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Addressing Sexuality: The Comfort and Preparedness of Occupational Therapy Students

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Abstract

Undergraduate sexual health education has the potential to increase confidence and the likelihood that healthcare professionals address sexual health in practice. This study explored Australian final year occupational therapy students' perceptions about their education, and their preparedness and comfort to address sexuality in their final practice placements and into their future careers. An online questionnaire with three sections for (a) demographics; (b) the students' attitudes towards sexual health (SA-SH) questionnaire, which is a 22-item Likert scale about student attitudes toward sexual health issues in their future profession; and (c) nine open questions regarding students' comfort and preparedness to address sexuality was used. The SA-SH scores of the 51 participants indicated 18 felt comfortable and well prepared; 30 felt comfortable and prepared in some situations and three participants felt uncomfortable and unprepared. Qualitative responses revealed: students considered sexuality was an important occupation; curriculum content meant they were most prepared to address sexuality with older people; personal values, gender, age, and culture factors influenced their preparedness; and comfort would increase with knowledge and experience. This paper demonstrates that both preparedness and comfort are required for occupational therapists to address sexuality effectively. The occupational therapy curriculum needs to focus on developing problem solving and practical skills using sexuality specific content, in particular how to initiate and respond when clients raise the topic. In conjunction with improvements to the curriculum, professional practice supervisors were identified as important educators as they can provide opportunities to address sexuality with clients and share their experiences while students are on placement.

Keywords

Sex, sexuality, occupational therapy, students, education, curriculum, SA-SH

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Addressing Sexuality: The Comfort and Preparedness of Occupational Therapy Students

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ABSTRACT

Undergraduate sexual health education has the potential to increase confidence and the likelihood that healthcare professionals address sexual health in practice. This study explored Australian final year occupational therapy students' perceptions about their education, and their preparedness and comfort to address sexuality in their final practice placements and into their future careers. An online questionnaire with three sections for (a) demographics; (b) the students' attitudes towards sexual health (SA-SH) questionnaire, which is a 22-item Likert scale about student attitudes toward sexual health issues in their future profession; and (c) nine open questions regarding students' comfort and preparedness to address sexuality was used. The SA-SH scores of the 51 participants indicated 18 felt comfortable and well prepared; 30 felt comfortable and prepared in some situations and three participants felt uncomfortable and unprepared. Qualitative responses revealed: students considered sexuality was an important occupation; curriculum content meant they were most prepared to address sexuality with older people; personal values, gender, age, and culture factors influenced their preparedness; and comfort would increase with knowledge and experience. This paper demonstrates that both preparedness and comfort are required for occupational therapists to address sexuality effectively. The occupational therapy curriculum needs to focus on developing problem solving and practical skills using sexuality specific content, in particular how to initiate and respond when clients raise the topic. In conjunction with improvements to the curriculum, professional practice supervisors were identified as important educators as they can provide opportunities to address sexuality with clients and share their experiences while students are on placement.

Introduction

Sexuality is integral to shaping every person's roles and identity and contributes to self-esteem (Lynch & Fortune, 2019). The importance people place on sexual activities varies across their life span and between people, but the right to have good sexual health is constant (Areskoug-Josefsson, 2016). Addressing the impact of a condition on sexual health is important; people have voiced their desire that healthcare professionals take the initiative and be competent and confident in discussing sexual health concerns (Post et al., 2008; Taylor & Davis, 2007; Wittenberg & Gerber, 2009).

Sex and sexuality are critical to a fulfilling occupational life for many people (Lynch & Fortune, 2019). A person's sexuality contributes to who they are (identity), what they like to do (occupational needs and desires), and what they actually do (occupational participation and level of engagement; Bergan-Gander & von Kürthy, 2006). Occupational therapists have the opportunity to play a meaningful and significant role in people's lives, inclusive of sex and sexuality (Rose & Hughes, 2018). Lynch and Fortune (2019) developed the occupational perspective of sexuality (OPS), a hierarchically aligned framework, which has potential to enable a broader, more holistic consideration of sexuality, assisting healthcare professionals and educators to better understand the ways in which they may address their clients' needs to do, be, become, and belong to their sexuality which ultimately involves a shift towards a more occupational understanding of sexuality.

Although health problems may impact sexual identity and occupations, occupational therapists appear reluctant to address sexuality with their clients (Hyland & McGrath, 2013; McGrath & Lynch, 2014; McGrath & Sakellariou, 2016). Undergraduate sexual health education has the potential to increase confidence and the likelihood that healthcare professionals will address sexual health in practice (Helland et al., 2013). However, previous studies have suggested that occupational therapy education fails to prepare students to comfortably address sexuality (Jones et al., 2005; Lohman et al., 2017; Payne et al., 1988). Lohman et al. (2017) reported teaching sexuality was important but only 3.48 hours of mainly lecture/teacher directed time was in the occupational therapy curriculum, which was not an improvement in the time spent in 1988 (Payne et al.,1988). Eglseder et al. (2018) reported an increase in the time spent to 7.27 hours but that it was still mainly lecture rather than practical time. The limited content and modes of delivery in occupational therapy programs were similar to findings from other professions (Criniti et al., 2014; Ford et al., 2013; Miller & Byers, 2010). Irrespective of the curricula content, current research indicates this is not translating to practice (Jones et al., 2005).

Practice placements are a core element of occupational therapy education, providing opportunities for students to integrate knowledge, professional reasoning, and professional behavior into their practice, and develop knowledge, skills, and attitudes to the level of competence required as a qualified occupational therapist (World Federation of Occupational Therapists, 2016). There has been an identifiable increase from the

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Payne et al. (1988) study with 2% of the respondents indicating that sexuality was addressed in practice education setting, to 15% in Eglseder et al. (2018). It is important to note that these findings were reported by the educators and not the students undertaking the placements.

Research is needed to explore how occupational therapy students perceive the education they receive and their predications of how well it prepares them to be comfortable and prepared to address sexuality in their final practice placements and into their future careers. The population chosen for this study was fourth year occupational therapy students from an Australian Occupational Therapy national course.

This study sought to answer the following research questions:

1. How do occupational therapy students perceive their readiness to discuss sexuality with clients, supervisors, and other professionals when on placement?
2. What factors influence a student's level of comfort or discomfort in addressing sexuality with clients?
3. Do students feel adequately prepared to address sexuality with clients, supervisors, and other professionals based upon knowledge and skills learned during their degree?

Methods

Study Design

An online questionnaire was used to collect quantitative (closed questions and rating scale questions) and qualitative (open questions) data. The questionnaire consisted of three sections: (a) demographic information including: gender, age, previous education, previous/current employment or volunteer experience in occupational therapy, allied health, medical or disability areas and previous practice placement areas; (b) students' attitudes towards sexual health (SA-SH) scale (Areskoug-Josefsson et al., 2016); and (c) nine open questions regarding students' comfort and preparedness to address sexuality. These questions, developed by the research team, addressed participants' opinions about the importance of addressing sexuality, if they were more/less prepared and comfortable to address sexuality with certain client groups, and whether they had addressed sexuality in previous practice placements.

The SA-SH is a 22-item Likert scale questionnaire about student attitudes toward sexual health issues in their future profession (Areskoug-Josefsson, Rolander, et al., 2019). The items are distributed across four domains – present feelings of comfort in addressing sexual health, future working environments, fear of negative influence on future client relations, and educational need, rated with five options: disagree, partly disagree, partly agree, agree, and strongly agree (Areskoug-Josefsson et al., 2016). The total sum of the item scores can be calculated. The three response classes of the SA-SH are in the following ranges: score 22-56: uncomfortable and unprepared; score 57-79: comfortable and prepared in some situations; score 80-110: comfortable and well prepared. The SA-SH has shown good psychometric qualities and is also reliable and valid to use with healthcare professional students (Areskoug Josefsson, Sjokvist, et al., 2019; Areskoug-Josefsson et al., 2018; Gerbild et al.,2017). These studies have

indicated good content validity, construct validity, internal consistency and intra-rater reliability for use of the SA-SH with students in social work, prosthetics, orthotics, physiotherapy, nursing, radiography and occupational therapy.

Participants

A convenience sample of fourth-year students enrolled in the Australian Catholic University Undergraduate Bachelor of Occupational Therapy program were invited to participate. All participants needed to be enrolled in the unit, OTHY401 Professional Practice Education 3, because it had the pre-requisite of passing all first, second, and third-year units. The participants also needed to have completed the fourth-year unit, OTHY400 Occupational Therapy: Aging Population and Health, as this unit explicitly covered the role of occupational therapists in addressing sexuality with older adults. The unit's content was the final explicit content students received on sexuality and was therefore relevant to the preparedness aspect of this research. There were 214 students eligible for participation. An email invitation was sent to all eligible students. An accompanying participant information sheet explaining the purpose of the study and a link to an online questionnaire was distributed. Completion of the questionnaire implied consent. Ethical approval was granted from the Australian Catholic University Ethics Review Committee with approval no: 2017-303E.

Data Analysis

The demographic and SA-SH quantitative data were analyzed using the Statistical Package for the Social Sciences (SPSS version 25). Descriptive statistics were used to analyze the demographic data and each item of the SA-SH within each of the four domains. Medians, quartiles (25% and 75%) and the lowest and highest values, and outliers were also calculated for each item of the SA-SH. Responses to the open qualitative questions were collated and thematic analysis was used to identify themes. Steps proposed by Braun and Clarke (2019) were utilized to highlight reoccurring concepts and a reflexive approach was used to reach consensus on the agreed meaning. Both researchers independently coded the data using their subjective understanding and developed themes through a reflective and analytical approach and then the researchers met and collaboratively reached consensus of shared meaning to finalize the themes. This process ensured the dependability and credibility of the data analysis, and an audit trail was maintained to enhance trustworthiness.

Results

Of the 214 students who were eligible for this study, 55 responded with 51 completing all sections and therefore their data were analyzed. A response rate of about 34% is commonly reported in most online survey studies (Nulty, 2008) with this study achieving a 24% response rate. The mean age of the participants was 23 years (SD $\pm$ 2.585, range 20-31), 46 identified as female and 5 as males. The percentage of male to females (9.2%) was equivalent to the registrant data recorded by the Occupational Therapy Board of Australia (2020). For 33 participants their final year of secondary schooling was their highest qualification, eight had Certificate III or IV qualifications, three had completed one year of a different degree, and seven had completed undergraduate degrees in other areas.

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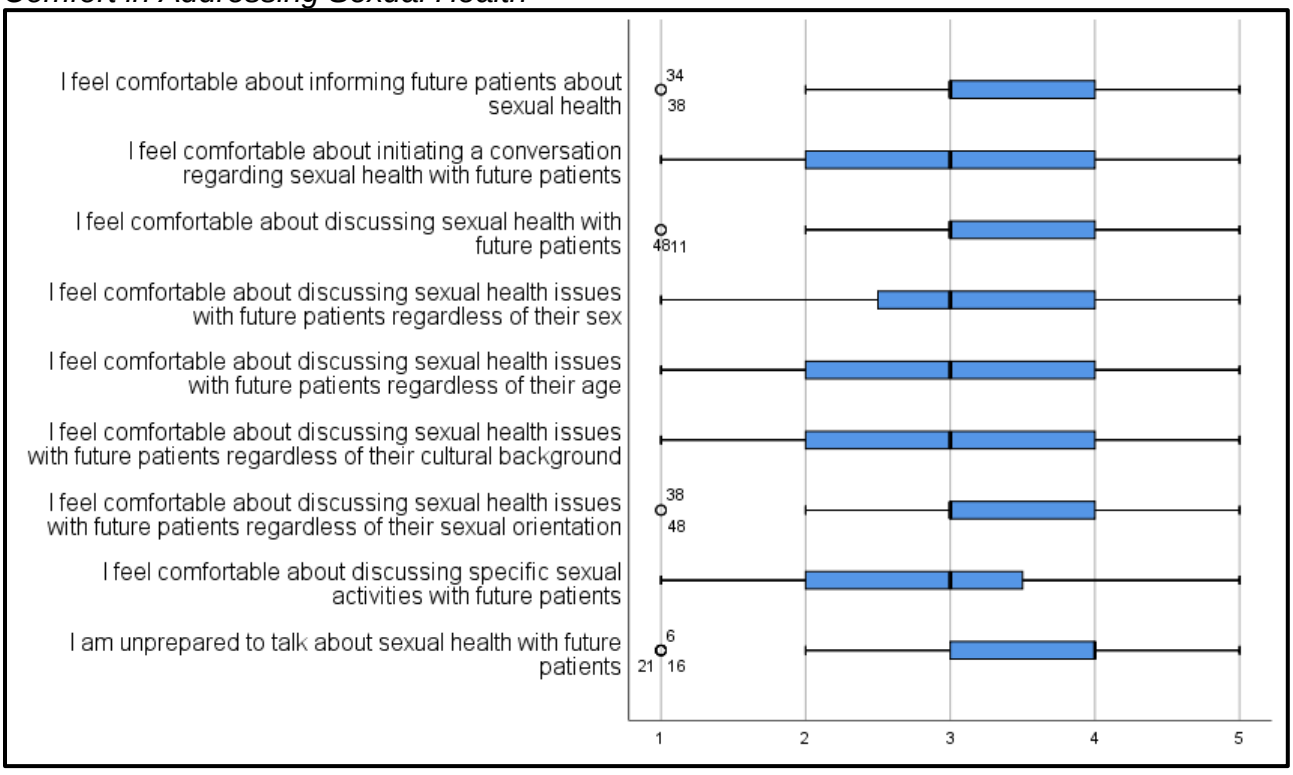
Using the SA-SH scoring criteria for the four domains, three (6%) participants scored in the uncomfortable and unprepared range (22-56); 30 (59%) were comfortable and prepared in some situations (57-79); and 18 (35%) participants were comfortable and well prepared (80-110). Results of the analysis are presented in Figures 1,2,3, and 4.

Comfort in Addressing Sexual Health with Future Clients

Although most students reported *partly agreeing* they would be comfortable informing patients about future sexual health most *agreed* they did not feel prepared, except for three participants (6, 16, 21) who *strongly disagreed* that they were unprepared (see Figure 1). Two participants (34 & 38) reported that they would feel very uncomfortable informing clients about sexual health (more so than others) and Participant 38 and 48 reported this was particularly related to sexual orientation. Culture and age, and to a lesser extent gender, were variables that influenced participants' comfort. Although many students reported *part agreement* to discussing sexual health regardless of gender, they felt less comfortable overall if they had to initiate the conversation.

Figure 1

Comfort in Addressing Sexual Health



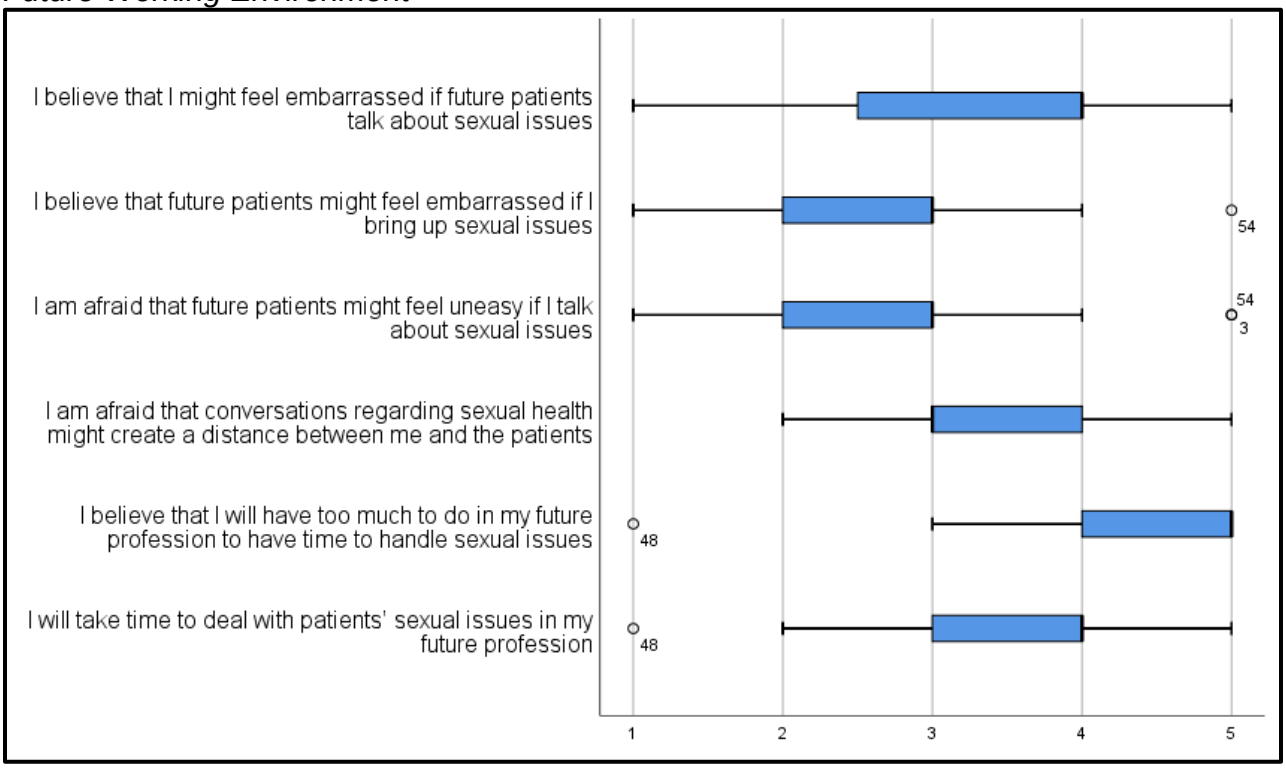
Note: (9 variables/questions); Medians and quartiles are reported by boxes, whiskers represent the lowest and highest values that were not outliers, and outliers are represented with º. 1 = disagree; 2 = partly disagree; 3 = partly agree; 4 = agree; 5 = strongly agree.

Future Working Environment

In contrast to most participants agreeing they would take the time to deal with patients' sexual issues in their future profession, they strongly felt they would have too much else to do and therefore would have limited time to address sexual issues (see Figure 2). Participant 48 was an outlier who *strongly disagreed* with spending time dealing with future patients' sexual issues for reasons unrelated to having sufficient time. Most of the participants *partly agreed - agreed* that discussing sexual issues might strain the relationship between them and their patients. Participants also *partly agreed*, but to a lesser extent, that patients might feel uneasy or embarrassed and acknowledged that they themselves would be the ones that would be embarrassed. Another outlier (Participant 54) strongly *agreed* that clients would be embarrassed and would feel uneasy if the professional was to talk about sexual issues.

Figure 2

Future Working Environment



Note: (6 variables/questions); Medians and quartiles are reported by boxes, whiskers represent the lowest and highest values that were not outliers, and outliers are represented with º. 1 = disagree; 2 = partly disagree; 3 = partly agree; 4 = agree; 5 = strongly agree

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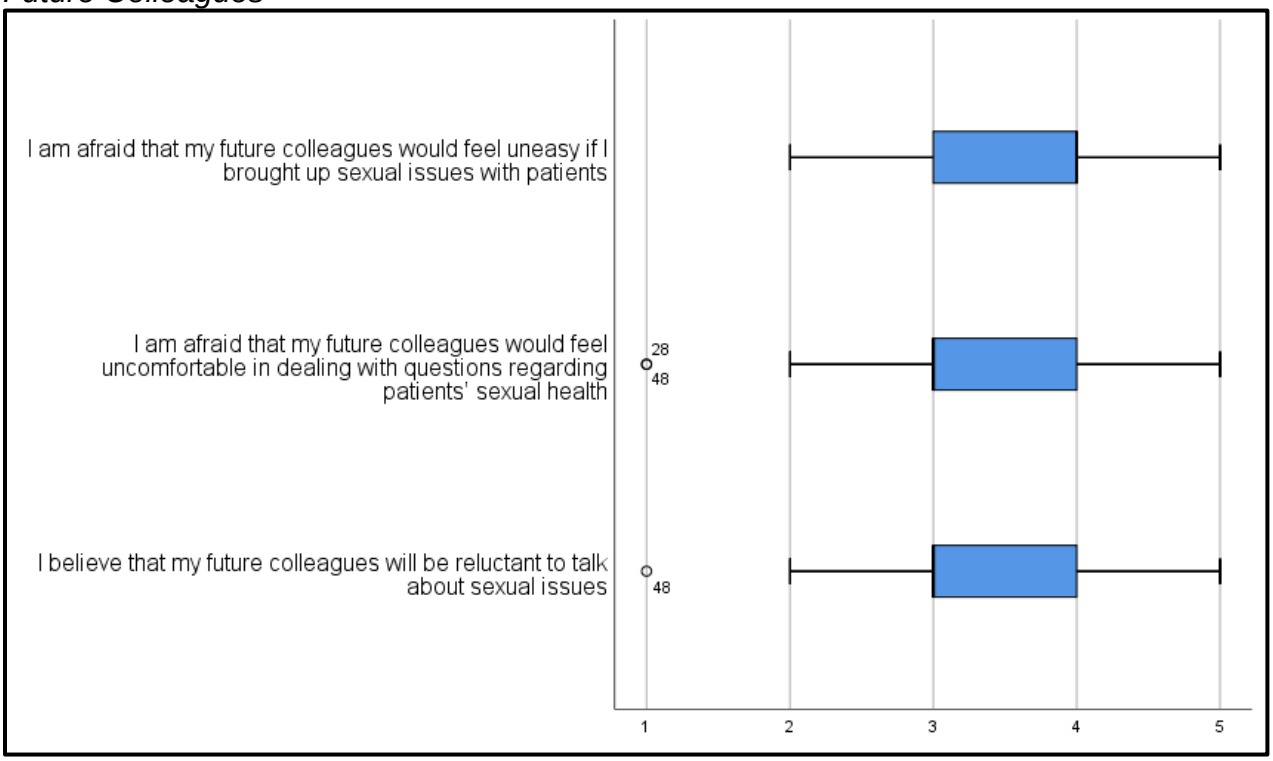
Future Colleagues

Most of the participants *partly agreed* that colleagues would be reluctant to talk about sexual issues or deal with questions about sexual health (see Figure 3). Participants were more afraid that future colleagues would feel uneasy if the participant was to bring sexual health issues up with patients. The outlier (Participant 48) was the only participant to strongly disagree that future colleagues would be reluctant to talk about sexual health issues and, along with Participant 28 *strongly disagreed* that colleagues would be uncomfortable to do so.

Figure 3

Future Colleagues



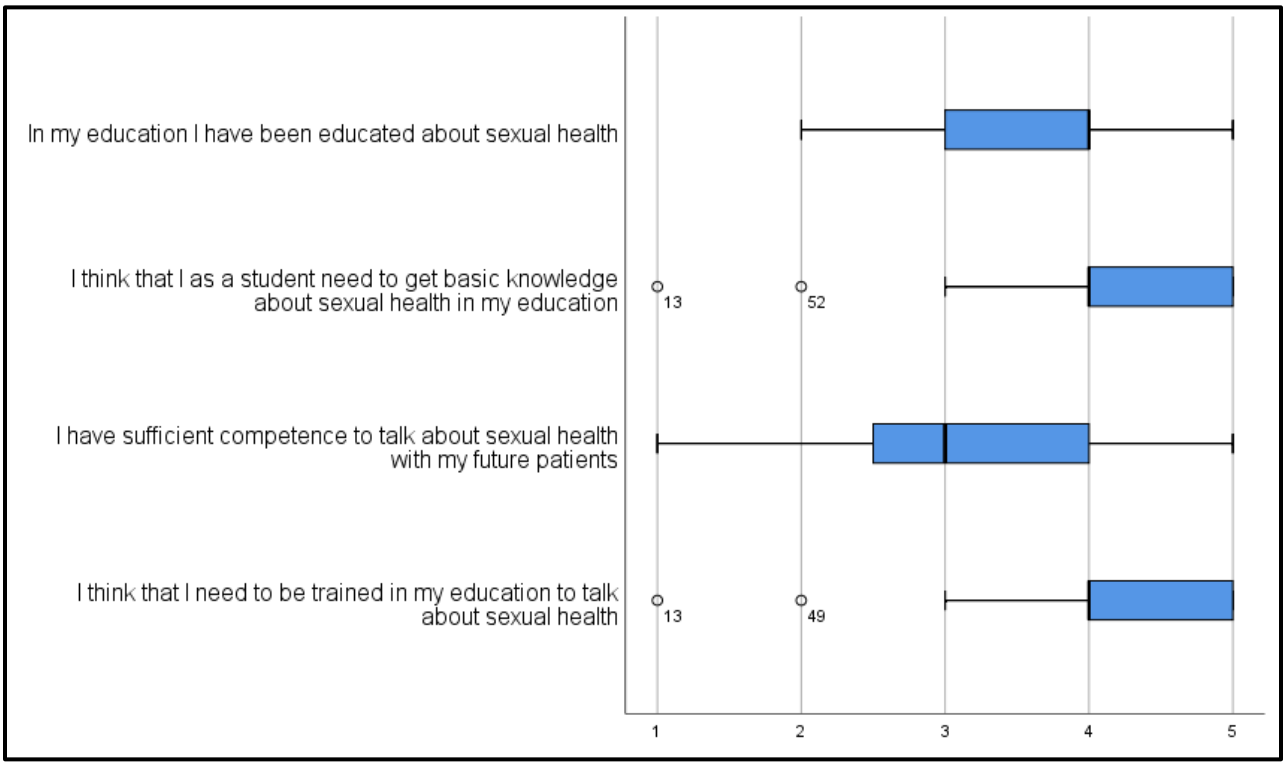
Note: (3 variables/questions); Medians and quartiles are reported by boxes, whiskers represent the lowest and highest values that were not outliers, and outliers are represented with ⁰. 1 = disagree; 2 = partly disagree; 3 = partly agree; 4 = agree; 5 = strongly agree.

Education

Most participants *partly agreed* to *agreed* they had been educated about sexual health and the majority *partly agreed* that they had sufficient competence to talk about sexual health with future patients (see Figure 4). However, most participants *agreed* to *strongly agreed* there was a need for education and basic knowledge on sexual health. Two outliers (Participants 13 & 49) *strongly disagreed* to *partly disagreed* they needed to be trained about sexual health and that students need to get basic knowledge about sexual health in their education (Participants 13 & 52).

Figure 4

Education



Note: (4 variables/questions); Medians and quartiles are reported by boxes, whiskers represent the lowest and highest values that were not outliers, and outliers are represented with ⁰. 1 = disagree; 2 = partly disagree; 3 = partly agree; 4 = agree; 5 = strongly agree.

Qualitative Results

Four themes were developed in the analysis process: 1) Addressing sexual health is an important occupational therapy role, 2) There is a difference between comfort and preparedness, 3) Inconsistent preparedness in addressing sexual health with different client groups, and 4) The importance of feeling comfortable in addressing sexual health with clients.

Theme One: Addressing Sexual Health is an Important Occupational Therapy Role

Most of the participants felt that addressing sexual health was a very important role for occupational therapists. Many participants reported it was very important because it was an occupation, and all occupations should be addressed. Some participants used similar terms, such as that it was a valued activity, important in everyday life, and part of a holistic approach. Participant 49 reported: “I think it should be viewed like any other role or daily occupation. Therefore, it’s importance should be stressed as much as

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anything else." This was strongly expressed by Participant 4 - "how can we claim to be client-centered and occupation-based unless we consider the client holistically, identifying all aspects of daily life with a respectful appreciation of what the client values."

Many participants also reported addressing sexuality was important because it contributed to a person's identity and linked closely to their emotional, physical, and psychological health. For most participants, importance was also based on whether it was valued by the client. As Participant 41 noted: "it is very important to be prepared to discuss sexual issues or sexuality with future clients. However, this will vary based on each individual client and whether this is an important concern for them." Some participants reported that clients might not know it was part of an occupational therapist's role, or clients might be too embarrassed to raise the concern, and therefore therapists needed to initiate the conversation so that it was not overlooked. As Participant 34 described: "I think talking about sexual health gives patients permission to talk about it openly, as though it is an important occupation for people."

Although overall participants reported it was very important, they also stated this did not necessarily mean they felt prepared to discuss sexual health with future clients.

Theme 2. There is a Difference Between Comfort and Preparedness

Many participants reported that being prepared was essential to feeling comfortable. Being prepared included having the skills to initiate or respond if the topic was raised, and having the knowledge, skills, and resources to answer questions and provide solutions. Participants felt that being prepared to respond to clients' concerns would mean they were more comfortable because they reported comfort largely being related to "not digging a hole for themselves" (Participant 38) by raising something they did not have the answers to. In contrast some participants reported they could be prepared and still feel uncomfortable, or that being uncomfortable did not mean they would not raise it with clients, as long as their discomfort was not obvious to the client. As Participant 3 reported: "you could have encyclopedic knowledge on how to address sexuality but still be uncomfortable due to a range of personal factors (religion, personal experiences, anxiety, etc.)."

Several participants responded they thought comfort was something that came over time with experience and practice and was more than just having sufficient knowledge to feel prepared. Being comfortable was also reported by two participants as being dependent on the issues raised and a degree of acceptance was needed to feel non-judgmental and accepting of all issues.

Theme 3: Inconsistent Preparedness in Addressing Sexual Health with Different Client Groups

Several participants indicated that unless the scenarios were specific to a client group, or were explicitly taught as sexual health content, they felt they had not been taught how to address it with that client group. Only a small number of students reported they could generalize knowledge and skills across client groups. As Participant 2 reported: "I

feel unprepared to address sexuality with young-middle aged adults as we have not been exposed to any scenarios or learning about this." Therefore, participants felt more prepared when sexuality was explicitly taught in the occupational therapy units. Participants reported direct teaching (a lecture and tutorial) in the Aging unit in fourth year and Physical Rehabilitation unit in second year and for the latter they felt more prepared as they perceived the sexual health concerns as being related to functional or practical concerns, they felt would be easier to problem solve. As Participant 15 reported: "Yes, I feel prepared to talk to the elderly about sexuality, however we have not spoken/been educated about how to address it within a younger population."

Interestingly, although many students reported feeling more prepared to work with older aged groups many still did not feel prepared or comfortable to initiate/raise the topic but rather they felt prepared if the client brought it up. Even those who felt prepared to initiate the topic reported a need to have more knowledge and skills to provide adequate support and intervention. Participant 28 reported,

> I believe the small amount we have done has provided me with some knowledge in regards to it being a part of the OT [occupational therapy] role, however it has not prepared me to actually address it or given me the skills to open up a conversation in a way which would be comfortable for all.

The difficulty of incorporating specific teaching in each unit was mentioned by two participants. Participant 40 reported that being prepared and able to address sexual health "with a range of client groups was very difficult to learn in the classroom and it is learning that really needs to be done in the 'real world' once basic knowledge has been established." As explained by Participant 21's comment about their third-year placement (a disability service): "If I was not able to experience the sex and disability sector then I feel as though I would have no idea how, where or why I would approach this particular subject with a client."

Several participants reported the person's culture as being influential and indicated that they knew they had to be sensitive to cultural (in this case ethnicity) issues but that they did not have the cultural knowledge of each group to be able to do this adequately. The feeling that some cultures and religious groups were more conservative than others and that they particularly felt underprepared to address sexuality with people from a different cultural group than their own was mentioned by several students. As Participant 17 reported,

> I feel there hasn't been enough education around how to approach sexuality with other cultures/religions where it may not be as widely accepted to openly discuss… and that I feel it may impact the therapeutic relationship if I were to offend them by asking.

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Another factor that participants identified as influencing how prepared they were to address the topic was their age compared to their client's age. They reported that they felt there was power imbalance with older clients as the older clients would have the experience and expert knowledge compared to them and that some clients might think they were too young to be able to help them. A small number reported inconsistencies about feeling either more or less prepared if it was with people the same age as themselves, and for one participant, if the client was the same age as their parents. A few participants reported that although it was less important as a focus for children and young people perhaps it did need to be addressed more often. Gender was only mentioned by some participants as being an influencing factor with concern that they were less prepared to address the issue with people of the opposite gender.

Theme 4: The Importance of Feeling Comfortable in Addressing Sexual Health with Clients

More than half the participants reported they thought it was very important to be comfortable to address sexuality on their final practice placement, but many reported feeling neither comfortable or prepared. Reasons given for it being important were that it was a topic that could come up in a range of practice contexts, that comfort was important to building rapport, that it would be unprofessional to appear flustered and uncomfortable, and if you were comfortable then your client would most more likely be comfortable. However, some participants reported that it was understandable that students might feel uncomfortable and that practice placements should provide the opportunities to become more comfortable, and supervisor support was important to this process. A few participants reported that it was not important because in their practice placements to date they had not yet seen it being addressed by clinicians, so they did not anticipate they would have to address it. Participant 17 reported that when your supervisor is assessing you, "it can be particularly awkward if your supervisor doesn't believe it is an appropriate area to discuss with a client."

When asked about client groups that participants felt more, or less, comfortable addressing sexuality with, most participants reported more comfort in addressing sexuality with clients of similar age to their own and of the same sex to themselves. This comfort level contrasted with feeling more prepared to address sexuality with older participants. A few participants reported cultural and religious beliefs that differed from their own might make them less comfortable and this was especially so with men as the majority of participants were female.

Discussion

This study sought to explore whether final year occupational therapy students were prepared and comfortable to address sexuality and whether their undergraduate curriculum had given them the knowledge and skills required. The quantitative data indicated that the students felt adequately prepared and comfortable, but the qualitative results provided a richer insight into their perceptions about preparedness, comfort, barriers to feeling prepared and comfortable, and changes that could enable them to feel more prepared and comfortable.

The present study showed participants perceived they could address the issue even when uncomfortable but not when they were not prepared, and that being prepared was one contributor to being comfortable. Participants conveyed that having the skills to initiate or respond to sexual issues and having the knowledge and resources to answer questions and provide solutions created a sense of preparedness. Feeling prepared was seen as enabling the participants to remain professional in front of their clients and not be in a position of raising a topic they were not able to answer. There appeared to be a strong relationship between who initiates the conversation and comfort, with most students reporting greater comfort if the client raised the sexual concerns as they felt more able to suggest they could get back to them if they did not know the answers. This illustrates the need for a greater focus on teaching skills and having opportunities to practice initiating and maintaining the conversation so everyone can feel comfortable. Some participants described a need to act as if comfortable even if not, or to 'fake it until you make it' as expressed by one participant. Students strongly reported that unless explicitly taught using case studies with a range of cultural groups, ages, disorders, and so on, then they did not have the skills; indicating their inability to generalize knowledge to different contexts. It would appear that educators, including professional practice educators, need to provide information, case studies, simulation activities, and assessment and intervention practice across all units. In aging, the area of practice where sexual content was explicitly taught, participants still expressed a need for further education and basic knowledge on sexual health. A desire to have more education which focused on communicating with clients of the opposite sex, different culture groups and of various age groups were common trends among the findings.

Effective and efficient communication is one of the most important tools for providing quality healthcare and improving client satisfaction (Leonard et al., 2004). The findings of this study and earlier studies indicate there is a need for further research to determine if more explicit teaching content and practicing the skill of initiating and responding to conversations would be beneficial or whether, as with many areas of practice, experience over time would increase comfort and preparedness (Areskoug-Josefsson et al., 2016). A further recommendation to address the reluctance of occupational therapists discussing sexuality is that therapy teams, among themselves and in interprofessional contexts such as client case conferences, would benefit from more frequent and open communication. Adding routine questions to initial assessments would also help create an expectation that sexuality is addressed with each client. Consideration could be given to educate occupational therapy students about the OPS framework, developed by Lynch and Fortune (2019), which affirms clients as sexual beings and considers their needs to do, be, become, and belong to their sexuality from an occupational perspective. Students could also be trained in the use of the PLISSIT (Annon, 1976) or EX-PLISSIT model (Taylor & Davis, 2007) to encourage them to give clients permission to raise sexuality issues. Although developed as a model for sexologists, it might provide the structure and direction that gives occupational therapists the comfort to raise the topic and patients to understand that the opportunity is available.

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Although, participants had completed approximately 680 professional practice hours, they reported not observing occupational therapists addressing sexuality on placement and that their placements had not provided the opportunity to practice their skills or to become more comfortable or prepared despite having completed these hours. For a small number of participants this had led them to report they did not consider sexuality as an important area of practice. Fortunately, most of the participants still regarded it as important and that it was a gap in their experience that they wanted to address. This finding highlights the role of professional practice, supervisor modeling of assessment and intervention in the practice setting, and the need for assessment tools and occupational profile guidelines that are an essential part of the client assessment process.

Participants' comfort with addressing sexuality during intervention was influenced by students' culture and gender, and the age of the clients, particularly if different to their own. Similar to their allied health counterparts in Areskoug-Josefsson, Thidell et al.'s (2018) study, participants indicated they did not feel comfortable discussing sexual health issues with clients from different cultural backgrounds. This was quite surprising considering Australia has such a culturally diverse community (Australian Human Rights Commission, 2016). It also reminds educators not to assume that living in a multicultural environment provides students with the necessary skills and knowledge to comfortably address sexuality with their clients. Sexual orientation was not reported as being an aspect of sexuality that they were uncomfortable addressing. This result perhaps suggests that in Australia, the community discussion and the debate that accompanied the introduction of the Australian Marriage Amendment (Definition and Religious Freedoms Act, 2017), which legalized same-sex marriage had helped students feel more comfortable discussing sexuality with addressing sexual orientation with their clients. However, similar to culture influences, it cannot be assumed that societal and environmental factors are sufficient to increase preparedness or comfort to address sexuality and that explicit course content is likely required to ensure students are well prepared and comfortable. These findings warrant the need for more explicitly taught curriculum content which focuses on cultural differences in relation to sexuality, considers sexuality across the lifespan and from gender and non-binary perspectives, along with opportunities to discuss and communicate about sexuality with each other and with consumers.

Limitations

This study provides preliminary evidence about the perspectives of final year occupational therapy students in one program, with a response rate of 24%, about their preparedness and comfort in addressing sexuality. Caution is required in generalizing the results, but the SA-SH questionnaire had previously been used to explore perceptions of nursing, physiotherapy, prosthetic, and orthotic students. Compared to these, the participants of this study had similar perceptions to their future colleagues; that is, whilst somewhat prepared, they would feel uneasy, uncomfortable, and reluctant to talk about sexual issues in the final practice placement. This study also had additional 9 open-ended questions developed by the research team that were not piloted prior to use therefore more research is required with a larger sample, across more university courses to confirm these findings and to inform curriculum development.

Implications for Occupational Therapy Education

- Occupational therapy curricula need to provide opportunities across the course, for students to practice assessment and practical skills in order for them to be prepared and comfortable to successfully address sexuality in their future practice.
- Preparedness and comfort go hand in hand. Preparedness involves having the skills to initiate or respond to sexual issues and having the knowledge and resources to answer questions and provide solutions, which in turn leads to the individual feeling more comfortable.
- A major change required to occupational therapy curricula is the opportunity for occupational therapy students to practice communicating about sexuality. Effective and efficient communication is one of the most important tools for providing quality healthcare and improving client satisfaction.

Conclusion

This paper explored how occupational therapy students perceived the education they received and how comfortable and prepared they were to address sexuality in their final practice placements and into their future careers. The results suggest both preparedness and comfort are required for occupational therapists to address sexuality effectively. Occupational therapy curricula need to focus on developing problem solving and practical skills using sexuality specific content, in particular how to initiate and respond when clients raise the topic. This educational initiative may be an effective way of assisting students to translate what is learned into practice. In conjunction with increases in the time spent, and improvements to curricula, professional practice supervisors were identified as important educators as they can provide opportunities to address sexuality with clients and share their experiences while students are on placement.

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