FAMILY PLANNING AND THE HANDICAPPED*

CAROLE WELMAN

(BA, RN, RM, Dip CHN)
Organiser of Nursing Services (Family Planning)
Department of Health and Welfare

OPSOMMING

Seksuele verhoudings is net so belangrik vir die gestremde as vir die normale mens. In gesinsbeplanning vir die gestremde is raadgewing een van die belangrikste aspekte.

Vir die bepaling van die geskikte gesinsbeplanningsmetode vir die gestremde pasiënt moet die verpleegkundige kennis dra van die genetiese faktore wat met die gestremdheid verband hou, die aard van die gestremdheid, die kliënt se motoriese en intellektuele vermoë en haar mediese geskiedenis.

'n Ondersteunende omgewing, waar die benadering by die individu en sy besondere gestremdheid aangepas word, is noodsaaklik. Gesondheidspersoneel moet ook deurgaans aandag gee aan die seksuele rehabilitasie van enige gestremde.

INTRODUCTION

People tend to ignore the fact that sexual relationships are as important for the disabled as for the normal individual. Health professionals often do not recognise that disabled individuals are capable of enjoying and taking part in a full range of sexual activities.

There are many problem areas which need to be considered but, with regard to family planning, counselling is of paramount importance.

GENETIC FACTORS

Before counselling can take place, it is necessary that the counsellor has a sound knowledge of the genetic factors involved. Genetic inheritance is one of the concerns of society, giving rise to the question of the morality of producing children with defects and thus depriving these children of a *meaningful* life.

In our society, reproduction depends entirely on the individuals concerned, but there are an increasing number of people who are seeking genetic advice and who request sterilisation or alternative effective methods of contraception.

Table 1 pinpoints some of the main disabilities and their related genetic factors.

TABLE 1 SOME OF THE MAIN DISABILITIES AND RELATED GENETIC FACTORS

Handicap	Hereditary	Not hereditary	Comments
Deafness	• Waardenberg's syndrome • Pendred syndrome • Collins-Treacher syndrome • Familial deafness	• Rubella syndrome • Athetoid form of cerebral palsy • Neonatal asphyxia • Intra-cranial and middle-ear infection	Physical disabilities that are conspicuous but do not adversely affect sexual function.
Blindness	• Robinson Harley lists 35 genetic abnormalities in *Textbook of Paediatrics* (page 1433 Saunders 1969)	• Trachoma • Infections of the eye	
Mental retardation	• Chromosomal abnormalities, such as Down's syndrome	• Conditions arising during pregnancy or labour or sometimes post-natally.	It is important for parents, or close relatives of a Down's child to obtain expert advice on the risk to further progeny.
Epilepsy		• Most cases	Heredity plays a relatively small part. Where two prospective parents are epileptic, genetic advice should be obtained.
Physical handicaps such as spina bifida and cerebral palsy			Causes are multi-factorial. These individuals have the problem of mechanical sex-fulfilment.

*Originally appeared in *Family Planning Medical/Technical Information Bulletin* No 4 April 1980. Article has been amended by the author.

COUNSELLING

It is important to bear in mind that even the most severely mentally and physically disabled women usually retain their reproductive potential. They are, therefore, legitimate clients for contraceptive methods.

It is a function of the family planning nurse to be able to provide the most effective and safest method of contraception for the client's

- medical condition
- lifestyle
- intellectual and motor capabilities.

Although, in a stable couple relationship, it is desirable that the partner most physically and intellectually able should be responsible for using a method, it is often necessary for some reason or other that the handicapped person takes this responsibility.

This necessitates, in addition to the usual pattern followed for non-handicapped persons, two important steps in the counselling process:

- the intellectual and technical requirements inherent in the use of each method must be matched to the disabled person's physical and mental capabilities, and
- the client's medical status must be checked against the possible hazards of all the feasible methods.

The following is a guide to counselling women with physical handicaps.

The initial visit

History-taking, physical examination and the ensuing discussion will take an hour or more. The client must be prepared for this and if necessary, several shorter visits can be arranged. It is important that the client knows how much time to allocate for each visit.

Matching the method to the client's physical and mental capabilities

Methods can be viewed as:

YOU -DO-IT

- barrier creams and foams
- diaphragm
- oral contraceptives
- rhythm methods.

These methods necessitate motor and intellectual performance and are therefore not suitable for quadriplegics and the intellectually handicapped.

The use of oral contraceptives includes storing the container, reaching for it, removing a pill and placing the pill in the mouth.

DONE-TO-YOU

- injectables
- intra-uterine devices
- sterilisation
- hysterectomy.

These methods are applied to a passive patient. However, because of operative procedures involved in most, and because of the permanency of some of these methods, the patient has to have a reasonably clear understanding of the procedures involved, and their eventual outcome and potential hazards.

Matching the client to the method

Some of the side-effects and complications of the different methods are usually accentuated for the handicapped because of the nature of their disability and their lifestyle. A few of the more important ones are highlighted here.

- **Oral contraceptives** The thromboembolic hazard is increased for people who are confined mostly or partly to wheelchairs.
- **Intra-uterine devices** These are inadvisable when the woman cannot feel symptoms of intra-abdominal discomfort indicating possible perforation or pelvic inflammatory disease. Also inadvisable where increased menstrual flow would be difficult to cope with.
- **Injectables** These may lead to weight gain and depression, which should be avoided in some sedentary and unhappy patients.
- **Sterilisation** This has few, if any, contra-indications specific to the handicapped. However, where sterilisation (or hysterectomy) of the mentally handicapped is concerned, the decision to sterilise can only be made as a result of a formal consultation procedure in which the individual's long-term interests are represented.
- **Hysterectomy** For the handicapped a hysterectomy has the attraction of reducing the hygienic problems associated with menstrual flow.

In order to carry out the matching processes mentioned above, it is necessary to determine the client's level of motor (physical) and intellectual function, present and past medical history and sexual history, as well as to perform a physical examination. Some important aspects regarding the above are discussed.

- **Motor (physical) and intellectual function** Levels of function are usually revealed through enquiry about daily activities. Information must be obtained about life-style, vocational accomplishment, degree of independence and the ability to perform personal hygiene tasks. This information will indicate the extent to which a *you-do-it* method could be relied on.
- **Past and present medical history** Evidence of fertility, past operations, past and present use of medical and non-medical drugs are of importance.
- **Sexual history** It is important to know the client's future plans for a family and partnership arrangement. Answers to questions about the reproductive process help in the assessment of sexual knowledge and intellectual function and form the basis for questions on sexual functioning.
- **The physical examination** The physical examination of the handicapped can be technically awkward. Early enquiry should be made about urinary function.

  The pelvic examination of women with damage to the spinal cord may be difficult. The limbs of paraplegic women tend to be flaccid, while quadriplegic women often have severe leg spasms while being examined. Spasms can usually be controlled by applying steady pressure to the affected limb, but often an assistant is needed to keep flaccid limbs from falling off the examining table.

  The physical examination is

important for three reasons:
— to determine the exact scope of movement
— to assess medical and pelvic conditions
— to educate the woman — many handicapped persons are ignorant or misinformed about the usual appearance or size of many parts of their body.

SUPPORT

Persons with mental disabilities, by virtue of their psychological impairment, have difficulty in using community facilities for family planning and in using methods effectively. Contraceptive method-related problems tend to be greater with mental disability.

A supportive environment for training and coping with suspicion and anxiety is essential. Usually, the more seriously disordered or retarded the individual, the more problems will arise and the greater the support that will be necessary.

The approach and action always depends on the type of handicap as each type of handicap needs a different approach. Those who have sensory disabilities, or mental or emotional handicaps, or physical limitations, all need quite different approaches. In addition to this, every person involved needs individual help and treatment. It is the nurse practitioner's duty to provide the necessary time, patience and understanding.

Sexual rehabilitation

An important, but often neglected, aspect of the disabled is sexual rehabilitation after injury or disease. Persons who have undergone surgery, such as a mastectomy, colostomy or amputation; and persons who have sustained injuries, such as spinal cord damage; will always require a certain amount of sex counselling. Patients who have suffered debilitating diseases such as disorders of the central nervous system, diabetes, certain renal conditions, and rheumatic and arthritic disorders, are often in need of sex counselling. Unfortunately this need is seldom recognised by health professionals. Yet the sexual effect of paraplegia, hemiplegia, and epilepsy, for example, can so readily be perceived.

In cases of traumatic origin, an individual's personality and capability may be altered beyond recognition of his or her former self, with potentially disastrous effect on existing relationships. In order to attain adequate and sustained sexual rehabilitation, it is imperative that the partner of the disabled person is involved in the therapy directed at the patient. This, however, is seldom done and is often the cause of a breakdown in the sexual relationship where one partner is physically disabled.

CONCLUSION

The sexual problems of the disabled are complicated and interactive between the disabled individual and society. Social attitudes toward the sexuality of disabled persons are evident in, for example, the lack of available resources for advice and practical help, the lack of privacy in residences, and in the discouragement of sexual relationships within establishments.

It would seem that many sexual problems among disabled people are problems of society rather than problems of the individual. Consideration of the sexual aspects of disability has not yet been fully incorporated into the treatment of disability as a whole by the professions or institutions concerned with the care of the handicapped.

REFERENCES

1. Epstein, B Sexual problems of the disabled *IPPF Medical Bulletin* Vol. 13 No. 2 April 1979.
2. Szasz, G *et al* — Guidelines to birth control counselling of the physically handicapped *Canadian Medical Association Journal* Vol. 120 June 1979.
3. David, H; Lindner, M Family planning for the mentally handicapped *Bulletin of W.H.O.* Vol. 52, 1975.
4. *Sexual problems of the disabled* — Discussions with Dr A Sha'ked, Director of the Institute for Sex Education, Mount Sheba Medical Centre, Tel Hashomer.

VOLTOOIDE NAVORSING COMPLETED RESEARCH

MATERNAL-INFANT BONDING IN THE NEONATAL PERIOD — A NURSING STUDY

Lucia Susan Pelser
Magister Curationis (Midwifery and Gynaecological Nursing)
Department of Nursing, University of Pretoria

The purpose of this study is to select appropriate guidelines along which early maternal-infant bonding can be facilitated by midwives, within the present South African nursing system. Extensive empirical data has been obtained and several case studies have been conducted in order to define the role of the midwife. The aim is to prevent the negative effects of the separation between the mother and child, be it physical, psychological or chemical of nature.

Attention is given to the newborn's needs; it's potential to interact; to motherliness; and maternal-infant bonding, as well as the effect of separation between the mother and infant.

It appears from this investigation that interaction between the mother and child is a prerequisite for maternal-infant bonding, and that the present practice of the hospital as place of birth, is detrimental to the process of interaction between the mother and infant.

The opportunity for father and infant interaction is greatly restricted within the practice, and siblings are totally excluded from the event. By eliminating these potentially harmful practices, the midwife can be highly instrumental in promoting maternal-infant bonding.