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Occupational Therapists' Perspectives on Psychosocial Treatment  
of Sexual Dysfunction with Mental Health Patients

by

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Advisor: Carla Wilhite, OTD, OTR/L

An Independent Study

Submitted to the Occupational Therapy Department

of the

University of North Dakota

in partial fulfillment of the requirements

for the degree of

Master's of Occupational Therapy

Grand Forks, North Dakota  
May 2010

Approval Page

This Independent Study, submitted by Brittany Siefert and Joseph Troudt in partial fulfillment of the requirement for the Degree of Master's of Occupational Therapy from the University of North Dakota, has been read by the Faculty Advisor under whom the work has been done and is hereby approved.

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Faculty Advisor

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Date

PERMISSION

**Title:** Occupational Therapists' Perspectives on Psychosocial Treatment of Sexual Dysfunction of Mental Health Patients

**Department:** Occupational Therapy

**Degree:** Master's of Occupational Therapy

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## ABSTRACT

Siefert, B., Troudt, J., & Wilhite, C. (2010, May). Occupational Therapists' Perspectives on Psychosocial Treatment of Sexual Dysfunction with Mental Health Patients.

**Purpose:** The purpose of this study is to investigate the perceptions of mental health occupational therapists about psychosocial treatment of sexual dysfunction with clients in psychiatric facilities.

**Methods:** Using qualitative methodology, student researchers interviewed six occupational therapists practicing in psychiatric settings as part of an exploratory study into the perceptions of clinicians about treatment of sexual dysfunction with people who have mental health disabilities. Semi-structured interviews utilized open-ended questions. Electronic recording of interviews was conducted and verbatim transcripts were created. Data was analyzed and emergent codes and themes were developed.

**Results:** Three themes emerged related to: scope of practice, perceived barriers, and client-centeredness during treatment in psychosocial practice.

**Discussion:** The results have implications for future practice among mental health practitioners treating sexual dysfunction. Occupational therapists agree it is within the scope of practice to address sexual dysfunction as it relates to the occupational therapy practice framework. However, therapists were not congruent about the actual implementation within their respective clinical practice settings. Treatment models that may be applicable to psychosocial settings are discussed.



## CHAPTER I

### INTRODUCTION

Sexual dysfunction is an impairment that affects both males and females as a result of a mental or physical impairment. Sexual dysfunction is a problem that interferes with the initiation, consummation, or satisfaction of sex (Davidson, 2009). For many, it is influenced by illness and effects of medication (Bancroft et al., 2008). As the orienting framework used by occupational therapists to guide practice, the Occupational Therapy Practice Framework: Domain and Process (AOTA, 2008) considers sexual activity an activity of daily living and within the scope of practice of occupational therapists when disruption of occupational functioning impacts sexual activity.

The stem of the problem originated in a psychosocial case report by a fellow occupational therapy student who reported working in an inpatient psychiatric facility with a client who was depressed and had attempted suicide because he was distressed about the sexual side effects of his anti-depressant medications and the subsequent effect on his marital relationship. Yet the client received no treatment planning in regard to his primary concern.

After discussing the case, it was hypothesized that mixed messages are given within the practice of occupational therapy in regard to treating sexual participation as an activity of daily living for persons with physical disabilities, and even more so for clients with psychiatric disabilities. A review of the literature confirms the former case; however

a paucity of literature exists for the latter. Therefore, it was deemed necessary to conduct a phenomenological study of the perceptions of psychosocial occupational therapists working with clients who experience disruption to sexual participation because of psychiatric or mental health issues.

The following chapters will further illustrate a need to investigate psychosocial treatment of sexual dysfunction with mental health patients, as well as reporting the results found in the study. The literature review highlights aspects of occupational therapy practice in regard to sexual dysfunction. The methodology describes the phenomenological design used by the researchers as well as methods used to validate study results. The results section describes the data collected from the participants. Lastly, the discussion section highlights issues of congruence and divergence in the perspectives reported by therapists in comparison to the occupational therapy framework. In addition, implications for practice are discussed for occupational therapists treating sexual dysfunction, as well as briefly outlining two published methods of addressing the sexual concerns of clients receiving occupational therapy services.

## CHAPTER II

### REVIEW OF LITERATURE

The following chapter describes the existing literature and research focusing on occupational therapists and sexual dysfunction in relation to mental health clients. The main purpose of the literature review pertains to understanding sexual activity as an important aspect of daily living included in the occupational therapy practice framework, as well as a critical client issue that may require skilled occupational therapy interventions. Other dimensions of the literature review include a client's right of care, barriers to treating sexual concerns of mental health clients, and the biopsychosocial elements of sexual dysfunction. The databases used to locate pertinent literature were PubMed, CINAHL, SCOPUS, OT Search, American Journal of Occupational Therapy and The Cochrane Library. Additionally, the Google search engine was utilized to search for information on the Web. Terms used to guide our search were: depression, sexuality, sex, mental health, marriage, unipolar, occupational therapy, therapy, treatment, intervention, sexual dysfunction, and PLISSIT model.

#### **Scope of Practice**

According to the Occupational Therapy Practice Framework: Domain and Process, sexual activity, as an activity of daily living, is “engaging in activities that result in sexual satisfaction” (AOTA, 2008, p. 620). The framework identifies sexual activity as an issue within the occupational therapy scope of practice because sex is an activity of

daily living whether it is a “sexual relationship, masturbation, fantasy or other solitary sexual activity” (Friedman, 1997, p. 20), as well as fulfilling the role of being a sexual partner that has value in a person’s life (Friedman, 1997). Thus, sexual activity comprises a legitimate area for occupational therapy practice and is indicated through the occupational therapy frame of practice. Sengupta and Stubbs (2008) acknowledge the need to consider sexual functioning as a part of daily occupational therapy practice, but feel it becomes an issue only when sexual functioning is problematic for a particular client. Other studies (Penna & Sheehy, 2000) have noted that sexual functioning is a concern among patients, but that treatment by occupational therapists occurs more frequently among those occupational therapists with greater practice experience than new therapists with less practice experience.

Highlighting the educational preparation of new occupational therapists, Payne, Greer and Corbin (1998) researched occupational therapy department chairs’ perspectives on sexual expression as an area of practice. Of the 50 occupational therapy department chairs (N=61) responding to the primary question of whether healthy sexual expression among patients is an important domain of occupational therapy practice: 64% revealed that sexual expression is an important domain of occupational therapy practice, while 20% did not feel it was an important aspect of occupational therapy, and 5% were undecided on the issue. When tasked with rank ordering of health care providers with responsibility for providing services in the area of sexual function, the majority of department chairs who agreed that sexual expression is an important domain of practice tended to rank occupational therapy higher on the list, indicating occupational therapists

were more responsible. On the contrary, those department chairs who were undecided or negative about the importance of sexual activity in the domain of practice ranked occupational therapy lower and ranked nurses and health educators higher. The authors of the study surmised there is ambivalence about the amount and type of preparation new therapists need to address sexual activity. Thus, an individual therapist's willingness and ability to address a client's sexual functioning will depend largely on the educational facility in which they received their training (Payne, et al., 1998) regardless of the practice framework. For those willing to fully utilize the constructs of the practice framework, occupational therapy practice will address sexual activity as an activity of daily living. However, sexual activity also represents an area that needs further development of practice guidance, effective interventions, and documenting outcomes of practice.

To begin addressing sexual activity as an activity of daily living, practitioners should understand that sexual activity is an innate component to every individual. Friedman (1997) describes sexual expression as a biological component throughout each person's developmental stages: genetic gender is identified at conception, sexual identity is identified at childhood, sexual experimentation is practiced by adolescents, and sexual expression is developed throughout adult and elder years. Others (Pollard & Sakellariou, 2007) note that sexual expression is also expressed through psychological components, such as desire, communication and occupation. Sakellariou and Simó Algado (2006b) describe that the most obvious component of sexual activity pertains to the function for basic reproduction, but also one that has evolved into a social feature that develops one's

sexual identity. According to Sakellariou and Simó Algado (2006b), understanding sexual expressions as an aspect of daily living will increase the inclusion of sexual activity as a legitimate issue within occupational therapy practice.

Within the occupational therapy domain of practice, performance factors are evaluated within each area of occupation. Sexual expression is included and pertains to a person's effectiveness in roles, habits and routines while engaged in occupations. These include flirting, dating, putting on make-up, undressing, cooking dinner for a partner, physical contact and intercourse (Pollard & Sakellariou, 2007; Sakellariou & Simó Algado, 2006a). Sexual expression encompasses these performance factors as it is executed in meaningful occupation. Sakellariou and Simó Algado (2006b) further state that the occupational nature of sexual activity, since it has a start and end point, can be intentionally and consciously repeated, and can have meaning to the person(s) involved. In addition, they note that sexual activity is an area of occupation that is labeled and consistently identified within each cultural group. However, the authors are also clear that occupational therapists are not experts in sexuality, but in occupation. The occupational nature of sexual activity is within the domain of expertise and not, per se, sexual counseling or sex therapy. Implications for occupational therapy include determining if and how a change in occupational life is affecting sexuality (Sakellariou & Simó Algado, 2006b). Thus, clients with occupational dysfunction may not have the necessary client factors to perform in sexually expressive activities, and warrant occupational therapy interventions to restore, remediate, or adapt.

### **Right of Care**

From a healthcare perspective, it is an obligation for healthcare workers, including occupational therapists, to provide individuals with necessary treatment, although studies indicate it is not sufficiently addressed in medical and rehabilitation settings (Estes, 2002). Health care practitioners "...routinely omit discussions of sexuality from patient interactions" (Coyle & Young, 1998, p. 62), although every individual has a right to be given the adequate care they deserve, including care for sexual health, according to the World Health Organization (2001). However, in a study of nurse practitioners, Coyle and Young (1998) discuss that aversion to addressing sexuality may stem from "...sources such as ignorance, religious conflicts, or even deep-seated personal reasons" (p. 66). They further argue that healthcare professionals may themselves be uncomfortable in sexual situations or even with their own sexuality and thus neglect to provide the right of care to the individual. Gallop, et al. (1993) discuss that the discomfort felt by treating clinicians negates the ability to provide the appropriate therapeutic intervention. Not addressing the issue when the client has clearly asked for services leaves the client feeling abandoned, unimportant and assuming that this issue is not something that can be addressed. Furthermore, it is the client's right of care to get the appropriate treatment, even if it relates to sexual dysfunction.

Not surprisingly, receiving treatment for sexual dysfunction in mental health care settings appears to be especially problematic and is an issue that is typically avoided among healthcare professionals in the field of mental health. For example, Shubalabe and Gillam (2005) identify the issue of sexual dysfunction in mental health as the "forgotten" and sometimes "taboo" aspect of their lives (§ 47). Healthcare professions

tend to ignore the fact that mental health clients are able to live by themselves in a community, where they are able to participate in sexual relationships and engage in sexual occupations.

According to Penna and Sheehy (2006), it is the responsibility of the healthcare professional, more appropriately occupational therapists, to facilitate development of the necessary skills to engage in relationships and occupations as a satisfactory component of their lives. Sakellariou and Simó Algado (2006) note that occupational therapists who do not provide clients in mental health settings with the necessary treatment to participate in meaningful sexual activities are occupationally unjust and operating against all values and beliefs that occupational therapy practice upholds. Furthermore, they add that occupational therapy practitioners need to enable clients to pursue meaningful sexual occupations in order to be faithful to our philosophy of holism and client-centered practice.

Unfortunately, the effects of discomfort in addressing sexual activity among healthcare professionals become discouraging to new practitioners in the occupational therapy field (Estes, 2002; Sengupta & Stubbs). Without curricular preparation, occupational therapy students are at risk of developing discomfort with the topic and may not address the issues of individuals who voice concerns. Additionally, occupational therapy students may lack the confidence in working with clients whose sexual background and experience are different than what they perceive (Friedman, 2007). Jones, Weerakoon, and Pynor (2005) assert this creates “negative feelings, thoughts and behaviors” (p. 103) towards clients who voice their concerns about sexual activity. The



inability to address these aspects of care as new graduates further discourages practitioners to address sexual issues with their clients in the future.

In fact, providing necessary care to individuals voicing concerns of sexual functioning appears to be beneficial. Campbell (2006) describes that patients who were evaluated and treated for sexual dysfunction are found to increase compliance with treatment and experience improved perceptions of quality of life. Sakellariou and Simó Algado (2006a) acknowledge the benefit of addressing a client's sexuality. They found that enabling individuals to pursue these occupations tends to increase the engagement of their sexual identity, without feeling ridicule or judgment. In addition, the subjects in their research reported beginning to feel like members of society again. By addressing sexual functioning and establishing appropriate treatment, individuals can enjoy meaningful activities related to sexual identity.

### **Barriers**

Occupational therapists encounter many barriers that make it difficult to treat for sexual dysfunction. According to Estes (2002), many healthcare professionals agree such barriers are evident and make addressing sexual expression in rehabilitation problematic. One of the identified barriers in addressing sexual expression is the values and biases therapists may hold in regard to sexual expression. According to Estes (2002), clinicians must become understanding and aware of their values, biases and judgments that may affect intervention with clients. Therapists who are not self-aware of their personal values and judgments about the client's lifestyle practices inhibit their ability to address and treat sexual dysfunction.

Another barrier to addressing sexual dysfunction is the level of discomfort portrayed by the therapist. A study by Jones, Weerakoon, and Pynor (2005) looked at the comfort levels of occupational therapy students during clinical interactions that have sexual implications. Aspects of interactions reported as the most uncomfortable to students were walking in on someone who is masturbating, patients making overt sexual remarks, and patients making covert sexual remarks. However, the students expressed more comfort with items related to homosexuality, addressing teen contraceptive use, and providing handicapped individuals information about sexual options. Additionally, male students were found to be significantly more comfortable than their female counterparts in dealing with individuals who make overt and covert sexual remarks or walking in on someone masturbating. Other levels of discomfort come up for students when discussing sexual expression with patients of different generations, opposite sex and cultural background (Estes, 2002).

The delineation of professional roles in addressing sexual dysfunction poses a significant barrier in treatment. Estes (2002) recognizes that occupational therapists have the knowledge and expertise to promote functional independence by incorporating aspects of “activity analysis, adaptation of task, environment, person and psychosocial impact” (p. 36). Additionally, Couldrick (1998) describes sexual expression as occupational in nature, and personally meaningful to clients; therefore, occupational therapists should develop core skills to address dysfunction. Friedman (1997) also adds holism as a requirement of treatment, and thus, it becomes the responsibility of occupational therapists to address sexual expression. Friedman (1997) goes on to note the

unclear role and responsibility of interdisciplinary professionals in addressing the issue, and how it conveys the message to clients that, “We don’t talk about sex here” (p. 22). Furthermore, Payne, Greer, and Corbin (1988) state that all healthcare professionals should be concerned about sexual functioning and take responsibility for acknowledging the subject and providing services to individuals; yet, in their study, occupational therapists ranked highest as the discipline most responsible for addressing sexual function. However, other disciplines, particularly nursing (Coyle & Young, 1998; Gillam, 2007), stake a claim in providing psychosocial treatment and education related to sexuality. The unclear delineation of addressing sexual function among clients becomes a barrier to providing the necessary treatment.

Lack of knowledge of the topic and treatment approaches creates an additional barrier for occupational therapists. The basis for learning about the issue stems from the curriculum provided in one’s education. A study by Payne, Greer, and Corbin (1998) revealed that 88% of occupational therapy department chairs indicated that formal class time was given to address the topic of sexual function through means of lecture and discussion. Furthermore, they identified that only 3.5 hours in the entire curriculum was devoted to sexual functioning. The department chairs indicated that class time was given to teaching students techniques for dealing with discomfort issues, developing interpersonal skills, and teaching desensitizing exercises to reduce a therapist’s anxiety when approaching patients about sexual matters. The department chairs described barriers to addressing sexual function in the classroom as lack of time and the topic was a low priority. Jones, Weerakoon, and Pynor (2005) found that 50% of third- and fourth-

year occupational therapy students felt that sexual functioning was not addressed in their training and felt additional training in intervention, sexual anatomy, physiological response to sex, relationship dynamics, effects of aging on the sexual process, and sex through social and culture context would increase knowledge and competence when approaching sexual function. Lacking a solid foundation in learning about the topic through one's education can lead to discomfort and embarrassment when initiating discussion about sexual expression, thus creating a huge barrier for addressing the issue with clients (Jones, et al., 2005).

Another potential barrier that occupational therapists may experience when addressing clients with sexual function is inappropriate sexual behaviors. Johnson, Knight, and Alderman (2006) describe inappropriate sexual behaviors as “verbal or physical act[s] of an explicit or perceived sexual nature, which is unacceptable within the social context in which it is carried out” (p. 688). Others have noted that sexual behaviors conveyed by clients may or may not be inappropriate, but healthcare professionals who are embarrassed or uncomfortable with the behavior may deem the act as inappropriate, thus overlooking sexuality as an aspect of care (Payne, et al., 1988). Still others suggest that providing training in sexuality during undergraduate education can increase the student's ability to become better equipped in addressing sexual function and keeping inappropriate sexual behavior from occurring (Sengupta & Stubbs, 2008).

The lack of interpersonal skills in approaching sexual dysfunction can be a difficult barrier for therapists. According to Jones, et al. (2005) healthcare professionals should develop the interpersonal skills necessary for addressing sexuality; including

developing one's level of comfort about one's own sexuality, interpersonal and treatment skills, and confidence in dealing with clients who have sexual complications. Making assumptions that patients do not want to talk about sexuality also needs to be revised, and instead be focused on the reality that healthcare professionals do not currently perceive they have the skills to address the issues (Sengupta & Stubbs, 2008).

Finally, one last barrier, exclusive to occupational therapy practice, is the inability to use an occupational behavior model to guide assessment and treatment of sexual dysfunction. Gary Kielhofner (as cited in Couldrick, 2005) feels the Model of Human Occupation is a theory that should not be sought to explain sexuality, further adding that sexual activity should be excluded from occupational therapy practice. Kielhofner's opinion is that sexual activity is a biological drive, instead of a meaningful occupation one participates in. Although the Canadian Model of Human Occupation includes addressing sexuality; the accompanying assessment (Canadian Occupational Performance Measure) requires the client to identify sexual dysfunction as a need for intervention (Couldrick, 2005) rather than through the direct assessment by the therapist.

### **Biopsychosocial Aspects**

From a physical disability perspective the indications for occupational therapy in the instance of sexual dysfunction may seem clearer to practitioners. However, when sexual dysfunction occurs in mental health, indications for treatment appear less clear for practitioners. Of the available literature, most is focused on sexual dysfunction as it relates to physical disability (Can et al., 2008; Deadman, 2007; Dean, 2008; Gracia et al.,

2004; Kaya et al., 2006; McCorkle et al., 2007; Shaver, Wilbur, Robinson, Wang & Buntin, 2006).

However, little if any research addressing a client's sexual dysfunction, secondary to mental illness, is found in the literature. Sexual dysfunction is influenced by illness and effects of medication (Bancroft et al., 2003; Costa, 2008; Gilliam, 2007; Miller, 2008; Nahmias & Froehlich, 1993; Rothschild, 2000; Shubalade & Gilliam, 2005). Researchers have studied depression as an illness affected by sexual function. For instance, Campbell (2006) identifies the loss of sexual desire as one of the most common sexual health problems that are present among females. Campbell (2006) further states that sexual dysfunction, loss of libido for women, is the "first [consequence] of depression and one of the last factors to resolve" (p. 15) while depression in men can affect sexual function by causing difficulty achieving or maintaining an erection, specifically in men aged 40 to 60 years (Harvard Medical School, 2006). Sexual dysfunction is also influenced by the effects of medication. Sexual side effects induced by medications, specifically antidepressants, appear to diminish sexual desire, influence performance to reach an orgasm, thus decreasing personal satisfaction (Harvard Medical School, 2006).

Components of sexual dysfunction also influence mental health diagnoses in regard to their psychosocial wellbeing. Friedman (1997) explains how dysfunction can interfere with sexual expression in regard to motor, sensory and cognitive perceptual function. For individuals with mental illnesses, cognitive/perceptual issues related to sexual dysfunction includes decreased attention span, behavioral changes, fear and decreased self-concept. In addition, the effects of sexual dysfunction decrease self-

confidence and confidence, while further increasing embarrassment and guilt (DiMeo, 2006).

Impacts of sexual dysfunction with mental health illness, medication side effects and psychological components further affect an individual's ability to have positive partner dynamics. Men report that they are fearful of physical affection with partners because it may precipitate sexual intercourse, thus making them feel like failures when they are unable to sexually perform (DiMeo, 2006). Additionally, the inability to perform sexually can constitute a threat to stability among couples, involving issues such as trust, intimacy, closeness, infidelity, stress and desire (DiMeo, 2006; Ostman, 2008).

This literature review highlights some aspects of occupational therapy practice in regard to sexual dysfunction. These include aspects of sexuality as part of daily living, a client's right of care, barriers, and biopsychosocial aspects of sexual dysfunction. The literature highlights a need for further investigation in the area of sexual dysfunction, especially in regard to psychosocial practice. Therefore, the researchers proposed a qualitative pilot study to explore occupational therapists' perspectives on psychosocial treatment of sexual dysfunction with mental health patients.

## CHAPTER III

### METHODOLOGY

Using a phenomenological research design, the investigators studied the perceptions of occupational therapists working in psychosocial settings with mental health clients who also have sexual dysfunction. Creswell (1998) states that a phenomenological study design captures “the lived experiences of several individuals about a concept or the phenomenon” (p. 51-52). According to Creswell (1998), a phenomenological design provides rich information that can be used to identify the meaning and understanding of common experiences by those who have experienced them. In this instance, the study was designed to investigate the perceptions occupational therapists hold toward treatment of sexual dysfunction as part of occupational functioning and activity of daily living with clients in psychosocial settings.

The orienting framework for the study is the Occupational Therapy Practice Framework: Domain and Process, which considers sexual activity an activity of daily living, therefore, within the scope of practice of occupational therapists when disruption of occupational function impacts sexual activity. Similarly, the International Classification of Functioning, Disability, and Health (2001) include active participation in intimate relationships (intimate, spousal, and sexual) as fundamental components of healthy functioning.



The review of the literature substantiated the need for the current study: there are mixed messages within the practice of occupational therapy in regard to treating sexual participation as an activity of daily living for persons with physical disabilities, much less for clients with psychiatric disabilities. A proposal for conducting research was developed and the study was approved on March 6, 2009, by the University of North Dakota Institutional Review Board, protocol approval # 200903-278.

### **Participants**

The participants were recruited through convenience and purposive sampling. The target participants were mental health occupational therapists practicing in geographically different psychiatric settings. The researchers recruited participants through the University of North Dakota Occupational Therapy Fieldwork Database from psychiatric settings located in Wyoming, Utah, Washington, Colorado, North Dakota, and South Dakota.

Ten occupational therapists were contacted to see if they would participate in the study and six therapists agreed to participate in the study, as shown in Table 1. However, two of the participants were interviewed at the same time; therefore, the researchers treated the data received from them as one participant, as indicated by participant C. Participants consisted of five female therapists and one male therapist. The participants had an average of 16.6 years of psychosocial practice experience and only one participant also worked in a setting other than psychosocial practice. Three participants had Masters Degrees in Occupational Therapy and the others had Bachelors

of Science in Occupational Therapy degrees. One participant also had a Masters Degree in Public Administration.

Table 1

*Demographic Data of Participants*

<b>Participant</b>	<b>Gender</b>	<b>Location</b>	<b>Years Practicing</b>	<b>Degree</b>
<b>A</b>	Female	South Dakota	5 years	Master's Degree in Occupational Therapy
<b>B</b>	Female	Wyoming	30 years	Bachelor's Degree in Occupational Therapy Master's Degree in Occupational Therapy
<b>C</b>	Female	Wyoming	Average 11 years	Bachelor's Degree in Occupational Therapy
<b>D</b>	Male	Utah	2 years	Master's Degree in Occupational Therapy
<b>E</b>	Female	Washington	41 years	Bachelor's Degree in Occupational Therapy Master's Degree in Public Administration

Note: Participant C is the combined interview between the two participants that were interviewed at the same time and due to this the student researchers treated the data received from them as one participant.

Informed consent was explained verbally at the time and place of the appointment with the subjects. The consent informed the participants about the procedures of the study, risks, benefits, confidentiality, and compensation of the study. The participants were given the opportunity to read the consent before deciding whether to participate. All participants were provided information about withdrawing from the study.

**Data**

The instrument used in this study was an open-ended, semi-structured interview designed and developed by the student researchers for the purpose of investigating the

participants' perceptions of treatment. The content of the interview included opening statements, questions, follow-up probes, and closing statements. The questions were designed and guided by the review of the literature to collect demographic information about the therapist (i.e., practice area, school degree was received from, level of education, and years of practice), to find what types of assessment and evaluation techniques were utilized at each setting and to identify the process of dealing with sexual dysfunction in psychosocial treatment. The questions were reviewed and approved by the University of North Dakota's Institutional Review Board. Interviews were conducted by the student researchers. Individual interviews were scheduled at the participants' convenience and ranged from 15 – 30 minutes. Information collected from each interview was recorded with a handheld, digital recorder. Additional notes by the student researchers were recorded in the space provided on the interview sheet. Researchers debriefed the subjects about the research topic after each interview was completed. In addition, each student researcher kept a reflective journal as an additional control.

The data collected in this study was maintained and safeguarded on an external storage device and stored in a locked filing cabinet. Written notes from the interview and reflective journal were also stored in this locked filing cabinet. The informed consent and any identifying information of the subjects were secured in a different location. Any information collected was disclosed only to the student researchers, student advisor, expert reviewer, auditor and the University of North Dakota Institutional Review Board. Any data provided by the subjects must be disclosed in a manner that does not identify

the subject, except as required by law. Thus, pseudonyms are used in reporting the results.

### **Settings**

The settings of the interviews varied among the participants. The first interview was conducted in a coffee shop located in a bookstore. The environment entailed moderate background noise from individuals coming in and out of the store. Participant and student researchers sat at a table against a wall to decrease the background noise and allow for a sense of privacy. The second interview was conducted in an office with the door closed and the office was quiet, but cluttered. The participant sat on one side of the desk facing the door and student researchers sat on the other side with the door to their backs. The third interview was conducted in an office setting at the facility where the individuals worked and the two participants and researchers sat in a circle. The fifth interview was completed in a large activity room at the facility where the participant works and researchers and participants sat around a table to complete the interview. The sixth interview was held in a small craft room at the facility where the participant works. The participant sat with her back towards the door on one side of the table and the researcher sat on the other side of the table.

### **Data Analysis**

Data received was transcribed verbatim and then categorized, coded and analyzed using the strategies described by Berg (2007). Data was transcribed by listening to the recording of the participants several times and typing what was heard through the recording. After transcriptions were completed, categories were developed by re-reading

transcriptions to identify like comments and to find emerging codes. Later the codes were turned into themes that best described the findings throughout the sample of participants. After the data was transcribed, a copy of each transcription was sent to the subject. The researchers contacted each participant to clarify that the data collected on the transcription was an accurate representation and to learn if the subjects wanted to add other pertinent information. If necessary, the researchers rechecked this information with the subject. During each step of the process, the researchers recorded any perspectives or biases in a reflective journal. After transcribing the data, the student researchers read through the interviews multiple times and developed common codes and themes. The codes identified as having similar phrases, patterns, relationships, and commonalities, were grouped together under nascent themes. The tentative thematic material was subjected to additional scrutiny until agreement was reached about each one. Quotes reflective of the themes were used to describe the results.

In order to reduce the chance of bias, the researchers used reflection, discussion, and journaling to help decrease bias risk. The data collected and analyzed was reviewed by an expert reviewer in the subject, University of North Dakota faculty member Sonia Zimmerman PhD, OTR/L, FAOTA, to validate results. An auditor inspected the procedural process and reviewed the data to ensure the validity of results. After the data had been analyzed, the researchers completed a final manuscript.

Triangulation was an additional method used to increase the trustworthiness of their findings (Creswell, 1998). The researchers used two types of triangulation. The first, triangulation of source, involved the researchers comparing their observations with the

transcription data to identify discrepancies and consistencies. The second type, analyst triangulation, involved the researchers analyzing and comparing their analyses against each other. In addition, peer review and debriefing were conducted by the project advisor. The researchers checked back with participants once the interviews were transcribed to make sure that all subjects' words were representative of what they meant to say. The researchers used the external auditor to review the transcriptions and the themes to make sure the researchers' findings were representative of the transcripts.

## CHAPTER IV

### RESULTS

Three themes emerged to describe the occupational therapists' perspectives of psychosocial treatment of sexual dysfunction with mental health clients: scope of practice, perceived barriers, and client-centeredness. The themes emerged from practitioners' experiences as they reflected on treating sexual dysfunction among mental health clients. The following quotes describe and reflect the evidence collected.

#### **Scope of Practice**

The majority of participants argued that sexual activity is within the scope of practice for occupational therapy. Participant D exclaimed, "Absolutely. Absolutely. It's within our scope of practice." Furthermore, participant D expressed, "I think its well within our domain, simply because we look at the whole person and everything that occupies [their] day." Participant E concurred that occupational therapy practice is ideal for treating the "behavioral issues" of sexual activity with mental health clients.

However, participant C commented that sexual activity is not an area of practice for occupational therapists, especially those treating mental health clients. Participant C noted that sexual activity is "not [addressed] in this setting, I don't think it is, but with physical disabilities and with spinal cord, stroke or whatever. I think it's appropriate in those cases for OTs to address it. But in this setting and because of the trauma, that's not

our domain to talk about it.” Additionally, she commented that “it’s not a primary ADL that needs covered in our facility, by us.”

One reason that sexual activity is not addressed in a mental health setting is that the frame of reference that guides assessment and treatment does not address sexual activity as an occupation. For example, the most frequently identified frames of reference used by the participants were the Model of Human Occupation, Occupational Adaptation and Cognitive Disability Model. Frames of reference are typically used to guide assessments. However, none of the above frames of reference or assessments mentioned by the participants is designed to capture sexual dysfunction.

### **Perceived Barriers**

A theme of multiple barriers to treating sexual dysfunction was identified by therapists and could be explained as intrinsic and extrinsic barriers. A pertinent intrinsic feature expressed by therapists was the level of their own comfort when treating for sexual dysfunction. Some of the participants felt comfortable when treating for sexual dysfunction, while others did not. However, the comfort level in addressing sexual dysfunction could also lessen depending on features of the client with whom they are addressing the issue. Female participant A said “I’m fine with it. I’m okay with it, as far as talking with everybody and coming up with ideas... [however] showing them techniques, I don’t think I can do that. The women I would be okay with, but the guys I would be kind of embarrassed with.” Participant B expressed a high level of comfort when addressing the issue with either gender, “as long as the patient is comfortable with me.” Additionally, Participant D described the level of comfort as it related to a client



engaged in a sexual activity within the hospital: “I’m walking in a room and someone is masturbating, generally I’ll just close the door and they can let me know when I can come in.” Some describe being uncomfortable about addressing sexual dysfunction with clients. Participant C said, “To be totally honest, I don’t feel comfortable about it, because it hasn’t come up and it’s something I don’t have a lot of experience in.”

Another intrinsic barrier in treating for sexual dysfunction is that many therapists are not initiating discussion the issue, but waiting until the client brings it up. Participant C admits to not initiating the issue: “I wait for them to bring it up.” Furthermore, she feels that if the issue is initiated, it may bring up issues of sexual abuse and trauma: “It [sexual dysfunction] brings upon a re-experiencing of trauma.”

The last intrinsic barrier expressed by therapists is attitudinal. Participant C states that “a lot of our long-term clients are going to be here for the rest of their lives and we don’t encourage them to have sexual relationships on campus.” Furthermore, she explained that it is “not appropriate...there are a lot of them who have had trauma and so it’s hard to know who has what issues.” The respondent continued, “they [mental health patients] have a lot of issues and the other patient has issues so it is not a good healthy relationship.” Additionally, therapists portrayed negative attitudes about mental health patients conceiving children. Participant C mentioned that, “We don’t want pregnancies with two people who have severe, chronic mental illnesses to have children.” Participant D added:

There is a real component between mental illness and genetics. There really is. You get two mentally ill people and [a] consenting relationship, the chance of

their offspring having a mental illness is exponential. Not that mental illness should be weeded out entirely, but the odds are not in their favor.

Therapists also explained many extrinsic factors that prevent them from treating sexual dysfunction among mental health clients. One common barrier that arose is their practice setting. Participant B, working in an acute setting, commented, “The facility I’m affiliated with...the interaction is so acute. They’re in and out within 24 hours, so I don’t have time with those patients to get to the topic.” Participant A noted that sexual dysfunction needs to be addressed at a “long-term or outpatient [setting]... not at a short-term place.” Lastly, Participant D added, “there’s only so much you can do in an environment like a hospital.”

Another barrier in treating the issue is the lack of education received. Of the therapists interviewed, none have received little, if any training in their education or through continuing education. Participant B stated, “Well back in the old days, we had a workshop for a day and we had to watch homosexual movies and all kinds of stuff. We had to write a song and get up and sing it. It was kind of desensitization to sexual issues, but not what you do about it.” Additionally, participant D explained their educational preparation: “We talked about it [sexual issues] for 15 to 20 minutes, which doesn’t give you a whole lot, but then again there are very few instructors that I was aware of [who have] expertise.” Participant C also described their training with sexual dysfunction as it relates to physical disability. “The only thing I can remember is in physical disability, like different positions or something. I don’t remember getting it in the psych sense.” The way most of the therapists reported learning how to treat sexual dysfunction comes from

experiences they have encountered with patients. Participant E stated “Ninety-nine percent of what I have learned has been from [working with] patients.”

The last extrinsic factor that poses a barrier in treating sexual dysfunction involves medication side effects. Participant D commented:

You see a lot of retardive dyskinesia, a lot of shaking and a lot of drooling. You also see a lot of lethargy, very tired and very drowsy. Unfortunately, some of the patients become so psychotic that they require large amounts of medications just to be able to survive, basically. One of the major effects I see though is poor compliance. They have no energy, they aren’t motivated, [and] they’re stuck in a hospital, why do they have to get dressed up?

Participant C also noted side effects such as “sexual side effects... sedation, being lethargic, appetite change, mood swings, and getting used to the mood swings.”

### **Client-centeredness**

Most of the therapists followed a typical therapeutic process of assessing a client. Participant A explained:

We usually start off with an assessment. Then, we identify the strengths and weaknesses...also depending on our patient’s cognitive capability; we have them involved in their goal writing and objectives and let them know how much help we’re able to provide and let them know what their expectations are.

Participant E described a two-prong approach to treatment:

[The team] looks why the clients are here and what the client needs to do to get out of here and stay out. Part of it is that, and then the team will then ask me for

specific services. The second thing I do is I always talk to the patient, what is important to them, what they really want to do, and what will help them get out and stay out.

Most of the therapists expressed a desire to meet the client's goals and utilizing client-centered practice. The types of treatment depicted by therapists appear to be mostly group sessions; however, one-to-one sessions are available for those who would benefit from the service. The interventions of treatment appear to vary among therapists.

Participant E mentioned, "I am a firm believer in crafts, because I think that it is what the profession was founded on to a large degree and have used it throughout my entire career. It was what I was taught to use and I find that it is extremely well received." Participant A described using social skills training, aromatherapy, and weighted vests. Furthermore, she explained intervention methods used at their setting as "tasks, task-focused activities, projective activities like collages and that type of stuff. We do coping skills, anger management, assertiveness and self-esteem." Participant B described the therapeutic relationship between the client and therapist, "I would say my primary [intervention] is the therapeutic-use-of-self." Lastly, participant D added intervention methods used at their setting include "work on community readiness skills...their laundry, ADL's, transportation, and use of community resources."

Some participants described sex as a topic that should require a multidisciplinary team intervention approach. For example, team members need to be aware of sexual dysfunction issues in order to determine what course of action should be implemented for treatment. Participants felt it would be beneficial to refer the individual's sexual

problems to another professional and stated the psychiatrist is a more appropriate discipline for providing treatment for sexual dysfunction.

Finally, a scenario about a client who attempted suicide secondary to sexual side effects from anti-depressants was read to each therapist by the student researcher and each therapist explained how they would treat the case study client with sexual dysfunction. The most common theme revealed by therapists is using an individualized treatment approach. Participant E began:

The first thing I would do would get him to sit down with the doctor about alternatives to the medication, because there are some medications that have fewer sexual side-effects. My experience is a lot of times [though] the alternatives do not work as well and then it becomes, do you want to be depressed or do you want to keep your marriage? I do not do marital counseling, but I would strongly recommend that he and the wife find a competent [psychologist] therapist to work out their conflicts. That perhaps the wife needs some education of how cope with this and a really good therapist could give them alternatives to activities that could then satisfy the wife without demanding the performance from the gentleman.

In addition, the therapist mentioned that they (OT and client) could be “doing some exploration how he could maintain his self-esteem...and spending a lot of time trying to figure out how to meet his sexual intimacy needs that he and his wife have.” Along these same lines, Participant A noted that “I would encourage them to talk to their doctor about different medications...I would encourage coping skills for marital conflict.” Participant

A described “self-esteem and assertiveness training” as pertinent intervention methods. Additionally, Participant D explained this approach: “There’s going to be quite a bit of coping skills, quite a bit of communication with the spouse, and it’s not definitely something that you’re going to take on as his issue, it’s something you’re going to take on as the marital unit.” Some participants felt that the therapist should address the intimacy and physical components of the issue. Participant B stated she would talk to the client about “what feels good, what is important to you, what kind of things have you tried, what kinds of things would you be interested in trying.” In addition, she mentioned that she would try incorporating an activity based on the client’s concern. Lastly, Participant B described a different approach in treating the issue, “I would look at the history and then I would use the sensory profile to help... if he’s not able to be stimulated, he may have a certain profile and there may be other things to look at.” Furthermore participant C added, “I would also encourage him to look at other issues besides his medication, it could be that he is too overwhelmed or too tired...there’s always a possibility if you’re looking at context.”

The above quotes are indicative of data captured from the participants. The resulting themes revealed aspects of therapeutic procedure, barriers to treating sexual dysfunction, and planning and implementing treatment that have implications for the practice of occupational therapy as well as support for the evidence already in the literature.

## CHAPTER V

### SUMMARY

The purpose of this study was to explore occupational therapists' perspectives on psychosocial treatment of sexual dysfunction with mental health patients. Using qualitative methods, the researchers obtained data from four individual therapists and one pair of therapists currently practicing in mental health. After analyzing the data, three themes emerged: scope of practice, perceived barriers and client-centeredness. The respondents' perspectives contribute to our understanding of psychosocial treatment of sexual dysfunction in mental health and the role of occupational therapy in working with this population.

The results expressed by therapists were both congruent and divergent with the literature. A consensus of the participants agreed that sexual activity was a domain of practice for occupational therapy. These perspectives also correlate well with the occupational therapy practice framework viewing sexual expression as an activity of daily living (AOTA, 2008). However, respondents still ignored issues related to this domain of practice in mental health settings. First, it becomes incumbent on clients to bring up issues addressing sexual dysfunction, rather than as part of a comprehensive occupational therapy assessment. Second, psychiatric practice settings discourage the issue from being addressed.

Participants also described their role in addressing sexual dysfunction. A majority of respondents did not feel they are the most appropriate team member to address the issue and feel that psychiatrists are the most appropriate health care professional to address the issue. These views vary from the literature where researchers identified occupational therapy practitioners as the most appropriate discipline to treat sexual dysfunction (Couldrick, 1998; Estes, 2002; Friedman, 1997).

Participants' expression of comfort in addressing sexual dysfunction is also congruent and contradictory with findings in the literature. While two of the five respondents reported being comfortable addressing sexual concerns with clients, other respondents indicated some level of discomfort with the topic. For those expressing comfort, therapists with greater practice experience seemed more comfortable with addressing issues of sexual dysfunction than therapists with less experience. Additionally, the male participant with the least practice experience revealed having a higher degree of comfort than half of the female participants.

Failing to address sexual concerns with the client as part of an evaluation poses another barrier in addressing sexual dysfunction. Respondents in this study explain that sexual concerns are not addressed until the client brings up the issue, and relates to the literature regarding misconceptions about clients' willingness or unwillingness to talk about sexual needs to the healthcare professional (Sengupta & Stubbs, 2008).

Practitioners' personal biases and attitudes about sexual relationships among mental health clients are also a significant and evident barrier expressed by occupational therapists. Sekallariou and Simó Algado (2006b) note that therapists ignore sexuality for



people with disabilities for “fear of legitimizing it” (p. 351) and therefore, oppress people with disabilities. They state (2006a, p. 74):

[P]articipation in sexuality is hindered, confined or otherwise restricted due to certain beliefs...that act in disabling ways and bring about a state of occupational injustice....An occupational justice approach to sexuality would mean that all people would be offered opportunities to express their sexual potential without being oppressed by confining social values and beliefs.

Practice setting also appeared to be problematic for therapists when addressing sexual dysfunction. Therapists expressed difficulties in treating for sexual dysfunction because individuals are in and out of the hospital so quickly. Additionally, they felt treating sexual dysfunction is most appropriate in long-term settings, thus, justifying the lack of assessment in short term settings. However, no research discovered in this literature has indicated the most appropriate setting to treat sexual dysfunction.

Lack of educational preparation and continuing training appeared to be a consistent limitation among therapists. Participants described a minimal amount of time (15-20 minutes) was spent on discussing sexual dysfunction during their education. Furthermore, they added that the information given to them was related to physical disability and not mental health settings.

Respondents also reported many sexual symptomatic issues related to medication. Occupational therapists using the practice framework could assess health management and maintenance to address medication management (AOTA, 2008). Revealing problems with medication side effects or medication compliance could assist individuals in

identifying and managing symptomatic issues related to libido changes or erectile dysfunction concerns, in concert with the doctor.

In regard to the therapists' current practice, there was a definite pattern in the interventions suggested by the therapists. They seemed to easily move toward self-management skills, coping, social skills, setting of personal boundaries, and self-regulation. A few occupational therapists mentioned interventions directed towards hypersexuality as acceptable practice in their settings. For these practitioners, this is the reality of practice.

### **Implications for Practice**

Occupational therapists have the necessary skills to address sexual dysfunction as it relates to the occupational therapy practice framework. The framework provides a guideline for providing occupational therapy interventions. The interventions applicable in treating sexual dysfunction are the therapeutic use of self, therapeutic use of occupations and activities, education process and advocacy (AOTA, 2008). In addition, the practice framework provides approaches to direct intervention based on the sexual dysfunction. The intervention approaches described in the practice framework are those adapted from Dunn, McClain, Brown and Youngstrom (as cited in AOTA, 2008). The practice framework's "create, promote intervention" approach is applicable in treating sexual dysfunction because it is "designed to provide enriched contextual and activity experiences that will enhance performance for all persons in the natural contexts of life" (AOTA, 2008, p. 657). In addition, the "establish, restore approach" is also applicable in treating sexual dysfunction because it is designed to "restore a skill or ability that has

been impaired” (AOTA, 2008, p. 657). Modify intervention approach is an appropriate method because it is “directed at finding ways to revise the current context of activity demands to support performance in the natural setting, compensatory techniques, enhancing some features to provide cues or reducing other features” (AOTA, 2008, p. 658).

Andamo (1980) developed a treatment model for occupational therapy practitioners when treating sexual dysfunction. This model serves as a guide for occupational therapy practitioners through evaluation, establishing goals and using treatment modalities. The model incorporates sexual health as a holistic approach when assessing the whole body. Thus, incorporating sexual function as a routine component of a performance can alleviate embarrassment and inhibition reflected by clients with sexual dysfunction concerns.

Andamo (1980) proposed addressing sexual function through a preliminary evaluation consisting of a problem checklist, problem clarification, and sexual history. The problem checklist is an ADL evaluation, which includes two sexual concerns: “sexual difficulties and worried about sexual activity due to illness” (p. 28). Problem clarification determines sexual dysfunction as a primary or secondary impotence. The primary impotence refers to “one who has never been sexually potent” (p. 29) and secondary impotence refers to a “patient who previously was sexually potent” (p. 29). Problem setting describes the context in which sexual dysfunction seems to be problematic. Next, a sexual history is compiled evaluating both premarital and marital sexual history. This evaluation describes “engagement in sexual

relationships...heterosexual and homosexual...practice masturbation...foreplay utilized” (p. 29). In additional sessions, compiling problems and sexual history with the significant others is also necessary in order to reach clarification with the couple.

A secondary sexual evaluation is also compiled from the patient and the sexual partner to identify factors associated with the dysfunction (Andamo, 1980). Andamo (1980) identifies these aspects as associated factors and specific potential causes. Associated factors accompanied with the dysfunction need be identified and validated in regard to facts and misconceptions among the issues. Next, specific potential causes are evaluated, both psychological and physiological. Identifying the origin of the issue can better link the cause between the client and sexual dysfunction.

Treatment goals are based on the results provided in the primary and secondary evaluation. Treatment goals suggested by Andamo (1980) include sexual anatomy and physiology of sexual functioning, knowing the effects of the disease or surgical procedure on sexual function, adapting to the disease or surgical procedure in the performance of sexual function, improving self-esteem and productivity, and increasing muscle strength, range of motion and energy levels. In regard to sexual dysfunction in mental health, Andamo (1980) suggested applicable treatment goals are also increasing self-esteem and sense of productivity. In addition, occupational therapists can increase self-esteem by improving “grooming, hygiene, socialization and/or vocation” (p. 32).

Lastly, other treatment modalities mentioned by Andamo (1980) include bibliotherapy, reading materials, adaptive techniques, socialization, grooming and hygiene, and energy levels. Bibliotherapy provides references that can be given to the

patient and sexual partner to help them become more knowledgeable about sexual dysfunction (e.g., sexual areas, sexual anatomy and responses, positions). Adaptive measures indicated are different sexual positions, different time and different context. Lastly, energy levels can be increased through increased physical activity and endurance training.

Another approach in treating for sexual dysfunction is the PLISSIT Model proposed by Jack Annon (1976). This intervention model is a four level approach for treating sexual concerns. Annon describes the four intervention levels as “Permission, Limited Information, Specific Suggestions, and Intensive Therapy” (p. 3). Friedman (1997) explains that occupational therapy practitioners are qualified to provide the first three levels of the PLISSIT intervention model to clients affected with sexual dysfunction. The last level of treatment, intensive therapy, is provided by a healthcare professional who has the skills to provide specialized treatment, such as a sex therapist (Esmail, Esmail, and Munro, 2001; Friedman, 1997).

Permission, the first level of treatment, allows clients to discuss their sexual concerns without feelings of embarrassment, but as normal feelings expressed with a diagnosis such as sexual dysfunction (Annon, 1976). Esmail, et al., (2001) explain that in order for clients to open up about their sexual concerns, a healthcare practitioner needs to “validate sexuality as a legitimate health care issue” (p. 4) before clients can begin discussing their sexual concerns.

The second level of treatment, limited information, occurs when the practitioner provides clients factual information with regard to their sexual concerns (Annon, 1976).

Friedman (1997) suggests that limited information can be provided in an array of media, such as written formats (brochures, handouts), lectures, and education programs.

Additionally, Esmail, et al. (2001) mention this level of intervention is also beneficial to correct any myths or misconceptions that arise with clients' sexual concerns.

The last level of treatment appropriate for occupational therapists to provide is Specific Suggestions. Annon (1976) describes that, in order to provide specific suggestions, a sexual problem history needs to be compiled. The sexual problem history should include the following: "description of current problem, onset and course of problem, client's concept of cause and maintenance of the problem, past treatment and outcomes, and current expectancies and goals of treatment" (p. 11). After accumulating the data, the therapist makes specific suggestions to provide treatment strategies to meet the desired goals.

### **Limitations**

The findings in this pilot study cannot be generalized to all occupational therapists working in mental health. The participants were only recruited from western states. Selecting participants from different states could have added different perspectives and may have generalized the results to a broader population. However, the study provides the opportunity to learn about a small set of practitioners' experiences in treating sexual dysfunction and provides points of discussion in regard to future practice implications.

Other limitations in this study include interviewing participants' public locations. Although the interview location was determined by the participants, the location was not always the most appropriate for an in depth interview about a sensitive topic. The public

locations may have hindered their responses. Lastly, one interview included two participants simultaneously. This posed a threat to validity, since one participant could have unduly influenced the other participant's response. An additional significant limitation of the study included the interviewers' potential impact on the results by asking participants leading questions, thus introducing subjectivity and biasing the results.

### **Recommendations**

While reviewing the literature for this project, the researchers found a lack of research and evidenced-based practice available for occupational therapy treatment of sexual dysfunction. Since the occupational therapy framework identifies sexual functioning as an area of practice, more research needs to be available on the topic of sexual functioning. Furthermore, there appears to be a need for occupational based frames of reference used to guide assessment and treatment of sexual function. Lastly, sexual function needs to be a topic addressed within curriculum. Encountering it within the curriculum, students can become encouraged to talk about the issue prior to becoming occupational therapists. In regard to the present study, it is recommended that future studies take measures to increase the validity and reliability of results (e.g. address internal consistency of the interview; practice interview skills; and, reach a representative sample of practitioners).

### **Conclusion**

This study is just the beginning of future investigations into psychosocial treatment of sexual dysfunction. The perspectives shared by therapists pose a need for addressing the issue as well as providing psychosocial treatment options. Occupational

therapists have the unique skills to recognize participation in meaningful life roles through occupation. Occupational therapists can use these skills to evaluate and treat for sexual dysfunction.



## APPENDICES

Appendix A  
Informed Consent

**INFORMED CONSENT**

**TITLE:** Occupational therapist perspectives on psychosocial treatment of sexual dysfunction of mental health patients

**PROJECT DIRECTOR:** Brittany Siefert & Joe Troudt

**PHONE #** 307-756-2013; 307-534-6108

**DEPARTMENT:** Occupational Therapy

**STATEMENT OF RESEARCH**

A person who is to participate in the research must give his or her informed consent to such participation. This consent must be based on an understanding of the nature and risks of the research. This document provides information that is important for this understanding. Research projects include only subjects who choose to take part. Please take your time in making your decision as to whether to participate. If you have questions at any time, please ask.

**WHAT IS THE PURPOSE OF THIS STUDY?**

You are invited to be in a research study about psychosocial treatment for sexual dysfunction because you are a mental health occupational practitioner working in psychiatric setting that the University of North Dakota Occupational Therapy Fieldwork Database.

The purpose of this research study is to investigate the perceptions of mental health occupational therapists about psychosocial treatment of sexual dysfunction with clients in psychiatric facilities. The researchers hypothesis that occupational therapist are not addressing or treating the issue of sexual dysfunction

**HOW MANY PEOPLE WILL PARTICIPATE?**

Approximately 10 people will take part in this study through the University of North Dakota. Participants are recruited from Wyoming, Colorado, Utah, South Dakota, North Dakota and Washington.

### **HOW LONG WILL I BE IN THIS STUDY?**

Your participation in the study will last one year. I will need you arrive at the prearranged location on the arranged date for the interview. The interview will take about one hour to complete.

### **WHAT WILL HAPPEN DURING THIS STUDY?**

The researcher will begin the interview with an opening statements, questions, follow-up probes, and closing statements. The researchers will debrief the subject to what the research was in regards to after the interview is completed. After the data is transcribed, a copy of the transcription will be sent to you. The researchers will you to make sure the data collected on the transcription is an adequate representation and if you need to add other pertinent information. If necessary, the researchers will recheck this information with you as needed.

### **WHAT ARE THE RISKS OF THE STUDY?**

There are no known risks in participating in this study. You may feel uncomfortable about the topic of the study. If you become upset by questions, you may stop at any time or choose not to answer a question. If you would like to talk to someone about your feelings about this study, you are encouraged to contact counseling service in your location.

### **WHAT ARE THE BENEFITS OF THIS STUDY?**

You may not benefit personally from being in this study. However, we hope that, in the future, other people might benefit from this study because the results will give mental health occupational therapist the necessary steps in dealing with this problem.

### **WILL IT COST ME ANYTHING TO BE IN THIS STUDY?**

You not have any costs for being in this research study.

### **WILL I BE PAID FOR PARTICIPATING?**

You not be paid for being in this research study. You will receive a copy of the final manuscript with results

### **WHO IS FUNDING THE STUDY?**

The University of North Dakota and the research team are receiving no payments from other agencies, organizations, or companies to conduct this research study.

## **CONFIDENTIALITY**

The records of this study will be kept private to the extent permitted by law. In any report about this study that might be published, you will not be identified. Your study record may be reviewed by Government agencies, and the University of North Dakota Institutional Review Board

Any information that is obtained in this study and that can be identified with you will remain confidential and will be disclosed only with your permission or as required by law. Confidentiality will be maintained by means of coding the data with an external device that will be kept in a locked filing cabinet in a locked office. Any identifying information will be in a different location than the collected data. The researchers, student advisor, auditor, expert reviewer and the University of North Dakota Institutional Review Board will have access to the data.

If we write a report or article about this study, we will describe the study results in a summarized manner so that you cannot be identified.

The information from the interview will be recorded in the space on the interview sheet and with a digital handheld recorder. All documents and electronic storage device will be destroyed after three years after data analysis is complete. The informed consents, written notes, demographic information will be shredded and disposed after three years of completion.

## **IS THIS STUDY VOLUNTARY?**

Your participation is voluntary. You may choose not to participate or you may discontinue your participation at any time without penalty or loss of benefits to which you are otherwise entitled. Your decision whether or not to participate will not affect your current or future relations with the University of North Dakota.

## **CONTACTS AND QUESTIONS?**

The researchers conducting this study are Brittany Siefert & Joe Troudt. You may ask any questions you have now. If you later have questions, concerns, or complaints about the research please contact Brittany Siefert at 307-756-2013, Joe Troudt at 307-534-6108, or Carla Wilhite at 307-268-2934 during the day.

If you have questions regarding your rights as a research subject, or if you have any concerns or complaints about the research, you may contact the University of North

Dakota Institutional Review Board at (701) 777-4279. Please call this number if you cannot reach research staff, or you wish to talk with someone else.

Your signature indicates that this research study has been explained to you, that your questions have been answered, and that you agree to take part in this study. You will receive a copy of this form.

Subjects Name: \_\_\_\_\_

\_\_\_\_\_  
Signature of Subject

\_\_\_\_\_  
Date

## Appendices B Interview Questions

Opening Statement: We are exploring how occupational therapists approach treatment of activities of daily living within our domain of practice with mental health clients. These include sex, intimacy, sexual expression and marital closeness.

1. How many years have you been practicing occupational therapy?
  - a. How many years have you been practicing in mental health?
  - b. Is this the only state you have been practicing in mental health?
2. What school did you attend?
  - a. What degree did you receive? Bachelors Degree, Masters Degree, Doctorate Degree
3. What assessment tools do you use?
4. How do you plan for treatment with clients?
5. What type of intervention methods do you use primarily?
  - a. Why do you choose that method?
  - b. What drives your choice?
6. Do you think sex is important? Why?
7. Here is a scenario for you to express your opinion on. The client is a 28 year-old male who was admitted for depression with suicidal ideations. He stopped taken antidepressants, because of the sexual side effects and irritability. The inability to perform sexually while being on antidepressants has resulted in marital conflict, thus increasing depressive episodes and suicidal ideations.
  - a. How would you typically treat or handle this client?
  - b. If you couldn't treat, who would you refer this client to?
  - c. How would you know it will be addressed by the referral?
8. What effects do you see of medications on clients?
  - a. Are sexual side effects the biggest complaints?
9. What other sexual dysfunction issues do client's express?
10. How comfortable do you feel addressing sexual function?
  - a. What would make you feel comfortable?
  - b. Did you learn about psychosocial treatment for sexual function in school?
  - c. How else did you gain competency?
11. Do you think providing treatment for sexual functioning is in our scope of practice?

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