A model for the promotion of sexual health by physical disability teams

Stage 1: The recognition of the service user as a sexual being

It is proposed this first stage should be integral to all pre-registration training. It is about social justice and equality. There may be practitioners who, for whatever reason, do not wish to develop their role in addressing sexuality issues. Yet, a positive approach to sexual health is possible.

Recognition, as the first step, supports sensitive skills of acknowledgement, normalisation, affirmation and validation. These can be used even where a disability professional does not wish to facilitate exploration of sexuality. As an example, the following could be used in a key worker assessment.

> 'You may have some sexual concerns (*acknowledgement*); many service users do (*normalisation*). It is not my area of expertise (*acknowledging limitations*) but I appreciate it is important (*affirmation*). If you wish, I can ask my colleague to speak with you.'

Recognition also helps to facilitate a positive response to the unsought sexual disclosure. Practitioners who dismiss or ignore unsought inquiries are contributing, albeit unwittingly, to the asexualisation of the disabled person. The following response indicates how a sexually affirming approach can be taken to an unsought inquiry.

> 'This is an important question (*affirmation*). It is a concern several of my patients with (*describe impairment*) have raised in the past (*normalisation*). However I don't think I am the best person on the team to talk to (*acknowledging limitations*). The nurse in our team has much greater expertise than I do. Can I ask the nurse to contact you?'

Or for the practitioner who is confident to move to the stage of exploration -

> 'This is an important question (*affirmation*). Perhaps we could book some time and a quiet room where it would be easier to talk.'

Acknowledging the importance and priority that sexual expression may have for the service user, affirms their sexual identity.

Stage 2: Permission to discuss their sexual concerns

Recognition of every service user as fully human, inclusive of sexual needs, provides the rationale for inviting them to discuss their sexual concerns, if they want to. For a disability team, it is about identifying those people wishing to explore their concerns and supporting them to talk to the appropriate member of the team. Because of the social taboo deterring talk of sexual behaviours, clear and direct permission is required. Until further empirical evidence is available, sensitive strategies are advocated, such as *indirect questions* or *statements* that invite service users to respond if they wish without seeking any personal information. Permission giving needs to invite disclosure about establishing and maintaining intimate relationships as well as sexual function. It can be done quite simply during any professional's initial assessment, for example

> 'I find some people also want to talk with me about their relationships or have questions about sex. I am happy to discuss these if you do have any concerns.'

This approach respects individuals' privacy yet invites people to proceed if they wish.

Dialogue is not the only option. Service user information leaflets and posters in clinical areas could explicitly include sexuality within the service provided by the team. Generic, nursing and occupational therapy assessment tools are all suited to include a permission giving statement. Because sexuality is essentially a private affair it is not possible to know who has sexual concerns. Therefore it is important that *every service user* is given an invitation to discuss his or her concerns. Therefore, some teams might decide that all those undertaking screening assessments should provide a statement that invites disclosure later in the process. For example,

> 'If you do have any questions you wish to explore about your personal relationships or sexual expression, do let your key worker know. We have quite a lot of resources within the team and if we can't help we probably know someone who can.'

The skills of the speech and language therapist are especially valuable in routine permission giving when dysarthria or aphasia is present.

Stage 3: Exploration

Providing permission to discuss sexuality, of itself, is insufficient because of its multi-faceted nature. Skill is required to identify the issues. It is feasible that all disability practitioners could help service users explore their sexual concerns. However where, for whatever reason, this was not possible, exploration could be assumed by specified team members. Thus permission giving by one person might lead to referral for exploration by another member of the team.

It is in the exploratory stage where the approach of the disability professional may differ vastly from that of the sexual health professional. The expert in sexual health might seek a sexual history and explore performance related to the human sexual response cycle. Whereas the expert in disability needs to understand how disability impacts on sexual health. It may be about social opportunity, self-identity, or moving a relationship toward intimacy. The service user may seek to explore how the consequences of impairment can be managed during intimacy, for example using a hoist, having a stoma or not being able to undress. It could be about role changes between sexual partners because of the care needed. Or it might concern the management of fatigue, spasticity or pain.

Stage 4: Addressing issues within the team's expertise and boundaries

Sexual counselling is a limited description of what can be done and may confuse disability practitioners about what rightly falls within their role. Disability professionals are familiar with needs identification, treatment planning and goal setting thus they could analyse sexual problems, devising specific, targeted goals that are properly within the team's expertise.

It requires a clear understanding of the different professional roles and might require inter-professional working. Physiotherapists might address biomechanical issues that cause discomfort during intercourse. The occupational therapist might provide information on simple electronic equipment like a vibrator or masturbator, for those with impaired hand

function[1]. The speech and language therapist may be able to assist the aphasic patient to communicate sexual concerns with their partner. The psychologist could address interpersonal skills and emotional adjustment, including issues related to body image and self-perception. Goals could include providing disability specific sexual information, for example on the risk of sexual activity causing another stroke. Increasingly disability specific information is becoming available (Kaufman et al 2003, Wells 2000; Cooper and Guillebaud 1999). Goal setting may also include enabling access to any assistance available to the non-disabled population. Examples include social opportunity, privacy, erotica and the use of sex workers.

Stage 5: Referral on and advocacy

Always some issues will fall outside the disability team's role; hence, the next step is referral on. That is providing information on, or referring service users to, appropriate agencies. Referral on may not be for intensive therapy, as often quite simple issues require referral, for example to the GP for a medical review, or to a family planning clinic for contraceptive advice. Where the problem is linked to the relationship, Relate might be the option. Where it is an issue of specific sexual issues then there is the psychosexual health service. For some disabilities, referral on may be to a telephone help line, like that provided by the Spinal Injuries Association.

When referring on advocacy may be necessary. This could be highlighting unavailable or inaccessible resources. It may include offering disability expertise to the main stream service. With the service user's permission, information on their functional ability may be particularly useful. Advocacy at the simplest level may be advice on the best methods of communication for the service user. Advocacy may improve access, for example the family planning clinic doctor may agree a home consultation when she understands that a hoist, available in the home, would be necessary to enable a pelvic examination.

Further information

This paper has been prepared for submission to the International Journal of Therapy and Rehabilitation by Lorna Couldrick 💻 couldrick@btinternet.com ☎ 01424 215205

[1] See www.fpsales.co.uk or www.beecourse.com