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SPEAKER:
You are listening to the AOTA podcast. Here is your host, Matt Brandenburg. Our presenting sponsor for the AOTA podcast is New York University Steinhardt's Department of Occupational Therapy.

MATT BRANDENBURG:
Alright. Today we are joined by Kathryn Ellis. Kathryn, hello and thank you so much for being on the show today.

KATHRYN ELLIS:
Hi, Matt. You're so welcome. Thank you for having me.

MATT BRANDENBURG:
Yes, it is our pleasure. I've been looking forward to getting to know you and asking you some important questions. You are a certified sexuality counselor and a doctor of occupational therapy. What is sexuality counseling?

KATHRYN ELLIS:
That's such a great question to start us off. So, I view sex counseling as the intervention that is focused on addressing people's sexual health goals and needs. It can involve psychoeducation making suggestions on adaptations or new patterns, and really helping people explore maybe their limitations and establish new thought patterns or behaviors that serve them better within the context of the occupation of sex. So, sex counseling is the modality that I do under the discipline of occupational therapy. And I just want to be really clear that I don't think of these things as two separate disciplines. And I certainly don't want OTs to think that they need to have a sex counseling certification. This is, you know, more so the sex counseling is the modality I use while doing OT.

MATT BRANDENBURG:
And thank you for that clarification. I think it's well instructed in OT curriculum that sex is an occupation. It's included in the occupational therapy practice framework. But framing it that way as a modality and approach really helps kind of understand how practitioners can begin to address sexuality in their own practice and in their own day to day. Why do you feel it's important for OT professionals to study and apply evidence related to sexuality and intimacy?

KATHRYN ELLIS:
Because pleasure is OT. Pleasure is an integral part of living life to the fullest. It's a sensory experience. It makes us so aware of our own autonomy. And so, you know, it's because pleasure is OT but also it's because patients are telling us they want this intervention. You know, we have research that says people with disabilities, people post cancer diagnosis, elderly folks, they feel a sexualized in the health care setting. They feel that the health care providers do not view them as a sexual person, you know? And so while I like to highlight the benefits of sex and the benefits of pleasure and how pleasure helps us thrive as humans and thrive and live life to the fullest. I also like to highlight that there are, there can be detrimental effects of not addressing sex, right? I always like to say, you know, we're not just talking about a good roll in the hay. We can be, it would be enough to. Right? But there are some serious effects of not addressing sex with our patients. I always like, you know, for example, people with intellectual and developmental disabilities are 30% more likely to experience a sexual assault, and they are much less likely to receive sexual health education that is accessible for them and that's a problem.

And that's where OT can step in and make that sexual health education one, accessible or just available and two presenting it in a way, from a learning perspective where people can access that information. So, you know, we've got, sex is so important because it really helps with that thriving piece in life, but also that surviving piece.

MATT BRANDENBURG:
I love that that's so well said. And, you know, if we're not addressing sex in our practice, then we're really not practicing at the top of our license. You didn't always work in the sex space, is that right? I think you started your career at Walter Reed in Washington, DC.

KATHRYN ELLIS:
Yeah, I started at Walter Reed in Washington, DC in 2011.

MATT BRANDENBURG:
I wanted to ask, what kind of motivated you to focus your practice in scholarship on sexuality and intimacy?

KATHRYN ELLIS:
Yeah, so I started addressing sex and intimacy, almost like day one as a brand new baby OT grad. So, it was 2011 and this was probably the second, I think this was the second week I was there. It was 2011, and we were getting tons of combat injured service members and they would come back with these catastrophic injuries and their whole world, you know, was turned upside down. And their partners, you know, either they themselves or their partners would have questions about sex. And it was the dynamic was such that almost, you know, none of the providers felt prepared to address sex with the patients or their partners. They weren't, the topic was not brought up and so they didn't, the patients and the partners didn't know who to ask these questions to. And when they did ask the questions, a lot of times it was met with provider discomfort or even in some cases, like disciplinary action, like it was inappropriate that they were asking these questions. And to be honest, sometimes the patients or the partners would ask the questions in a way that was like humor some or shock and all.

But the reality is, is that they were doing it that way because no one, they didn't know how else to approach it. So, I saw a lot of different barriers there. I saw that it was really important for the patients, and it was really important, and the providers were really lacked a lot of competency around it. And so I remember the specific, you know, where I like figured out that I was really comfortable with it, was a really specific scenario. An OT came into the office and she was like beet red. And everyone was asking like, what happened? Are you OK? What's going on? And she was saying that she was doing a shower with a service member and something, you know, about these service members, that or these wounded warriors, oftentimes the first time that they can shower is something that's really celebrated because they don't necessarily have opportunities to shower on deployment, and then they get injured and then they cannot shower. So, a lot of times these folks had not showered in maybe like three months or four months or six months.

So it was always a really, you know, it was kind of like you celebrate the first time they can get on the toilet and the first time they can take a shower.

MATT BRANDENBURG:
Yeah, yeah.

KATHRYN ELLIS:
Those were always, like, the best days in OT. So, she was in the shower with the service member and his spouse, and, you know, those showers are, like, is like a lot of people is small, small shower. And the wife had on a white t shirt, and she took the white t shirt off, and she was just in her bra, and she looked at her husband, kind of cheeky, and she said, we don't want to have a white t shirt contest up in here. So, as the OT is like in the office, she's telling the story and I'm trying to like, I'm listening and I'm like waiting to, I'm trying to listen for like where something went wrong and because I'm like loving the story. I'm like in my head I'm like, that's so cool. That's so sweet. It's really flirty. Good for them, but I'm also seeing the reaction from my coworker that is one of, like, extreme discomfort and feeling like maybe, you know, that that was like, inappropriate or that she let them, you know, she shouldn't have let her take her shirt off, like all of this unneeded responsibility that the OT was taking on about this scenario.

And so it was really in that moment that I just really got cued into the fact that I have a specific comfort level and that for the most part, a lot of my coworkers and a lot of the providers there did not. So, I started honing my clinical skills. I started being like the point of contact to talk about sex. And in doing that, I also said, OK, well, I also feel like I need to establish myself as an educator, you know, we need more people doing this work. So, I almost day one, as a new OT, I would go, I want this education route to be an educator. And I went the route of a clinician that was really honing their skills, and then it really grew from there.

MATT BRANDENBURG:
I love that. Thank you for sharing that story. I think you touched on some really important points, especially how your comfort level and competency allow you to really address sexuality and intimacy when working with people. And how could OT professionals really study and apply evidence related to sexuality and intimacy to kind of gain that same level of comfort and competency in their own practice?

KATHRYN ELLIS:
Yeah. Well, I mean, I really want to highlight that in the beginning it was just a comfort, right? So there was no competency and I was still bringing it up with patients and addressing it with them. You know, I was doing the OT process and activity analysis and I was learning from my patients. You know, I think that when it comes to sex, we clinicians often want to feel like they're doing it perfect and it's not possible. It's simply not possible. So in the beginning, I learned so much from my patients just by asking them like, well, what are your concerns and what are your challenges? And not only like, what are your goals, but like, what's making it hard to achieve those goals and then applying that OT process to break down those barriers or to enable participation. You know, that's the... I always want to reduce the barrier to entry to the OT. You know, you could start doing this tomorrow. How we apply evidence and research. We don't have it.

MATT BRANDENBURG:
OK.

KATHRYN ELLIS:
We have education, which is, you know, there are a couple people in the profession that are providing education. You know me for one, I'm a continuing education provider with the Institute for Sex and Occupational Therapy, and I offer a certification for occupational therapists, the Certified Sexuality OT, that helps you build that competency in your skill set so that you can improve how you're addressing sex with your patients.

MATT BRANDENBURG:
I love that, and you also have a number of publications, including, I believe it's three books now.

KATHRYN ELLIS:
Yes. Yep.

MATT BRANDENBURG:
And I wanted to talk about one with you today. You co-authored the book Sexuality and Intimacy, which is available in the AOTA store. Can you kind of introduce us to this publication? Who's the intended audience of this book, and how do you hope it helps practitioners kind of gain some of that competency we're talking about?

KATHRYN ELLIS:
Yeah, the intended audience is all OTs, OT students and OT professors. The book offers some really different perspectives on the foundational information. So, for example, foundational sexuality education within OT might have focused a lot on positioning. It feels like a safe topic for OT. It's very mechanical. It feels very OT. However, this textbook is groundbreaking in that it is presenting sexuality foundations from a much more broad perspective. And for example, we speak about desire and arousal, reproduction, trauma informed care, you know, what are what are the foundations of talking to LGBTQIA+ individuals about sex? So, you know, it's a great text for introductory, but it's also a great text for intermediate and advanced OTs on this topic to see this other perspectives on these foundations.

MATT BRANDENBURG:
I love the way your book is designed and the information it contains. It seems like it really emphasizes client centered care. You've mentioned already some important aspects of occupational therapy's role in sexual and intimate occupations. If you had to give us just like one brief answer to that, what is OTs role in sexual and intimate occupations?

KATHRYN ELLIS:
Well, fortunately, we have the Occupational Therapy Practice Framework, which is provided by Doctor Bethan Walker and colleagues. So you all have to check that out. And it does such a nice job of outlining the role of OT because again, as I mentioned, you know, it can feel really safe to stay in that positioning realm. And so there are eight domains. The first one is sexual activity. Right? So this is kind of the the mechanics of sex, the physicality of what people are doing. The second one is sexual interest, which I also call that sexual desire. It's the, I'm not actively having sex but I want to or I don't want to, I'm not interested, but I want to be interested. And a lot of times, what we don't often think about within OT is the occupations that we do throughout the day and I'm not talking the sexual ones. Right? But I'm talking about just our daily occupational engagement influences so much our sexual desire and our sexual interest. So, for example, the occupation of, you know, having a good workout can make people, you know, increase their desire for sex.

Perhaps, you know, the occupation of mothering or breastfeeding is something that makes it difficult then to transition into a sexual space. So, we have to think about all the ways that we engage in occupation and sequence that together as influential to sexual desire or sexual interest. The third is sexual response. So this is more like the physiological reactions, the erection, the orgasm. And so with the role of OT, you know, that might be pelvic floor therapy, that might be psychoeducation on the physiological process of interaction and coping strategies for anxiety, which will positively impact the ability to, you know, maybe have an erection or have an orgasm. Right? If we reduce the anxiety, these sexual responses will be easier. Then we've got sexual expression. And this is such a fun one, helping people explore that, build that self awareness of who they want to be as a sexual person and how they want to express that. You know, there's so much messaging on how everyone is supposed to be as a sexual person and how they're supposed to express themselves as people typically get order and kind of go through life they start establish more autonomy about the ways that they even view themselves as a sexual person and how they want to communicate that to the world.

Then we have got sexual self view, that's a lot. Again, with that messaging, people can kind of have this like stereotyped or templated idea of what they're supposed to do and prefer. We can do psychoeducation and self-exploration to help people get more in touch with that view of themselves. And then there's intimacy. So, this is that like intimate partnership where you're negotiating, communicating, conflict management. And then the last two are sexual health and family planning. So this has to do with that health maintenance, you know, that might be helping an individual with intellectual and developmental disabilities access, understand and make a decision on the birth control that they want to use. So, as OTPs, we're always looking at the client's physical, cognitive and emotional requirements and barriers to engaging in these occupations and then working with the client to break down those barriers and establish new approaches or new patterns.

MATT BRANDENBURG:
Thank you so much. Like you said, it's so much more than just the mechanics of sex. And there's so much related to sexual and intimate concepts that OTPs can and really should be aware of to better help the people that they work with. I really love how in your book you emphasize how one's own positionality in these areas of occupation kind of has an impact, and how they provide care and how they should approach providing care. What should OT practitioners know about themselves before beginning to address sexuality and intimacy with their clients?

KATHRYN ELLIS:
This is one of my favorite topics to talk about. So, I wrote this chapter with Sameera Qureshi and it is... Sameera is an OT who has spent her whole career as an educator on sexual health for Muslims. And so I worked with Sameera on chapter three, which is a guided self-reflection of yourself as a sexual person. And we have over 75 prompts to get to know yourself more as a sexual person and consider your beliefs, attitudes, preferences. And in doing that, identify potential bias that you might have of other people who differ from you, which everyone differs from you. Right? Like we all differ from each other when it comes to sex. So, this self-reflection is evidence based and best practice for health care providers. Yet, it is so infrequently a part of education or curriculum or the literature. The reason this is so important is because of the lack of dialogue, the silence and the omission of sex from most educational conversations. This leaves us and others unconsciously convinced that our perception is the norm more than other topics.

So I always say, you know, my best set of data is myself. And unless I'm actively thinking about myself or actively learning about how other people are experiencing sex, then it's going to be really easy for me to, you know, put myself few on other people and make assumptions about other people because we don't do this in community with each other. We do it in a lot of privacy and a lot of secrecy and a lot of shame. So, take this. Right? So take a Bible study group and a running club. So, a Bible study group is, you know, you might read a passage, you read a passage in Isaiah, it speaks to you. You text it to the Bible study. Text, you know, group chat and saying, here's a piece of scripture that really motivated me today. Like, hope you all have a great day. And then everybody's responding back, texting, you know, thanks. This is how I interpreted it. So what's the difference here, right? The difference is that people aren't usually having those conversations around sex in community and fellowship with other people.

Another example, right, is like a running club. So a new sneaker hits the market and everyone on the group chat is like, hey, did you try out the new sneaker? One person is saying, yeah, I loved it. I ran ten miles on it. It's great for running uphill. Another person is saying like, yeah, I tried it out, I hated them. My feet are too fat and too sweaty for them. So again, there are these really nuanced conversations about, you know, the running shoe that people are having and that people aren't necessarily having those nuanced conversations about sex. And so when we're not hearing about sex and learning about all the different ways that there are to have sex, then we really are just going based off of our own personal experiences and that can create a ton of bias and a ton of barriers to that therapeutic process. So, this chapter three is one, just a really like interesting chapter because, you know, our hope is that the reader, you know, you're viewing it really from the lens of just you as a sexual person.

And it's not even until like maybe the last couple paragraphs of the chapter that we even address you as the clinician. And so it can be a really interesting process to learn about yourself.

MATT BRANDENBURG:
I love that, and I think that's true with any implicit bias that someone has kind of ingrained in themselves. It takes reflection and introspection to identify that and work on improving it to a point where you are able to serve and help and collaborate with others. I love also how your book has a voyeuristic content section in the introduction. Can you explain to us what voyeurism is and why it may be a very educating principle for practitioners who could find themselves questioning the ethics of addressing sex and intimacy.

KATHRYN ELLIS:
Yeah, or they think about, you know, they're questioning the ethics of what they may feel when they're doing it or when they're reading about it.

MATT BRANDENBURG:
Yeah, yeah.

KATHRYN ELLIS:
Yeah, so when working with patients on sexual activity, we as clinicians are exposed to sexually relevant content and information about somebody else and that can feel voyeuristic. So voyeurism is the practice of taking pleasure in observing something private, most often thought of as something sexually private. Because in our culture, as I was just mentioning, sex always seems to be very private. And so the OT can really worry, like, am I prying too much? Is my curiosity ethical? Am I crossing a boundary? Why am I getting excited? You know, for the reader who is reading our book, you might say, why am I getting excited about reading this content? Is that OK? And you know, furthermore, the OT might feel excited and satisfied by the discussion from an intellectual perspective, and I can share that I feel this way every day. Every day, I am genuinely intrigued and excited from a clinical and an intellectual perspective whenever I am discussing sex with a patient. Now, it's also possible that some of these conversations, which again, are always sexual in nature, invoke an actual sense of sexual pleasure or sexual curiosity.

I will say this happens to me much less frequently, especially since I've been doing this work for so long. But it might happen if I hear something new that I didn't know about or if a patient is talking about their preferences. And it just so happens that those preferences might be similar to my own personal preferences. And clinicians might worry like, again, is this OK, what does this mean? And Dr Ungco and I... Dr Ungco is the co-editor of the textbook. You know, we really wanted to comfort the reader and the clinician and highlight that this is completely normal and not an ethical violation. You know, you are a sexual being. You are a whole human. And we cannot erase that part of you when you go into an OT session. Right? But what we... we cannot erase it and we don't want you to ignore it. What we really want you to do is to pay close attention to it, because that is how you will ensure that these internal feelings aren't influencing the therapeutic relationship. So, some guidance that we have for clinicians is to consider what assessment questions are truly voyeuristic and what is essential questions for the therapeutic process.

So, using that strict criteria of need to know because these questions we ask like they are, they're personal, right. We're asking personal questions like, how do you orgasm and what do you do when you're having sex? And which those questions are always most commonly need to know, but we want to be sure that everything is going through that lens of like, are these need to know questions that can really help the clinician feel like they're not prying, they're not being prying with this information. And actually reading the textbook is a great way to practice this skill, because it's so much more of a safer context to feel these feelings in an educational setting where there is no patient versus a clinical setting where there is a patient, you know, like I had mentioned, like these, any time, maybe a sort of voyeuristic feeling comes up for me. It's super, super infrequent. I would say that it was always infrequent for me, but it certainly happened more in the beginning part, right, of the work that I was doing.

Context is so important with sexual arousal and oftentimes just sexually relevant content can feel exciting or a little arousing, right? And so you might worry that you're feeling it, you know, if you're reading the textbook, you might be like, oh my God, you know, am I feeling it too much? Like, how much is too much? And, you know, I would just like to highlight that when you're reading the textbook, you're reading it in privacy, you're reading it in the safety of your own room. You're, it's a very safe learning experience, right? And you likely in a different context, such as when you are at work, when you are with a patient, when you are wearing your hospital uniform, there's a different context there, and you might not feel those feelings in that different context.

MATT BRANDENBURG:
OK. That paints a better picture for me of what voyeurism is and kind of how to handle those feelings if as a practitioner, they do arise. So,F I really appreciate that. We've heard now what some of the barriers are that practitioners face when it comes to addressing this topic with their clients, what some of those occupations throughout the lifespan are. What additional foundational knowledge should practitioners understand prior to really integrating sexual and intimate occupations into their practice or their academics, policy or research?

KATHRYN ELLIS:
Yeah. So I think that, you know, additional foundational principles needs to be LGBTQIA+ affirmative care, culturally responsive care, and cultural humility. So those aren't necessarily things that fall under sex, but it's really essential and probably trauma informed care, right? So, it's really essential for the clinician to come in with some of that foundational knowledge.

MATT BRANDENBURG:
I love that. Thank you. What are some of the additional barriers that practitioners face when it comes to addressing sexual and intimate occupations with their clients?

KATHRYN ELLIS:
Well, there are many, and these are well documented in the literature, But I always like to say that change happens at all levels. And so we really need to take the onus off the individual clinician. And so I like to really highlight some of the barriers that are present in academia and curriculum and leadership at a hospital. So, some of the academic barriers is that there's not an ACODE standard. And so OT professors don't have to include it in curriculum. Now, you know, there is a significant effort that I have seen within academia to address sex. And there's some incredible professors that are really spearheading this, but it is not widespread change yet at all. It is not widespread adoption and that is where we need to go. So, we really need to listen to the professors that are doing this work and, you know, try to implement that throughout curriculum and having an ACODE standard. Also leadership at hospitals, right. So, like supervisors, managers, rehab directors acknowledging, you know, you don't have to be the one that's doing this work, but you do need to nurture one person on your staff to specialize in this work.

The same way that you might nurture somebody who, you know, if you're a rehab director, right? Like you might have a driving rehab specialist, you might have a vision rehab specialist, you might have a lymphedema specialist, a splinting specialist, and you put money towards their continuing education. And that is something at the leadership level. You know, not having that leadership, encouragement and resourcing is a barrier for that individual clinician.

MATT BRANDENBURG:
How do you recommend practitioners really work to overcome those barriers? You know. It makes sense that sex is the way humans come into existence, you know, and even when it's not for reproductive purposes is an important aspect of life that should be addressed. What can OTs do to try and combat some of those barriers?

KATHRYN ELLIS:
Again, just really want to shine light on people that are in leadership positions. So, academia, ACODE, AOTA does an amazing job at highlighting this work. Supervisors, managers, so that's where, you know, we need to see a lot of advocacy work. For the individual clinician I always, I have a couple of suggestions that I always like to share. One is doing continuing education. Right. So, either working on your certified sexuality OT courses through the institute, you know, reading research and trying to translate into the practice by one, just addressing it with your clients. You don't need permission. You do not need permission to address sex with your clients from your leadership. And but, trying to start the conversation where you work. I mean, this is definitely what I did at Walter Reed, right? So, I would talk to my coworkers about sex. I would do an in-service. So, an in-service is a really great way to demonstrate your interest in being the point of contact within your clinic on addressing sex.

And also, I think when you're talking to leadership and you're trying to validate and justify the work that you're doing, if you're getting pushback or, you know, and I would say, like, you might, yeah, you might get pushback, right or you might not get pushback, but you don't really get resourcing. And so when you're really trying to advocate for resources for this, then you have to explain what's the why. Why is this so important? So we know, if you are excited about addressing sex with your patients, you are that way because you know why it is important. But there are a lot of people that don't share that why. So you really want to be educating your leadership on why it is important, right. So you might want to talk about the outcomes for the patient, which are, we'll have lower injuries or have a higher quality of life, or reduce the amount of divorce that happens after an injury. And it could be, you know, patient satisfaction. So you're really trying to communicate to the leadership why this is going to be beneficial.

MATT BRANDENBURG:
Absolutely. Those are great recommendations. Our presenting sponsor is New York University, Steinhardt's top ranked department of occupational therapy, which now offers an entry level OTD for aspiring occupational therapists. NYU additionally offers advanced degrees for practicing therapists that can be completed in person or online, study and work with leading educators, researchers, and master clinicians in the vibrant setting of New York City and have access to a diverse patient population and extensive health care system. Learn to deliver exceptional patient care or deepen your knowledge and practice as you focus on applied scientific inquiry and clinical areas such as pediatrics, developmental disabilities, mental health and assistive rehabilitation technologies. Take the next step by visiting Steinhardt's.NYU.edu/OT to learn more.

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The second half of the textbook that you co-authored focuses on kind of helping readers to understand how to address sexual and intimate occupations in their practice.

I want to ask if you can give us a sneak peek into your own approach with your own practice. How do you initiate the OT process with your own clients?

KATHRYN ELLIS:
I think of the physical, cognitive, and emotional aspects of sexuality and intimacy. And, you know, all of these are integrated into specific occupations that sequenced together make out the sexual routine. So, I'll list some questions that I ask in and avow and highlight which ones typically have more of an influence. So, you know, I always ask about pain and that's really getting at some of the physical or maybe the emotional activity demands of participating in sexual activity. I ask about orgasm, erection, lubrication. These are sexual responses. Maybe that's controlled more by physical or emotional. You know, I'll ask like who is initiating the sex and how are they initiating the sex? This is maybe getting more at the emotional and cognitive aspects of that, the activity demand of initiating sex. I always ask about anxiety, anxiety related to sex or during sex, or maybe leading up to sex and thinking about, you know, that that's, that could be a cognitive learned behavior or an emotional response.

I always ask about childhood messages related to sex that they learned growing up. This is kind of getting at the cognitive and emotional piece. And I also ask, you know, and I say it, I say, in awkward and explicit detail, like, how are you having sex? What is the most enjoyable aspect for you and how do you orgasm? It's really important. Those last two questions are two different questions. What do you find most pleasurable about sex and how do you orgasm? About 80%, this is anecdotal, but 80% of the time of the responses are those are two separate things. So 80% of the time, people, you know, list two different answers for those two questions, which I always think is really interesting.

MATT BRANDENBURG:
How does that number change as people work with you?

KATHRYN ELLIS:
Well, what it's really getting at is, you know, someone might say, I orgasm from oral sex and then I'll say, OK, well, what is, you know, in the whole sexual routine, in the whole sexual dance, what are you finding? What's the most pleasurable? Like, why do you, what do you really enjoy? And 80% of the time, they're telling me something different from what brings them to orgasm. So, they might be saying something like, oh, well, I really love, like, the teasing before the oral sex or I really, I just absolutely love, like having my ear nibbled or my neck kissed, so I don't view it as a bad thing that those aren't in alignment. I'm really not surprised. Right? Like the orgasm is what, you know what that lasts couple of seconds when, like, the pleasure from neck kissing or earlobe kissing, like, could last much longer than that.

MATT BRANDENBURG:
Got it. Thank you, thank you. What are kind of some of the key indicators or measuring measures that you or practitioners and clients can use to analyze performance and kind of track progress towards some goals that they're working towards.

KATHRYN ELLIS:
So, I always want to be client centered. So oftentimes, you know, we learn through experience. And so after a session I always have homework for people either individuals or couples and I have homework for them. And usually that homework is occupation based. It's, you know, either trying a different approach or doing a different sequence, initiating sex in a different way and then we come back together and we talk about how that worked. So that's usually the measure for success is like how well did that recommendation go? And either it didn't work great. And then we need to think of a different recommendation or it went really well. And then we kind of like, you know, chip that go off and go on to the next goal. But it's a highly, highly collaborative process. And so if maybe a certain piece of homework like didn't go well, then I want to know why. And I want to talk about, you know, what were even the barriers then to that homework.

MATT BRANDENBURG:
And I love how collaborative of a process this is. It seems like that's, you know, the best way to provide this type of care. But given that it is so collaborative, what should practitioners make sure they understand about the diversity in sexual and intimate experiences and perspectives prior to really designing and implementing sexuality and intimacy interventions?

KATHRYN ELLIS:
Yeah, that's such a great question. So, look, we cannot be expected to have experienced all of the sexual activities that we should be expected to as an OT do an activity analysis on. So, what I'm saying is that I don't want OTPs to get hung up on the fact that we can't address any type of sex if we haven't personally had sex that way. All of the different ways to have sex is so vast and expansive, and it is a very long list, so we can't possibly understand the diversity and we are not expected to. So we need to use cultural humility, which in this context is don't act surprised when you hear something new. If you are confused ask clarifying, need to know questions and don't make assumptions. So, I'll tell a story. You know, I was working with a couple, and this happened like, just recently, and I've been educating on this topic for 13 years, and I educate and I instruct people on exactly what I didn't do. So, or to be cautious of exactly what I did. So, I was working with this couple who would do pegging.

So, the female partner would put on a strap on that had a dildo, and she would use that to peg her male partner. And I heard this information, and for probably the next four sessions, I was envisioning the position of doggy style like a kind of doggy style position. And it turns out, and this was my fault for not knowing this, right? And not asking this question, but that was my assumption. It turns out that actually what they do is they use a swing and he's in the doorway and they use a swing and they're facing each other while they're doing it. And so it was this really great experience for me where I was, you know, envisioning and doing activity analysis on the mechanics that were totally different from the way the couple was actually doing it. And so that's where you have to practice that cultural humility and be like, oh, wow, like that was in retrospect, I realized that was an assumption that I had made.

MATT BRANDENBURG:
That's a wonderful illustration of the importance of not making assumptions and not acting shocked in the moment when you hear something and following those recommendations that you've given us. Could you share with us maybe another case study or a clinical example of how you were able to guide a client through the OT process and achieve an improved sexuality or intimacy outcome?

KATHRYN ELLIS:
Yeah. So I worked with this, I think a great case that I always like to talk about is a lady that I was working with who had really significant low back pain, and it made her, you know, so she had that right and then she also had low desire, a lot of anxiety around sex. And she felt really bad about herself that, you know, she used to really enjoy sex. And her partner, her husband really enjoyed sex. And it was really, you know, difficult for her. So she came in with a lot of, like, negativity and shame. And so what we really got to the bottom of was that there was a considerable amount of anxiety and anticipatory anxiety. And the way that she described it to me was I get worried because I don't know what my husband will want to do. And this is really interesting because a lot of couples get into a sexual routine and a sexual pattern that they never agreed to, that they never talked about, but they just do the same thing a couple of times, and then that's how they have sex for like, the rest of their life.

And if there is an issue that makes that kind of sex no longer enjoyable or painful or not possible, then a lot of times they really struggle to establish, you know, a new routine, right? Or to even say, like, hey, I don't want to have sex in that way, because that way causes me pain. And so I talked to her about, you know, that this doesn't need, this idea of I don't know what he will want to do. I said, this doesn't need to be private information. This is not you know, you're having sex with each other. That question is not off limits, right. Like, so I kind of phrased it as, you know, the two of you can get together before sex and establish a game plan and see what he might be interested in doing that night and what you might be interested in doing and what that he has suggested are things that you don't want to do. So you kind of write out, you know, this is like metaphorical, but you write out your list, you cross out things you don't want to do, and then you do the things that are, you know, shared and agreed upon.

And that was really great for her anxiety and her low back pain. Because low back pain, you know, with pain that fluctuates. It's sometimes she, you know, wants to do everything on the list, plus the bonus features. And sometimes she wants to, like, do one thing right. So, that was really helpful for her. And then in talking to her about, you know, in just expanding that perspective that, you can do some of the sex, but not all of the sex. Then it led her to get more creative, and what she did is she went and took, like sexy pictures of herself and sent them to her husband so that like, at times when maybe she did not want to do anything, that they can look at these pictures together and he can masturbate with them together, or he can look at them privately and masturbate, but that, it can still be like she can still feel like she's like a part of it and participating in it. And I just thought that was like such a fabulous, like, way to accommodate yourself. And like, I just thought that was amazing.

MATT BRANDENBURG:
Yeah, that's such a wonderful example. And it's sounds really empowering the way that this couple was able to problem solve and collaborate through that and, kind of, improve their, their performance of this important occupation. So....

KATHRYN ELLIS:
Yeah.

MATT BRANDENBURG:
I love that. Kathryn. What further studies or research is needed to continue advancing the role of occupational therapy in sexuality and intimacy?

KATHRYN ELLIS:
We need a lot more research on the intervention and the modalities. Definitely. I would love to see some work around sensory processing and sex as well, sensory processing and arousal as well.

MATT BRANDENBURG:
And what additional resources or certifications related to these topics would you recommend to our listeners?

KATHRYN ELLIS:
Yeah, so I always like to highlight the free resources that are on the Institute for sex and OTs website, which is a sexintimacyOT.com. So I have a free continuing Ed course. I've got tons of blog articles. I also have the Educational Illustrations Library project, which is sketches of sex scenes that are specifically for professors, and the professors can use them with the students to do activity analysis or any other learning activity or experience that you want. I also like to highlight that we have an educator's guide for the textbook, and this was put together by Professors Erin Connor and Devlin New. And this outline, this is on AOTAs website. And this outlines learning objectives, learning activities and ACODE standards for each chapter of the textbook for you to, you know, integrate that into your curriculum. Look, exposing yourself to more sexually relevant things is going to be so helpful. So that could be like listening to podcasts, reading research articles on pleasure, listening to Ted talks, take continuing education, go to museum exhibits, or like a burlesque show and really just opening up more like bringing these conversations into your life by opening up more about sex with your friends, your coworkers, your partners.

Any exposure is going to make this easier.

MATT BRANDENBURG:
Well, thank you. Those are wonderful resources. We've arrived now, Kathryn, to the Golden Nugget segment of our show. If you could share one final piece of advice or recommendation with practitioners, what would it be?

KATHRYN ELLIS:
It would be to start. Start today. We have a perception that the barrier to entry, to talking about sex with our patients is so high. It's not. You're an OT, you know how to do an activity analysis and sex is listed as an ADL. You will only get better with more repetitions. So, my challenge to everyone listening is to say the word sex to a patient, a coworker, a colleague, your professor, your students within the next 48 hours and just start a conversation.

MATT BRANDENBURG:
I love that. That's a wonderful challenge. And, you know what, I'm committing now to take that challenge and to I'm going to say the word sex in the next 48 hours in my practice as well, Kathryn.

KATHRYN ELLIS:
That's amazing.

MATT BRANDENBURG:
Yes. We're going to have to have you back on the show so we can talk about how it went and how I can get better and learn more as it relates to practice in this area.

KATHRYN ELLIS:
Yes. I would love that.

MATT BRANDENBURG:
Awesome. Well, thank you so much for your time, Kathryn. It's been wonderful learning from you. And I really appreciate sharing everything you have.

KATHRYN ELLIS:
Yeah, of course. Thanks so much, Matt. And I really appreciate AOTA prioritizing this topic and just sharing this helpful information with the members and the listeners. This was a lot of fun. Thank you.

MATT BRANDENBURG:
Absolutely, absolutely.

SPEAKER:
Thank you, listener, for tuning in. And thank you to NYU Steinhardt Program and Occupational Therapy for sponsoring this episode. Thanks for listening to the AOTA podcast. Tune in again next time.