Sexual Health Rehabilitation and Neuro-Clients

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BACKGROUND

Neural control is a prerequisite for sexual function (Rees, 2007). Sexual function begins in the brain, particularly in the amygdala, mesencephalic tegmentum and septal nuclei (Rees, 2007). Certain neuro-conditions affect these areas and other areas of the body which can disrupt sexual intimacy. For example, 84% of males and 60% of females enjoyed their sex lives before their stroke as compared to only 30% of males and 31% of females after stroke. As well as, 95% of males and 76% of females were satisfied with sexual activity before their stroke as compared to only 26% of males and 37% of females after stroke (Monga et al, 1986). There are a few myths about sexual activity and people with neuro-conditions:1) People with disabilities are not sexual and are not desirable 2) Sexual activity must be spontaneous and come naturally 3) Sexual health education is unneeded (Kaufman et al, 2007) Patients with neurological conditions want to receive information about sexuality and sexual rehabilitation, but no one is providing it (Kniepmann, 2018; Northcott & Chard, 2000). Patients and their spouses recommend that health professionals address this topic, provide information, and refer people to support groups for peer exchange of information and support (Kniepmann, 2018).

CLIENT HISTORY

S. J. is a 75 y.o. female patient presenting to the Duke University Outpatient clinic for right-sided weakness secondary to left corona radiata ischemic stroke on 12/13/19. She has a history of sickle cell trait, CVA 25 years ago with residual LUE hemiparesis, diverticulosis without bleeding, OA status post knee replacement. She is married and attends OT sessions with her husband present. Both the client and her husband define physical sexual activity as an important ADL that has never been addressed by any healthcare practitioner.

RESEARCH QUESTION

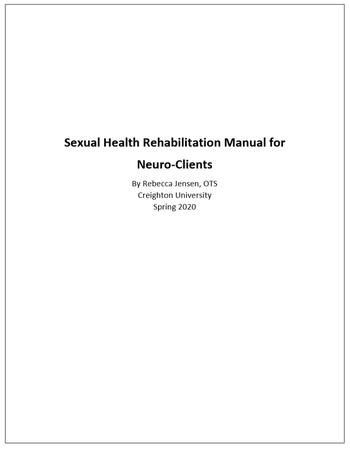
Will providing written education to patients with neuro-conditions increase quality of life, sexual health satisfaction, and value of Occupational Therapy?

METHODS

The S.J. and her husband filled out a pre-survey to determine if they were appropriate for sexual health education. After the pre-survey and appropriateness was determined, they received another set of questions to stimulate discussion and reflection about what aspects of physical sexual activity is important to them, and what barriers were preventing them from participating in this ADL. When they returned to the next session, the occupational therapist reviewed their responses and provided client-centered education based on those responses (Figure 1-4). The education provided was information to assist in resuming physical sexual activity by reducing barriers and if/when a referral was recommended. The occupational therapist, client, and her husband had an open discussion about the provided information, and they verbalized understanding. The client and her husband had two weeks of time to comprehend, ask questions, and utilize the educational information. S.J. and her husband then filled out a post-survey to determine if the education increased sexual health satisfaction, increased quality of life, increased the value of Occupational Therapy, and if a referral for further evaluation and treatment were needed. Surveys used a Likert scale with 0 meaning not at all, and 10 meaning absolutely.

RESULTS

With the surveys using the Likert scale 0-10, with 0 meaning not at all and 10 meaning absolutely, S.J. and her husband answered the question, “The educational information provided was helpful to understand good sexual health practices” with a 7/10. They answered the question, “My quality of life has increased since the educational information was provided” with an 8/10. They answered the question “I value occupational therapy more since they addressed sexual health.” with a 9/10. They did not request a referral for more specific treatment or evaluation, nor did they make suggestions on how to improve the information provided to them. They stated that “it was very informative.”



Sexual Health Rehabilitation Manual for Neuro-Clients

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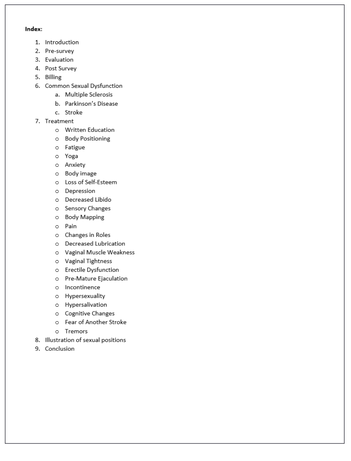

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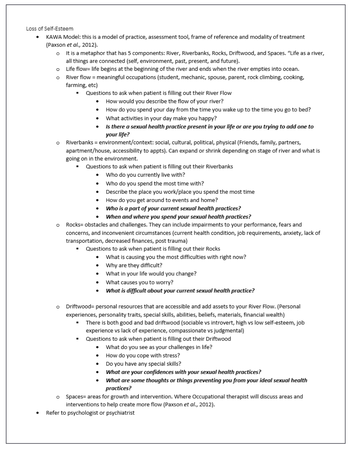
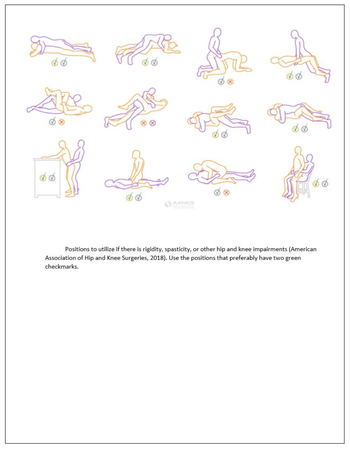


Loss of Self-Esteem

- KAWA Model: this is a model of practice, assessment tool, frame of reference and modality of treatment (Paxson et al., 2012).
  - It is a metaphor that has 5 components: River, Riverbanks, Rocks, Driftwood, and Spaces. “Life as a river, all things are connected (self, environment, past, present, and future).
  - Life flow= life begins at the beginning of the river and ends when the river empties into ocean.
  - River flow = meaningful occupations (student, mechanic, spouse, parent, rock climbing, cooking, farming, etc)
    - Questions to ask when patient is filling out their River Flow
      - How would you describe the flow of your river?
      - How do you spend your day from the time you wake up to the time you go to bed?
      - What activities in your day make you happy?
      - ***Is there a sexual health practice present in your life or are you trying to add one to your life?***
  - Riverbanks = environment/context: social, cultural, political, physical (Friends, family, partners, apartment/house, accessibility to appts). Can expand or shrink depending on stage of river and what is going on in the environment.
    - Questions to ask when patient is filling out their Riverbanks
      - Who do you currently live with?
      - Who do you spend the most time with?
      - Describe the place you work/place you spend the most time
      - How do you get around to events and home?
      - ***Who is part of your current sexual health practices?***
      - ***When and where you spend your sexual health practices?***
  - Rocks= obstacles and challenges. They can include impairments to your performance, fears and concerns, and inconvenient circumstances (current health condition, job requirements, anxiety, lack of transportation, decreased finances, post trauma)
    - Questions to ask when patient is filling out their Rocks
      - What is causing you the most difficulties with right now?
      - Why are they difficult?
      - What in your life would you change?
      - What causes you to worry?
      - ***What is difficult about your current sexual health practice?***
  - Driftwood= personal resources that are accessible and add assets to your River Flow. (Personal experiences, personality traits, special skills, abilities, beliefs, materials, financial wealth)
    - There is both good and bad driftwood (sociable vs introvert, high vs low self-esteem, job experience vs lack of experience, compassionate vs judgmental)
    - Questions to ask when patient is filling out their Driftwood
      - What do you see as your challenges in life?
      - How do you cope with stress?
      - Do you have any special skills?
      - ***What are your coeficiences with your sexual health practices?***
      - ***What are some thoughts or things preventing you from your ideal sexual health practices?***
  - Spaces= areas for growth and intervention. Where Occupational therapist will discuss areas and interventions to help create more flow (Paxson et al., 2012).
- Refer to psychologist or psychiatrist



Positions to utilize if there is rigidity, spasticity, or other hip and knee impairments (American Association of Hip and Knee Surgeries, 2018). Use the positions that preferably have two green checkmarks.

Figure 1-4 are examples of what types of information a client might receive after filling out the pre-survey based on their needs. For more information on what the sexual health manual contained, please ask.

BOTTOM LINE FOR OT

Some studies suggest that any health professional would be appropriate for the responsibility of discussing sexual intimacy, including occupational therapists (Northcott & Chard, 2000). Occupational therapy would be an ideal healthcare profession to cover sexual health because sexual intimacy is an activity of daily living and sexual function is in the Occupational Therapy Practice Framework (OTPF) (Northcott & Chard, 2000). Patients and their spouses desire three main themes to be addressed through their sexual health education 1) maintaining intimacy in new ways, 2) redefining sexuality and exploring options, and 3) closing information gaps (Kniepmann, 2018). People who receive education and treatment have an increase in their overall satisfaction with sexual function, as well as an increase in quality of life compared people who do not (Zamani, 2017). Providing written materials about sexual dysfunction encourages patients to discuss their sexual concerns with their spouses, which subsequently enhances their coping strategies and quality of life (Christopherson, 2006). Elderly couples who were assigned to an educational program revealed a significant sexual satisfaction compared to those who did not (Goldman, 1990).

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