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Sexual Rehabilitation of People with Physical Disabilities: Sexuality and Spinal Injury

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1. Introduction

This article intends to discuss the sexuality of people with physical deficiencies, focusing on sexual rehabilitation. It is based on a comprehensive review intending to explore some fundamental concepts, theoretical reflections and practices in the text about this thematic dealing with: (a) Concepts about sexuality and disability, (b) The sexuality of people with physical disabilities and (c) The sexual rehabilitation of people with a spinal injury.

1.1 The concept of sexuality and disabilities

Thinking about sexual rehabilitation means thinking about affective, emotional and sexual restructuring of the individual using the vast concept of sexuality defended here as a base, according to Foucault (1988), as a social and historical concept.

Sexual practices, corporal and sexual biological expressions are expressed in difficult cultures and under different social and economic conditions. Therefore sexuality refers to a comprehensive phenomenon of human eroticism, considering the organic, psychological and social issues. Additionally, its expression is vast and widespread and depends on different cultural contexts and historical moments (Anderson, 2000; Bozon, 2004; Blackburn, 2002; Daniels, 1981; Maia, 2010; 2011).

In this sense, even though the phenomenon of the sexual response can be described physiologically, it is important to remember that its expression depends on psychosocial representations. The perceptions of desire, excitation and orgasm, have to do with the way in which these pleasurable corporal experiences were received throughout their life and how they are considered in different societies.

Foucault (2002) proposes that sexuality, including the instinctual direction of the desire, the representation of the body, gender, diverse sexual practices, is constructed from a combination of social, cultural, historical and discursive institutions mediated by the knowledge-power discourse. This social discourse regarding sexuality generates norms that should be controlled based on the idea that it would be normal or abnormal. These models considered as defining normality standards involve issues such as gender, race, ethnicity, educational level and economic among other questions that always involve power (Stoller, 1998; Weeks, 1999).

Therefore, sexuality, understood as historical and cultural phenomenon, reflects the concepts, values and parameters about "normal" and "pathological" that set themselves in contexts where sexual practices occur (Maia, 2010; Stoller, 1998). The sexuality considered

“normal” contains certain sexual patterns, which in our society, are related to questions like: being heterosexual, having a thin and skinny body, having sexual and reproductive health and having a sexually functional response.

We want “normal” sexuality based on these standards, believing that if we’re “adequate”, we’ll feel pleasure and happiness (Maia, 2009). It’s important to point out that not corresponding to certain sexual standards imposed by societies do not make somebody asexual, but it can result in fragmented sexual expression and cause unhappiness and social maladjustment. Thus, functional and dysfunctional social practices reflect a notion of normalcy and ideology.

Another important concept is disability as a social construction, because the organic and functional limits of the human body correspond to disadvantageous representations when society is based on the notion of productivity and competitiveness (Aranha, 1995; Amaral, 1995; Marques, 1997; Omote, 1999; Ross, 1998; Tomasini, 1998). I am referring to the exclusion of those who possess unequal conditions for productivity, such as the elderly and people with deficiencies.

“Disability” refers to a series of general conditions that limit someone’s life biologically, psychologically or socially throughout their development (Maia, 2006). It emerges as something that separates the subject from normalcy; it is considered a deviation, placed in a condition of “defectiveness”, “insufficiency” and “imperfection”. The way in which such differences are judged reflects how we conceive what is and what should be normal and healthy (Amaral, 1995; Maia, 2009; Omote, 1999; Tomasini, 1998; Siebers, 2008; Sorrentino, 1990).

Therefore, even though the disability and difference appears in a biological body or atypical behavior, it can only be considered a “disability” as a social phenomenon, that is out of the subject’s control, and not intrinsic to them. It is society that judges and classifies that as a disability or not, and establishes the parameters of what it means to be host that difference in comparison to everybody else (Amaral, 1995; Aranha, 1995; Omote, 1999). That judgment results in stigmatization (Goffman, 1988).

Generally, social opinion places disability as a condition of disadvantage based on socially undesirable attributes. It’s evident that disability isn’t just a mere detail, but a label, a stamp that makes its subject deal with a series of difficulties, a constant fight for equal rights, favorable conditions in order to be a conscientious citizen (Maia, 2006; 2011). Siebers (2008) claims that disability is a minority identity that has been historically seen as a condition that’s a target for medical intervention, but should be understood as a product of society, constructed in the context where it manifests itself. The disability isn’t a personal and individual problem, but a social and collective one (Edwards, 1997; Maia, 2011; Mitchell & Synder, 1997; Pristley, 2001; Siebers, 2008).

Thus, we can grasp that the concept of disability is created and maintained by society. That is, the social belief about the phenomenon, in this case, the whole idea is therefore social, cultural and historical (Amaral, 1995; Marques, 1997; Omote, 1999; Ribas, 1998; Siebers, 2008; Tomasini, 1998). According to Aranha (1995, p.69) “those who don’t correspond to the efficiency/production parameters, will naturally be worthless by becoming contradictions to the system exposing its limitations”.

Above all, it’s because of this, that it is necessary to understand – and reflect – about the prevailing concept in relation to disabled people and disabilities and deficiencies in our society at this historic moment. Certainly, despite the advance represented by the inclusive paradigm even though in practice, there aren’t any guarantees, of accomplishing the best

possibilities of developing a life healthy and worthy of a conscientious citizen in relation to education, work, and also sexuality (Maia, 2006; 2011).

It's possible to deduce that one of the great barriers to inclusion is the stigma, and this, as in all prejudice, also disregards diversity with respect to sexuality. Considering sexuality and disability as social conditions, think about the biological body in terms that sexual rehabilitation results in questioning which social meanings are subjective components and which are feelings of personal inadequacy.

1.2 The sexuality of people with physical disabilities

The capacity to love and be loved and the erotic desires that are inherent to human beings are preserved under any limitation; that is to say that no human being loses their sexuality even when they have certain motor or physiological restrictions. Many times social prejudice turns sexuality impossible in people with disabilities.

"It's necessary to be clear that sexuality is independent - or not - on the existence of incapacity; in other words, sexuality is inherent to human beings; the differences occur in the manifestation of the sexual activity, which can be modified in some cases. Disability isn't definitely synonymous to asexuality or sexual problematic" (Pinel, 1999, p.214-215).

The greatest difficulties in the expression of sexuality in the case of people with physical disabilities refer to social questions more than to organic limitation. The main questions are prejudice, misinformation, discrimination, inability, lack of adequate sexual orientation, insufficient or inadequate process of sex education by their Family, disbelief in the capacity of disabled people to express their sentiments and sexual desires, values, and distorted ideas associated with physical disabilities (Blackburn, 2002; Pinel, 1999; Maia, 2006; 2011).

The sexuality of the disabled person is a multi-faceted phenomenon: economic, political, cultural and educational questions (Fróes, 2000; Maia, 2006). Additionally, people with a disability suffer the effects of beauty standards, perfection and happiness, especially when they are women. Many people with a disability incorporate the expectations of sexual standards and internalize the even more difficult task of reaching them, when the disability exists (França & Chaves, 2005; Louro, Faro & Chaves, 1997; Maia, 2011; Sorrentino, 1990; Werebe, 1984).

Authors such as Anderson and Kitchin (2000) have defended that the majority of day-to-day difficulties encountered by people with disabilities in relation to sexuality is caused by the failure of available education resources and services to provide them with clarification about the subject. According to Pinel (1999) the majority of people with disabilities reproduce a social image that can generate socialization problems related to deprivation of affection, emotional dependence and also difficulties in becoming adults capable of fighting for their rights including those related to sexuality.

So, the sexuality of people with disabilities is perceived in common sense-that reflects on work with teachers, diverse professional, and clients themselves and their family members - based on different myths. Some of these myths are: people with disabilities are asexual: they have no feelings, thoughts and sexual needs, people with disabilities have a hyper sexuality: their desires are uncontrollable and exacerbated, people with disabilities are unattractive, undesirable and unable to love and have a sexual relationship, people with disabilities are unable to enjoy *normal* sex and have sexual dysfunctions related to desire, excitement and orgasm, reproduction for people with disabilities is always problematic because people are infertile, have children with disabled or are unable to take care of them

(Andreson, 2000; Amaral, 1995; Baer, 2003; Giami, 2004; Kaufman, Silverberg & Odette, 2003; Maia, 2011; Maia & Ribeiro, 2010; Pinel, 1999; Salimene, 1995).

Those ideas are myths because they don't correspond to the truth. People with disabilities are always sexual beings, even though they might have some sort of physical or sexual limitation: they don't characterize themselves as asexual nor as hypersexual, their anxieties, necessities and desires are the same as those with healthy bodies. Additionally, possible problems in the sexual response phases, such as desire, excitement and orgasm are common in groups with and without disabilities. In both cases there are resources and behavioral technologies that can help overcome these obstacles, therefore the sex life of a person with a disability is not synonymous with incapacity and unhappiness.

Belief in these myths reveals a biased way of understanding the sexuality of disabled people as deviant from normal standards and it becomes an obstacle to love and to have sex for these who are stigmatized by the disability and because of this, clarifying these myths is a necessary task to minimize the prejudice that sustains and reproduces them (Maia & Ribeiro, 2010).

1.3 Sexual rehabilitation of people with spinal cord injuries

1.3.1 Spinal cord injury: Characteristics, etiology and prognosis

Spinal cord injury is a medical condition that severely affects various bodily functions, often causing motor paralysis, loss of sensibility in certain body parts and lack of bladder or bowel control. These symptoms may be temporary, but often are permanent (Ducharme & Gill, 1997). Spinal cord injury, therefore, is defined as a clinical condition that produces alteration in motor, sensory and neurovegetative functions, which also are reflected in profound psychological and social changes.

The spine consists of vertebrae superimposed on a regular basis, held together by ligaments and disposed on the center line of the posterior trunk. Its function is to hold the bones of the body and protect the spinal cord. The spine is divided into four regions - cervical, thoracic, lumbar and sacral. The spinal canal serves to protect the spinal cord, the roots of spinal nerves and the meninges (Baer, 2003; Cardoso, 2006).

To define the spinal cord injury it is important to consider the specific circumstances of each case, depending on the level and extent of injury. A neurological examination is able to evaluate the injury by determining the level of damage, whether it will result in paraplegia or quadriplegia and whether it is complete or incomplete. Cardoso (2006) explains:

“Thus, tetraplegia is defined as the loss or impairment of motor and/or sensory function in the cervical segments of the spinal cord caused by destruction of neural elements within the spinal canal resulting in a alteration of function of the upper and lower limbs, trunk and pelvic organs. (...) In turn paraplegia is defined as the loss or impairment of motor and/or sensory function in thoracic, lumbar or sacral spinal cord, because of the destruction of neural elements within the spinal canal. In paraplegia the upper limb function remains intact, but depending on the level of the injury, trunk, lower limbs and pelvic organs may be functionally impaired” (p.58).

Other issues arising from spinal cord injuries are secondary complications such as pressure ulcers, urinary infections, pain, spasticity, and obesity, problems that worsen with time (Salimene, 1995, Maia, 2011).

The causes of spinal cord injuries can be grouped into traumatic and non-traumatic. In the first group, the lesions occur in car accidents, falls, firearms, at work or in sports practice, etc.. In the second group are the medical conditions (spinal tumors, myelitis, scoliosis,

multiple sclerosis, congenital malformations, spinal vascular accidents etc (Cardoso, 2006; Salimene, 1995, Maia, 2006).

Spinal cord injury affects mainly young male adults. It is rare among children and these data are similar in different countries (Baer, 2003; Pinel, 1999; Salimene, 1995). Moreover, the spinal segments that suffer most injuries are located between the cervical articulations. The severity of neurological impairment resulting from a spinal cord injury reflects the nature and magnitude of the violence of the injury, which may result from bending, compression, hyperextension and flexion-rotation against any region of the column where this impact operates (Cardoso, 2006).

Concerning these aspects, the prognosis will depend crucially on the area and the extent of injury. According to Cardoso (2006), considering the injuries in general, there is a mortality rate of 38% soon after the injury or the initial phase, due to respiratory or trophic disease. However, currently, the expectation of life of individuals affected by the injury has increased significantly.

1.3.2 The sexual response in people with spinal cord injury

Physical disabilities, especially those of the spinal cord, were total and partial paralysis, loss of motor functions and feeling in the legs (paraplegia), or in the legs, torso and arms (tetraplegia) can have direct implications on the sexual response mechanism. That is to say problems in the sexual phase (penile erection or vaginal lubrication) and even more in the orgasm and ejaculation phases. Depending on the level and extension of the spinal cord injury, some sexual response alterations are recurring, specially in men, where changes in ejaculation can occur (ejaculation lock) and in the erection (partial or complete erectile dysfunction or maintenance) and retrograde ejaculation (Baer, 2003; Cardoso, 2006; Ducharme & Gill, 1997; Maia, 2010, Maior, 1988; Pinel, 1999).

Sexual function consists of three levels, the psychic, gonadal, and neuromuscular, and for its manifestation to occur normally, good functioning and integration of these three levels are necessary (Maior 1988). Salimene (1995) says it's evident that spinal cord injuries accentuate physical and functional limitations, but that's not to say that there's necessarily going to be problems in relation to the overall sexual manifestation. According to Cardoso (2006), the limbic system and spinal cord centers constitute sexuality's neurological substrate, but this is influenced by cognitive and sociocultural mechanisms like fears, expectations and beliefs, and by personal evaluation of one's sexual response.

From a psychological point of view, sexual desire seems to be associated with cognitive activity and, from an organic viewpoint, it is related to cerebral activity, activity through the limbic system, influenced by testosterone. Desire is governed by many biological mechanisms in relation to availability and the subject's receptivity with the other that had psychological and social influence. In people with physical disabilities and spinal cord injuries, desire is a phase where they might or might not suffer alterations, especially arising from psychological and social issues, more than organic ones. It is common to hear between those with spinal cord injuries, that desire decreases after the lesion, what could be related to the lesion, but also to mechanisms that affect the nervous system and even reduced mobility, and spasticity and problems with intestinal and bladder control. On the other hand, physical intimacy, even degenitalized can be gratifying and this can increase sexual desire (Cardoso, 2006, Maia, 2011; Maior, 1988; Pinel, 1999).

From a neurological point of view, the autonomous nervous system is the main culprit for human excitement capacity and many psychological factors can prevent a person from

feeling excitement by blocking their neurological signs. To define the excitement of the person with the spinal cord injury, it's necessary to know the level and extent of the injury and if the sacral reflex arc was affected. If the reflex pathway is maintained, which occurs in spinal cord injuries above the sacral segments, the reflex erection is possible, but in complete lesions, the psychogenic erection would already be inexistent. Men with complete upper lesions can maintain their reflex erection capacity, but not the psychogenic; in incomplete upper lesions, reflex erections would be normal and the psychogenic could exist. In the complete lower lesions, the reflex erections would be impossible and psychogenics would be possible and in incomplete lower lesions, both erections would be possible. However, in every case, the organic alterations depend on the emotional and social alterations (Cardoso, 2006; Maia, 2011, Maior, 1988; Pinel, 1999).

The orgasm, however, can be felt in some cases even though it's a complex phenomenon. Although the penile and vaginal sensations might not be felt in people who have spinal cord injuries, other physiological changes related to the orgasm, extragenital, for example, can be observed and felt by those people: other erogenous zones let the subject experience sensations of pleasure and corporal satisfaction or even the satisfaction of being with the other person. As a result of ejaculatory problems, masculine infertility is also frequent, mainly in complete lower lesions (Cardoso, 2006; Maior, 1988; Pinel, 1999).

In women, the ability to get pregnant is preserved, but changes in the sexual response can also occur, such as alterations in the clitoral or anal stimulation sensitivity, reduced lubrication and congestion of external genitalia. For men and women, orgasms are experienced more frequently in incomplete lesions or even the so-called "phantom orgasms" or "paraorgasms" that are pleasurable sensations after stimulation of the erogenous zones that are not affected by the lesion (Maia, 2006; Maior, 1988; Pinel, 1999; Salimene, 1995). Pinel (1999) explains:

"Sexual response involves profound changes in the body as a whole and not just non-genital: blood pressure and heart beat increases, the person becomes breathless, with skin blushes. As well as the orgasms are not identical in intensity to the same person, the organic alterations will cause changes in the perception. [...]. Today we know that orgasm is possible after a spinal cord injury. Although it is not easy or automatic, orgasm can be built, regardless of erection, ejaculation or vaginal lubrication. This, however, usually involves a work of re-identification and redefinition of sensations [...]. The relearning of the spinal cord injured person goes further than physiotherapy and caring of bladder and intestines. It includes social, emotional and sexual restructuring that enables the person to life again" (Pinel, p.220).

Feminine reproduction is preserved after the lesion. In the case of men, the chance of ejaculation is low and some fertility treatments that can be used or recommended are: insemination, in vitro fertilization, gamete intrafallopian transfer, and intracytoplasmic sperm injection (Full-Riede, Hausmann & Schneider 2003) or electroejaculation, penile vibratory stimulation, pharmacological agents that induce ejaculation (Baer, 2003).

It's common for people with spinal cord injuries to make comparisons with their sex life before the injury, associate erections and orgasms as indispensable phenomenona of sexual intercourse and this increases feelings of failure, a higher degree of anxiety and depression that end up decreasing desire and excitement (Baer, 2003; Cardoso, 2006; Pinel, 1999). In addition, some authors (Ferri & Gregg, 1998; Silva & Albertini, 2007; Soares, Moreira & Monteiro, 2008) argue that socially determined gender questions influence coping with the

disability in a different way. That is, the impact of acquired disability may have different psychosocial implications when it comes to men or women.

1.3.3 The sexuality counseling

The spinal cord injury also involves important psychological changes that must be considered in clinical treatments for this population. It is common, given the situation of extreme physical and emotional dependence of other people, spinal cord injured people express attitudes of rejection and denial of reality. There are also feelings of denial, grief, anger, and also reactions of depression and low self-esteem (Maier, 1988; Maia, 2006; Puhlmann, 2000).

“The most common psychological reactions of people who become physically disabled involve emotional dependence, rejection of reality attitudes, , alternated phases of depression and euphoria, loss of self-esteem, lack of confidence and satisfaction withown body, presence of inferiority and neglect feelings, decreased sexual desire, or excessive preoccupation with sexuality. There are also conflicts with body image and feelings of shame, fear and isolation appear, with concerns of social and sexual rejection” (Puhlmann, 2000, p.36).

In this sense, sexuality is an important issue that deserves special attention of professionals in rehabilitation programs, because sexual dysfunctions are common in people suffering from spinal cord injury. However, few health professionals have specific training to attend this demand (Major, 1988; Maia, 2011, Pinel, 1999).

The possibility of having a sexual dysfunction, especially among men is usually a humiliating and difficult condition because society in general values (and relates) social and sexual power. Sexual dysfunction treatment can be done with medication, always under the supervision of a doctor associated with sexual therapy or psychotherapy.

In the case of organic causes, the sexual dysfunctions are usually treated with the following treatments: intravenous, with the use of substances such as papaverine, phentolamine and prostaglandin E1 which basically is a penile injection that causes muscle tissue relaxation thus favoring the erection, b) urethral medication system with the introduction of prostaglandin E1 in the urethral canal c) oral medication such as sildenafil, which inhibits enzymes and assists smooth muscle with sexual stimulation. Other invasive treatments can be vascular surgery (low success rate) and even a penile implant, placed in the corpus cavernosum, which provides a mechanical or flexible hydraulic base. Other treatments can be no invasive and non-pharmacological, such as the use of a penis pump or penile rings (Baer, 2003; Ducharme & Gill, 1997; Full-Riede, Hausmann & Schneider 2003; Maier, 1988).

Problems such as urinary incontinence and spasticity are also common. Some techniques that decrease spasticity are recommendable like the appropriate temperature at the spot of sexual relation, massaging and antispasmodic medication. Also, there are certain positions that are important for stabilizing the articulation. In the case of incontinence, it's necessary that the bladder and rectum be emptied before the sexual relation and the use of mattress protectors and towels facilitate the necessary hygiene (Full-Riede, Hausmann & Schneider 2003).

Today, there are different tools for sexual dysfunction arising from spinal cord injuries spanning from sexual therapy technique that can help a person recover their sexual function response. Sexual therapy and rehabilitation process counseling for the population with physical disabilities, more specifically those with spinal cord injuries, have proven to be an important path to sexual health (Blackburn, 2002; Cardoso, 2006; Chigier, 1981; Maia, 2006; Maier, 1988; Puhlmann, 2000).

According to Maior (1988), sexual counseling programs for people with spinal cord injury are made from general strategies of sex therapy, including education and information, attitude change, elimination of anxiety before the performance, techniques of communication improvement and sexual behavior change, attending the impact of injury on sexual function. These programs should include an initial assessment phase, a work contract and planned counseling sessions that can be individual or in group.

At the initial assessment is necessary to survey the following information: (a) how was sexuality before and after the injury, (b) how is anal, bladder, urethra and genitalia sensitivity; if any drugs and medicines are used and how is the control of spasticity, (c) investigation of the sexual response: desire, arousal, orgasm, (d) investigation of the reproductive functions: menstruation, ovulation and ejaculation (Major, 1988; Maia, 2006). Maia (2006, p.182) says that is also necessary to investigate "sexual experiences prior to the injury, the frequency of interest and involvement in sexual activities, the most sensitive areas of the body, emotional relationships (whether or not a male or female partner) and desire to have children".

So, before intervention, a diagnostic evaluation is necessary in which information regarding sexual response before the injury is gathered, what the ideas about sexuality were, urinary function, intestinal and sexual evaluations are necessary, questions specifically related to masculinity and femininity. Objective data such as skin sensitivity, reflex or voluntary motor activity, the entirety of the reflex arcs, the level and degree of the spinal cord injury etc., are important for an appropriate diagnostic. The author adds that the more sexuality is seen as genital and focused on sexual functions, the more difficult sexual rehabilitation will be (Maior, 1988).

Some psychologists and sexual therapists have invested in specialized care for people with disabilities in order to ease possible dysfunctions arising from the disability, with several behavioral techniques or the use of equipment and "sex toys", such as vibrators and lubricants (Baer, 2003; Füll-Riede, Hausmann & Schneider, 2003; Maior, 1988; Puhmann, 2000).

"Sometimes people with disabilities need to be touched to have an erection. In this case, the accessories that stimulate the sensations of the skin across the body can be used. [...]. The stimulation of sexual organs can be produced with the caress and with the encouragement of sensory responses. To make this process dynamic, we can use contrast of cold and heat, or strength and weakness stimuli, seeking to provoke the activation of reflexes and deep sensation. The very touch of warm and cold hands can trigger reflex erection, massages with aromatic oils, or the subtle touch of soft tissues may facilitate arousal and are being widely used by disabled people. The so-called electric massagers and vibrators have facilitated not only male ejaculation in some cases of physical disability, where the ejaculatory reflex is impaired, but also the female orgasm, by strengthening local stimuli" (Puhmann, 2000, p.105). Along with this, it also takes time. Sexual readjustment does not happen immediately because restructuring conditions require time, trust and practice. Masturbation could be a form of practicing without any demands from the partner and help one get to know one's self sexually. It's necessary to have good communication, reduce anxiety and to clarify expectations, talking about feelings of pain under special conditions such as in spinal cord injury. It's necessary to relearn spontaneity, know how to express fantasies and sexual desires. Experimenting various sexual techniques such as oral and anal sex and trying different positions can be a very important resource for sexual rehabilitation (Baer, 2003; Ducharme & Gill, 1997; Kaufman, Silverg & Odette, 2003). Finally, feeling desired and having high self-esteem is essential for sexual rehabilitation (Baer, 2003).

Psychotherapy processes can help reconstruct the personal perception of what it's like to desire and be desirable, and this them should be given priority before applying sexual techniques. The first step for a subject is recognizing themselves as erotic human beings with disabilities. Other things should be considered along with the sexual response side: the existence of sensations of pain, fatigue, motor limitations, impaired ability to communicate assertively, unfavorable cognitive conditions (destructive thoughts and beliefs), privacy issues, difficulty in perceiving stimulation and finally, there can be issues due to side effects from medication. All of this needs to be considered. In any case, sexual health should be ensured, preventing the transmission of sexually transmitted diseases and unplanned pregnancy or situations of violence (Ducharme & Gill, 1997; Kaufman, Silverg & Odette, 2003).

In sexual rehabilitation, it's necessary to discuss the organically produced responses by the disability that in general, becomes problematic and join the psychological and social issues. The psychological issues are prioritized when attending people with disabilities beyond or together with sexual techniques, addressing subjects such as: body image, confronting myths and prejudice, restructuring of masculinity and femininity, reflecting about aesthetics standards, emotional difficulties that involve marital relationships, expectations about reproduction or even the difficulties of occurring sicknesses.

"From the point of view of attitudes, body image is a central issue. If a deficiency altered the appearance and/or mobility of a person beyond the accepted rules, the dislike of the body can assume proportions that interfere in the sexual encounter. Basically, if you hate the appearance of your body and how it behaves, will not be easy gladly offer it to a lover. Learn to love your own body, no matter how far he is from the ideal induced by the cinema (or even a more reasonable standard) takes time and is part of a wider process of self-acceptance" (Vash, 1988, p.90).

Fear of sexual dysfunction, feelings of inferiority, and problems with their companion or finding a sexual partner, lack of knowledge about how the body works, limitations due to spinal cord injuries, possibilities in sexual relations, possible problems and solutions are common self-esteem problems (Baer, 2003; Fürll-Riede, Hausmann & Schneider, 2003; Kaufman, Silverg & Odette, 2003; Maior, 1988; Puhlmann, 2000).

"A new image must be constructed from the reactions of this body and the reactions of others to a new body. [...]. Initially, many adopt an attitude of isolation and even of indifference to your problem. To establish their new body image, the spinal cord injured people need to know their limitations and modifications, including how to deal with equipment that use (wheelchair, crutches, urine collector), in a new experience of his own body; they must be able to expose this situation which is different to the others. [...]. People who base their self-esteem in physical capacity will probably struggle to readjust after injury [...]. Develop a new body image and restore self-esteem and sexual identity are the basic points for re-balancing of personality, appearing then confidence to assume a positive social and sexual role" (Major, 1988, p.25).

Finally, effective education programs and sexual rehabilitation should consider, above all, a few basic procedures.

In first place group work is required. Group sessions are indispensable for sharing experiences, frustrations and successes. Many subjects need to perceive that they are not alone in confronting sexual difficulties. Besides, family groups or couples are interesting alternatives to the extent that many times family support is necessary to recover self-esteem. Maior (1988, p.93) says that:

“It is agreed that discussion groups should work from six to twelve people, including disabled people, partners and professionals. Although most programs work with groups, to each participant is given the option of complement individual counseling, individually or in couple with a partner”

Secondly, care should be given by a multidisciplinary team trained in the area, including psychologists, physical therapists, sexual therapists, doctors, etc. A treatment group that includes various professionals is essential in the whole care of people with a spinal cord injury (Baer, 2003; Cardoso, 2006; Maia, 2011; Major, 1988).

Sexual rehabilitation work should be comprehensive, considering emotional, labor issues, medical and disabling conditions, economic and social conditions, gender questions and sexual identity, ultimately other conditions need to be met by diverse professional if we hope to reach the person's overall sexual satisfaction.

2. Conclusion

Disability and sexuality are famous social phenomena, that's to say, they depend on social and historical representations about their conditions. Being disabled or dysfunctional manifests itself in the forms of personal and social normality that are socially constructed. Given these forms, feelings of maladjustment are common among people with and without disabilities. In the case of people with physical disabilities, these sentiments are common, because the disability is visible and stigmatizes the subject a deviant, which ends up being generalized for their sexuality.

The sexuality of people with physical disabilities reflects many social myths that were wrongfully put on these people such as having an atypical and unhappy sex life. However, despite possible organic difficulties, it's psychosocial questions that most reflect these difficulties, especially in the sexual area.

In this sense, the sexual rehabilitation of people with physical disabilities should include organized dysfunction treatment with the use of behavioral treatment and medication associated with sexual or psychotherapy that includes reflection on social models of normality, corporal difficulties, aesthetics and sexual function. It's important to consider manifestations such as problems with desire, excitement, orgasm or fertility, low self-esteem etc., result in internalized prejudice, in other words, the root is in the permanence of stigmatizing and prejudiced representations within society. We should join forces, ensuring teamwork (doctors, psychologists and other professional) and work the injured patients, family and/or spouse together.

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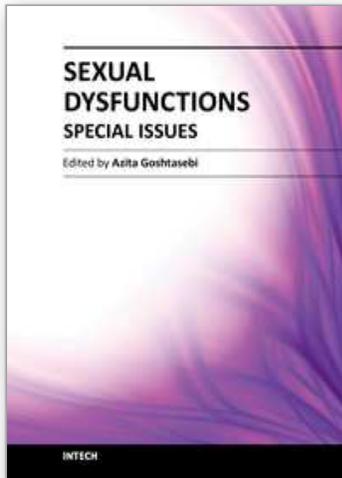
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Sexual dysfunctions have recently recognized as one of the major public health problems. This book enhances our scientific understanding of sexual function and dysfunction from different perspectives. It presents evidence-based interventions for sexual dysfunctions in difficult medical situations such as cancer, and gives a valuable overview of recent experimental researches on the topic. Published in collaboration with InTech - Open Access Publisher, this imperative work will be a practical resource for health care providers and researchers who are involved in the study of sexual health.

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