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Sexuality in Long-Term Care

Open Your Mind (And Close the Door, Please)

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June 8, 2017

Objectives

1. Recognize prevailing perceptions about sexuality and older adults as well as the capacity of elders with dementia to consent to sexual activity
2. Describe the challenges faced by long-term care providers in facilitating safe sexual expression among residents and for managing inappropriate sexual expression
3. List ways to preserve residents’ rights to intimacy and sexuality while complying with regulatory requirements
4. Identify the role of occupational therapy as it relates to sexuality and intimacy in long-term care
Myth or Fact??

Most older adults are not interested in or able to have enjoyable sex
Myth ...
- Most older adults are interested in sex and many lead active sex lives
  - 87% of married men and 89% of married women in the 60-64 age range are sexually active
  - 54% of sexually active older people have sex at least two to three times a month

Older adults do not have to worry about contracting sexually transmitted diseases like HIV/AIDS
Myth ...
  • Older adults should practice safe sex
  • There are about 75,000 individuals in the US over the age of 50 diagnosed with HIV/AIDS
    • This is approximately 10% of the total number of cases in the US

Physical challenges keep seniors from having sex
Myth ...
- Though having sex as you get older may require creativity, it is possible to remain sexually active
- Many people encounter obstacles and do not discuss with their primary physician

Seniors can't avoid pain during intercourse.
Myth ...
- Women experience biological changes that may result in uncomfortable or painful intercourse
- Other types of pain may require a change in position, additional pillows for support, or an OTC pain medication before or after sex

Sex is dangerous when you reach a certain age
Myth ...
• Sex is unlikely to cause anything worse than aches and pains from unused muscles or arthritic joints

Sexual problems are just part of normal aging, without any solutions
Myth ...
- While some issues exist, many are treatable by the physician
- Physicians are trained to address issues of sexuality in an unbiased, empathetic, and non-judgmental manner

Physical Changes in Women
- Lower libido or slowing of sexual arousal
- Hot flashes and/or night sweats
- Sleep disturbances
- Emotional changes
- Vaginal dryness and itching
- Increased sensitivity to sounds
- Dry skin
- Weight gain and/or food cravings
Physical Changes in Men

- Longer time to obtain erection
- Inability to maintain erection
- Increased time between erections

Introduction
Definitions

- **Sexuality**
  - A part of personality that encompasses sexual beliefs, attitudes, values, behavior, and knowledge

- **Intimacy**
  - Interpersonal relationship between two people who may or may not be engaging in sexual activity

Definitions

- **Sexual expression**
  - Kissing, fondling, masturbation, oral sex, intercourse, touching, hugging

- **Expressions**
  - Sending flowers, providing comfort and warmth, dressing up, expressing joy, maintaining beauty and physical appearance, flirtation, affection, passing compliments, proximity and physical contact
Domains of Sexuality

- Biological
- Psychological
- Cultural

By the Numbers ...

- 45% of older men and 8% of older women think of sex at least once a day \(\text{(Fisher, 2010)}\)
- 28% of men aged 66-71 living in the community report having intercourse at least once a week \(\text{(Marsiglio & Donnelly, 1991)}\)
- 60% of men and 43% of women ages 80-91 remain sexually active \(\text{(Starr & Weiner, 1981)}\)
Sexuality in Long-Term Care

- 25% of people living in SNF say they are lonely
- 40% saying they are sometimes lonely
  - A major fear is that they’ll die alone

Consider Their History ...

- Grew up at a time when sexual behavior was never discussed
- Sexual activity was suppressed
- Education was minimal
- Modesty was an important value
- Gender differences exist
Strategies to Address Needs

- Touch
  - For example, hair grooming, hand massage, manicure or pedicure, ROM exercises, back rub, taking pulse
- Consistent staffing
- Counseling and Education

Staff Attitudes About Resident Sexuality
The “ICK” Response

Sexual Expression in LTC

- Love and caring
- Romance
- Eroticism
Staff Responses to Sexuality

- Standing guard
- Reactive protection
- Guarding the guards
- Proactive protection


Inappropriate Responses

- Placing notes on the medical record
- Reporting sexuality at meetings
- Snickering or giggling
- Discussing sexuality with colleagues
- Reprimanding or otherwise scolding
- Praying over the person
- Invasion of privacy
SAID Survey (Kuhn, 2002)

- Competent and consenting residents who are single are entitled to be sexually intimate
- Competent and consenting residents who are married, but not to each other, are entitled to be sexually intimate with one another in a care facility
- Residents with dementia are not capable of making sound decisions regarding sexual relationships
- A spouse living in the community is entitled to become intimately involved with someone else if the spouse has dementia and lives in LTC
- A resident with dementia is entitled to be sexually intimate with two different residents as long as there is no sign of coercion in these relationships

SAID Survey (Kuhn, 2002)

- A resident is entitled to masturbate in private as long as his or her personal safety is ensured
- Two residents of the same sex are entitled to be sexually intimate as long as it is consensual
- If family members object to a relative with dementia having sexual relations with others, it is the duty of the staff to prevent such activity
- A resident displaying hypersexual behavior should be transferred out of the facility
- No one should interfere in the sexual lives of residents as long as no laws are broken
Training Programs

- Uncover staff bias, morals, thoughts
  - Staff can direct the training and individualize it to their population
- Debunk myths about older sexuality
  - Helps caregivers recognize that sexuality is a human need that does not disappear with age

Maslow’s Hierarchy of Needs

- Self-actualization: morality, creativity, spontaneity, problem solving, lack of prejudice, acceptance of facts
- Esteem: self-esteem, confidence, achievement, respect of others, respect by others
- Love-Belonging: friendship, family, sexual intimacy
- Safety: security of body, of employment, of resources, of morality, of the family, of health, of property
- Physiological: breathing, food, water, sex, sleep, homeostasis, excretion

Staff Training Program Elements

- Resources
- Education
- Support
- Protection
- Empowerment
- Confidentiality
- Tactfulness

(Lorenz, 2009)

Federal Regulations and State Survey Guidelines
Survey Guidelines

- **FTag 175**
  - The resident has the right to share a room with his or her spouse when married residents live in the same facility and both spouses consent to the arrangement.

- **FTag 164**
  - The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.

Survey Guidelines

- **FTag 241**
  - The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident’s dignity and respect in full recognition of his or her individuality.

- **FTag 460**
  - Be designed or equipped to assure full visual privacy for each resident
Survey Guidelines

- FTag 242
  - The resident has the right to make choices about aspects of his or her life in the facility that are significant to the resident
- FTag 246
  - Accommodation of Needs
- FTag 223
  - The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.

Family Influences on Resident Sexuality
Reactions of Family Members

- Supportive
- Angry
- Indifferent
- Unsupportive
- Humiliated
- Embarrassed

Kubler-Ross Stages of Loss (1997)

- Denial
- Anger
- Bargaining
- Depression
- Acceptance
Spousal Issues

- How am I obliged as a spouse or partner to someone who no longer recognizes me?
- How do I maintain a sexual or intimate relationship when my feeling toward my spouse have changed?
- How to I handle my feelings of anger, frustration, and entrapment?
- How do I cope with my spouse’s changes in sexuality? (e.g., hypersexual, accusations of unfaithfulness, suspicion)
- How can I meet my spouse’s needs? I love my spouse, but I cannot bring myself to be intimate.

Adult Children

- Feel the need to make decisions including separation
- Many not be aware of parent’s sexual behavior
- Does the facility need to tell them EVERYTHING?
In most cases, the facility will choose the direction of the family members over the wishes of the resident

Consider ...
A “sexual power of attorney” because without one, the adult children will feel free to control the intimacy of loved ones
Dementia

Ways Dementia Affects Sexuality

- Early stages: interest in sex, but performance issues
- Partner with AD may have interest and capability; way to retain one normal area of a relationship
- Partner with AD is hypersexual
- Person with AD has no interest or thinks sexual activity is unacceptable
Spouse/Partner Issues

- Female caregivers uncomfortable with partner’s increased sex interest; males do not experience the same (Duffy, 1995)
- With loss of communication ability comes loss of reciprocal feelings
- Spouse may feel alienated and withdraw affection that was once important to both partners

Dementia and Bathing

- Caregiving tasks as opportunities to strengthen the relationship (Donovan & Corcoran, 2010)
- Emphasizing relational aspects of bathing versus the task minimizes negative behaviors (Rader et al., 2006)
- Recognizing mutuality of the task facilitates positive encounters (Skovdahl et al., 2003)
What Can Be Done?

- Verbal affirmations and flirting
  - Pet names for personal body parts
  - Playful, sexually suggestive tone
  - Bring up a past time in the relationship
- Physical affection
  - Smiling, shoulder patting, holding hands, hugging, kissing
- At times, recipient initiated affectionate behavior that ignored by the caregiver

Role of Occupational Therapy

- Encourage partners to be aware how caregiving affects relationships
- Provide a safe space where partners can talk about their concerns
- Assist caregivers to understand inappropriate sexual behaviors
- Encourage/assist with communication
- Promote awareness so caregivers do not miss intimate opportunities
The Move to LTC

- Affection often increases when the spouse with AD is moved into LTC
- Nursing homes can be places of isolation and loss
- Physical contact from others and intimate relationships can be calming and reassuring

The Question of Consent

- MMSE score 14+ has been used as the cut off for consent to sexual activity
- MMSE does not address emotional state

Is the MMSE enough?
Is Assessment Enough?

- Observation
- Interviews with staff, family
- Involve other professionals
- Team meeting to discuss findings

Interview for Consent (Lyden, 2007)

- Interviewer should have good and comfortable relationship with client
- Utilize someone familiar to assist if impaired speech or translator needed
- Explain the reason behind the meeting
- Assess rationality, knowledge, voluntary agreement
Criteria for Sexual Capacity

- Voluntariness
- Safety
- No exploitation
- No abuse
- Ability to say “no”
- Socially appropriate time and place

Determining Functional Competence

- Determine whether the resident has the ability to express his or her desires
- Determine what critical interests or values might be affected by acting upon the desires
- Determine if the resident can consider these interests when making a decision
- If not, then the nursing home needs to consider or decide whether the value of the intimate relationship outweighs the value of the critical interest affected
For What?

Capacity/competence can only be assessed in relation to a specific demand or task

Keep in Mind

- Cognitive memory may be impaired, often times emotional memory is not
  - Cognitive impairment does not erase the need for affection or intimacy
- If a person can consent to one relationship, that doesn’t mean they can consent to another
  - Each relationship must be approached differently
Dilemma of Adultery

Is the nursing home’s obligation to the resident or to his/her spouse?

Do we hold a person with dementia at a higher standard than everyone else?

System Bias?

- System bias relies on the opinion of the non-resident spouse, not the resident (Tenenbaum, 2009)
- Our responsibility should be to the resident
  - Should we end an intimate relationship based solely on the request of a non-resident spouse?
Helping to Decide

- Substituted judgement
- Best interest
- Functional competence
- Authentic self

What Can We Do?

- Include sexual history in admission records
  - For example, orientation, sleeping arrangements at home, level of sexual interest, capacity
- Facility should have a consent policy; all staff must be trained to follow it
Assumptions to Follow (Ballard, 1995)

- Individuals with AD may behave in childish ways, but must be treated as an adult
- People with AD are still sexual and may express a variety of sexual behaviors
- You cannot force someone with AD to remember
- Behaviors are not always as they seem

Inappropriate Behaviors
Definitions

- Disinhibition
  - Lack of restraint; disregard for social conventions
- Hypersexuality
  - Abnormally high desire to engage in sexual activities

Inappropriate Behaviors

- Fondling, hugging, kissing strangers
- Masturbating in public
- Undressing in public
- Using sexual language
- Sexually suggestive activity
- Initiating sexual activity
- Aggressive sexual overtures
- Exposing oneself
- Urinating in public
- Requesting excessive genital care
- False accusation of sexual abuse
Gender Differences

- Men like to touch and women like to be touched (Mayers, 1998)
- Women want comfort/affection; men are more aggressive/forceful (Nay, 1992)
- More inappropriate sexual behaviors from men than women (Archibald, 1998)

Categories of Sexual Expression

- Intimacy seeking behaviors
- Disinhibited behaviors
- Nonsexual behaviors
Consider This ...

- Is the behavior related to past abuse?
- What are the biases and beliefs of the person reporting the behavior?
- What is the sexual history of the resident?
- Is the person compensating for loss?
- Is this a case of misunderstanding/ misinterpretation?

Assessing Behaviors  (Ballard, 1995)

- Exactly what is the resident doing?
- A pattern? Happening frequently?
- Is the behavior sexual? Or does it have another cause?
- A triggering incident?
- Changes to the environment?
- Has medical condition changed? New medication added?
Assessing Behaviors  (Ballard, 1995)

- Forgotten social rules?
- Need for attention?
- Why is this behavior a problem?
- For whom is it a problem?
- Risk/benefit analysis?
- Psychological need?
- Caregiver misinterpretation?

Behavior Log

- What activity was going on right before this incident occurred?
- What happened right before the behavior?
- What was the behavior?
- What action did staff take regarding the behavior?
- Was action / intervention effective?
How to Respond  (Stimson, 2012)

- Remain calm
- Be respectful
- Reassure others the patient means no harm
- Show no awareness
- If in a common area, lead resident away
- Step away from the situation
- Do not reprimand, scold or yell

After the Event  (Stimson, 2012)

- What form does the behavior take?
- Could there be a social, environmental or psychological cause?
- How did you form your judgment and does this behavior offend your attitudes, cultural beliefs or values?
- Does resident pose a risk to others?
Pragmatic Tips

- Approach the resident as an adult
- Modify the environment to encourage desired behaviors
- Staff assess their own beliefs/biases
- Chart and evaluate behaviors objectively
- Inform family when behaviors have legal, ethical, or social consequences
- Ensure families know sexual history will be assessed

Interventions

- Behavioral treatments
  - E.g., restrictive clothing
- Medications
- Person-centered routine
Keep in Mind ...

- Sex offenders may be your residents
- History of sexual abuse
- Ensure any relationship is consensual

Lesbian, Gay, Bisexual, and Transgendered Residents
Statistics

- 73% of gay and lesbian survey respondents said that discrimination occurred in retirement communities
- Greater than 1/3 said they would go back into the closet if they were forced to move into one

(Johnson, Jackson, Arnette, & Koffman, 2005)

Definitions

- Gender
  - The state of being male or female
- Gender Identity
  - How individuals perceive themselves and what they call themselves
Definitions

- Agender
  - People who identify as agender may describe themselves as genderless, lacking gender, or gender neutral
- Cisgender
  - Self-identity conforms with the gender that corresponds to their biological sex

Definitions

- Transgender
  - Person whose gender identity, expression or behavior does not correspond to that person's biological sex assigned at birth
- Queer
  - A term used to refer to lesbian, gay, bisexual, and often transgender people
Fears of Moving to LTC

- Fear of caregiver neglect or rejection
- Fear of not being accepted by other residents
- Concern about offending others
- Preference for gay-friendly residential options in LTC

(Stein, Beckerman, & Sherman, 2010)

Family Circle

- Delay in moving into LTC
  - Family members care for them longer at home
- Family members may not be true family members
  - Circle of friends
What Can We Do?

- Intake/Admissions
  - Most nursing homes do not ask about sexual orientation (Doll, Bolender, & Hoffman, 2011)
  - Revise forms to read domestic partner or same-sex partner
  - Clearly indicate confidentiality

What Can We Do?

- Staff attitudes
  - Don't assume resident is heterosexual
  - Treat residents with respect and dignity
  - Anti-discrimination policies that specify sexual orientation and gender identity
  - Staff response
What Can We Do?

- Environment and marketing
  - Pictures in common areas
  - Reading material in the library?
  - Pamphlets, posters, websites, brochures, resident rights policies contain inclusionary language

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What Can We Do?

- Be client-centered
- Match treatment approaches to the specific needs of your client
- Ask about body/transition status ONLY as related to care provided
- How might occupational needs differ?
- Remain aware of gender-based evaluations and assessment tools
Environment

Hindrances to Privacy

- Unlocked door policies
- Evening bed checks
- Roommates
- Staff access to health-related information
  - Private rooms do not always guarantee privacy

(Calkins & Cassella, 2007)
Tag F164

- The resident has the right to personal privacy and confidentiality ...
  - Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.

What Can We Do?

- Wait for permission to enter a room
- Discuss sensitive information when others are not present
- Cordon off a “visiting room” for overnight guests
Visiting Room

- Call light
- Meals
- Assistance from staff
- Emergency orientation/medical emergency
- Confidentiality
- Staff provision of care
- Fees
- Showering facilities
- Arrival and departure times

Visiting Room

- Daytime hours
- Locking door
- Respect, confidentiality, dignity
- Furnishings
- Follow-up
No Spare Room?

- Schedule visits when roommate is out
- Help couple make arrangements at a local hotel
- Make an unoccupied room available
- Find ways to make resident rooms more private
- Add locks on the inside of the room
- Accommodate family caregivers

Health and Sexuality
Diseases Affecting Sexuality

- Diabetes
- Hypertension
- Heart disease
- Incontinence
- Kidney disease
- Stroke
- Neurological disorders
- Cognitive disorders

PLISSIT (Wallace, 2008)

- Permission
  - Give clients permission to speak about sexual concerns
  - Validates as a legitimate health concern
  - Ask if it is okay if you ask questions
  - Develop an environment of openness and comfort
PLISSIT (Wallace, 2008)

- Limited Information
  - Informative, educational approach
  - Patients may be given books, magazines, videos, etc. to provide relevant and accurate information

PLISSIT (Wallace, 2008)

- Specific Suggestions
  - Provide tips, directions, exercises used to treat sexual problems
  - Tailored to meet specific needs of each case
  - Sexual history of client/partner is obtained

continued
PLISSIT  (Wallace, 2008)

- Intensive Therapy
  - Which cases are resulting from additional underlying causes?
  - Is a referral to a medical professional needed?

Risk of HIV and STDs

- Many have had only one partner
- Less likely to know risks of contracting HIV
- Many do not use protection
  - 60% of unmarried women 58-93 said they had not used any sort of protection

(Lindau, Leitsch, Lundberg, & Jerome, 2006)
Reasons for STDs  (Resnick, 2003)

- Women cannot get pregnant; do not choose to use protection
- Rate of STDs is 2X as high in older men using medications for ED
- Better health, sexually active longer
- Older adults have ignored safe sexual practices

Reasons for STDs  (Resnick, 2003)

- Older adults raised when men made the decisions
  - A man does not wear a condom if he chooses not to
- Men have many options for sexual partners
- Internet dating sites
- Men are ignoring safe sex practices
For Whom is the Policy?

- It appears as though LTC facilities make decisions based upon the wishes of the family instead of the resident
- Adult children are primary consumers of LTC services and thus need to be catered to
Policy Elements

- Admissions
  - Gather information re: sexual history, interest, activity
- Working definitions
  - E.g., sexuality, intimacy, sexual behavior
  - What is considered normal and acceptable?
  - How will you determine consent?

Policy Elements

- Consent
  - Expression allowed with consent and benefits outweigh risks
  - Care staff may decide whether to permit sexual behavior/activity
  - Staff determine and document consent
  - With family objection, facility seeks a mutually agreeable solution
Policy Elements

- Risk
  - Assess for resident’s ability to understand risks/consequences of an intimate relationship
- Harm or offense
  - Interference from staff should only occur if there is significant harm or offense to others AND
  - If harm is greater than benefits

Policy Elements

- Shared rooms
- Staff training
- Reporting procedure
- Appropriate staff interventions/responses
- Sexual ethics committee
- Police involvement
- Resident sexual education and support
- Case studies
Successful Policy  (Ballard, 1996)

Reviewed at least every 2 years

- Holistic approach considering social, emotional, spiritual, physical, sexual needs
- Staff feel comfortable addressing intimacy and sexuality
- Guidelines for resolving dilemmas
- Families understand potential for intimate relationships and facility policies

Role of Occupational Therapy
Why is this ADL Not Addressed?

- Therapist discomfort
- Lack of educational preparedness
- Assumption some other discipline is addressing it
- Not enough time to address it in the confines of healthcare

(Hattjar, 2007)

Holistic Approach

- An occupation important to the client
- Sexuality, intimacy, and sexual activity are key components to a holistic approach
- Consider that sexual expression may be a higher priority to an individual than other ADL
Role of OT

- Efficiency techniques
- Energy conservation
- Joint protection
- Adaptive methods and equipment
- Education

(Couldrick, 1998)

OT Practice Framework (AOTA, 2014)

- ADL/Personal device care includes using, cleaning, maintaining contraceptive & sexual devices
- ADL/Sexual activity includes engaging in activities that result in sexual satisfaction or meet relational or reproductive needs
- Social Participation with a peer/friend includes engaging in activities at different levels of interaction and intimacy, including engaging in desired sexual activity
OT Role

Therapists need to believe that clients' sexual expression is a legitimate domain of professional concern
(Couldrick, 1999)

Arthritis and Sexuality
By the Numbers

- In the US, 46 million adults have some form of arthritis
- Most prevalent in women, obese individuals, those who do not regularly exercise

(CDC, 2008)

Osteoarthritis

Common symptoms include:
- Joint stiffness after rest
- Joint crepitus
- Joint deformity
- Limited ROM due to pain limitations
- Joint tenderness, swelling, and joint pain

(Porth, 2004)
Gout

- Sudden, severe attacks of pain, redness, joint tenderness at night after exercise, medications, food/alcohol intake, dieting
- Mostly affects base of great toe, also affects tarsal joints, instep, ankles, knees, heels, wrists, fingers, elbows (Porth, 2004)
- Attributed to fatty diet, medical conditions (HBP, high cholesterol, diabetes, heart disease) (Primastea et al., 2011)

Fibromyalgia

- Chronic condition with widespread pain in muscles, tendons, ligaments
- Fatigue/tender points throughout the body, usually in a symmetrical pattern

(Hallberg & Bergman, 2011).
Effect of Sexuality

- Physical problems
  - General pain, discomfort, joint pain, joint swelling, stiffness (Newman, 2007)
- Self-esteem
  - Lower libido, diminished sense of attractiveness/desirability

Role of OT

- Assessment including COPM, ROM, grip, prehension, balance, mobility, pain
- Joint protection techniques
- Energy conservation to address fatigue
- Thermal agents
Joint Protection

- Respect pain as a signal to stop
- Maintain muscle strength and ROM
- Use each joint in its most functional anatomical/functional plane
- Avoid positions of deformity
- Use the largest and strongest joints for the job

Joint Protection

- Ensure correct patterns of movement
- Avoid staying in one position for long periods
- Avoid starting an activity that cannot be stopped immediately
- Balance rest and activity
- Reduce the force on joints
Introduction

- Over 1 million Americans are diagnosed every year (ACS, 2010)
- Most common types
  - Women: breast, lung, colorectal
  - Men: lung, prostate, colorectal
- After shock of diagnosis lessens, QOL including sexuality and intimacy become a part of recovery
Treatments Affecting Sexuality (Men)

- Radiation therapy
  - May cause infertility, make erection difficult
    - Smoking, heart disease, HPB, diabetes may make problems worse
- Hormone therapy
  - May cause mood changes, decreased sexual desire, ED, trouble reaching orgasm

Treatments Affecting Sexuality (Men)

- Chemotherapy
  - May cause lowered testosterone levels, decreased libido, infertility
- Surgery for penile, rectal, prostate, testicular, pelvic cancers may affect sexual function and fertility
- Side effects like fatigue, anxiety can lower interest in sexual activity
Treatments Affecting Sexuality (Women)

- Chemotherapy
  - May cause symptoms of early menopause, vaginal infections, infertility
- Hormone therapy
  - Can cause hot flashes, vaginal discharge or pain, trouble reaching orgasm

Treatments Affecting Sexuality (Women)

- Radiation therapy
  - Can cause infertility, symptoms of menopause, pain during sex, risk of birth defects, vaginal stenosis, itching, burning, dryness, or atrophy
- Surgery for cancers of uterus, bladder, vulva, endometrium, cervix, ovaries may cause infertility
- Side effects like fatigue, anxiety can lower interest in sexual activity
Psychological Issues

- Facing mortality
- Changing self-esteem
- Changing or losing occupational roles
- Effects on relationships
- Financial pressures
- Altered body image
- Vulnerability

Other Issues

- Postoperative pain
- Joint pain
- Loss of/change in body parts
- Infertility
- Changes in body function
- Nausea and vomiting
- Hair loss or baldness
- Fatigue
- Hormonal changes
- Numbness
- Painful vaginal intercourse
- SOB
- ED
Other Issues

- Lower production of estrogen and testosterone (Katz, 2007)
- Decreased sensation = difficulty with arousal
- Impaired blood flow = decreased arousal & lubrication, difficulty with orgasm & erections
- Decreased desire

BETTER Model (Mick et al., 2003)

- Bring up intimacy issues
- Explain
- Tell
- Timing
- Educating
- Recording
Education

- Assess physical side effects and how to manage
- Assess physiological effects
- Encourage creativity and flexibility
- Improve communication

Loss of Desire and Arousal

- Fantasy or erotica
- Use of sex devices
- Teasing touch
- Sensual arousal
- Hormonal interventions
- Medication changes
- Creative scheduling
- Try new things
- Self-exploration
Vaginal Pain

- Lubricants
- Vaginal renewal program
- Dilators (Lancaster, 2004)
- Biofeedback and Kegel exercises
- Muscle massage
- Relaxation training
- Positional variations
- Pillows, bolsters, wedges
- Localized hormone treatments

Erectile Difficulty

- Oral medications
- Hormones
- Penile injections
- Pellets
- Vacuum devices
- Vibrators
- Experiment with outercourse
- Different positions
Ejaculation Issues

- Premature ejaculation
  - Kegel exercises can improve muscular control
- Painful ejaculation
  - Seek physician advice

General Pain

- Thermal agents (heat, ice)
- Stretching and tension-release exercises
- Guided imagery
- Warm shower or bath
- Positional changes for comfort
Diabetes and Sexuality

Introduction

- 800,000 new cases diagnosed each year
- 18.8 million people have been diagnosed
  - 7 million estimated to have it, but are undiagnosed
- 7th leading cause of death in the US

(CDC, 2011)
Symptoms

- Neuropathy
  - Bladder urgency or incontinence, constipation or diarrhea, erectile dysfunction or retrograde ejaculation, vaginal dryness, sweating
- Obesity
  - Positional problems, joint pain, decreased mobility and body movement

Referral to Therapy

- ROM
- Mobility and transfer skills
- Endurance
- Education
- Modify habits and routines
- Promote healthier lifestyle
Issues/Treatment for Men

- ED
  - Oral medications, vacuum pumps, suppositories or pellets, penile injections
- Retrograde ejaculation
  - Medications

Issues/Treatment for Women

- Decreased vaginal lubrication
  - OTC vaginal lubricants
  - Use sidelying position, pillows/bolsters for support
  - Kegel exercises to strengthen pelvic muscles
Cardiovascular Disease and Sexuality

Introduction

- Comprised of HBP, CAD, CVA, CHF
- Risk factors include inactivity, obesity, HBP, smoking, high cholesterol, diabetes (CDC, 2006)
- Over 631,000 Americans die each year from CVD
  - Leading cause of death for both men and women
Myths Debunked

- Sex is no longer permissible after a cardiac event
- Any person diagnosed with heart disease will experience chest pain during sexual activity
- For older adults sexual activity is no longer important

Risk for Sexual Activity

- Risk is similar to mild to moderate activity effort (Jackson, 2009)
- Low risk (majority of patients)
  - Safely encouraged to initiate or resume sexual activity
  - Medium risk
  - Evaluation by a cardiologist is suggested
- High risk
  - Medically stabilized before resuming sexual activity
Physical Barriers

- Palpitations
- Arrhythmia
- Ongoing problems related to heart failure
- Heart muscle problems
- Valve problems
- SOB
- Irregular heart beat
- Chest pain

Pain

- Protect/buffer sternum area until healing has occurred
- Use pillows or positioning aids to avoid pulling at incision site
- Do not lay supine: increased pulmonary demands, fluid pooling
- Avoid anal sex as this can stimulate the vagus nerve
Other Issues

- Lack of libido
  - May be due to anxiety or depression. Seek MD advice.
- Erectile dysfunction
  - Medications dilate blood vessels and should be used with caution

Resuming Activity

- Defer sex for at least 7-10 days after a cardiac event (Katz, 2009)
- High risk individuals, obtain a stress test before resuming (DeBusk et al., 2000)
- Usually by 6 months post, most couples will resume sexual activity
Referral to OT

Stress reduction
- Stress ball
- Visual imagery
- Progressive/guided relaxation
- Table top creative activity
- Yoga
- Stretch and relax techniques

Referral to OT

Energy conservation
- Activity planning
- Activity ranking
- Energy awareness
- Activity adaptation
- Activity simplification
- Opt for meaningful tasks
TBI and Sexuality

Introduction

- CDC estimates 1.7 M people sustain a TBI every year
- More than 124,000 have long lasting effects of TBI
- TBI can overlap with PTSD
Reported Issues

- Reduced sex drive
- Reduced frequency
- Ability to provide satisfaction
- Perform intercourse/achieve orgasm
- Social/relationship skills, self-esteem
- Cognitive challenges
- Behavioral changes including hypososexuality or hypersexuality

Therapy Intervention

- Muscle tone
- ROM
- Sensation
- Coordination
- Balance
- Functional mobility
- Pain
Interventions for Pain

- Alternative positioning
- Gentle stretching
- Heat/medication prior to activity
- Adequate lubrication
- Desensitization using dilators
- Medications from MD

Interventions for Memory

- Memory aids (e.g., log book)
- Track occurrences of activity
- Checklist of preparatory activities (e.g., contraception, medication, etc.)
Interventions for Low Vision

- Compensation and adaptation
- Quickly turn head
- Entirely search blind area when moving or changing positions

Inappropriate Behavior

- Don’t wait for a crisis
- Avoid change
- Don’t overstimulate
- Enhance orientation
- Augment verbal communication
Inappropriate Behavior

- Avoid changes in the environment
- Expect variability
- Plan and anticipate
- Attend to those behaviors you want increased
- Ignore those behaviors you want extinguished

Therapist Conduct

- Model appropriate behavior
- Be consistent with follow through
- Do not discuss personal issues
- Present a cohesive and unified front among the IDT
- Never debate care issues in front of the client
Stroke and Sexuality

Introduction

- In US, 700,000 strokes each year
- About 2/3 will survive
- Residual issues
  - Hemiplegia or hemiparesis
  - Communication or oral-motor limitations
  - Mood or personality changes
  - Cognitive impairments
  - Visual-perceptual impairments
  - Bowel and bladder dysfunction
Positioning

- Tone, weakness, ROM may eliminate some positions
- Therapy may address ROM, strength, spasticity, sensation, pain
- Begin with man on top, woman on top, sidelying, or seated
- Consider warm bath before activity to address spasticity
- Use pillows, positioning aids, props

Sensation and Pain

- Body mapping
  - Allows understanding of sensory changes and which areas are sexually charged
- Communication with partner to find pain-free positioning
- Genital hypersensitivity may require desensitization (Kaufman, et al., 2007)
Fatigue

- Timing and planning to manage energy expenditure
- Self-assessment log or diary of activity
- Pace, pause, change the activity to something less strenuous when tired
- Best position is side lying

Oral-Motor Impairment

- Kissing may be a challenge as muscles in mouth are not strong
- To minimize aspiration during kissing, client be in a higher position to create a chin tuck
- Oral sex issues include leakage, endurance, aspiration. Washcloth for leakage, breaks for endurance, change position (partner seated in front)
- Head of bed at 30 degrees
- Use non-verbal communication for pain
Visual Impairment

- Client must know where neglected arm/leg are for safe positioning
- OT to train compensatory techniques for lubrication application

Incontinence

- Ensure complete emptying of the bladder or rectum before sex
- Avoid alcohol or caffeine
- Perform intercourse in bathtub or shower (Kaufman et al., 2007)
- Use sidely position
Thank you!

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