings. These age-related changes,

specifically the high cognitive decline, affect one's ability to provide consent for engaging in sexual activities (Syme & Steele, 2016). This inability to provide sexual consent then interferes with one's self determination, fundamental rights, and independence.

According to Syme and Steele (2016) skilled nursing facilities are tasked with the challenge of deciding whether or not individuals who are experiencing cognitive decline should continue to engage in sexual activity. Many skilled nursing facilities lack policies and procedures in the area of sexual expression management and consent (Syme & Steele, 2016). Health care professionals must ensure they are not reducing individuals to their diagnosis of declining cognition, but rather, considering the individual as a whole, including their wants, needs, and rights (Mahieu & Gastmans, 2012).

Gordon (2016) illustrated an example of how an ethical dilemma may present itself in these situations. A woman was living in a nursing home after being diagnosed with dementia. Her husband, a previous state senator, would often visit her. During these visits, the two would engage in sexual activity. The staff of the facility informed the husband they believed his wife was unable to provide consent for these activities, and therefore, he should not initiate or engage in sexual activity with her anymore. Though the physician had determined she was unable to provide sexual consent, the husband and wife continued to engage in sexual activities. Ultimately, the husband was arrested and charged with rape (Gordon, 2016). This case became famous in the state of Iowa and it created controversy in surrounding areas. Many individuals did not agree that it was the physician's role to determine whether or not the wife could consent to sexual activity, as they believed sexual intimacy lay outside the medical context (Gordon, 2016).

While, some may argue that sexual activity falls outside a physician's scope of practice, it does fall within the scope of occupational therapy. Therefore, occupational therapists should be working with physicians and healthcare teams to help decide what is best for each individual, based on their unique circumstances. Gordon (2016) identifies the humane approach is to have guidelines that allow for intimate and sexual relationships for some members of this population, dependent on their client factors. Furthermore, Gordon (2016) suggests considering if there was a long-standing, intimate relationship between the couple prior to the cognitive decline. Additionally, health care professionals should examine any reasons that may suggest anything other than a healthy marriage. Before making the decision, the facility should ask whether or not the couple was engaging in sexual activity prior to the cognitive decline (Gordon, 2016). Skilled nursing facilities who do allow individuals to continue engaging in sexual activity must ask themselves whether they should uphold one's sexual preferences prior to deterioration or allow individuals to make decisions about new sexual activity partners during their cognitive decline (Cook, Schouten, Henrickson, & McDonald, 2017). As it is likely not appropriate to ask these questions of the individual experiencing cognitive decline, health care professionals will potentially need to involve family members in the process of determining one's ability to provide consent (Gordon, 2016). The healthcare team should also consider testing the individual's cognition to determine whether or not they are capable of providing consent. An assessment tool was developed to specifically evaluate one's ability to provide consent for sexual activities.

Sexually Transmitted Diseases. According to Benjamin Rose Institute on Aging (2017), older adults in today's society are engaging in sexual activity despite age-related

changes. Medications, such as those designed for erectile dysfunction, have enabled individuals to continue to engage in sexual activities as they age. Moreover, there is a high divorce rate in the middle age range in America. Older adults are turning to online dating, which makes it difficult to know the sexual history of the individuals with whom they engage in sexual activity (Benjamin Rose Institute on Aging, 2017). Benjamin Rose Institute on Aging (2017) also found that older adults are less likely to perceive themselves at risk for contracting a sexually transmitted disease (STD). In today's education system, adolescents and teens are provided with educational courses regarding safe sex; however, this sexual educational curriculum was not available to the geriatric population when they were in school. STD prevention was developed after 1980, when the human immunodeficiency virus (HIV) and acquired immune deficiency syndrome (AIDS) were discovered (Benjamin Rose Institute on Aging, 2017). At this time, the majority of the current geriatric population were middle aged and already married; therefore, they missed this crucial information during their formative education years. Older adults with STDs are more likely to receive the diagnosis too late, making it impossible to benefit from the current medications, which are capable of only treating the disease in its early stages (Benjamin Rose Institute on Aging, 2017). A reason for this late diagnosis is due to feelings of embarrassment to ask health care professionals to test for such diseases. Additionally, many STDs are non-symptomatic which makes it difficult to treat in the early stages of disease which can result in irreversible damage to the individual (Benjamin Rose Institute on Aging, 2017).

According to Macdonald, Lorimer, Knussen, and Flowers (2016) there is a scarcity of condom use interventions for both middle aged and older adults. In addition,

there is not enough evidence to prove that the existing interventions are effective for this population (Macdonald et al., 2016). Because of this, there is an identified need for theory-based interventions targeting condom use among the older adults to be evaluated and published (Macdonald et al., 2016). Beyond the need for interventions addressing sexual health for this population, it is also necessary to explore and understand how medical professional's knowledge, perspectives, and interactions have the ability to affect sexual health well-being in their older clients.

Ageism. Ageism, or being prejudiced against someone due their age (World Health Organization, 2016), is relevant in today's society, and it often shapes assumptions about older adults' abilities to be intimate. Bauer, Haesler, and Fetherstonhaugh (2016) identified the tendency for society to accept the stereotype that older individuals are sexless and undesirable. According to Hillman (2012), the predominant portrayal of older adults consists of depicting them as depressed, helpless, and sexless individuals. The younger generations focus on the arousal aspect and associate sexuality with beautiful bodies. In popular ads and greeting cards, the geriatric population is portrayed as rigid, out of touch, and helpless. Those TV ads that do portray older adults' sexuality are only the ones selling products to treat erectile dysfunction (Hillman, 2012).

Societal ageism is also something that some older individuals experience, which makes them anxious to engage in or share their sexual experiences. Multiple research studies have noted how society views sexual behaviors among the older population as uncomfortable or inappropriate. Benbow and Beeston (2012), Doll (2013), and Taylor and Gosney (2011) all emphasize that the current societal view portrays older individuals

as asexual beings. The idea that this population no longer enjoys, needs, or pursues any type of sexual or intimate relationships has created a stigma which hinders this population from freely speaking to their medical advisors for advice or to request help with sexual problems (Taylor & Gosney, 2011). Apart from heterosexual residents finding it uncomfortable to speak to their medical providers about sexuality, an American survey found that 67% of doctors and nurses report that homosexual patients received substandard care and/or were at times denied care (Age Concern, 2002).

Health Care Professionals Attitudes, Knowledge, and Perceptions. Literature has shown that certain staff characteristics are positively correlated to knowledge and attitudes, including race, age, religion, and educational level in regard to sexual activity in the geriatric population (Di Napoli, Breland, & Allen, 2013). According to Chen et al. (2017), health care staff with higher qualifications were found to have a better understanding of sexuality in older adults. Literature has shown the majority of health care professionals working with older adults do not have accurate information regarding sexuality in later life. However, health care staff attitudes toward older adults engaging in sexual activity is permissive (Chen et al., 2017). The majority of staff who work with the geriatric population are in support of education and additional training for staff and residents (Chen et al., 2017). Regardless of these reports, communication between the geriatric population and health care professionals about sexual issues or activity has been poor (Bauer et al., 2016). While some individuals prefer to keep their sex related questions to themselves, there is evidence showing a desire to be able to discuss sexual issues with healthcare professionals (Bauer et al., 2016). There are often barriers to facilitate discussions between health care professionals and clients regarding the matter

of sexuality. Some barriers identified in current research include: negative attitudes, clients' shame or embarrassment, and a perception that the healthcare professional is not interested or cannot help in the matter (Bauer et al., 2016). Often, doctors also avoid these discussions due to their own personal discomfort in discussing sex with the geriatric population (Benjamin Rose Institute on Aging, 2017). Taylor and Gosney (2011) carried out a study which demonstrated 78% of patients who were experiencing erectile dysfunction did not discuss it with their primary physician, even though it was affecting their overall satisfaction and quality of life. Additionally, the researchers found that there were a number of reasons health care professionals did not pursue addressing sexuality with their older patients (Taylor and Gosney, 2011).

According to Taylor and Gosney (2011), the information provided by healthcare professionals during interviews revealed feelings of being undertrained, being fearful of offending their patients, or lacking the time to pursue the subject. Moreover, healthcare professionals may assume older adults are not engaging in sexual activity due to their age (Benjamin Rose Institute on Aging, 2017). In order to promote addressing sexuality, Bauer, Haesler, and Fetherstonhaugh (2016) suggest the idea of normalizing sexual behavior in older adults. They also encourage the use of posters and pamphlets that display older adults in intimate and sexualized roles to promote an attitude of openness and acceptance.

Researchers have identified a need for healthcare professionals to act in the following areas: to define the role of health professionals in identifying the decline in geriatric sexual interest and activity (Tsatali & Tsolaki, 2014); to proactively address sexuality and extend the knowledge about safe sex and sexual function to older adults

(Freak-Poli et al., 2017); to develop and evaluate communication strategies in order to have discussions regarding sexuality and sexual health (Bauer et al., 2016); to address sexuality early and to incorporate the client's values, beliefs, and concerns (Sakellariou & Algado, 2006); to develop interventions intended to educate staff attitudes and knowledge regarding sexuality in the older adult (Di Napoli et al., 2013); and to ultimately ensure the older adult's need and desire for sexual fulfillment, and human intimacy is being met (Mahieu & Gastmans, 2012).

Practice Holistic, Client-Centered Cared. The term holistic care has different meanings depending upon the interpreter (Finlay, 2001). Therefore, while some health care professionals set out to deliver holistic services, they may not be providing true holistic care (Finlay, 2001). According to Sakellariou and Algado (2006), occupational therapists must consider sexuality as an identity component of the individual, and must include it in the intervention process. Not recognizing sexuality as an integral component to therapy may lead to less than optimal therapeutic outcomes. Of even more concern, is those occupational therapists who do not address sexuality could be considered ageist, ultimately, reinforcing societal stigmas (Sakellariou & Algado, 2006). To address the person holistically in regard to sexuality, one may benefit from including ethical concepts such as empathy, responsibility, respect, and vulnerability (Mahieu & Gastmans, 2012). Moreover, respecting an individual's right to autonomy has been the prevailing factor in permitting sexual behavior in older adults residing in healthcare facilities (Cook, Schouten, Henrickson, & McDonald, 2017; Mahieu & Gastmans, 2012). According to Cook et al. (2017), health care professionals should ensure that each individual's rights are being met while his/her well-being is also being evaluated. Unyielding policies may

not have the person's best interest in mind, regarding an individual's well-being. Instead, client centered and flexible approaches are more desirable, when determining an individual's autonomy for sexual activity (Cook et al., 2017).

Therefore, occupational therapists are equipped with the skills to address these concerns in a holistic manner, and may apply problem solving techniques within the realm of occupational therapy services (Sakellariou & Algado, 2006). In situations where sexual concerns are not apparent, occupational therapists should make an effort to include the topic of sexuality in the intervention process, which could be the occupational therapists merely mentioning how important sexuality can be to quality of life (Sakellariou & Algado, 2006). To prevent miscommunication, Bauer et al. (2016) suggest defining terminology and clarifying when broad terms or metaphoric language are used.

According to Krupa (2016) the Canadian framework has emphasized the importance of practicing client centered care. Krupa (2016) identified these five ways in which to facilitate a client centered approach.

- Power: Are you using language your clients will understand?
- Listening and Communicating: Are you truly listening to what your clients are trying to tell you, looking beyond their words to the meaning they are trying to convey
- Partnership: What do you bring to this partnership? What does your client bring to this partnership?
- Choice: Am I providing opportunities for real choice when I work with this client?
- Hope: How do you understand and express hope in working with this client?

Additional barriers to engaging in sexual activity.

Lack of sexual partner. Freak-Poli et al. (2017) identified the greatest barrier to maintaining sexual function while aging is in the pursuit of a sexual partner, and that, his barrier has a greater impact on women than men. Literature has shown sexual activity and physical intimacy are more prevalent in older adults with partners and older men, while very few women without a partner were engaging in sexual activity (Freak-Poli et al., 2017). Women who were not engaging in sexual activities reported the lack of activity was due to a partner's illness and/or personal health issues, while men reported that their partner's willingness or lack thereof was the main factor for their continued or discontinued sexual function (Tsatali & Tsolaki, 2014).

Depression and anxiety. Depression in older adults can result from a variety of reasons. Depression is most commonly described by older adults as feelings of irritability, a decline in pleasure, isolation, change in appetite and energy, and insomnia (Mann et al., 2008). Mann et al. (2008) have found depressive symptoms in the older adult can cause a decrease in enjoyable activities, fluctuation in weight, sleep patterns, and psychomotor agitation or slowness. Pollock and Weksler (2000) identifies change in physiology, genetics, and side effects from prescribed medications to be the leading cause for depression in the older adults.

Although depression can negatively affect many factors in life, a research study conducted by Taylor and Gosney (2011) revealed that sexual dysfunction in older adults who are experiencing depression is less likely to be addressed or treated when compared to younger adults.

Both depression and anxiety can have an immediate influence on sexual function in older adults, including the motivation to engage in sexual activities (Tsatali & Tsolaki, 2014). Although both anxiety and depression affect sexual desire and arousal, Sousa, Dhingra, and Sonavane (2016) explain how depression and anxiety can occur directly in the form of a disease or indirectly through prescribed medication. Regardless of the onset, men may experience delayed ejaculation or increase feelings of lack of intimacy due to depression and anxiety (Tsatali & Tsolaki, 2014).

Other commonly experienced health issues/changes. Age-related changes can have an impact on sexual function in many different ways. However, there are also age-related conditions and co-morbid diseases commonly experienced during the aging process that affect sexual activity. Ginsberg (2006) identifies chronic arthritis as an age-related disorder that can cause pain and swelling in joints which results in a decreased range of motion in the individual. Another common disease experienced by the aging male is prostate cancer (Ginsberg, 2006). As with all cancers, treatment for this can have severe side effects which influence a man's sensation, penile function, and overall motivation and sexual desire. Sousa, Dhingra, and Sonavane (2016) identify diabetes, stroke, hypertension, and cardiovascular disease as other common medical issues that are experienced in old age. According to Sousa et al. (2016), cardiovascular disease can result in erectile dysfunction due to insufficient vascular functioning. Sousa et al. (2016) also identifies diabetes mellitus as a cause for reduced vaginal lubrication in women due to neuromuscular inefficiencies.

One of the most common age-related changes in women is menopause. Menopause is when a woman's period ceases, and it most commonly occurs between the

ages of forty and fifty-five (Ginsberg, 2006). Once menopause begins, women become at risk for cardiovascular, musculoskeletal, and psychological diseases (Ginsberg, 2006). Some symptoms commonly experienced during menopause are hot/cold flashes, urogenital issues, sexual dysfunction, change in sleep, change in mood, and decreased cognition (Ginsberg, 2006). As noted on the “Age-Related Changes” page, menopause can cause a variety of physiological changes which negatively affects sexual activity satisfaction. Additionally, Ginsberg (2006) also described how menopause can change a woman's view on their own sexuality and personal identity as a woman. This has been proven to be detrimental towards a woman's desire to be intimate with their partner, and can negatively affect the satisfaction they experience during sexual activity.

Test Your Knowledge

Below you will find short quizzes that will allow you to test your own knowledge on sexuality in the older adult!

How much do you know about sexuality and the older adult.

Question One: Erectile Dysfunction is an inevitable part of aging for men.

- Answer Options:
 - True
 - False: CORRECT
- Explanation: According Ginsberg (2006), erectile dysfunction occurs through psychogenic or organic causes. If the onset is more sudden, the cause would be psychogenic due to anxiety, depression, or stress. If the onset is slower, the cause would be organic due to physiological dysfunction such as hypertension, multiple sclerosis, or other diseases (Ginsberg, 2006).

Question Two: What percent of women over the age of fifty reported being interested in sexual activity over the last month?

- Answer Options:
 - Approximately 45%: CORRECT
 - Approximately 10%
 - Approximately 70%
 - Approximately 30%
- Explanation: 43.5% of females over the age of fifty expressed they had interest in engaging in sexual activity within the last month, with 30% of women reporting interest on a daily basis (Kalra et al., 2011).

Question Three: The older population has a high level of STDs because they are not safe and engage in sexual activities without thinking.

- Answer Options:
 - True
 - False: CORRECT
- Explanation: According to Ginsberg (2006), the older population is more susceptible to STDs due to a decreased immune system and high rates of comorbidities (ex. decreased renal function). Also, women are more susceptible to HIV due to decreased lubrication and vaginal wall thinning (Ginsberg, 2006).

Question Four: What is the greatest barrier to maintaining sexual function while aging?

- Answer Options:
 - Lack of desire
 - Physical Inability

- Lack of Partner: CORRECT
- Explanation: Freak-Poli et al. (2017) identified that the greatest barrier to maintaining sexual function while aging is in the pursuit of a sexual partner. The authors further explain that this barrier has a greater impact on women than men.

Question Five: Hypersexual behavior is a common behavior seen in older individuals with dementia.

- Answer Options:
 - True
 - False: CORRECT
- Explanation: According to Hartmans, Comijs, and Jonker (2014), abnormal sexual behavior, such as hypersexuality, is a rare symptom among individuals with dementia.

Question Six: The aging process is affected by many different aspects of life; research has shown that sexuality does not play a role in the satisfaction of one's life as they age.

- Answer Options:
 - True
 - False: CORRECT
- Explanation: According to Ginsberg (2006), sexuality is an important factor for a person to enjoy a full and happy life. A healthy sexual life in congruence with physical wellness can promote more overall satisfaction with life (Ginsberg, 2006).

Question Seven: Approximately how many older adults are satisfied with their sex life?

- Answer Options:

- Approximately 79%
- Approximately 23%
- Approximately 54%: CORRECT
- Approximately 41%
- **Explanation:** In 1999, the AARP foundation surveyed older adults and found 54.9% of the participants reported being satisfied with their sex life (Harvard Health Publishing, 2017).

Occupational therapy's role in addressing sexuality.

Question One: True or False. Addressing sexual activity with older adults falls within the scope of practice in occupational therapy?

- Answer Options:
 - True: CORRECT
 - False
- **Explanation:** According to Macrae (2013), sexuality can be addressed by practitioners in any setting. Intervention can occur in homes, group homes, nursing homes, rehabilitation centers, community mental health centers, pain centers, senior centers, hospitals, retirement communities, and other venues (Macrae, 2013).

Question Two: What occupation does sexual activity fall under?

- Answer Options:
 - Instrumental activities of daily living
 - Leisure
 - Activities of daily living: CORRECT

- Work
- Explanation: According to the American Occupational Therapy Association (2014), sexual activity is an activity of daily living (ADL). Sexual activity is defined by the American Occupational Therapy Association (2014) as any activity that results in sexual satisfaction, and/or meet relational or reproductive needs.

Question Three: Which of the following Canadian Model of Client Centered Enablement skills refers to encouraging, guiding, challenging, expanding choices, holding accountable, seeing the big picture, listening, mentoring, motivating, posing powerful questions, reflecting, reframing, and supporting?

- Answer Options:
 - Collaborating
 - Consulting
 - Coaching: CORRECT
 - Coordinating
- Explanation: According to Krupa (2016) coaching refers to the skills of encouraging, guiding, challenging, expanding choices, holding accountable, seeing the big picture, listening, mentoring, motivating, posing powerful questions, reflecting, reframing, and supporting.

Question Four: _____ are designed to be used by the occupational therapist in order to provide their clients with the means to participate in their valued occupations, or to find ways to make a difference in their health or well-being.

- Answer Options:
 - Outcome measures

- Intervention approaches
- Enablement skills: CORRECT
- Therapeutic modes of self
- Explanation: According to Krupa (2016), enablement skills are designed to be used by the occupational therapist in order to provide their clients with the means to participate in their valued occupations, or to find ways to make a difference in their health or well-being.

Question Five: Which approach is being used in the following scenario? An occupational therapist provides an educational session for older adults on the proper use of condoms in an attempt to eliminate or decrease the potential risk of contracting a sexually transmitted disease associated with unprotected sex.

- Answer Options:
 - Maintain
 - Modify
 - Create/Promote
 - Prevent: CORRECT
- Explanation: According to the American Occupational Therapy Association (2014), the prevention approach is designed to prevent the occurrence or evolution of barriers to performance in context.

Question Six: _____ is the ongoing assessment of one's satisfaction with their life, hope, self-concept, health, functions, and socioeconomic factors.

- Answer Options:
 - Quality of life: CORRECT

- Participation
- Well-being
- Role competence
- Explanation: According to the American Occupational Therapy Association (2014), quality of life is an outcome which refers to the ongoing assessment of one's satisfaction with their life, hope, self-concept, health, functions, and socioeconomic factors.

Question Seven: PLISSIT is a framework that healthcare professionals can utilize when addressing sexuality with clients (Annon, 1976). PLISSIT stands for:

- Answer Options:
 - Propose, limited information, safe sex, involve, try
 - Plan, illicit, specific suggestions, interactive therapy
 - Permission, limited information, specific suggestions, intensive therapy:
CORRECT
 - Pace, listen, identify, select, screen, improve, test
- Explanation: According to Annon (1976), PLISSIT stands for Permission, Limited Information, Specific Suggestions, and Intensive Therapy.

Question Eight: Which of the following statements falls under the Permission component of the PLISSIT model?

- Answer Options:
 - I have a brochure that may help you understand your situation better.
 - Have you attempted different positions to help alleviate your arthritis pain?

- Do you have any concerns related to your injury and your sex life?:

CORRECT

- I know a specialist that I can refer you to that can better meet your needs.
- Explanation: According to Annon (1976), a client should first assent to discussing sexual activity with their occupational therapist. This can be achieved by simply asking permission to talk about sexual activity concerns a client may have during therapy (Annon, 1976).

Question Nine: Which assessment tool assesses individuals with learning disabilities and their capacity for engaging in sexual activity with other people?

- Answer Options:
 - The Sexual Assessment Tool
 - The Capacity Assessment for Sex: CORRECT
 - Sexual Consent Capacity Assessment with Older Adults
 - Activity Index and Meaningfulness of Activity Scale
- Explanation: According to Dodd (2012), the Capacity Assessment for Sex (CAS) tool was developed to assess individuals with learning disabilities and their capacity for engaging in sexual activity with other people.

Question Ten: What is NOT measured by the Sexual Consent Capacity Assessment with Older Adults

- Answer Options:
 - Understanding the consequences of sexual activity
 - Having a basic understanding of sexual knowledge
 - Possessing safety skills

- Personal satisfaction with one's ability to engage in sexual activities:

CORRECT

- Explanation: According to Syme and Steele (2016) the Sexual Consent Capacity Assessment with Older Adults was originally created to assess individuals in three different areas: understanding the consequences of sexual activity, having a basic understanding of sexual knowledge, and the possession of safety skills.

Barriers to engaging in sexual activity as an older adult.

Question One: Healthcare professionals are not addressing sexual activity with their clients as a result of _____.

- Answer Options:
 - Feelings of being undertrained
 - Being fearful of offending their patients
 - Lacking the time to pursue the subject
 - All of the above: CORRECT
- Explanation: A study was completed by Taylor and Gosney (2011) which aimed to assess why healthcare professionals were not addressing sexual activity with their patients. The results revealed healthcare practitioners believed they were undertrained, were fearful of offending their patients, and felt they lacked the time to pursue the subject (Taylor & Gosney, 2011).

Question Two: At what age does one's grey matter begin to diminish?

- Answer Options:
 - Forty-five
 - Sixty

- Eighty
- Twenty: CORRECT
- Explanation: According to Harada, Natelson Love, and Triebel (2014), once someone turns twenty, their grey matter begins to diminish. This decline is most widespread in the frontal cortex. However, grey matter also declines in the temporal cortex, at a slower rate. This is believed to be caused by neuron death (Harada, Natelson Love, & Triebel, 2014).

Question Three: Which cognitive age-related change is described as an inability to self-monitor, plan, organize, reason, be mentally flexible, and problem solve?

- Answer Options:
 - Executive functioning: CORRECT
 - Memory
 - Attention
 - Processing speed
- Explanation: According to Harada, Natelson Love, and Triebel (2014), executive functioning is an inability to self-monitor, plan, organize, reason, be mentally flexible, and problem solve.

Question Four: What is NOT a reason for the high STD rate among older adults?

- Answer Options:
 - In today's culture, older adults are less likely to know the sexual histories of their partners
 - Older adults do not care about contracting sexual transmitted diseases: CORRECT

- Older adults were never provided the educational courses regarding safe sex that adolescents and teens receive in the current educational system
- Explanation: According to the Benjamin Rose Institute on Aging (2017), older adults are getting divorced at a higher rate and turning to online dating, which makes it difficult to know the sexual history of their partners. Moreover, sexually transmitted disease prevention was developed after 1980, when the human immunodeficiency virus (HIV) and acquired immune deficiency syndrome (AIDS) were discovered. At this time, the majority of the current geriatric population were middle aged and already married; therefore, they missed this crucial information during their formative education years (Benjamin Rose Institute on Aging, 2017).

Question Five: What is NOT a leading cause for depression in older adults?

- Answer Options:
 - Traumatic events: CORRECT
 - Changes in physiology
 - Genetics
 - Side effects from prescribed medication
- Explanation: According to Pollock and Weksler (2000), the leading cause for depression in older adults include changes in physiology, genetics, and side effects from prescribed medications.

Question Six: Which age-related disorder/disease affect one's ability to engage in sexual activities?

- Answer Options:

- Diabetes
 - Stroke
 - Hypertension
 - Cardiovascular disease
 - All of the above: CORRECT
- Explanation: Sousa, Dhingra, and Sonavene (2016) identify diabetes, stroke, hypertension, and cardiovascular disease as age related disorders which negatively impact an individual's ability to engage in sexual activities.

Question Seven: Cognitive age-related changes are critical in assessing one's ability to _____?

- Answer Options:
 - Seek help from healthcare professionals
 - Provide consent to engage in sexual activity with a partner
 - Select a suitable partner
 - Consider safety when engaging in sexual activity
 - All of the above: CORRECT
- Explanation: According to Harada, Natelson Love, and Triebel (2013), certain skills and abilities are negatively impacted as a result of the decreased white matter and grey matter. These skills include crystallized and fluid intelligence, processing speed, attention, memory, language, visuospatial abilities and construction, and executive functioning (Harada, Natelson Love, and Triebel, 2013).

Forum

A forum was created for occupational therapists to discuss concepts related to addressing sexual activity with the geriatric population. Due to the sensitivity of the topic of sexuality, the forum allows users to be anonymous during discussions. Website users are encouraged to use the forum to seek advice, connect with other occupational therapists, offer their own suggestions, and promote the enablement of older adults to engage in sexual activity. *Below is a screenshot of the forum page that is available on the website.*



Summary

Section IV provides a comprehensive written version of our online product. The actual website contains additional website links and digital components that could not be provided in written form. Upon completing the product, the authors carefully examined each component and compiled a number of inhibitory and beneficial components that would influence future use of the website. The following section will provide limitations and recommendations that have been identified by the authors for future use.

CHAPTER FIVE

Summary

This scholarly project is designed to equip occupational therapists with information and strategies for holistically addressing sexual activity with the older adult. After conducting a thorough literature review, several barriers were identified that prevent the geriatric population from safely engaging in sexual activity. Moreover, the literature discussed the significant role healthcare professionals, including occupational therapists, hold in addressing sexual activity with their clients. Yet, the literature also demonstrates that health care professionals are not addressing sexual activity due to feelings of discomfort, a lack of understanding, and/or the lack of skill/ability (Bauer et al., 2016; Taylor & Gosney, 2011). This website is designed to provide the pertinent background knowledge occupational therapists need to address sexual activity with their clients. The information covers information about the older adult, occupational therapy's role in addressing sexual activity, barriers the older adult encounters when engaging in sexual activity, models and assessment tools that can be utilized when addressing sexual activity with clients, additional resources, and an online forum for occupational therapists to reach out and discuss these concepts with fellow occupational therapists.

The development of the website was guided by the Canadian Model of Occupational Performance and Engagement (CMOPE). The CMOPE emphasizes that in order to support an individual's health and wellbeing, one should be able to participate in the occupations that are meaningful to them (Krupa, 2016). Moreover, the CMOPE

recognizes that any individual; despite illness, disease, or life disruptions; can continue to participate in those occupations meaningful to them (Krupa, 2016).

Upon completion of the product, a few limitations were identified. First, in order to utilize this resource, occupational therapists must have access to a computer, monitor, and internet. Depending on the location and setting the occupational therapists' work in, it may prove difficult to access the website as needed. This product also assumes occupational therapists prefer to learn via web-based resources. As with all individuals, occupational therapists have unique preferences. Personal learning style will play a role into whether or not occupational therapists would choose to utilize this resource. In addition, the domain is a ".net". As such, it may not be recognized as a credible source. Locating and obtaining a more credible domain is an action that can be pursued in the future. Lastly, many occupational therapists don't feel comfortable talking about sex, feel they do not have the necessary training, are fearful of offending their patients, or lack the time to pursue the subject (Taylor & Gosney, 2011). These barriers may limit the number of people who actively pursue and utilize the website.

After recognizing the limitations, four recommendations were developed to aid in strengthening the product. The following are the suggestions made in order to continue to develop and enhance the website. As mentioned above, the developers would like to pursue a more credible domain. As such, occupational therapists can feel assured the information they are obtaining through the website is accurate and evidence based. It is also imperative to remain current with the ever-changing medical world. For this reason, the need for routine updates with healthcare and societal trends would be necessary so as to remain evidence based. Additionally, feedback will continually be sought from

therapists using the site in order to determine its ease of usability, recognize concerns, respond to questions, and receive suggestions to ultimately, continue enhancing the product. Moreover, in order for this website to become more prominent, a plan on how to promote its usefulness will be developed. The students are considering presenting the product as a poster presentation at the upcoming WYOTA and AOTA conferences. By doing so, the students will bring awareness of the product to attending occupational therapists. A second method to promote the website will be to provide local nursing home facilities and health clinics who serve a higher number of older adults an in-service on the usability on the product in their facilities. The information provided within the website is applicable and beneficial to occupational therapists, and as such, the developers would like to strive to reach as many occupational therapists as possible.

For many people, sexual activity is a meaningful occupation. As individuals age, barriers begin to arise, making it difficult to engage in sexual activity. As defined by the American Occupational Therapy Association (2018), “occupational therapy is the only profession that helps people across the lifespan to do the things they want and need to do through the therapeutic use of daily activities (occupations)”. As such, occupational therapists should be addressing sexual activity as a routine part of evaluations completed with their geriatric clients. Yet, occupational therapists are opting to not include sexual activity in their practice due to feelings of discomfort, a lack of understanding, and/or the lack of skill/ability (Bauer et al., 2016; Taylor & Gosney, 2011). As health care professionals, occupational therapists have a responsibility to ensure individuals are engaging in safe sexual practices. The literature has demonstrated a gap in occupational therapy services, indicating the need for a resource practitioners can utilize when

addressing sexual activity with their older clients. As such, a website designed to equip occupational therapists with information and strategies for holistically addressing sexual activity with the geriatric population was determined to be the most efficient manner to promote awareness and provide a resource for occupational therapists across the country.

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Appendix A

Rev. 133EE23

PHOTO RELEASE FORM

I, Vicki Hughes

hereby agree and consent as follows.

A. I consent and authorize Amber Fernandez, MOTS and Ashleigh Mora, MOTS, located in Casper, WY to use my likeness in any photograph, video or other digital media ("Photos") in any and all of its publications, including print or web-based publications.

B. I irrevocably authorize Amber Fernandez, MOTS and Ashleigh Mora, MOTS to copy, edit, enhance, crop, or otherwise alter any Photo for use in their publications. I also waive any rights for approval or inspection of any Photos.

C. I understand and agree that all Photos are the property of Amber Fernandez, MOTS and Ashleigh Mora, MOTS, and will not be returned to me.

D. I acknowledge that I am not entitled to any compensation or royalties with respect to the use of the Photos.

E. I agree to release and forever discharge Amber Fernandez, MOTS and Ashleigh Mora, MOTS and its affiliates, successors and assigns, officers, employees, representatives, partners, agents and anyone claiming through them, in their individual and/or corporate capacities from any and all claims, liabilities, obligations, promises, agreements, disputes, demands, damages, causes of action of any nature or kind, known or unknown, which I, and anyone claiming on behalf of me, may have or claim to have against Releasee in connection with this Release.

F. I have carefully read and fully understand all the provisions of this Photo Release Form and am freely, knowingly and voluntarily signing.

SIGNATURES

Vicki Hughes
Signature of Releasor

10/8/18
Date

Vicki Hughes
Printed Name of Releasor

PHOTO RELEASE FORM

I, PAT HUGHES
hereby agree and consent as follows.

A. I consent and authorize Amber Fernandez, MOTS and Ashleigh Mora, MOTS, located in Casper, WY to use my likeness in any photograph, video or other digital media ("Photos") in any and all of its publications, including print or web-based publications.

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E. I agree to release and forever discharge Amber Fernandez, MOTS and Ashleigh Mora, MOTS and its affiliates, successors and assigns, officers, employees, representatives, partners, agents and anyone claiming through them, in their individual and/or corporate capacities from any and all claims, liabilities, obligations, promises, agreements, disputes, demands, damages, causes of action of any nature or kind, known or unknown, which I, and anyone claiming on behalf of me, may have or claim to have against Releasee in connection with this Release.

F. I have carefully read and fully understand all the provisions of this Photo Release Form and am freely, knowingly and voluntarily signing.

SIGNATURES

Pat Hughes
Signature of Releasor

10-4-2018
Date

PAT HUGHES
Printed Name of Releasor