

# Addressing Clients' Sexuality



When asked "What is an OT?", I would often reply that an OT is part Sherlock Holmes, part daughter (or son), part drill sergeant, part angel, part mother (or father), and part girlfriend (or boyfriend).

The "part" I used most often with my clients was Sherlock Holmes. I would have to get out my imaginary magnifying glass and discover what motivated the client—what he or she really wanted to accomplish, and how to make it relevant to OT treatment.

On several occasions during my nearly 20 years of clinical practice, the topic of sexuality and sexual expression has surfaced. Having worked as a personal care attendant (prior to going to OT school) during the aftermath of the Independent Living Movement (1980s) in Berkeley, CA, I spoke with many clients who shared their stories of (sexual) wishes, desires and experiences with me. This gave me a sense that it was normal for disabled people to be sexually active, and for me not to be afraid if the topic came up in OT treatment. It made sense; sexuality can be considered one of the activities of daily living.

One example that sticks out in my mind was my work with Mr. Allen, a 62-year-old gentleman who had (incomplete) quadriplegia as a result of a lower motor neuron disorder brought on by ETOH-related liver damage. He was dependent in all areas of self-care and mobility, and was a long-term resident of a skilled nursing facility in southern California.

The first time I met him, I was doing a dining room screening for self-feeding deficits to determine if any of the clients in the dining room could benefit from OT. Mr. Allen was reclined in a geri-chair, with his sunglasses and headphones on, and was cussing because he couldn't pick up a cracker with tuna salad on it.

The nurse's aide was working with another client, and Mr. Allen was trying to feed himself. I heard the ruckus, and watched him from across the room. He must have tried for three minutes to get that cracker. I saw a potential OT client! I asked

him if I could have permission to look at his chart and see if he might be eligible for therapy to help him increase his independence in self-care. He agreed.

After I took him on as a client, during a self-care training session at bedside, he mentioned that he wanted to get independent so he could get out of the nursing home, live on his own, and get some (sex). I was able to tap into his psychosexual motivation and give him exercises (sexual position and movement simulation) to increase his hip and trunk control, strength and endurance, which would come in handy with transfers, sitting balance and ADL. I told him to keep his bedrails up, and flex and extend his hips while lying on his back (in a pseudo-sexual intercourse pattern), and this would help him get both ADL and possible sexual function back (and maybe lead to his "getting some").

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He was pleased with the support and encouragement. He worked every night on these exercises, and reported his progress with a big grin on his face the next day in OT session. Later he was able to roll over by himself, and complete this exercise in a prone position.

I remembered from my sexuality education that clients do well when you give them "permission" to be sexual beings. They have insecurities and look to us for affirmation of their sexuality. So, I gave him "permission" to explore his genitals with his hands, and explained that this activity would help his functional grip, help normalize sensation (both in his hands, and his privates) and could lead to sexual pleasure and possible future function. Again, he expressed gratitude with my willingness to address his sexual issues.

Well, after working with Mr. Allen for approximately four months, he was completely independent in transfers from bed

to wheelchair and commode, dressing, peri-hygiene following toileting, and bathing at bedside and supervised (following set up) in the shower, independent with wheelchair mobility and simple meal preparation. We even had cooking group once a week and made tuna, ham and egg salad sandwiches. He could crack and peel boiled eggs as well as build his own sandwich with his (quadraplegic) hands. Later, he was able to find a studio apartment with the help of the facility social worker, and moved out on his own.

Several times he came back to the nursing home to visit, and encourage others to become independent. One other gentleman, Bill, about the same age with a CVA, was able to follow in Mr. Allen's footsteps, and became independent and moved out about a year later.

I am not sure if Mr. Allen ever got some, but I know he was happier because he gained independence and had hopes of getting some in his own environment. Mr. Allen knew that without our work together he probably would have lived in the nursing home for the rest of his life, and that aspect of his self (sexual expression) would never be realized. I will always remember how motivated and successful in OT treatment Mr. Allen was, and am still pleased that I could be a part of it. ■

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