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# Addressing the Educational Needs of Occupational Therapists Regarding Sexuality in an Acute Care Setting

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Addressing the Educational Needs of Occupational Therapists

Regarding Sexuality in an Acute Care Setting

Hannah Burleigh

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### Abstract

Despite the knowledge that sexuality is an important factor of well-being for individuals with disabilities, occupational therapists (OTs) continue to under-address this topic with clients (McGrath & Sakellariou, 2016). Additional education on sexuality may help OTs improve their knowledge and confidence in discussing and addressing sexuality with clients during intervention. The purpose of this study is to determine the educational needs of occupational therapists working in acute care who are alumnus of Elizabethtown College to promote the discussion of sexuality in practice. The research questions of the project are: 1) Do OTs in acute care educate clients on sexuality? 2) What methods do they typically use to provide this education? 3) What are the educational needs and preferences of acute care therapists?

Participants completed an anonymous online survey with questions related to their knowledge levels regarding sexuality, current comfort level addressing and educating needs and preferences related to sexuality. Survey questions were developed using principles of Adult Learning Theory, which states adult learners are self-directed, experienced, and motivated to learn (Rothwell, 2008). Survey responses were analyzed and reviewed for common trends, which included a perceived lack of education, difficulty initiating discussion, an openness to learn more information, and a perceived lack of time in the acute care setting. This information was utilized to create an educational resource for therapists to be distributed by the researcher.

Addressing the Educational Needs of Occupational Therapists  
Regarding Sexuality in an Acute Care Setting

**Literature Review**

Sexuality is a core characteristic of what makes us human (MacRae, 2013). Sexuality includes a specific state of mind representing our internal feelings, the experience of being male or female, interactions with the same or opposite gender, establishing relationships, and self-expression (MacRae, 2013). Sexuality creates a sense of self and is an important part in development and growth throughout the lifespan (MacRae, 2013). Sexual feelings can include holding hands, flirting, touching, kissing, masturbating, and having sexual intercourse (MacRae, 2010). Culture, ethnicity, education, and religion can impact how sexuality is expressed (MacRae, 2013).

**Sexuality and Disability**

Sexuality is one of the main concerns of people with disabilities, which many previous studies have revealed (Sakellariou & Algado, 2006). Sexuality can affect how someone deals with the world around them (Burton, 2013). Feeling inadequate in those areas, due to disability, can impact their ability to pursue other areas of one's life (Burton, 2013). Sexuality is also commonly related to someone's opinion of themselves and has been found to be a predictor of marital satisfaction, success in vocational training, and adjustment to disability (Burton, 2013). In Western societies, physical attraction and intimacy is often associated with love (Burton, 2013). Due to this belief, if a person sees themselves as incapable of expressing their sexuality, they may feel incapable of loving or being loved (Burton, 2013). Adaptive equipment, commonly used for people with disabilities, can also decrease someone's perceived confidence in their attractiveness and sexuality (Burton, 2013).

## Sexuality and Occupational Therapy

Due to their holistic approach to treatment, occupational therapists are well suited to address sexuality with clients. Sexuality can affect an individual's valued occupations, roles, identity, and safety (Rose & Hughes, 2018). Occupational therapy can have a powerful role in creating meaningful and significant change in a person's life due to viewing the client as a whole (Rose & Hughes, 2018). Sexuality is frequently mentioned in a variety of OT practice documents and textbooks. According to Wilcock and Townsend (2014):

occupation is used to mean all things people want, need, or have to do, whether physical, mental, social, **sexual**, political, or spiritual nature and is inclusive of sleep and rest. It refers to all aspects of actual human doing, being, becoming, and belonging. (p. 542)

This important thought is also discussed in the *Occupational Therapy Practice Framework: Domain and Process, 3rd Edition* (OTPFIII), which lists sexual activity under activities of daily living (ADLs) (American Occupational Therapy Association [AOTA], 2014). Although sexuality is classified as a self-care occupation, such a classification can reduce sexuality to only the physical act of sexual intercourse and does not explain the other occupations through which sexuality is expressed (McGrath & Sakellariou, 2016). Reducing the term to strictly sexual activity can become an issue when sexual functioning is perceived as problematic (Sakellariou & Algado, 2006).

Occupational therapists can include the topic of sexuality during the evaluation and intervention processes of therapy (MacRae, 2013). MacRae (2013) claims an occupational therapy environment can be a safe place to address important areas of sexuality, which allows the client to express their fears and concerns.

**Evaluation.** To begin the occupational therapy evaluation process, it is important the therapist express empathy, sensitivity, and openness to create a strong therapeutic relationship and encourage communication (Burton, 2013; MacRae, 2013). In addition, OTs should make the client feel comfortable with discussing sexuality by first giving them permission to discuss feelings and potential problems (Burton, 2013). Once a client feels safe asking the OT about sexual matters regarding their disability, the therapist can move on to other activities such as bathing, dressing, toileting, and sexual hygiene (Burton, 2013).

**Intervention.** Intervention regarding sexuality can revolve around three main methods: health promotion, remediation, and modification (MacRae, 2013). Health promotion consists of support groups, stress-relieving activities, and educational programming, such as one intervention about safe sex for teens with developmental disabilities. Remediation can consist of restoring skills such as strength, endurance, range of motion, communication, and social engagement (MacRae, 2013). Modification involves changing the routine or environment to allow for sexual activity. In general, therapy intervention can focus on a variety of topics, including but not limited to psychological work on self-esteem, anxiety management, body image, sense of sexual-self, and communication (Ewer-Smith, Trent, & Lewis, 2018).

All OT interventions should include goals that increase self-esteem and enable the client to love and feel loved (Burton, 2013). The therapist's role in addressing sexuality is to improve feelings of self-worth and promoting a positive body image to help the client minimize feelings of self-worth, attractiveness, sexuality, sensuality, and capability of intimacy (Burton, 2013). This goal can help to enhance the development of healthy life balance by engaging in meaningful occupations (Burton, 2013).

*Examples of occupational therapy intervention with specific populations.* There is a variety of literature regarding potential occupational therapy interventions related to sexuality for specific populations. Sexuality can be addressed with older adults, clients of the Lesbian, Gay, Bisexual, Transgender plus (LGBT+) community, clients with physical disabilities, developmental disabilities, or others seeking occupational therapy services as a part of the holistic approach (MacRae, 2013). Occupational therapists should learn about sexuality and what it means to each specific client to acknowledge it as an important area of concern (Sakellariou & Algado, 2006).

One exploratory study was done to determine the sexual activity and sexual satisfaction in men with spinal cord injury (Alexander, Sipski, & Findley, 1993). A questionnaire was sent to all 92 subjects based on the American Spinal Injury Association (ASIA) (Alexander, Sipski, & Findley, 1993). Eighty-six percent of the subjects stated they experienced sexual desires and 68% had reported being sexually active during the last 12 months (Alexander, Sipski, & Findley, 1993). Sixty-five percent of subjects reported experiencing an orgasm since injury, but most had rated it weaker than before injury. Men with paraplegia also reported a more satisfactory sex life than those with tetraplegia (Alexander, Sipski, & Findley, 1993). Overall, this study confirmed earlier findings that men experiencing spinal cord injury can still have sexual satisfaction; however, there may be some lasting effects on sensitivity and functioning from their injury that can be addressed in therapy.

A national, population-based study was conducted on middle-aged and older adults with diagnosed and undiagnosed diabetes (Lindau et. at., 2010). This study's aim was to describe their sexual activity, behavior, and problems they experience due to their condition. Sixty percent of individuals with partners reported being sexuality active (Lindau et. at., 2010). Women who

were diagnosed with diabetes were less likely to be sexually active than men with diabetes or women without diabetes. Individuals with partner's activity did not differ by gender (Lindau et. at., 2010). Elevated orgasm problems were reported among men with diagnosed and undiagnosed diabetes compared with that of other men, however erectile difficulties were elevated among men with only diagnosed diabetes (Lindau et. at., 2010). Women whose diabetes was undiagnosed were less likely to discuss sex with a healthcare professional (11%) than women with diagnosed diabetes (19%) and men with undiagnosed (28%) or diagnosed (47%) diabetes (Lindau et. at., 2010). This study proves many middle-aged and older adults with diabetes are still sexually active, similarly to individuals without diabetes. Women with diabetes were more likely than men to cease sexual activity, although the study does not have an explanation for this finding (Lindau et. at., 2010).

Occupational therapists can also aide in the lives of sexual abuse victims (Burton, 2013). Therapy sessions for this population may focus on positive body image and safe communication (Burton, 2013). After using correct terminology, the therapist can communicate and relate to the client in an appropriate and safe way (Burton, 2013). Therapists can use this education as a starting point in discussion about abuse (Syron, 2010). Occupational therapy can help address these areas of concern within treatment.

Sexuality can also be discussed regarding many mental health conditions and experiences. Cognitive impairments such as traumatic brain injury, cerebrovascular accident, and multiple sclerosis can affect sexual functioning and relationships (Burton, 2013). Clients with these conditions may experience a lack of concentration, social and communication difficulty, and decreased awareness (Burton, 2013). Depression can also affect sex drive, especially during the new onset of disability existing in 61% of individuals with TBI and spinal cord injury



(Burton, 2013). Anxiety can also cause performance problems, specifically when males are under a great deal of emotional distress and find the ability to maintain an erection is inhibited. This can lead to increased anxiety and create a cycle of dysfunction (Burton, 2013). It may be helpful in this situation if the client and their partner not focus solely on maintaining an erection but rather than focusing on sensuality and making one another feel good.

In conclusion, sexuality can be addressed in many different populations within occupational therapy because every individual experiences internal feelings regarding sexuality, interacts with others, and establishes relationships. Occupational therapists should learn what sexuality means to each specific client to acknowledge their individuality as a sexual being (Sakellariou & Algado, 2006).

### **Models to Guide Practice**

Models of practice in occupational therapy can serve as a lens by which intervention can be framed to best meet the needs of given client populations. Several models, including PLISSIT and the rights-based approach are two which apply to this inquiry.

**PLISSIT.** There are two primary approaches healthcare professionals, including occupational therapists, may use to guide practice when addressing sexuality with clients. The PLISSIT Model is the first approach. The PLISSIT model is a program originally used educational strategies and behavioral interventions to combine sexuality into the rehabilitation of people with spinal cord injuries (Madorsky, 1983). Now, this program is used not only for spinal cord injuries, but to address other conditions as well (MacRae, 2013). The PLISSIT model stands for: Permission, Limited Information, Specific Suggestions, and Intensive Therapy. The model is flexible, comprehensive, and provides a framework for addressing problems within sexuality during intensive therapy (Madorsky, 1983).

**Permission.** Permission to discuss sexuality is most effective when immediately asked by staff or peers (Madorsky, 1983). Sexuality should be introduced to the client hours within their admission, preferably during the evaluation process (Madorsky, 1983). All staff are encouraged to discuss permission and be supportive of the client's concerns related to sexuality; however, it is important to keep in mind staff, clients, and their significant others may have varied levels of openness when discussing the topic (Madorsky, 1983).

**Limited information.** This step refers to explaining the effect disability has on sexual functioning (Burton, 2013). Going into detail is not necessary early in the process of counseling in an effort to not overwhelm the client (Burton, 2013). Information is discussed regarding male and female anatomy, sexual response cycles, and fertility (Madorsky, 1983).

**Specific suggestions.** The rehabilitation team must also learn the client's personal strengths, their relationships, sexual history and their level of adjustment to their disability (Madorsky, 1983). Specific suggestions will be individualized for each client, but may include the use of counseling groups, sexually explicit movies, positioning recommendations, medication management and bladder and bowel routines (Madorsky, 1983). The specific suggestion stage, as described by Taylor and Davis (2007), is the problem-solving stage to address a particular problem that the client has with their sexuality. The therapist obtains the client's sexual history to identify any concerns.

**Intensive therapy.** Therapy is designed individually for each client or couple by a specially trained professional and is outside of the realm of practice for most occupational therapists (Madorsky, 1983). Intensive therapy may occur in the rehabilitation setting or at home and can include a variety of individualized exercises pertaining to performance concerns, communication, social skills and sexual awareness (Madorsky, 1983). Clients are given

opportunity outside of the hospital to improve these skills and return on a regular basis to review their experiences and explore emotional reactions.

Sexual rehabilitation was first mainly addressed in the 1970s for clients with disabilities (Madorsky, 1983). The majority of training occupational therapists receive about discussing sexuality with clients is through the use of the PLISSIT model (McGrath & Sakellariou, 2016). When occupational therapists use the PLISSIT model, they are informing their clients it is safe and appropriate or them to ask questions, the therapist will follow the amount of information they want to share and refer a client to another specialist for intensive therapy (Krantz, Tola, Pontarelli, & Cahill, 2016). Additional training on Step 3 (Specific Suggestions) may help occupational therapists feel more comfortable when collaborating with teams and conveying the understanding an individual's ability to engage in occupation may reduce life satisfaction (Krantz et al., 2016).

**Rights-based approach.** Because occupation is at the root of occupational therapy, denying someone the right to engage in sexual activity is an occupational injustice (Sakellariou & Algado, 2006). It was only in the 20th century when sexuality was deemed as an important natural part of the human experience. Oppression has caused the topic to not always be included as an integral part, but instead as a trait some individuals, including individuals with disabilities, should not possess (Sakellariou & Algado, 2006). In many cases, they are denied their sexuality and human nature, and are seen as asexual individuals (Sakellariou & Algado, 2006). However, this is not the case. All individuals experience sexuality in a variety of ways, regardless of demographics such as disability.

Justice is defined as social happiness and avoiding negative self-talk, and occupational justice is non-comparative and individualistic-subjective (Sakellariou & Algado, 2006). In other

words, it is not concerned with comparing a person's level of participation in occupation to someone else; there are important elements to occupational injustice that are individualistic. Occupational injustice is also concerned with the level of fairness and happiness constituted from the unrestricted participation in occupation (Sakellariou & Algado, 2006). Sakellariou & Algado define occupational injustice as the "injustice that occurs when participation in occupation is barred, confined, restricted, segregated, prohibited, undeveloped, disrupted, alienated, marginalized, exploited excluded, or otherwise restricted" (2006). This injustice is seen to be out of the individual's control. Because the main purpose of occupational therapy is to promote occupational justice through the engagement in meaningful occupation, an occupational injustice can directly affect an individual's success in engagement in therapy.

Researchers agree a rights-based approach is the best way for occupational therapists to discuss sexuality with their clients to respond to their needs and desires (Berglas & Ozer 2014; McGrath & Sakellariou 2016). First, an understanding of human rights, of which are three main categories, will facilitate discussion on a right-based approach regarding sexuality (McGrath & Sakellariou, 2016). The first category is civic and political rights, which includes rights such as freedom to express one's self and to practice religion (McGrath & Sakellariou, 2016). Secondly are economic, social, and cultural rights, which includes the rights to food, education, work, and healthcare (McGrath & Sakellariou, 2016). Finally are solidarity rights, which requires international cooperation between states to prevent war, famine, pollution, and to provide disaster relief (McGrath & Sakellariou, 2016). For people with disabilities, a human rights-based approach can offer an effective way to promote equal access to sexuality. A rights-based approach understands disabled people have the same rights as the able-bodied, and these rights are protected by the government (McGrath & Sakellariou, 2016). Sexual rights should not be

seen as less important than other human rights, allowing for the right to express sexuality in an individual way.

Adopting a rights-based approach in occupational therapy intervention must require therapists to support the right to sexuality, respect sexual diversity, and recognize sexuality is an important area of human occupation (McGrath & Sakellariou, 2016).

### **Incorporating Sexuality into Occupational Therapy Practice**

Despite the knowledge that sexuality is an important factor of well-being for individuals with disabilities, occupational therapists continue to under-address this topic with clients (Eglseder, Webb, & Rennie, 2018). A cross-sectional internet-based survey was conducted on 120 occupational therapists, revealing participants reported low levels of awareness, knowledge, and confidence related to addressing sexuality with clients (Hyland & McGrath, 2013). A 1988 study conducted by Payne, Greer, and Corbin was the first to determine the status of occupational therapy and sexual function in the United States (Lohman, Kobrin, & Chang, 2017). The purpose of this study was to determine the best method therapists could use to deliver sexual information to clients (Lohman et al., 2017). Here, a questionnaire survey was given to 67 department chairs of university programs. The study found on average 3.5 hours of education included sexual functioning, and the programs focused most in interacting with clients. The occupational therapy programs reported they did not include the subject of sexuality in curriculum due to a lack of time or the belief that sexuality was of low priority (Lohman et al., 2017).

In another study regarding individuals with schizophrenia, only 18% of the occupational therapists provided sex education to their clients, even though a majority stated that sex education was a domain of concern in occupational therapy (Penna & Sheehy, 2000). The

majority of those did so by verbal advice that was very informal, using no method or theory to support their teaching. Failing to address sexuality, or addressing it incorrectly, can lead to compromised therapeutic outcomes and decreased client satisfaction (Lohman et al., 2017).

### **Why Sexuality is Under-Addressed**

Empirical literature shows people with disabilities have concerns regarding their sexuality (Rose & Hughes, 2018). A coconstructed autoethnography between an occupational therapist and a sex educator who experienced a stroke was conducted to understand the importance of sexuality as a core aspect of identity, and discovered the ways rehabilitation currently excludes sexuality, and the potential role of occupational therapy in addressing sexuality. The client, who was the sex educator, never felt comfortable enough to initiate the discussion about sex due to fears of feeling awkward or causing offense; therefore, her concerns never were addressed (Rose & Hughes, 2018). The investigators concluded the rehabilitation setting did not offer opportunities for addressing sexuality due to the worry of seeming inappropriate, which is a common theme seen in research as a reason why sexuality is under-addressed by therapists and clients alike (Rose & Hughes, 2018). Sex is highly personal and sometimes a difficult topic to discuss. Occupational therapists should be addressing this topic by creating a sexually inclusive environment (Rose & Hughes, 2018).

Literature suggests a variety of reasons as to why sexuality is under addressed in OT practice. These may include a lack of knowledge, client factors, therapist safety, fear of causing offense or anger, perceived lack of relevance, institutional policies, personal beliefs and attitudes, and damage to professional reputation (Lohman et al., 2017; McGrath & Sakellariou, 2016). Each reason reduces the likelihood the therapist will identify and discuss issues of sexuality

during rehabilitation and contribute to creating a culture in which sexuality is often ignored in professional practice (McGrath & Sakellariou, 2016).

### **Problem Statement and Research Questions**

Sexuality is a difficult topic for many to discuss specifically between occupational therapists and their clients. Failing to address sexuality can lead to poor therapeutic outcomes (Lohman, Kobrin, & Chang, 2017). Increased education on the topic may help occupational therapists better discuss sexuality with clients and decrease discomfort (Eglseder, Webb, & Rennie, 2018; McGrath & Sakellariou, 2016). Increased efforts should be taken to decrease the gap between ideology and practice regarding intervention towards sexuality (Eglseder et al., 2018). Education is a crucial addition to the domain of OT to establish a more holistic approach in occupational therapy practice (Eglseder et al., 2018). The purpose of this study was to determine the educational needs of occupational therapists working in acute care who are alumnus of Elizabethtown College to promote the discussion of sexuality in practice. This information will then be used to create an educational resource for therapists to use which will be distributed by the researcher. The research questions of the project are:

- (1) Do OTs in acute care educate clients on sexuality?
- (2) What methods do they typically use to give this education?
- (3) What are the educational needs and preferences of acute care therapists?

### **Methods**

The methods section will address the design, participants, data collection and analysis measures. The results of this inquiry led to the development of educational resourcing for practicing therapists regarding sexuality and rehabilitation.

### **Study Design**

This exploratory study utilized a researcher developed survey approach. Survey research is defined as a method of inquiry that requires collecting data using structured questions to allow for self-report and is beneficial because it allows a large population to be reached, multiple variables and data can be collected, and a wide variety of statistical manipulation to be used (Kielhofner & Taylor, 2017). Prior to participant recruitment and data collection, this study was approved as exempt by the Elizabethtown College Institutional Review Board (IRB).

### **Participants**

Purposive sampling was used to recruit participants for this study. Purposive sampling is the selection of individuals based on certain predetermined criteria by the researcher (Kielhofner & Taylor, 2017). Inclusion criteria for this study included current occupational therapists practicing in acute care who were alumni of Elizabethtown College. Exclusion criteria included individuals who were not a part of the Elizabethtown College alumni email list and who were not an acute care therapist. An email was sent to all current alumnus via the Etown College Alumni Association which included the content of the survey, a link, and contact information of the researcher in the form of a recruitment script (Appendix A).

Therapists practicing in acute care were chosen as the primary focus population because this is often a client's first experience of healthcare after injury. Many clients, depending on diagnosis and health condition, may only see acute care therapists prior to discharge home, and will not have further opportunities to discuss sexuality. Acute care hospital settings are fast-paced environments in which the immediate health needs of clients are managed. Patients are treated for their illness and then often discharges within hours of admission. The main goal of acute care is quick and efficient patient care (Britton, Rosenwax, & McNamara, 2015). Another reason this practice setting was chosen was due to the researcher's personal interest.



## **Data Collection**

An online survey was developed by the researcher and served as a needs assessment to determine the educational needs and preferences of occupational therapists regarding sexuality. The survey was developed using principles of Adult Learning Theory to motivate each occupational therapist to have a direct involvement in the education that they receive later regarding sexuality (Rothwell, 2008). The Adult Learning Theory was originally created around the main principles of andragogy. Adults need to be involved in the planning of their own education and their experiences should provide their foundational knowledge (Knowles, 1988). Due to this sense of self, adults require autonomy when learning new things, otherwise they lose interest (Rothwell, 2008). To teach adults effectively, new concepts must relate to what they already know (Rothwell, 2008).

Adult learning is also purpose driven. Adults learn when they see the relevance of the information (Rothwell, 2008). For example, learning new information may help the occupational therapist to better treat clients, or can even lead to promotion (Rothwell, 2008). Adults are more interested in learning about information that has relevance and an impact to their career (Knowles, 1988). When they see value in their learning and can comprehend the information, they are more receptive to learning new information (Rothwell, 2008). All questions allowed for each participant to determine how relevant sexuality was in their own practice and to allow them to create their own reference guide based on the educational needs they reported.

The survey (Appendix B) consisted of 14 questions including demographic questions and Likert scale questions with optional free text boxes to allow for further elaboration. The questions focused on evaluating participants' current comfort with addressing sexuality, the approaches they use, their typical client caseload, and their educational preferences when

learning new information. The survey was anonymous and was created via the secure Elizabethtown College Survey Monkey account. Informed consent of the survey was included in the first page, and completion of the survey indicated their consent to participate (Appendix B). The survey was available from February 22<sup>nd</sup>, 2019 to March 8<sup>th</sup>, 2019.

### **Data Analysis**

Descriptive statistics were used to describe therapist demographics. Frequency distributions were calculated for each Likert scale response and displayed as percentages. Open-ended responses were used to supplement participant's responses and were reviewed for commonalities. All responses were anonymous and kept in the secure Elizabethtown Occupational Therapy Department Survey Monkey account.

## Results

Table 1			
<i>Therapist Demographics</i>			
		n	%
<b>Years of Experience</b>	0-5 Years	6	54.54
	5-10 Years	5	45.45
<b>Client Age Range</b>	18-100 Years		
<b>Client Gender</b>	Male + Female	8	72.72
	Male, Female, Transgender	1	0.09
	Unspecified	2	18.18
<b>Client Diagnosis</b>	Neurological	9	33.33
	Orthopedic	4	14.81
	Cardiac	3	11.11
	Trauma	3	11.11
	Cancer	2	0.07
	Other	6	22.22

*Note.* Reports are from 11 participants. 2 participants were not included due to not completing the entire survey.

### Participants

A total of thirteen OTs responded to the survey; however, two surveys were not completed in their entirety and were thus excluded as part of the data analysis (N=13). Eleven surveys were then included as part of the results (n=11). The participants varied in terms of years of experience as practitioners and types of clients they worked with (Table 1). All the occupational therapists who participated have been practicing for 10 years or less. Therapists reported primarily working with adults ranging in age from 18-100 years old, and neurological injury was the most commonly reported diagnosis.

### Survey responses

The following information details the findings of the survey based upon participants information. Results shed light as to the current feelings and practices of acute care OTs toward the topic of sexuality.

**I feel that addressing sexuality with my clients is important (Figure 1a).** Therapists were asked to respond to if they felt addressing sexuality was important. As seen in Figure 1a, responses were varied to whether addressing sexuality was important in acute care practice. Participant 3 states: “I believe sexuality is an important part of overall mental health, happiness, body image, and well-being and that it can result in a higher quality of life.” However, many participants agreed that acute care may not be the place to do this due to a perceived lack of time to address sexuality due to discharge requirements, lack of client rapport, and decreased length of stay. Participant 6 states: “This is challenging to do in the acute care setting as the length of stay is continually decreasing.” Even though there are challenges in the acute care setting, many agreed that they would address this concern if it arose, however they felt that most of the time there were more important things to address in acute care such as strength, endurance, cognition, and performance of activities of daily living.

**I consistently talk about sexuality with my clients (Figure 1b).** Sixty-six percent of therapists responded “disagree,” indicating that they do not consistently discuss sexuality. Most therapists reported not discussing sexuality with their clients in the acute care setting unless the client were to bring it up first. One therapist did say, however, that asking about sexuality was required by their department. Typically, younger clients are more likely to ask about this topic who are between the ages of 18 and 40. Many therapists reported not asking their clients at all.

**I am comfortable discussing sexuality with my patients (Figure 1c).** While 37.5% of participants reported feeling comfortable discussing sexuality with clients, other participants felt they could have more knowledge in this area. Participant 12 stated: “I am more comfortable discussing it if they bring it into the conversation first. I am uncomfortable initiating the

conversation.” Overall, the therapists who chose “disagree” found initiating the topic with clients to be difficult due to a fear of client response or causing offense.

**I am knowledgeable about the different approaches to discuss sexuality (Figure 1d).**

Therapists reported the most common approaches they have used are surveys, the Canadian Occupational Performance Measure (COPM), the PLISSIT model, positioning techniques, equipment education, and pain management.

**I have received adequate education from my current workplace or academic education (Figure 1e & 1f).** Most participants reported they have not received adequate education from their current workplace regarding sexuality. Half of the participants agreed they have received adequate education from their academic career, however some did not agree with this statement as well.

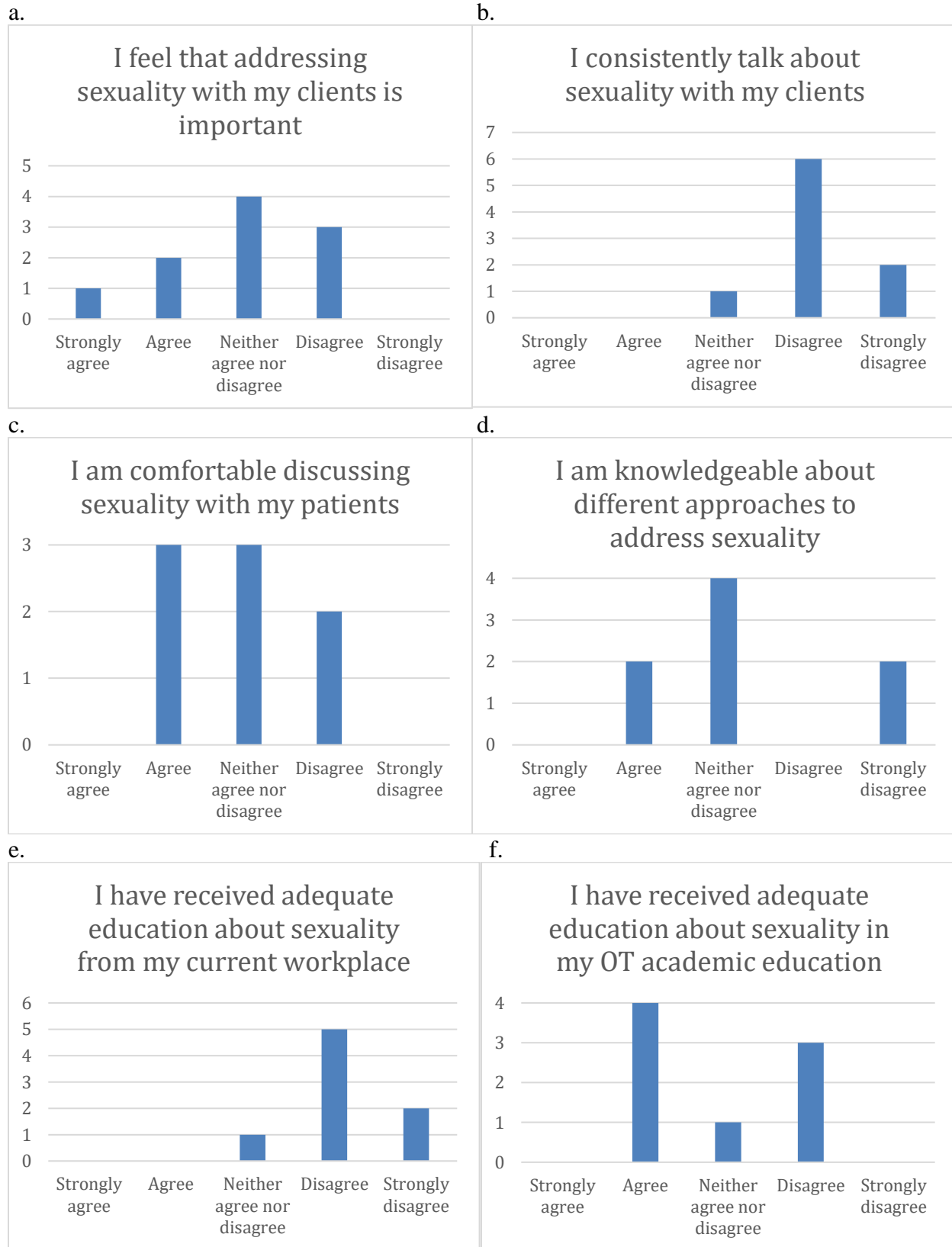


Figure 1: Occupational therapist Likert scale responses.

**Educational preferences.** As seen in Figure 2a, 87.5% of therapists responded strongly agree or agree, indicating they were interested in receiving additional education on sexuality and did not have a specific preference of the format or contents of the resource. The participants also stated in Figure 2d and 2e that they would be interested in learning strategies for discussing sexuality and diagnosis-specific information. One participant provided additional information about their learning needs. Participant 3 stated: “I think having the topic broken down into how to start the conversation, areas that should be addressed and then using the framework specific decreased areas of function and interventions/ questions to ask would be very helpful.”

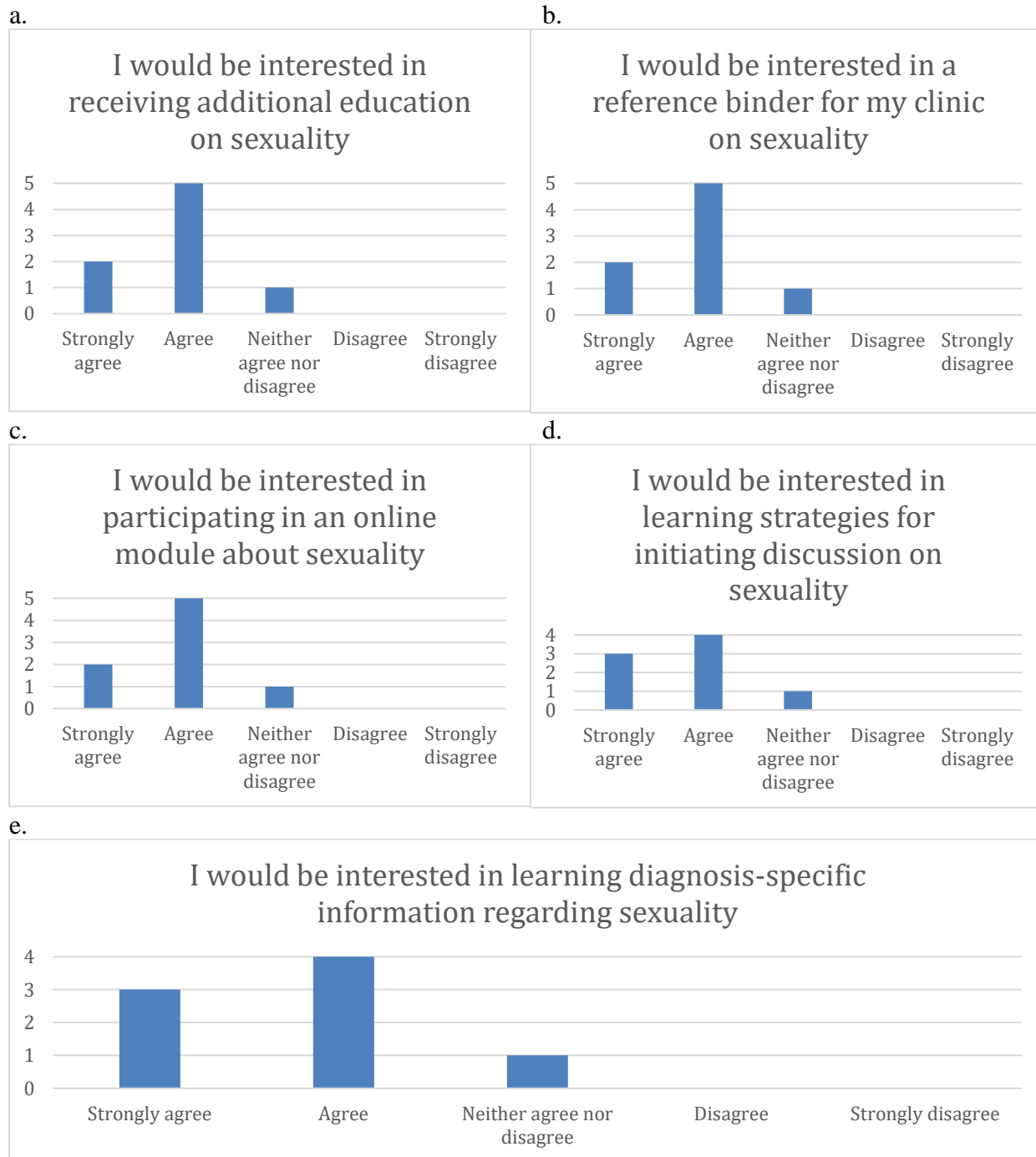


Figure 2: Additional education interests.



### Discussion

Consistent with other studies, the OT practitioners in this study reported they do not consistently discuss sexuality with clients (McGrath & Sakellariou, 2018; Rose & Hughes, 2018), which could be due to lack of education or training they have received. A majority of occupational therapists who participated in this study reported receiving inadequate education from their current workplace regarding sexuality. Although it seems that sexuality is being addressed more in OT education than ever before, current research suggests this still does not translate to clinical practice. Clients still report inadequate attention to their sexual health needs (Eglseder, Webb, & Rennie, 2018).

Another reason why clinicians may not be addressing sexuality is a lack of comfort initiating discussion with clients. While 37.5% of therapists in this study responded that they do feel comfortable, 62.5% of participants either felt neutral or uncomfortable initiating discussion. This can be due to a lack of knowledge, client factors, therapist safety, fear of causing offense, lack of relevance, policies, personal beliefs, and professional reputation (McGrath & Sakellariou, 2018). Some also reported they feel more comfortable if the client is the first to bring up the conversation; however, clients have reported in previous studies feeling the same way and believe the therapist should be the one to initiate discussion (Rose & Hughes, 2018). If therapists and clients alike are not initiating conversation, this can create a cycle of sexuality never getting addressed during occupational therapy evaluation and intervention. Therefore, the clients' full needs are not being met.

Literature suggests acute care therapists are under increased pressure and often have a difficult time providing full interventions due to time constraints and caseload demands (Britton, Rosenwax, & McNamara, 2015), which is consistent with the reports of the participants in this

study. Many participants reported a perceived lack of time in acute care to discuss sexuality due to discharge requirements, lack of time to build client rapport, and decreased length of stay. The cycle of constant assessment and discharge often left little time for therapists to treat other areas of occupational performance, including sexuality. Due to this small time frame with clients, occupational therapists can overlook sexuality and not discuss the topic with clients (Britton, Rosenwax, & McNamara, 2015). While this may not always happen in an acute care setting, addressing client concerns cannot be ignored.

Due to a lack of time in the acute care setting, another setting may provide a better environment to address sexuality (Britton, Rosenwax, & McNamara, 2015). For example, one participant suggested inpatient rehabilitation to be more fitting. However, more research is needed to confirm inpatient rehab is a better environment. Because acute care can be one of the first or only form of occupational therapy a client receives, addressing this information while the client is still in the hospital should still not be overlooked. Throughout the cycle of a client receiving therapy, each practitioner could pass this obligation onto a different form of care, leaving the client no opportunity to bring up the topic on their own.

Therapists in this study reported being interested in learning new information about sexuality. Emerging practice within occupational therapy places an emphasis on the concept of holistic care, and due to this idea, many occupational therapists are motivated to seek new information to better treat clients in a holistic way, which includes the discussion of sexuality (Sakellariou & Algado, 2006). Adult learning theory proved to be beneficial in exploring the therapists' educational needs and preferences related to sexuality because it allowed them to voice their own opinions and interests about what they wanted to learn. It may be helpful to incorporate this into future learning experiences about other new and uncomfortable topics. The

therapists see the value of their learning and are receptive to learning more about sexuality because they can connect concepts to what they already know about occupational therapy practice from their previous education (Rothwell, 2008). While the therapists did not specify a preference for a specific type of delivery for education, it can be assumed varying methods would be beneficial to give the therapists a choice in how they receive the education and to make it an individualized learning experience, consistent with adult learning theory.

### **Limitations**

This study was limited in that it has a small sample size from only one practice setting. Future research should focus on increased sample sizes from a variety of practice settings, including inpatient rehabilitation, outpatient, skilled nursing facilities, and other common occupational therapy service environments that include adults, as educational needs and preferences may differ across practice settings. In addition, while the results of this study were used to create an educational resource for participating therapists, due to time constraints of the academic semester, the effectiveness of this resource was not evaluated.

### **Conclusions & Implications for Occupational Therapy Practice**

Sexuality is an important aspect of the human experience and OT practice. If occupational therapists want to provide holistic care to clients, sexuality cannot be ignored as part of intervention. This study demonstrated that while occupational therapists in acute care believe sexuality is important, many do not discuss it due to a variety of reasons. This can include the contextual demands of the acute care setting, lack of education and decreased comfort. In the past couple of years, occupational therapy has shifted to a more holistic approach (Sakellariou & Algado, 2006). In order to more fully incorporate sexuality into occupational therapy practice, increased opportunities need to be created for additional education and training

in both academic and professional venues. While education should be individualized for each group of therapists to be meaningful, general topics should include how to initiate discussion on sexuality, diagnosis-specific suggestions, and extra resources to suggest to clients.

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## Appendix A – Recruitment Text



Elizabethtown College  
Alumni Association™

### Assistance Needed from Acute Care Occupational Therapists

#### Opportunity to Participate in Research Study with Elizabethtown College

**The Problem:** Despite the knowledge that sexuality is an important factor of well-being for individuals with disabilities, occupational therapists continue to under-address this topic with patients. Research suggests that sexuality is under-addressed frequently during the occupational therapy process due to many reasons: lack of knowledge, client factors, therapist safety, fear of causing offense, lack of relevance, policies, personal beliefs, and damage to professional reputation. Studies about sexuality and occupational therapy in general are scarce. A failure to address sexuality in practice (or addressing it incorrectly) can lead to compromised therapeutic outcomes and decreased client satisfaction.

**Purpose of the study:** The purpose of this study is to determine the educational needs of occupational therapists working in acute care who are alumnus of Elizabethtown College to promote the discussion of sexuality in practice. This information will then be used to create an educational resource for therapists to use which will then be distributed by the researcher. Additional education on sexuality may help OTs improve their knowledge and feel more confident in their abilities to discuss sexuality with their clients and incorporate into treatment sessions. By completing this study, we hope to answer the following questions: 1) Do OTs in acute care educate clients on sexuality? 2) What methods do they typically use to complete this education? 3) What are the educational needs and preferences of acute care therapists?

**How you can participate:** Click the link below. This voluntary survey will ask you some questions about how and how often you address sexuality in practice, and what areas of sexuality you want to learn more about. The survey results will be kept anonymous. It will take approximately 20 minutes to complete.

**When:** The online survey will be distributed the week of 2/11 and should be completed by March 8th, 2019.

**Who:** A certified Occupational Therapist working in an acute care setting

**Survey Link:** <https://www.surveymonkey.com/r/28NGC8N>

Please contact Hannah Burleigh, OTS at [burleighh@etown.edu](mailto:burleighh@etown.edu) or 484-888-1858 should you have any questions.

Office of Alumni Relations – Raffersperger Alumni House  
Elizabethtown College  
One Alpha Drive  
Elizabethtown, PA 17022

800-877-3694 | [alumni@etown.edu](mailto:alumni@etown.edu)

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## Appendix B – Informed Consent and Survey Questions

**Acknowledging Consent for this Survey**

Title of Research: Addressing the Educational Needs of Occupational Therapists Regarding Sexuality in an Acute Occupational Therapy Setting

Principal Investigator(s): Hannah Burleigh, OTS & Gina Fox, OTD, OTR/L

Purpose of Research:

Despite the knowledge that sexuality is an important factor of well-being for individuals with disabilities, occupational therapists continue to under-address this topic with clients. Sexuality is an under-addressed topic in occupational therapy due to many reasons: lack of knowledge, comfort level, client factors, therapist safety, personal beliefs, and fear of causing offense. A failure to address sexuality in practice, or addressing it incorrectly, can lead to compromised therapeutic outcomes and decreased client satisfaction. The purpose of this research is to better understand the educational needs of a group of practicing occupational therapists in an acute care setting regarding sexuality. This information will then be used to create a meaningful and effective resource guide that can be used to help them feel more comfortable initiating discussion regarding sexuality.

Procedures:

The anonymous online survey will be sent to each occupational therapist who is a part of the Elizabethtown College occupational therapy alumni group using a recruitment email. The recruitment email will also be posted to the Etown OT Facebook page. Etown OT alum will receive an email which includes a link containing the consent form and the survey. This voluntary survey will include questions related to the therapists' comfort level with discussing sexuality with their clients, current knowledge of sexuality in practice, as well as perceived learning needs regarding sexuality. Descriptive statistics will be used to analyze survey questions, and open-ended responses will be analyzed for common themes. The data will be used to create an educational resource for the occupational therapists to use in their clinic to help them feel more comfortable addressing sexuality.

Risks and Discomforts

I understand that no risks or discomforts are anticipated from my participation in this study.

Benefits

While there may be no direct benefit from participating in this study, survey responses provided by therapists may, in the future, help healthcare professionals better understand the needs of occupational therapists related to education on sexuality. In addition, the responses from these surveys will be used to create an educational resource that therapists can use in their daily practice.

Compensation

I understand that I will not receive any compensation for participating in this study.

### Confidentiality

All information will be password protected under the Elizabethtown College Survey Monkey account. Only the researchers listed on this form will have access to the study data and information. The additional information gathered during this study will remain confidential and all records will be kept private and locked in a file during the study. The results of the research will be published in the form of an undergraduate paper and may be published in a professional journal or presented at professional meetings. In any report or publication, the researcher will not provide any information that would make it possible to identify me.

### Withdrawal without Prejudice

My participation in this study is strictly voluntary; refusal to participate will involve no penalty. If I initially decide to participate, I am still free to withdraw at any time.

### Contacts and Questions

If I have any questions concerning the research project, I may contact Hannah Burleigh ([burleighh@etown.edu](mailto:burleighh@etown.edu)) or Gina Fox ([foxg@etown.edu](mailto:foxg@etown.edu)). Should I have any questions about my participant rights involved in this research I may contact the Elizabethtown College Institutional Review Board Submission Coordinator, Pat Blough at (717)361-1133 or via email at [bloughp@etown.edu](mailto:bloughp@etown.edu).

### **Statement of Consent:**

- I have read the above information. I have asked questions and received answers. I am willing to participate in this study.
- I understand that by completing this survey, that it indicates my consent to participate.

---

This survey is designed to review your educational needs as an occupational therapist regarding sexuality. Please answer questions honestly and to the best of your ability, however if you do not feel comfortable answering a certain question, you may skip it. For many questions, there will be an additional text box to allow you to clarify your responses.

1. How many years have you been an occupational therapist?
  - a. 0-5 years
  - b. 5-10 years
  - c. 10-20 years
  - d. 20+ years
2. What types of clients do you normally work with?
  - a. Type box
3. I feel that addressing sexuality with my clients is important
  - a. Strongly agree
  - b. Disagree
  - c. Neutral
  - d. Agree

- e. Strongly agree
- 4. I consistently talk about sexuality with my clients
  - a. Strongly disagree
  - b. Disagree
  - c. Neutral
  - d. Agree
  - e. Strongly Agree
- 5. I am comfortable discussing sexuality with my patients
  - a. Strongly disagree
  - b. Disagree
  - c. Neutral
  - d. Agree
  - e. Strongly agree
  - i. Text box pops up to explain why or why not**
- 6. I am knowledgeable about different approaches to address sexuality.
  - a. Strongly disagree
  - b. Disagree
  - c. Neutral
  - d. Agree
  - e. Strongly agree
  - i. Pop up box for when they state agree or disagree, what approaches have you heard of?**
- 7. I have received adequate education about sexuality from my current workplace
  - a. Strongly disagree
  - b. Disagree
  - c. Neutral
  - d. Agree
  - e. Strongly agree
- 8. I have received adequate education about sexuality in my OT academic education
  - a. Strongly agree
  - b. Disagree
  - c. Neutral
  - d. Agree
  - e. Strongly agree
- 9. I would be interested in receiving additional education on sexuality
  - a. Strongly disagree
  - b. Disagree
  - c. Neutral
  - d. Agree
  - e. Strongly Agree
- 10. I would be interested in a reference binder for my clinic on sexuality
  - a. Strongly disagree
  - b. Disagree
  - c. Neutral
  - d. Agree
  - e. Strongly agree

11. I would be interested in participating in an online module about sexuality
  - a. Strongly disagree
  - b. Disagree
  - c. Neutral
  - d. Agree
  - e. Strongly Agree
12. I would be interested in learning strategies for initiating discussion on sexuality
  - a. Strongly disagree
  - b. Disagree
  - c. Neutral
  - d. Agree
  - e. Strongly agree
13. I would be interested in learning diagnosis-specific information regarding sexuality
  - a. Strongly disagree
  - b. Disagree
  - c. Neutral
  - d. Agree
  - e. Strongly agree
14. Provide any additional information about your learning needs in regards to sexuality.
  - a. Text box

Appendix C – Educational Resource

See attached.