Needs Assessment for Developing an Educational Project in the Field of Sexuality and Intimacy in Occupational Therapy

Hadassah Fortinsky, Ofra Shaham

Hadassah Fortinsky, MA, OT, Reuth Medical Rehabilitation Center, Masters Student, Department of Occupational Therapy, School of Health Professions, Tel Aviv University. hadassah.fortinsky@gmail.com

Ofra Shaham, PhD, LMFT, Department of Occupational Therapy, School of Health Professions, Tel Aviv University.

Key words: staff attitudes, communication barriers, sexual activity, occupational therapy, sexuality

Abstract

Background: Sexuality, an essential part of human health, is part of sexual function within the domain of activities of daily living according to the occupational therapy practice framework. While patients report sexuality as an important issue in rehabilitation, research shows that health professionals, including occupational therapists (OT's), report both discomfort with communication and lack of knowledge about sexuality. The purpose of the needs assessment was to evaluate the attitudes, knowledge levels, and skill requirements of physical rehabilitation OT's. **Method:** A needs assessment was performed (N=53 OT's), using an online and written questionnaire, to explore attitudes, knowledge and learning needs regarding sexuality in rehabilitation patients. **Results:** Analysis of the questionnaire showed that although 85% of the respondents attributed a high level of importance to discussing sexuality, 87% reported having low levels of knowledge and felt uncomfortable discussing sexuality with patients. Respondents expressed both a need to practice communication with patients and increase their knowledge about sexuality. To address their learning needs, respondents rated a lecture series and practice sessions as having the potential to be most useful. **Conclusions:** The present needs assessment identifies limitations within OT education regarding intervention in the domain of sexuality with patients. Considering the results, a three part seminar was developed to be conducted subsequent to this study. The seminar includes both information and experiential components to enhance the learning and skill development necessary to address sexuality with patients in physical rehabilitation.

This article was written as part of the requirements for completing a master's degree in the project track in the Department of Occupational Therapy, Tel Aviv University, under the supervision of Dr. Ofra Shaham.

The main message: A survey of occupational therapists knowledge and comfort level about sexuality was performed. The needs assessment found that the lack of knowledge and tools about sexuality created a barrier to communication and implementation of sexuality into practice. As a result of the needs assessment a seminar for OT's was designed.

Background

Sexuality is an essential part of human health. Both sexuality and intimacy are broad topics and can be defined in many ways. The World Health Organization (WHO) defines sexuality as "a central aspect of being human throughout life … and is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviors, practices, roles and relationships" (WHO, 2010). Intimacy adds another dimension and it is defined as having "a situation in which you have a close friendship or sexual relationship with someone" (Intimacy, 2018). Although often an inherent part of sexuality, intimacy is discussed in the literature often in contexts where sexual activity is limited due to illness or disability (Benoot, Saelaert, Hannes, & Bilsen, 2017). In line with current views on the definition of health, the International Classification of Diseases defines health as "a state of complete physical, mental and social well-being" (WHO, 2001). When illness occurs and a person is required to undergo physical rehabilitation, there is usually a significant decrease in their well-being and functional status (Inouye et al., 1993). As part of health restoration, through the process of rehabilitation, the issues of sexuality and intimacy would be expected to be part of the overall intervention process.

Indeed, several studies illustrate the importance of sexuality in the realm of rehabilitation. A study on men with spinal cord injuries (SCI) found that 27% of men reported sexual adjustment difficulties, 74% relationship difficulties and yet only 22% received counseling (Alexander, Sipski, & Findley, 1993). In women with SCI, 69% were satisfied with their post injury sexual activity, but they were not content with the information provided during rehabilitation and felt a need for professional intervention (Charlifue, Gerhart, Menter, Whiteneck, & Manley, 1992). In Rosenbaum, Vadas and Kalichman's (2014) study on sexuality after stroke they noted a decrease in sexual satisfaction post-stroke and more importantly, called on rehabilitation specialists, including occupational therapists, to receive training in addressing

sexuality in the treatment of post-stroke patients. These topics are not a commonly discussed with the patients (Dyer & das Nair, 2013). Occupational therapists can play a vital role in facilitating patients in rehabilitation to deal with basic issues of sexuality and intimacy that arise during the rehabilitation process (Andamo, 1980).

Literature survey

Given the paucity of literature on sexuality and rehabilitation in occupational therapy, themes from the literature of different health professionals will first be examined followed by knowledge from the OT literature. The literature shows that for three decades the topic of sexuality in rehabilitation suffered from a lack of discussion (Glass, 1995; Rosenbaum, Vadas, & Kalichman, 2014; Zwerner, 1982). Health professionals surveyed neither initiated conversations with their patients nor felt comfortable with topics of sexuality and intimacy in the rehabilitation setting. Indeed, a systematic review by Dyer and das Nair (2013) had the title "Why don't healthcare professionals talk about sex?". Their review of eight studies in the UK found several important themes. They found that while health care professionals reported that they felt it was important to discuss sexuality with patients, in practice it was not routinely discussed. The article identifies studies that showed three reasons for the lack of the discussion. The first was that initiating a discussion about sexuality with patients was akin to opening a pandora's box, indicating that the area is considered partially unknown to the health professionals (Gott, Galena, Hinchliff, & Elford, 2004; Rubin, 2005; Stead, Brown, Fallowfield, & Selby, 2003). The second reason was that the health professionals explained that administrative issues such as lack of time, resources and privacy prevented them for bringing up this sensitive topic (Gott, Galena, Hinchliff, & Elford, 2004; Gott, Hinchliff, & Galena, 2004; Hinchliff, Gott, & Galena, 2004; Hinchliff, Gott, & Galena, 2005; Rubin, 2005; Stead, Brown, & Followfield, 2002). The final reason was the lack of experience and expertise felt by the health professionals on the topic of sexuality. An additional study where 66% of patients in a cardiac setting responded that sexuality was never discussed with them, concluded that one of the main reasons the lack of a private place for the discussion to take place (Byrne, Doherty, Murphy, McGee, & Jaarsma, 2013).

Other studies suggested that communication barriers were due to several factors including the perceived discomfort of the patient in initiating and discussing sexuality related issues as well as the patient's ethnicity (Helland, Garratt, Kjeken, Kvien, & Dagfinrud, 2013; Shavit-Buckley, 2008). Hinchliff, Gott, & Galena (2005) point to the specific population of gay and lesbian patients, whose family physicians

felt unfamiliar with their specific needs and therefore were reluctant to discuss sexuality issues with them. Another reason for the communication barrier may be due to the lack of preparation health professionals received during their academic studies. Several studies found lack of training during the academic careers of nursing and occupational therapy students and other health care professionals contributed to the difficulty in initiating the topic with patients (Areskoug-Josefsson, Larsson, Gard, Rolander, & Juuso, 2016; Helland, Garratt, Kjeken, Kvien, & Dagfinrud, 2013). Additional studies confirmed that these findings also hold true in the geriatric population where both patients and health professionals feel uncomfortable discussing issues of sexuality (Bauer & Fetherstonaugh, 2016). It is interesting to note that despite the lack of communication with patients about sexuality reported in the literature and the communication barriers described above, health professionals surveyed repeatedly expressed the importance discussing the issue with their patients (Hautamäki, Miettinen, Kellokumpu-Lehtinen, Aalto, & Lehto, 2007; Haboubi & Lincoln, 2003; Lindau et al., 2007).

One noted exception within the field of rehabilitation medicine is in the specialty of spinal cord (SCI) rehabilitation. Many articles have been written covering the issue of sexuality and SCI, going back even as far as the 1960's (Anderson, 2004; Deforge et al., 2006; Hanson & Franklin, 1976; Otero-Villaverde et al.,2015; Suwanwela, Alexander Jr., & Davis Jr, 1962). Specific assessments of sexuality after SCI exist and scales on attitudes and comfort levels of discussing sexuality with patients were designed for the patient and professional population of those with SCI (Kendall, Booth, Fronek, Miller, & Geraghty, 2003). Reasons for this gap between discussing and treating SCI's versus other areas of medicine and rehabilitation are not specified in the literature. It can be speculated that because of the neurological assessment of bowel and bladder control, and therefore implied sexual function, standardized assessment of SCI somehow forces the staff to acknowledge the issue of sexual function (Marino et al., 2003). Though sexual function includes but does not encompass the area of sexuality, it may provide a starting point for discussion with patients, which the literature above showed is currently still challenging for many health care professionals.

Sexuality and Occupational Therapy

Occupational therapy in the United States bases practice on the guidelines set out in the Occupational Therapy Practice Framework (OTPF, 2014). In Israel it is based on the Mata'm, the Israeli Occupational Practice framework (MATAM committee, 2016). In both frameworks, sexuality appears only in

the form of sexual activity as part of Basic Activities of Daily Living (BADL). Sexual function in the Israeli practice framework is defined as "engaging in activities that result in sexual satisfaction and/or as a means to fertility" (American Occupational Therapy Association, 2008; MATAM committee, 2016). This definition appears to be limited when compared to the definition of sexuality defined by the WHO as discussed above. This gap between the definition in the frameworks of practice in occupational therapy and the broader definition of sexuality shows a wide gap that reflects the role of the occupational therapist and sexuality in Israel today.

In the Hebrew occupational therapy literature, no articles were found on sexuality in the area of adult physical rehabilitation. The occupational therapy literature in English on sexuality has several foci. Some articles reiterate the frustration found by other health professionals regarding the lack of knowledge and skills to interact and assist patients in the area of sexuality in rehabilitation (Agnew, Poulsen, & Maas, 1985; Conine, Christie, Hammond, & Smith, 1979). Several publications review the role of occupational therapists in providing and adapting assistive devices for sexual activity (Kennedy, 1987; Taylor, 2011). Another researcher designed a decision tree to assess the capacity for the geriatric institutionalized population to participate in intimate relationships (Lichtenberg, 2014). This article was cited by other researchers possibly due to the heightened understanding of sexuality in the geriatric population based on Lindau et al.'s comprehensive study in 2007 and due to the challenge of the cognitive decline in the institutionalized population (Lindau et al., 2007). Bernadette Hattjar (2012) compiled an entire book "Sexuality and occupational therapy: Strategies for persons with disabilities", in which she covers occupational therapy approaches to dealing with different medical conditions and their effect on sexual function and sexuality. Sakellariou & Algado (2006) specifically discuss the difficulty occupational therapists have in discussing sexuality with patients. The attitudes and beliefs regarding sexuality in people with disabilities of either occupational therapists or occupational therapy students were assessed in several articles (Agnew, Poulsen, & Maas, 1985; Areskoug-Josefsson, Larsson, Gard, Rolander, & Juuso, 2016; Lohman, Kobrin, & Chang, 2017). Much of the literature concluded that changes in attitudes and beliefs of occupational therapists will allow the therapists to be more involved in dealing with sexuality with their patients (Whitney & Fox, 2017).

Other articles outline further developments of the role of occupational therapists in sexuality. Miller (1984)

describes the role of the occupational therapist as part of the Sexual Health Service in a spinal cord rehabilitation team and in 2017 an article was published outlining the intervention of an occupational therapist with a cancer patient (Braveman, Hunter, Nicholson, Arbesman, & Lieberman, 2017). In addition to these descriptions of occupational therapy interventions, there are occupational therapists who are part of multi-disciplinary teams receiving training to address the sexuality needs of patients in rehabilitation (Higgins et al., 2012; Simpson, Anwar, Wilson, & Bertapelle, 2006).

While the overall literature on sexuality and occupational therapy is sparse, the literature search found even fewer on intimacy. Articles on intimacy discuss the need for adults to touch and feel close to other individuals without the necessity of a sexual relationship (Lichtenberg, 2014). The importance of touch is especially important in those with limited mobility and difficulty with sexual performance (Taylor, 2011). In the above article the effect of assistive devices on intimacy is examined. Benoot, Saelaert, Hannes and Bilsen (2017) discuss the discovery process couples go through when dealing with sexuality after cancer (2017). They found that intimacy was an important factor in readjusting to the cancer-related changes that affected their ability to be sexually active prior to having cancer.

Considering the above described lack of information and level of discomfort by occupational therapists in physical rehabilitation a survey was designed. The purpose of the survey was to discover Israeli occupational therapist's level of knowledge, comfort level and learning needs regarding sexuality in physical rehabilitation. This was the second phase of the needs assessment.

Method

A needs assessment was performed to assess the potential role of occupational therapists in Israel regarding sexuality and intimacy in the physical rehabilitation. The primary purpose of the needs assessment was to gather information from Israeli health care professionals and assess their knowledge and attitudes towards dealing with the issue of sexuality and intimacy in rehabilitation. In addition, the needs assessment surveyed the reasons that health care professionals do not raise the issue with their patients. A second purpose of the needs assessment was to map out a potential program to encourage increased discussion and attention given to sexuality and intimacy during the physical rehabilitation process.

Three phases of a needs assessment were performed, as recommended by Altschuld and Witkin (2000): pre-assessment, assessment and post-assessment. The

pre-assessment included a literature review as presented above, of the present situation of professionals and patient's encounter with sexuality in general and physical rehabilitation in particular. A special emphasis was placed upon searching for details regarding the Israeli experience. The assessment consisted of both an online and pen-and-paper survey with 53 occupational therapists. The post-assessments comprised an analysis of the findings and the development of a program based on the findings. This paper will describe the 3 stages of the process of the needs assessment conducted as part of the requirements for completing the Master's degree program in occupational therapy at Tel Aviv University.

The questions of the survey were inspired by a questionnaire for use by health care professionals working in SCI rehabilitation called the "Knowledge, Comfort, Approach and Attitudes towards Sexuality Scale" (Kendall, 2003). The original survey was designed to be filled out by all health professionals in order to gather information about the topic of sexuality in spinal cord rehabilitation. The researcher modified the questions to suit the general physical rehabilitation population and to shorten the questionnaire from 47 to 20 questions. The researcher applied and received approval from the Helsinki committee at Reuth Medical and Rehabilitation Center to distribute a paper-and-pen modified version of the questionnaire to all health professionals at the center. In addition, the identical questionnaire was posted on relevant social media sites to be filled out by healthcare professionals online. After both the online and written surveys were completed the researcher decided to analyze the data exclusively from the occupational therapists in order to address the unique needs of occupational therapists.

The survey consisted of 20 questions. All questions had closed answers, with an option for comments. Profession, age and years of practice in the profession were the first three questions. A copy of the full questionnaire is attached as an appendix (appendix 1). To summarize, the questionnaire consisted of questions on the subjective knowledge level of health professionals on sexuality in rehabilitation, on attitudes towards sexuality and on comfort levels - all based on a 5-point likert scale. In addition, three questions offered lists of reasons for the respondents' lack of discussion with patients, and suggestions for encouraging more discussion with patients. All together 53 occupational therapists responded. Results from the written surveys were tallied with online results into one data set.

Results

The results showed that 33% of the OT's

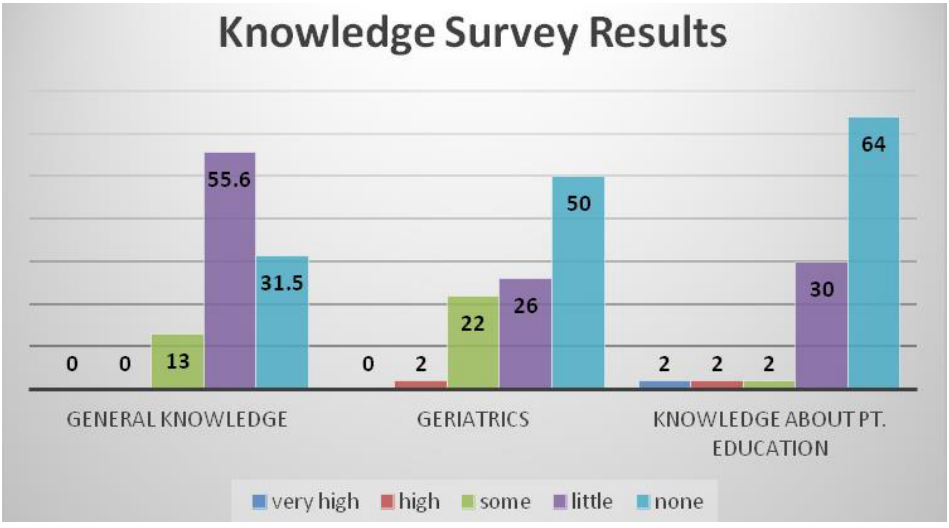

Figure 1. Self-reported levels of types knowledge of sexuality in rehabilitation (percentage of respondents)

had 1-4 years of work experience in rehabilitation, 43% had 5-9 years and 24% over 10 years of experience. When asked about how much knowledge the OT's felt they had about sexuality and rehabilitation, 87% of respondents stated that they had little or no knowledge about sexuality in rehabilitation, 78% had little or no knowledge of sexuality within geriatrics. More than 90% of OT's answered that they had little or no knowledge on sexuality education or guidance for their patient population (figure 1).

Regarding comfort level with discussing sexuality with patients in rehabilitation, 68% of OT's answered very low or low levels of comfort and 24% felt comfortable. Forty percent responded that they would be uncomfortable if patients were to raise the issue of sexuality with them (figure 2 for more detail).

Considering the high levels of discomfort and low levels of self-reported knowledge it is interesting to note that 85% of respondents agreed that it was important to discuss sexuality with patients in rehabilitation. When asked what would be most helpful to increase communication about sexuality there were many positive responses to suggestions proposed in the questionnaire (Figure 3). Eighty seven percent said they would like to learn more about sexuality, 83% said they would like to learn how to talk about sexuality and 79% said they would like tools to deal with the topic of sexuality with patients.

In light of the high numbers who agree that sexuality is an important topic the author designed a seminar about sexuality in rehabilitation for occupational therapists.

Discussion

The results from the survey reflected findings in other research studies regarding attitudes of health professionals in sexuality. This survey added to the current knowledge by focusing on the attitudes and knowledge levels of occupational therapists in Israel and in the area of physical rehabilitation. Results showed that many of the occupational therapists surveyed agreed that discussing intimacy and sexuality was an important part of physical rehabilitation, and were interested in receiving more information in this area. A variety of modes of education were offered in the survey and the highest ranking were those of learning groups and how-to-talk training.

Recommendations

The rationale for designing a seminar to deal with the issue of communication about sexuality in physical rehabilitation in Israel was based on the results of the survey discussed above. As a follow up to the proposed education training program, a research study examining the efficacy of the training program on comfort and knowledge levels of occupation therapists is recommended. In addition, the study may show the strengths and weaknesses of the different modes of information used in the education training program in order to refine the program for future use.

The seminar has 4 goals based on a sexuality education program developed in Holland for the health professional team (Gianotten, Bender, Post, & Höing, 2006): The results of the training program cited above showed an increase in the health professionals' relevant knowledge, in their ability to recognize patients' sexual problems and in their skills in broaching and discussing sexual issues. Most impressive to note is that these improvements had not diminished at the follow-up measurement. The 4 goals are:

1. To enable occupational therapists to feel comfortable discussing sexuality and intimacy with patients in physical rehabilitation.
2. Occupational therapists will recognize signals indicating concerns regarding sexuality in their work with patients.
3. To enable occupational therapists to use professional tools to deal with sexuality and sexual issues with patients in physical rehabilitation.
4. To teach occupational therapists to recognize cases that require referral to other health professionals regarding the issues of sexuality and intimacy.

A 3-part seminar was designed whereby

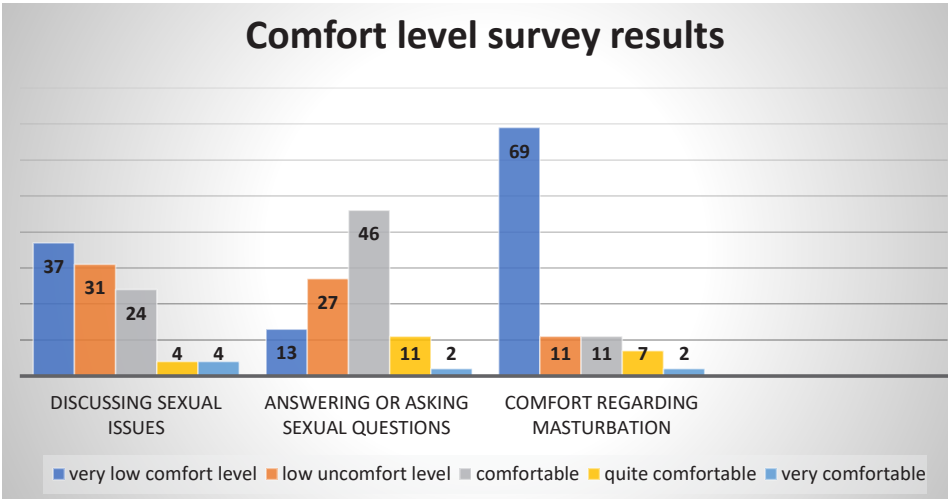

Figure 2. Comfort level regarding discussing and thinking about sexual issues (percentage of repsondents)

the occupational therapists would both learn and experience dealing with topics of sexuality relevant to physical rehabilitation. A psycho-educational approach to the seminar is necessary due to the gap in knowledge, while an experiential component will allow all participants the opportunity to actually talk about sex. Several topics will be covered in the seminar in a specific order to enable the occupational therapist time to process the new material and their potentially new role in their clinical work.

First, information about sexuality will be taught and discussed using theoretical material and opportunities for personal reflection. Concepts on sexual function and dysfunction will be introduced to allow the therapist increased knowledge regarding sexuality. The effect of different impairments on sexuality and sexual functioning will be covered (Hattjar, Parker, & Lappa, 2008). Interviewing and listening skills will be practiced throughout, with specific focus on the topic of sexuality and through the use of the theoretical model PLISSIT, acronym for Permission, Limited Information, Selective Suggestions and Intensive Treatment, to guide the process (Annon, 1976). The PLISSIT is a widely used model by psychologists, social workers and sex therapistsin the area for intervention in rehabilitation and sexuality (Taylor & Davis, 2007). It is a graded approach based on the individual's needs for information and intervention. The basic levels (permission, limited information and selective suggestions) can be used

by all health professionals to address sexuality and the more advanced level (intensive treatment) is for specially trained professionals in the area of sexuality. Finally, in order to integrate the information, theoretical frameworks for occupational therapy intervention in sexuality will be introduced in order to put into context the role of the occupational therapist regarding sexuality (Kennedy, 1987; McGrath & Sakellariou, 2016). There will be role playing and simulated discussions between therapist and patient about sexual issues. To measure changes in attitudes and comfort levels in the participants as a result of the seminar, a pre and post seminar questionnaire will be distributed.

There are several advantages to using the design of a three part seminar for sexuality training. The seminar allows learning in several modalities. Studies have shown that learning is enhanced when a variety of methods such as frontal instruction, active participation and practice are part of the process (Jung, Choi, Lim, & Leem, 2002; Pearson & McLafferty, 2011; Torke, Quest, Kinlaw, Eley, & Branch, 2004). It is hoped that will then lead to a possible change in attitudes and knowledge level of the participants as shown in the Holland program described above (Gianotten, Bender, Post, & Höing, 2006). The idea of dividing the seminar into 3 parts allows time between the different parts of the seminar for the therapist to practice skills. To increase awareness of attitudes it is necessary to allow time in order integrate the new knowledge acquired as well as reflect on the material. The use of a seminar will serve to broaden the number of occupational therapists incorporating sexuality in their clinical practice in addition to publicizing the role of occupational therapists in the area of sexuality.

A client centered approach is always maintained throughout the seminar as is recommended in many areas of practice regarding changing attitudes and behaviors in health care (Gavin et al., 2014; Townsend & Polatajko, 2007). This approach has been shown to be effective in eliciting change by encouraging more active participation, assisting each therapist in goal setting in the seminar and fostering a better understanding of the patient's disabilities (Phipps & Richardson, 2007; Sumsion, 2005; Wressle, Eeg-Olofsson, Marcusson, & Henriksson, 2002).

Summary

Discomfort, lack of knowledge and differing attitudes contribute to the current practice of occupational therapy in Israel that rarely includes dealing with patient sexuality and intimacy. The goal of the article was to present a needs assessment performed on occupational therapists regarding their attitudes, level of knowledge and comfort in the area of sexuality in

Figure 3. Occupational therapists report what would be of assistance regarding patient communication (percentage of respondents - more than 1 answer was accepted)

physical rehabilitation. Further questions asked the therapists to record ways than would enable them to communicate with their patients about sexuality. The needs assessment was summarized and results pointed to a need to fill the gap in practice and comfort level in discussing patient sexuality. Additionally, therapists indicated a need for practical tools to treat sexual issues related to occupational therapy. A three-part seminar was developed for occupational therapists that would include both information and practical experiential activities to familiarize therapists with the attitudes and language of sexuality and to practice discussing the topic with patients. Studies have not yet been done to assess the efficacy of the seminar. To assess the seminar, currently available questionnaires can be adapted for use before and after or a questionnaire can be designed which is more specific to the Israeli occupational therapist population. In addition, a retrospective assessment of patient medical charts could see whether the topic of sexuality was part of the intervention of occupational therapy in the rehabilitation setting. The seminar has the potential to be adapted for other health professionals based on the literature findings that many other health professionals report difficulties in communicating with patients about sexuality. It is hoped that the knowledge gained from the needs assessment and educational program on sexuality, will contribute to the holistic practice of occupational therapy.

References

ועדת המתע"מ המחודש (2016). *העשייה המקצועית בריפוי בעיסוק בישראל - מרחב ותהליך*. תל אביב: העמותה הישראלית לריפוי בעיסוק.

Agnew, P. J., Poulsen, A., & Maas, F. (1985). Attitudes and knowledge of occupational therapy clinicians and students regarding the sexuality of disabled people. *Australian Occupational Therapy Journal, 32*(2), 54-61.

Altschuld, J. W., & Witkin, B. R. (2000). *From needs assessment to action: Transforming needs into solution strategies*. USA: Sage.

Alexander, C. J., Sipski, M. L., & Findley, T. W. (1993). Sexual activities, desire, and satisfaction in males pre-and post-spinal cord injury. *Archives of Sexual Behavior, 22*(3), 217-228.

Andamo, E. M. (1980). Treatment model: Occupational therapy for sexual dysfunction. *Sexuality and Disability, 3*(1), 26-38.

Anderson, K. D. (2004). Targeting recovery: priorities of the spinal cord-injured population. *Journal of Neurotrauma, 21*(10), 1371-1383.

Annon, J. S. (1976). The PLISSIT model: A proposed conceptual scheme for the behavioral treatment of sexual problems. *Journal of Sex Education and Therapy, 2*(1), 1-15.

American Occupational Therapy Association. (2014). Occupational therapy practice framework: Domain & process 3rd edition. *American Journal of Occupational Therapy, 68*, S1-S48.

Areskoug-Josefsson, K., Larsson, A., Gard, G., Rolander, B., & Juuso, P. (2016). Health care students' attitudes towards working with sexual health in their professional roles: survey of students at nursing, physiotherapy and occupational therapy programmes. *Sexuality and Disability, 34*(3), 289-302

Braveman, B., Hunter, E. G., Nicholson, J., Arbesman, M., & Lieberman, D. (2017). Occupational Therapy Interventions for Adults with Cancer. *American Journal of Occupational Therapy, 71*(5), 7105395010p1-7105395010p5.

Bauer, M., Haesler, E., & Fetherstonhaugh, D. (2016). Let's talk about sex: older people's views on the recognition of sexuality and sexual health in the health-care setting. *Health Expectations, 19*(6), 1237-1250.

Buckley, K. (2008). *The Relationship Between Occupational Therapists' Knowledge, Comfort Level, and Frequency of Addressing Sexuality in Stroke Rehabilitation.* Unpublished

master's thesis, D'Youville College, Buffalo, NY.

Byrne, M., Doherty, S., Murphy, A. W., McGee, H. M., & Jaarsma, T. (2013). Communicating about sexual concerns within cardiac health services: Do service providers and service users agree?. *Patient education and counseling, 92*(3), 398-403.

Campbell, J., Gilmore, L., & Cuskelly, M. (2003). Changing student teachers' attitudes towards disability and inclusion. *Journal of Intellectual and Developmental Disability, 28*(4), 369-379.

Charlifue, S. W., Gerhart, K. A., Menter, R. R., Whiteneck, G. G., & Manley, M. S. (1992). Sexual issues of women with spinal cord injuries. *Spinal Cord, 30*(3), 192.

Conine, T. A., Christie, G. M., Hammond, G. K., & Smith, M. F. (1979). An assessment of occupational therapists' roles and attitudes toward sexual rehabilitation of the disabled. *The American Journal of Occupational Therapy 33*(8), 515-519.

Deforge, D., Blackmer, J., Garritty, C., Yazdi, F., Cronin, V., Barrowman, N., ... & Moher, D. (2006). Male erectile dysfunction following spinal cord injury: a systematic review. *Spinal Cord, 44*(8), 465.

Dyer, K., & das Nair, R. (2013). Why don't healthcare professionals talk about sex? A systematic review of recent qualitative studies conducted in the United Kingdom. *The Journal of Sexual Medicine, 10*(11), 2658-2670

Gavin, L., Moskosky, S., Carter, M., Curtis, K., Glass, E., Godfrey, E., ... & Zapata, L. (2014). Providing quality family planning services: recommendations of CDC and the US Office of Population Affairs. *Morbidity and Mortality Weekly Report: Recommendations and Reports, 63*(4), 1-54.

Gianotten, W. L., Bender, J. L., Post, M. W., & Höing, M. (2006). Training in sexology for medical and paramedical professionals: a model for the rehabilitation setting. *Sexual and Relationship Therapy, 21*(3), 303-317.

Glass, C. A. (1995). Addressing psychosexual dysfunction in neurological rehabilitation settings. *Journal of Mental Health, 4*(3), 251-260.

Gott M, Galena E, Hinchliff S., & Elford H. (2004) "Opening a can of worms": GP and practice nurse barriers to talking about sexual health in primary

care. *Family Practice, 21*, 528–36.

Gott, M., Hinchliff, S., & Galena, E. (2004). General practitioner attitudes to discussing sexual health issues with older people. *Social Science & Medicine, 58*(11), 2093-2103.

Haboubi, N. H. J., & Lincoln, N. (2003). Views of health professionals on discussing sexual issues with patients. *Disability and Rehabilitation, 25*(6), 291-296.

Hanson, R. W., & Franklin, M. R. (1976). Sexual loss in relation to other functional losses for spinal cord injured males. *Archives of Physical Medicine and Rehabilitation, 57*(6), 291-293.

Hattjar, B., Parker, J. A., & Lappa, C. L. (2008). Addressing sexuality with adult clients with chronic disabilities: Occupational therapy's role. *OT Practice, 13*(11).

Hautamäki, K., Miettinen, M., Kellokumpu-Lehtinen, P. L., Aalto, P., & Lehto, J. (2007). Opening communication with cancer patients about sexuality-related issues. *Cancer Nursing, 30*(5), 399-40

Helland, Y., Garratt, A., Kjeken, I., Kvien, T. K., & Dagfinrud, H. (2013). Current practice and barriers to the management of sexual issues in rheumatology: results of a survey of health professionals. *Scandinavian Journal of Rheumatology, 42*(1), 20-26.

Higgins, A., Sharek, D., Nolan, M., Sheerin, B., Flanagan, P., Slaicuinaite, S., ... & Walsh, H. (2012). Mixed methods evaluation of an interdisciplinary sexuality education programme for staff working with people who have an acquired physical disability. *Journal of Advanced Nursing, 68*(11), 2559-2569.

Hinchliff, S., Gott, M., & Galena, E. (2004). GPs' perceptions of the gender-related barriers to discussing sexual health in consultations: A qualitative study. *The European Journal of General Practice, 10*(2), 56-60.

Hinchliff, S., Gott, M., & Galena, E. (2005). 'I daresay I might find it embarrassing': general practitioners' perspectives on discussing sexual health issues with lesbian and gay patients. *Health & Social Care in the Community, 13*(4), 345-353.

Intimacy. (n.d). in Cambridge Dictionary. Retrieved November 27, 2018, from https://dictionary.cambridge.org/dictionary/english/intimacy

Inouye, S. K., Wagner, D. R., Acampora, D., Horwitz, R. I., Cooney, L. M., Hurst, L. D., & Tinetti, M. E. (1993). A predictive index for functional decline in hospitalized elderly medical patients. *Journal of General Internal Medicine, 8*(12), 645-652.

Jung, I., Choi, S., Lim, C., & Leem, J. (2002). Effects of different types of interaction on learning achievement, satisfaction and participation in web-based instruction. *Innovations in Education and Teaching International, 39*(2), 153-162.

Kennedy, M. (1987). Occupational therapists as sexual rehabilitation professionals using the rehabilitative frame of reference. *Canadian Journal of Occupational Therapy, 54*(4), 189-193.

Kendall, M., Booth, S., Fronek, P., Miller, D., & Geraghty, T. (2003). The development of a scale to assess the training needs of professionals in providing sexuality rehabilitation following spinal cord injury. *Sexuality and Disability, 21*(1), 49-64.

Korpelainen, J. T., Nieminen, P., & Myllylä, V. V. (1999). Sexual functioning among stroke patients and their spouses. *Stroke, 30*(4), 715-719.

Lavin, M., & Hyde, A. (2006). Sexuality as an aspect of nursing care for women receiving chemotherapy for breast cancer in an Irish context. *European Journal of Oncology nursing, 10*(1), 10-18.

Lichtenberg, P. A. (2014). Sexuality and physical intimacy in long-term care. *Occupational Therapy in Health Care, 28*(1), 42-50.

Lindau, S. T., Schumm, L. P., Laumann, E. O., Levinson, W., O'Muircheartaigh, C. A., & Waite, L. J. (2007). A study of sexuality and health among older adults in the United States. *The New England Journal of Medicine, 357*, 762–774.

Marino, R. J., Barros, T., Biering-Sorensen, F., Burns, S. P., Donovan, W. H., Graves, D. E., ... & Priebe, M. (2003). International standards for neurological classification of spinal cord injury. *The Journal of Spinal Cord Medicine, 26*(sup1), S50-S56.

McLaughlin, J., & Cregan, A. (2005). Sexuality in stroke care: a neglected quality of life issue in stroke rehabilitation? A pilot study. *Sexuality and Disability, 23*(4), 213-226.

Miller, W. T. (1984). An occupational therapist as a sexual health clinician in

the management of spinal cord injuries. *Canadian Journal of Occupational Therapy, 51*(4), 172-175.

Otero-Villaverde, S., Ferreiro-Velasco, M. E., Montoto-Marqués, A., De La Barrera, S. S., Arias-Pardo, A. I., & Rodriguez-Sotillo, A. (2015). Sexual satisfaction in women with spinal cord injuries. *Spinal Cord, 53*(7), 557-560.

Pearson, E., & McLafferty, I. (2011). The use of simulation as a learning approach to non-technical skills awareness in final year student nurses. *Nurse Education in Practice, 11*(6), 399-405.

Phipps, S., & Richardson, P. (2007). Occupational therapy outcomes for clients with traumatic brain injury and stroke using the Canadian Occupational Performance Measure. *American Journal of Occupational Therapy, 61*(3), 328-334.

Rosenbaum, T., Vadas, D., & Kalichman, L. (2014). Sexual Function in Post-Stroke Patients: Considerations for Rehabilitation. *The Journal of Sexual Medicine, 11*(1), 15-21.

Rubin, R. (2005). Communication about sexual problems in male patients with multiple sclerosis. *Nurs Stand, 19*, 33–37.

Simpson, G., Anwar, S., Wilson, J., & Bertapelle, T. (2006). Improving the rehabilitative management of client sexual health concerns after neurological disability: evaluation of a staff sexuality training programme in New Zealand. *Clinical Rehabilitation, 20*(10), 847-859.

Sakellariou, D., & Algado, S. S. (2006). Sexuality and occupational therapy: exploring the link. *British Journal of Occupational Therapy, 69*(8), 350-356.

Stead, M. L., Brown, J. M., Fallowfield, L., & Selby, P. (2002). Communication about sexual problems and sexual concerns in ovarian cancer: a qualitative study. *Western Journal of Medicine, 176*(1), 18.

Stead, M.L, Brown, J.M., Fallowfield, L. & Selby, P. (2003). Lack of communication between healthcare professionals and women with ovarian cancer about sexual issues. *British Journal of Cancer, 88*, 666– 671.

Sumsion, T. (2005). Facilitating client-centred practice: Insights from clients. *Canadian Journal of Occupational Therapy, 72*(1), 13-20.

Suwanwela, C., Alexander Jr, E., & Davis Jr, C. H. (1962). Prognosis in spinal cord injury, with special reference to patients with motor paralysis and sensory preservation. *Journal of Neurosurgery, 19*(3), 220-227.

Taylor, B. (2011). The impact of assistive equipment on intimacy and sexual expression. *British Journal of Occupational Therapy, 74*(9), 435-442.

Taylor, B., & Davis, S. (2007). The extended PLISSIT model for addressing the sexual wellbeing of individuals with an acquired disability or chronic illness. *Sexuality and Disability, 25*(3), 135-139.

Torke, A. M., Quest, T. E., Kinlaw, K., Eley, J. W., & Branch, W. T. (2004). A workshop to teach medical students communication skills and clinical knowledge about end-of-life care. *Journal of General Internal Medicine, 19*(5), 540-544.

Townsend, E. A., & Polatajko, H. J. (2007). Advancing an occupational therapy vision for health, well-being, and justice through occupation. *Ottawa, ON: CAOT Publications ACE.«Enabling Occupation II présente une vue en coupe tranversale du MCRO-P pour définir et délimiter le domaine de préoccupation des ergothérapeutes, c'est-àdire l'occupation humaine.*

Whitney, R. V., & Fox, W. W. (2017). Using reflective learning opportunities to reveal and transform knowledge, attitudes, beliefs, and skills related to the occupation of sexual engagement impaired by disability. *The Open Journal of Occupational Therapy, 5*(2), 8.

World Health Organization. (2001). International Classification of Functioning, Disability and Health: ICF. World Health Organization.

World Health Organization, 2010. Developing sexual health programmes: a framework for action. Geneva. (WHO/RHR/HRP/10.22; http://whqlibdoc.who.int/hq/2010/WHO_RHR_HRP_10.22_eng.pdf, accessed 28 January 2015)

Wressle, E., Eeg-Olofsson, A. M., Marcusson, J., & Henriksson, C. (2002). Improved client participation in the rehabilitation process using a client-centred goal formulation structure. *Journal of Rehabilitation Medicine, 34*(1), 5-11.

Zwerner, J. (1982). Yes we have troubles but nobody's listening: sexual issues of women with spinal cord injury. *Sexuality and Disability, 5*, 158-171.

11. איך היית מרגיש אם מטופל/ת היה מעלה תכנים לא תואמים כלפייך?

1 2 3 4 5

1= לא נוח בכלל 5= מאד נוח

12. האם יש לך משהו להוסיף הנוגע לתחושת חוסר נוחות הקשורה למיניות?

_____

השאלות הבאות קשורות לעמדות שלך לגבי מיניות

13. מיניות זה רק נושא לרופא או פסיכולוג:

1 2 3 4 5

1= מאד מסכים 5= מאד לא מסכים

14. מה החשיבות של העיסוק במיניות בתהליך השיקום?:

1 2 3 4 5

1=לא חשוב כלל 5=מאד חשוב

15. האם מטופלים מעלים את נושא המיניות בנוכחותך?

1 2 3 4 5

1=אף פעם 5=הרבה

16. האם את/ה מעלה את נושא המיניות בשיקום עם מטופל?

1 2 3 4 5

1=אף פעם 5=הרבה

17. מה מונע ממך מלהעלות את נושא המיניות? (אפשר יותר מתשובה אחת):

אין מקום שקט לדבר
אני לא מומחה - לא פונים אלי
מיניות לא חשובה למטופלים
זה לא לעניין באשפוז שיקומי
אין לי מספיק ידע/מידע
הם קשישים/זקנים - זה לא כל כך חשוב להם
בן/בת זוג בקשו לא לדבר על זה
אין לי ניסיון לדבר על זה
המטופל רווק או אין צורך לדבר על זה
אחר _____

18. מה יעזור לך להעלות את הנושא עם מטופלים?

מקום שקט לדבר
הדרכה - על איך מדברים על זה
כלים - איך עוזרים למטופלים
שמות של אנשי צוות מומחים בנושא
ללמוד יותר על הנושא של מיניות בשיקום
שזה יהיה חלק מהאנמנזה/טופס קבלה
שזה יהיה חלק מישיבות צוות רב-מקצועיות על מטופלים
תרגולים עם הדרכה על "איך לדבר על הנושא"
אחר_____

19. אם מדובר בללמוד/לקבל כלים/ הדרכה, איך הכי טוב לך?

קבוצה קטנה של הדרכה
הרצאה אחת
סדרה של הרצאות
תרגול של שיחה ומתן מידע ומשוב
חומר לקריאה בחוברת או מחשב
סרט וידיאו של הדרכה
לימוד משותף עם אנשי צוות
סימולציות של שיחה עם מטופל

20. איך ומתי הכי טוב לדבר על מיניות עם מטופלים?

_____

תודה על השתתפותך במילוי הסקר

Appendix 1

Sexuality in rehabilitation survey - in hebrew

שאלון על מיניות ואינטימיות בשיקום

אני מודה לך מאוד על השתתפותך. הנך מתבקש להשיב על שאלון העוסק ב"מיניות ואינטימיות בשיקום".

המידע חסוי, והנתונים אשר יאספו במסגרתו יישמרו בידי עורך המחקר בלבד ויסומנו בקוד מספרי ללא שם מזהה. לא יתבצע בנתונים כל שימוש מלבד צרכי מחקר הנוכחי. זכותך לסרב להשיב על השאלונים כעת או בכל זמן אחר. אורכו של מילוי השאלונים הוא כ-15-25 דקות. הפריטים שיופיעו לפניך בשאלונים מנוסחים בלשון זכר ומיועדים לנשים ולגברים כאחד. בכל שאלה, הנך מוזמן לפנות לחוקר, חנה קרפין ו/או הדסה פורטינסקי באמצעות כתובת המייל או הנייד. מילוי השאלונים מאשר/ת כי הבנת את המידע שלעיל והסכמת מרצונך להשיב על השאלונים. השאלון מיועד לאנשי מקצועות הבריאות בנושא מיניות ואינטימיות בשיקום.

1. כמה שנים את/ה עובד/ת בשיקום?
א. 0-4
ב. 5-10
ג. 10+

2. מה המקצוע שלך?
רפואה/סיעוד/ריפוי בעיסוק/פיזיותרפיה/עבודה סוציאלית/פסיכולוגיה/קלינאות תקשורת/ אחר_____

3. כמה מידע יש לך על מיניות בשיקום?:
1 2 3 4 5
1= מעט מידע 5= הרבה מידע

4. כמה מידע אתה/ה מעריך/ה שיש לך על ההשפעה של מצב רוח ירוד על מיניות?
1 2 3 4 5
1= מעט מידע 5= הרבה מידע

5. כמה ידע יש לך על מיניות בגיל 65+?:
1 2 3 4 5
1= מעט מידע 5= הרבה מידע

6. כמה מידע את/ה מעריך/ה שיש לך על התנהגויות מיניות לא תואמות? (מטופלים מדברים בקול רם על מיניות, הערות מיניות לצוות וכו'):
1 2 3 4 5
1= מעט מידע 5= הרבה מידע

7. כמה מידע את/ה מעריך/ה שיש לך בהדרכה בתחום מיניות ?:
1 2 3 4 5
1= מעט מידע 5= הרבה מידע

8. האם את/ה מרגיש/ה בנוח לשאול או לענות לשאלות של מטופלים הקשורות למיניות?
1 2 3 4 5
1= לא נוח בכלל 5= מאד נוח

9. אם לא נוח לך, למה?:
_____

10. איך היית מרגיש/ה אם היית נכנס לחדר ורואה מטופל מאונן?:
1 2 3 4 5
1= לא נוח בכלל 5= מאד נוח