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Sexual Recovery Programming: A Mechanism for Influencing Occupational Therapy Practice

Methods

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Sexual Recovery Programming: A Mechanism for Influencing Occupational Therapy Practice Methods

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By

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Abstract

Neglecting to address sexuality in OT practice contributes to societal oppression and deprives individuals with disabilities from exploring this occupation (Sakellariou & Simó Algado, 2006a). Therapist discomfort, lack of educational preparedness, and not having enough time are some noted barriers to addressing sexuality in OT practice (Hattjar, 2012). This Doctoral Capstone Experience (DCE) explored the inclusion of sexuality and intimacy in practice at Community Rehabilitation Hospital. Following a needs assessment, a gap was found in provision of holistic practice methods. Former patients were concerned about sex post injury, but these needs went unresolved as therapists never initiated the conversation of sexuality during patient recovery. Knowledge and time were identified by OT clinicians as the greatest barriers to implementation of sexuality. Sexual recovery programming was designed to address the gap through creating a screening tool, developing resources, leading patient education, and providing OT staff in-services. These implementation components were intended to increase confidence in abilities, debunk common myths and stigmas, and equip OT clinicians with knowledge to promote consistent incorporation of sexuality into OT practice. Sexual recovery programming created a professional and theoretical method for OT clinicians to address sexuality and intimacy with patients during the rehabilitation process. Based on these findings, an annual in-service and monthly discussions on addressing sexuality in healthcare were recommended for continuation of holistic service delivery. Similar methods should be pursued in additional practice areas to promote an inclusive healthcare environment and ensure client-centered practice through honoring the holistic values of the OT profession.

Introduction

Sexuality is often portrayed as an intimate and taboo topic in an idealistic society. This societal view sets the foundation for stigmatization and promotes an exclusive environment, in terms of addressing sexuality, within the context of health care provision. *The Occupational Therapy Practice Framework: Domain and Process, 3rd Edition* recognizes sexual activity as an activity of daily living and identifies intimacy as a form of social participation (AOTA, 2014). Though sexual activity and intimacy are supported in the Occupational Therapy (OT) framework, OT clinicians are not addressing sexuality at a desired rate (McGrath & Sakellariou, 2016).

Stigma of Sexuality and Disability

The term sexuality is holistic in nature, encompassing components of the human experience. MacRae (2013) defines sexuality as, "a core characteristic and formative factor for human beings…basic to our sense of self" (para 1). Mechanisms to express sexuality include holding hands, flirting, touching, kissing, masturbating, and having sexual intercourse (MacRae, 2013). Despite the recognition of sexuality as an aspect of humanity, societal norms often steer both direction and portrayal of sexuality. According to Tepper (2000), "sex is portrayed as a privilege of the white, heterosexual, young, single, and non-disabled" (p. 285). This stigma amplifies for individuals with disabilities, often leading to the notion of asexuality amongst this population (Tepper, 2000). Internalization of these societal views have the ability to affect confidence, desire, and self-concept (Esmail, Darry, Walter, & Knupp, 2010). In a focus group conducted by Fritz, Dillaway, & Lysack (2015), one participant who sustained a SCI offered perspective on the impact of societal perceptions. She stated, "I think the hardest thing that I've had to come to grips with is that people look at me as an asexual being…I just think it's a

common response to women with disabilities" (Fritz et al., 2015, p.7). These stigmas perpetuate negative bias towards sexuality and disability, which stifles potential for open conversation, education, and relevant information (Esmail et al., 2010). Individuals with disabilities are not immune to sexual or intimate feelings. As clinicians it is necessary to address sexuality, within the scope of OT practice, to promote healthy sexual expression and well-being.

Barriers to Holistic Practice

The field of OT has adopted a client-centered, holistic approach to patient care reflected in addressing psychosocial components along with physical or cognitive impairments. Considering this concept, electing to exempt sexuality from practice, challenges the values of the OT profession as a whole. The opportunity to explore the role of OT in terms of sexuality and disability begins in the classroom. Areskoug-Joefsson, Larsson, Gard, Rolander, & Juuso (2016) investigated attitudes of healthcare students towards addressing sexual health with patients. Researchers found physical therapy (PT) and OT students were not educated on sexual health at the rate of other healthcare students, and healthcare students as a whole did not feel prepared to address sexual health with patients (Areskough-Joefsson et al., 2016). This lack of educational preparation may influence practice methods of future OT clinicians. Hattjar (2012) outlines potential barriers to acknowledging sexuality consistently in OT practice. These contributing factors include: therapist discomfort, lack of educational preparedness regarding sexuality, assuming other health care disciplines are addressing the topic, and not having enough time due to productivity standards (Hattjar, 2012). As consumers of society, OT clinicians may also thread bias into practice, failing to recognize clients as sexual beings or address sexuality during the therapeutic process (Sakellariou & Simó Algado, 2006b). The failure to recognize sexuality in OT practice contributes to societal oppression and deprives individuals with disabilities of an

opportunity to explore this occupation, creating an occupational injustice (Sakellariou & Simó Algado, 2006a). McGrath & Sakellariou (2016) propose OT clinicians should view sexuality through a rights-based approach, emphasizing sexuality as a human right for individuals with disabilities (McGrath & Sakellariou, 2016). Overcoming these barriers will be essential to honoring the values of the OT profession and ensure provision of holistic and client-centered care.

Sexual Recovery and Disability

Individuals with life-altering disabilities such as stroke, traumatic brain injury (TBI), spinal cord injury (SCI), or amputation must learn to adapt occupations during the recovery process. Sexuality must not be excluded from the process of adaptation, as this occupation holds meaning to individuals recovering from injury. Sexual recovery, in this context, refers to the journey of sexual rediscovery and expression post injury (Beckwith & Kwai-sung Yau, 2013). This process of recovery should be guided by qualified healthcare professionals, namely OT clinicians, to promote holistic care (Fritz et al., 2015). Several studies have investigated client views of sexuality post injury. Beckwith & Kwai-song Yu (2013) and Fritz et al. (2015) explored perceptions of women post SCI finding that participants viewed resources received on sexuality as lacking. During the recovery process, no education or resources were provided directly by OT clinicians (Fritz et al., 2015). Robinson, Forest, Ellis, & Hargreaves (2011) suggested that resources on sexuality were outdated, poor quality, and focused on males.

There is a distinct need to establish appropriate resources, as sexuality is a concern of individuals with disabilities post injury. Common concerns regarding sexuality post SCI have included lack of bowel and bladder control during intimacy (Robinson et al., 2011; Fritz et al., 2015). In addition, the impact of the caregiver role post injury, particularly when in a

relationship, has the potential to shift dynamics. Women with SCI felt "objectified, degraded, and humiliated" during times the partner assumed a caregiver role (Robinson et al., 2011, p. 16). It is critical for OT clinicians to assist clients with navigating these concerns and provide relevant resources. In a study on sexual health issues and individuals with physical disabilities and chronic disease, researchers found 67.0% of participants wanted help with sexuality and 9.0% did not know the appropriate health professional to contact (Kedde, Van De Wiel, Schultz, & Vanwesenbeek, 2016). The method of addressing sexuality in OT practice has neglected to incorporate client-centered interventions and has not accounted for specific needs of clients (Robinson et al., 2011). Song, Oh, Kim, & Seo (2011) conducted a 1-day sexual rehabilitation program for stroke patients and spouses and found sexual knowledge did not improve, but sexual satisfaction and frequency increased (Song et al., 2011). These findings support the need for OT clinicians to integrate sexual recovery in practice. Clients clearly have concerns about sexuality post injury, and it is the role of OT clinicians to initiate conversation and acknowledge the importance of addressing this widely neglected topic in practice.

Recognition Model

The process of integrating sexuality in practice poses a challenge for many OT clinicians. However, this challenge does not eliminate the need to address sexuality with clients during recovery. The Recognition Model was born from results of a research study that found individuals' sexual needs were not being recognized by healthcare professionals at a desired rate (Couldrick, Sadlo, & Cross, 2010). This model sought to present an inclusive, systematic process to address sexuality in practice. Couldrick, Sadlo, & Cross (2010) identify the 4 stages of this model as follows: (stage 1) recognition of the service user as a sexual being, (stage 2) provision of sensitive, permission giving, strategies, (stage 3) exploration of the sexual problem/concern,

(stage 4) address issues that fit within the team's expertise and boundaries, and (stage 5) referral on when necessary. The first stage establishes the foundation for addressing sexuality with clients and requires the OT clinician to view sexuality as a natural component to the human experience. Once this open mindset has been embraced, the client is offered an opportunity to express any concerns. Should the client indicate disinterest in the topic, privacy is respected and sexuality is not addressed. However, if the client indicates interest, the therapist then collaborates with client to explore concerns, provide resources or relevant evidence-based intervention strategies, and identify wants and needs. These services should only be provided within the scope of OT practice, and a referral to another health specialist may be necessary in certain instances (Couldrick et al., 2010). This model was utilized as a tool and resource for OT clinicians to professionally and ethically guide the conversation of sexuality with clients who demonstrate interest. It was the basis for the sexual recovery program. The aim was to increase comfortability with discussion and provide support for initiating the topic. The structure of the Recognition model may also increase confidence with addressing sexuality within practice (Valvano et al., 2014).

Sexual Assessment Framework

Although navigating the realm of sexuality for OT clinicians may be a daunting task, an established guide to assess and treat may help to extinguish discomfort when approaching the topic. The Sexual Assessment Framework provides an inclusive approach to addressing seven components of sexuality (Kokesh, 2016). Kokesh (2016) outlines these components which include: Sexual Knowledge; Sexual Behavior; Sexual Self-View; Sexual Interest; Sexual Response; Fertility and Contraception; and Sexual Activity. Sexual knowledge encompasses the values of sexuality and supports client education, while Sexual Behavior focuses on the sexual

relationship. Sexual Self-View regards recognition of the self as a sexual being and Sexual Interest hones in on the desire component of sexual activity. Sexual Response includes the process of arousal and Fertility and Contraception refers to medication management. Sexual Activity involves client factors related to the act of sex (Kokesh, 2016). This framework was utilized and explored in conjunction with the Recognition Model to ensure a holistic approach to addressing sexuality in OT practice.

Sexuality and Inpatient Rehabilitation

Inpatient rehabilitation provides an ideal setting to address sexuality with clients. Community Health Network (https://www.ecommunity.com/services/inpatient-rehabilitation) is home to an inpatient rehabilitation facility (IRF) that serves individuals who have experienced SCI, amputation, TBI, and stroke. Inpatient rehab is intensive, as individuals must tolerate three hours of therapy per day, five to six days per week. There were no formal means of addressing sexuality at Community Rehabilitation Hospital, which created an opportunity for the development of a sexual recovery program aimed at integrating sexuality into OT practice. This program was devoted to sexual recovery for individuals with life-altering disabilities and implementation reflected the PRECEDE-PROCEED model. Gielen, McDonald, Gary, & Bone (2008) described this client-centered model as having a strong focus on health promotion and development of a foundation to apply ideals, through a series of phases, in order to plan and evaluate programs to create change. The first set of phases include: (phase 1) social assessment, (phase 2) epidemiological, behavioral, and environmental assessment, (phase 3) educational and ecological assessment, and (phase 4) administrative and policy assessment and intervention alignment. The second set of phases include: (phase 5) implementation, (phase 6) process evaluation, (phase 7) impact evaluation, and (phase 8) outcome evaluation (Gielen, McDonald,

Gary, & Bones, 2008). These phases served as a guide to plan and implement the sexual recovery program to bridge the gap in holistic service delivery regarding sexuality and disability.

Methodology/ Instrumentation

Designing the context of a sexual recovery program at Community Rehabilitation Hospital required extensive consideration of the current issue. OT clinicians are not addressing sexuality in practice and patients are experiencing a gap in holistic care as a result (Sakellariou & Simó Algado, 2006a). Investigating this neglected area of practice included an in-depth evaluation of service providers and consumers. Conduction of a needs assessment was the first step in determining current practice methods and establishing a sound foundation for sexual recovery programming (Bonnel & Smith, 2018).

Participants

Thirty OT clinicians and 286 former patients affiliated with the Community Rehabilitation Hospital support groups were invited to participate in a survey regarding sexuality and OT practice, specific to the IRF setting. Purposive sampling was utilized to recruit participants. Participant criteria included former patients who sustained SCI, amputation, TBI, or stroke, as well as licensed OT clinicians currently employed and practicing at the site. Former patients were required to be graduates of the inpatient rehabilitation process and sampling was achieved through contacting members of support groups who met inclusion criteria. The Program Lead of Community Rehabilitation Hospital served as the liaison, contacting support group members and eligible OT clinicians via e-mail. Two e-mails were drafted by the student investigator, which contained a brief description of the project. The e-mail specific to OT clinicians included the survey as an attached word document, while the e-mail to former patients included a link to an online survey. These drafts were then forwarded to participants by the

Program Lead. Individuals with SCI, amputation, TBI, or stroke were targeted specifically as these injuries are recognized as life-altering. AOTA (2016) describes a life-altering change as having to "make many physical and psychological adjustments to be able to participate fully in everyday life" (p. 1). Sexuality and intimacy after injury often requires these adjustments and modifications, which are within the scope of practice for OT clinicians (MacRae, 2013).

Design and Procedure

A mixed-methods approach was utilized to collect data on the perceptions of OT clinicians and former patients in relation to addressing sexuality and intimacy during the recovery process. Quantitative data were yielded from a survey, while qualitative data were developed from open-ended questions and informal interviews with OT staff. Informal interviews with OT staff were conducted in the acute therapy office at Community Rehabilitation Hospital. Respondents were contacted via e-mail and invited to participate in a voluntary survey with instructions to complete within one week. Anonymity of each participant was ensured to respect ethical guidelines. Printed copies of the survey were also available in designated locations for OT clinicians. Survey questions were formulated from themes identified in literature and included quantitative and qualitative components. The surveys and interview guide were reviewed by an associate professor of the School of Occupational Therapy at the University of Indianapolis, who has experience with survey development and research related to sexuality and disability. Suggestions for improvement were incorporated and necessary revisions were applied. Survey content, though qualitative and quantitative in nature, differed between OT clinicians and former patients. Both surveys focused on sexuality and intimacy. However, survey content for OT clinicians focused on clinical practice methods, while the patient survey focused on the experience of sexual recovery during the rehabilitation process.

Assessment of Need

The patient survey was designed electronically and intended to identify specific needs of patients at this site. Evidence directed the survey content, as there continues to be a distinct need for sexuality to be addressed during the recovery process. Fritz et al. (2015) found women with SCI experienced significant challenges navigating sexual positioning in relation to level of injury. The only education these participants received on sexuality was related to reproduction post injury (Fritz et al., 2015). Kedde et al. (2016) found 50% of individuals with chronic disabilities wanted professional guidance with adapting to sexuality post-disability (Kedde et al., 2016). With respect to these literature findings, survey content focused on sexuality and intimacy in relation to type of injury, level of concern, availability of resources, and initiation of the topic during rehabilitation. Survey material consisted of 12 questions including multiple choice, yes or no, and open-ended.

The survey distributed to OT clinicians was intentionally designed in pre-post format to measure level of comfortability, education, knowledge, attitudes, confidence, current practice methods, and barriers in regards to addressing sexuality in OT practice. In addition to the pre-survey, an informal face-to-face group interview with OT staff and an informal face-to-face individual interview with the Director of Rehabilitation Services was conducted. These interviews were devised to gather feedback regarding current practice methods and provided an open forum for OT staff to offer input for sexuality program development. Interview and survey questions reflected current literature findings, which indicate that approaching the topic of sexuality is often difficult for patients, and healthcare professionals are not providing desired education (Esmail et al., 2010). Furthermore, intervention practices often do not include sexuality and intimacy, as the significance of integrating sexuality within healthcare is not

emphasized in academia (Esmail et al., 2010). Considering these findings, questions were aimed at understanding the perceptions of OT clinicians in regards to incorporating sexuality and intimacy into OT practice.

The pre-post survey consisted of 16 items. Occupational therapy clinicians were informed of the intent and encouraged to refrain from participating in the post-survey if electing not to partake in the pre-survey, as this would negatively impact consistency of outcome measures. The format included multiple choice, 10-point rating scale, 5-point Likert scale, ranking of barriers, and one open-ended item. Participants were asked to rank perceived barriers from 1-5, 1 being the most prevalent barrier and 5 being the least prevalent barrier. These barriers included: Comfortability, Knowledge, Priority, Time, and Support. Occupational therapy clinicians were also asked to identify level of comfortability discussing sexuality with clients across 6 components on a 10-point rating scale, 1 being least comfortable and 10 being most comfortable. These 6 components included: initiating the conversation of sexuality, providing resources on sexuality and intimacy, discussing resources on sexuality and intimacy, incorporating scenarios regarding sexuality and intimacy in therapy sessions, educating on adaptive equipment utilized for sexual intercourse, and leading a support group focused on sexual recovery after a disability.

Perceptions of the OT Clinician. There were a total of 11 OT clinicians (36.67%) who completed the attached pre-survey. However, it should be noted one participant partially completed the survey. Responses from this participant were considered only when presenting demographic information and data related to level of comfortability addressing sexuality with clients. Quantitative data were analyzed in Microsoft Excel. Demographic information for OT clinicians were coded and assigned a number prior to analysis. The level of experience varied among OT clinicians. Some had been practicing for 30+ years (27.27%, n=3), while others had

been practicing 0-5 years (36.36%, n=4). The majority held a Master's degree in OT (63.64%, n=7), and sexuality was recalled to be addressed only occasionally within their prior academic curricula (45.45%, n=5). With respect to level of confidence addressing sexuality and intimacy with clients, the majority of OT clinicians either strongly disagreed (40%, n=4) or disagreed (50%, n=5) with feeling confident in abilities. In regards to frequency of addressing sexuality in OT practice, most OT clinicians never addressed sexuality (54.55%, n=6). In addition, the majority of OT clinicians strongly disagreed they incorporated components of sexuality and intimacy into intervention sessions with clients (80%, n=8). For the purpose of this experience, addressing should be thought of as a general term intended to represent the OT process as a whole, while incorporating into intervention should be regarded as one method of addressing sexulality.

Modes were calculated for barriers to integrating sexuality in OT practice. Occupational therapy clinicians ranked these barriers in the following order: (I) Knowledge, (II) Time, (III) Priority, (IV) Comfortability, and (V) Support. These findings highlighted knowledge as the most prevalent barrier. A total of 50% (n=5) of OT clinicians strongly disagreed with having adequate knowledge on sexuality and intimacy in relation to client care. While half of participants agreed sexuality and intimacy is essential to address in this practice setting (50%, n=5), the majority of respondents were impartial to OT clinicians being a designated healthcare provider to address the topic (70%, n=7). Averages were calculated in Microsoft Excel regarding level of comfortability discussing sexuality with clients and then ranked from least comfortable to most comfortable, according to the 10-point scale. In regards to sexuality and intimacy, participants were mildly uncomfortable discussing (5) and providing (4.73) resources and initiating the conversation (3.91). Participants were least comfortable leading a support group

(2.64), incorporating scenarios into therapy sessions (3.09), and educating on adaptive equipment utilized for intercourse (3.18).

These findings connected to the informal feedback gained in face-to-face interviews. OT clinicians expressed concern with not having formal education or knowledge to provide adequate services related to sexuality. Consequently, some OT clinicians were most interested in hands-off resources, such as educational videos to offer patients. Most all participants wanted diagnosis specific resources related to sexuality and intimacy. Patient length of stay was also posed as a concern, as the IRF utilizes the Functional Independence Measure (FIM) to guide evaluation and intervention. One PT, who serves as the therapy lead and was present during the informal interview with the Director of Rehabilitation Services, commented on the documentation system. The PT mentioned the documentation system does not include sexuality and intimacy, which fails to cue therapists to address this component of care. The open-ended question of the survey, which allowed participants to identify additional barriers to integrating sexuality into OT practice, provided informative responses. One OT clinician commented on the impact of length of stay and prioritization of care, stating, "there is such a short amount of time to accomplish so much." Cognitive barriers, not having supported handouts, and lack of knowledge base for specific diagnoses and interventions were also cited as barriers to integrating sexuality into OT practice. Understanding OT clinician perspectives on addressing sexuality and intimacy in practice allows for recognition of current issues in order to develop meaningful solutions.

Perceptions of the Patient. Twenty-one former patients (7.34%) completed the electronic survey. The majority of participants were stroke survivors, with a 57.14% response rate (n=12). Four participants (19.05%) were individuals with SCI, while three (14.29%) participants had an amputation. Participants with TBI (4.76%, n=1) and a diagnoses identified as

other (4.76%, n=1) provided the lowest response rate. Of the 21 participants, 42.86% (n=9) were concerned about sex post injury. Though majority of participants were not concerned about sex post injury, over half of participants were interested in attending a support group on sexuality and intimacy after injury (57.14%, n=12). However, 95.24% (n=20) were not given any information or resources on sexuality during rehabilitation. Regarding accessibility of resources, the majority of former patients were unaware sexuality resources were available in designated locations at the IRF (66.67%, n=14). Though some respondents indicated concern about sex, only one (4.76%) participant asked a therapist about sex post injury. During the rehabilitation process, therapists never initiated the conversation of sexuality post injury with participants. When asked to identify if therapists initiated the discussion of sex post injury, 100% (n=21) of participants responded therapists did not start the conversation. Understanding specific needs of OT clinicians, as well as patients served, was a vital component to ensure development of a holistic, feasible, and beneficial sexual recovery program.

Discussion of Need. These findings suggest a significant gap in holistic OT practice methods in relation to patient care and are concurrent with current literature. There is a lack of inclusion of sexuality in curricula of OT programs as indicated by results of the survey, which leaves OT clinicians unprepared to address the topic in practice (Areskough-Joefsson et al., 2016). OT clinicians lack of agreement with incorporating sexuality into intervention sessions established a potential connection in regards to lack of knowledge as the most prevalent barrier to implementation. Though OT clinicians indicated knowledge and time were the greatest barriers to implementation, the participants felt supported by managers and coworkers to address sexuality with clients. However, productivity standards create less time and little priority in the recovery process, which are reflected by rankings of the perceived barriers (Hattjar, 2012). OT

clinicians should be equipped to navigate these barriers to provide client-centered care regardless of extraneous factors.

Many former patients were concerned about sex post injury, but these needs went unresolved. This often leaves individuals to explore concerns independently and without professional guidance (Fritz et al., 2015). OT clinicians lack of knowledge, education, and confidence in abilities may contribute to the shortcomings of OT practice with respect to addressing sexuality and intimacy. The topic of sexuality was never initiated with former patients, and though OT clinicians are mildly uncomfortable providing and discussing resources, only one former patient was given the opportunity to receive information. Failure to recognize sexuality and intimacy as the role of OT may relate to this lack of initiation. Most OT clinicians expressed feeling indifferent to the role of addressing sexuality belonging to the OT profession. However, many acknowledged sexuality and intimacy was essential to address in an IRF setting. This finding supports a need to advocate for the role of OT clinicians when addressing sexuality and intimacy.

Extinguishing the gap in patient care through development of relevant resources, in-service presentations focused on sexuality education, and advocating for the importance of addressing sexuality in this practice setting was the priority for inclusion of OT clinicians in the sexual recovery program. The main focus was to increase the confidence in abilities, debunk common myths and stigmas, and equip OT clinicians with knowledge to promote preparation and integration of sexuality into OT practice. In addition, patient education was a pertinent component of the sexual recovery program. Most former patients expressed interest in attending a support group on sexuality and intimacy. This was achieved through leading diagnosis specific

support groups with information on the topic and increasing accessibility of resources for individuals interested.

Integration of Theory

In an effort to integrate sexuality and intimacy consistently in OT practice, a screening tool was developed with the intention of distribution within the first week of each patient's stay at the IRF. The Meaningful Activity Tool (MAT) was inspired by the lack of non-sexuality specific tools available to screen for interest in the topic. Kielhofner & Neville (1983) revised the Interest Checklist developed by Matsutsuyu (1969), creating the Modified Interest Checklist (Henry, 1998). The Modified Interest Checklist is a client-centered tool focused on identifying the level of participation in meaningful leisure activities (Henry, 1998). This tool has been utilized across multiple populations in OT practice, from first-time mothers to individuals with progressive conditions such as multiple sclerosis (Horne, Corr, & Earle, 2005; Cahill, Connolly, & Stapleton, 2010). The Modified Interest Checklist is intended to explore meaningful interests of clients to identify level of occupational engagement (Horne et al., 2005). Though the Modified Interest Checklist includes dating as an activity choice, sexuality and intimacy are not included in the tool. Therefore, there was a need to develop a non-invasive screening tool, incorporating instrumental activities of daily living as well as sexuality and intimacy to determine client interest and promote OT clinician initiation of the topic. The MAT was reviewed by an Associate Professor of OT at the University of Indianapolis, as well as the Director of Rehabilitation Services, and feedback was applied. The MAT focuses on leisure and social participation across 10-domains, which offers a less intrusive mechanism to screen for sexuality and intimacy concerns. These domains include: Household Management, Pet Care, Outdoor Activities, Exercise, Hobbies, Games, Meal Preparation, Community Outings, Sexuality & Intimacy, and

Communication. Included under each domain are three activities related to the heading and patients are instructed to circle meaningful activities to be addressed during the rehabilitation process. Domains and activities included in the MAT are threaded throughout *The Occupational Therapy Practice Framework: Domain and Process, 3rd Edition* (AOTA, 2014). Refer to Appendix A to reference the MAT. The intent was to prepare patients for participation in these meaningful activities after recovery. The MAT respects the first and second stage of the Recognition Model (Couldick et al., 2010). By distributing this tool to all patients during the first week of rehabilitation, the OT clinician recognizes the patient as a sexual being and offers permission for the patient to indicate concerns related to sexuality and intimacy after injury. Should the patient not indicate sexuality and intimacy as a concern, privacy on the topic is respected. However, this provides a unique opportunity to also incorporate meaningful leisure and social activities into intervention sessions to promote holistic, client-centered care.

If the patient indicates sexuality and intimacy as a concern, the next proposed step was to distribute the Sexuality Questionnaire developed by Hattjar (2012), which addresses type of concerns, current beliefs, relationships, and desired method of receiving education. Patients may also indicate if they prefer not to discuss sexuality and intimacy in therapy sessions (Hattjar, 2012). The Sexuality Questionnaire honors stage 3 and stage 4 of the Recognition Model (Couldick et al., 2010). This questionnaire delves deeper into exploring patient concerns and encourages OT clinicians to further address sexuality and intimacy in OT practice, within level of expertise. To respect the fifth stage of the Recognition Model, the OT clinician may refer to a qualified professional (Couldick et al., 2010). This referral should be made if the patient wishes to discuss sexuality and intimacy with another health professional or if the OT clinician feels concerns are outside the OT scope of practice.

Effectiveness of the sexual recovery program was measured using the Goal Attainment Scale (GAS). As a whole, the sexual recovery program encompassed: development and accessibility of updated resources for OT staff and patients, integration of the MAT and Sexuality Questionnaire, educational in-services to OT staff, and support groups for patients to address concerns identified in the needs assessment. Three specific overall goals for the sexual recovery program were procured based on specific needs of OT clinicians and patients at the site. Refer to Appendix B to reference detailed goals and objectives.

Methodology/ Intervention

Findings from the assessment of need support an inconsistency among OT clinician practice methods in terms of addressing sexuality in OT practice. Neglecting to address this area of practice, which is considerate of human nature, creates a negative impact on provision of holistic services (Sakellariou & Simó Algado, 2006a). Therefore, development of meaningful implementation strategies was a fundamental element of program development to promote client-centered practice, address patient concerns, and improve current practice methods of OT clinicians regarding sexuality and intimacy (Bonnel & Smith, 2018).

Components of Implementation

In order to support program sustainability, implementation strategies had to reflect specific needs of OT clinicians and patients at the site. Occupational therapy clinicians identified knowledge and time as most prevalent barriers to addressing sexuality and expressed concerns with the lack of formal education on the topic. In addition, OT clinicians desired diagnosis specific resources and supported handouts on sexuality and intimacy, which reflected their mild level of discomfort discussing and providing resources. Despite this mild level of discomfort, the majority of former patients were not given information or resources on sexuality, nor were they

informed of availability. Some former patients were concerned about sex after injury and most expressed interest in attending a support group on the topic; however many reported that therapists never initiated the conversation of sexuality post injury. Based on these identified needs, components of implementation sought to improve holistic practice methods of OT clinicians to better serve patients during the rehabilitation process. Robinson et al. (2011) suggested, "specific guidelines for sexuality in rehabilitation for women should be formulated and included in the role and the scope of practice for occupational therapists" (p. 16-17). This suggestion was considered during development of sexual recovery programming and integrated on a broader level to include patients with life-altering disabilities. Though specific guidelines were not formally developed, a theoretical based method of addressing sexuality in at the IRF was proposed and implemented to integrate sexuality and intimacy within the scope of practice for OT clinicians.

Meaningful Activity Tool. The first component of sexual recovery programming was development of the MAT. It is important to note this is an informal screening measure, as it was developed by the student investigator, and should be viewed as a non-standardized, site specific tool. It should also be noted the development and implementation of the MAT satisfies components of the Commission of Accreditation of Rehabilitation Facilities (CARF) standards related to sexuality (CARF International, 2018). CARF International (2018) is an accreditation service with a mission to "promote the quality, value, and optimal outcomes of services through a consultative accreditation process and continuous improvement services that center on enhancing the lives of persons served" (CARF International, 2018, para 1). The sexuality standards CARF (2017) outlines include sexual counseling, sexual health, sexual function, and intimacy in relation to patient care. Though the sexuality-based standards specifically reference

individuals with limb loss and spinal cord dysfunction, the content also extends to encompass individual goals and needs of patients served. One standard in particular requires provision of services to screen and assess for sexual function in individuals with spinal cord dysfunction (CARF, 2017). Therefore, improving standards related to sexuality at the site was partially achieved through integration of the MAT in this setting. While the MAT offers a solution to screen and informally initiate the topic of sexuality and intimacy in OT practice, it also requires accountability on the part of the OT clinician. Integration of the tool ensures some form of sustainability and consistency in regards to integrating sexuality and intimacy in OT practice at the site.

Ultimately, distribution of the MAT within the first week of evaluation is at the discretion of the therapist; therefore, gleaning input from OT clinicians was an integral aspect to consider prior to solidifying the MAT. This input was obtained through a brief, informal meeting held in the acute therapy gym. Occupational therapy clinicians were contacted via e-mail and invited to attend a meeting to discuss the proposed screening tool. The student investigator led the meeting, which introduced the role of OT in addressing sexuality, outlined the CARF standards related to sexuality, and explained the intention and format of the screening tool. The Recognition Model was also explained, particularly as it related to the MAT and Sexuality Questionnaire. Paper copies of the MAT, Sexuality Questionnaire, CARF standards, and a document outlining the Recognition Model were distributed to all in attendance. These documents were reviewed during the meeting and explained briefly. OT clinicians were informed of the intended screening process, including distribution of the MAT within the first week of evaluation. Should the patient indicate interest in sexuality and intimacy on the MAT, the Sexuality Questionnaire was presented as a follow-up method to understand the best way to approach the topic. Occupational

therapy clinicians were receptive of presented information and appreciated the user friendly nature of the MAT. One OT clinician appreciated the screening tool was one page due to perceived time constraints. Another therapist commented that distributing the tool would be relatively easy on the day of evaluation. In reference to suggestions for edits, a few OT clinicians expressed concern that patients would indicate interest in all topics and proposed a ranking system in place of circling items. While this suggestion was understood and appreciated, it was explained the tool is designed to be simplistic in nature to account for patients with cognitive difficulties. As a potential compromise, the student investigator proposed this situation as an opportunity to converse with the patient and provide professional guidance with ranking activities of most importance.

With exception to this concern, the OT clinicians in attendance were in agreement with utilizing the MAT in OT practice and expressed interest in incorporating the tool immediately. The student investigator explained educational in-services would be held in the near future to discuss the integration of sexuality into OT practice in-depth. The MAT and Sexuality Questionnaire were then e-mailed to the Director of Rehabilitation Services, who placed both documents in the facility t-drive for OT clinicians to easily access. Occupational therapy clinicians were notified of the location of noted documents through an e-mail drafted by the student investigator. A recap of meeting content, along with attachments distributed during the session, was outlined in the e-mail for those who could not attend. The Director of Rehabilitation Services approved included content prior to distribution of the e-mail.

Sexuality Resources. Once a method of integrating sexuality into the evaluation process has been established, updating resources and developing meaningful handouts for the site was a critical component. To promote accessibility of resources, a dedicated folder on the facility t-

drive was created for sexuality and intimacy education materials. The sexuality and intimacy folder is available under the OT section of the t-drive. Two subfolders were also included in this section of the t-drive. One folder was labeled "Patient Handouts and Resources," while the other was titled "Resources for OT clinicians." The subfolder including patient education materials are easily accessed by OT clinicians for distribution to patients as necessary, pending the functional concern. However, the subfolder designed specifically for OT clinicians focused more on materials to improve their clinical knowledge on sexuality and intimacy as desired.

The "Patient Handouts and Resources" subfolder included diagnosis specific resources, handouts, and links on existing online resources. Specific diagnoses included the following life-altering disabilities: TBI, stroke, SCI, and amputation. Relevant literature and reliable sources were utilized to guide development of evidence-based resources to address patient needs. The student investigator reviewed sexuality and intimacy related handouts currently utilized at the site and updated as necessary to improve educational materials available to patients. Creation of updated resources reflected needs and concerns identified in the survey of former patients, as well as suggestions obtained from former patients during support groups. During the support group for individuals with stroke, TBI, amputation, and SCI, members were invited to offer feedback regarding resources that were desired during their recovery process. Patients expressed concerns including but not limited to: desire, safety of resuming sex after injury, impact of level of injury on sexuality, and perception of the partner following injury. This feedback was intently considered and applied during the process of resource development for patients. Newly developed resources cover sexuality and intimacy as related to the following: bowel and bladder management, pain and medication management, positioning, adaptive equipment, body image

and self-view, desire post injury, impact of the caregiver role, energy conservation strategies, and sensation.

The subfolder labeled “Resources for OT Clinicians” was intended to offer OT clinicians the opportunity to expand professional knowledge relative to sexuality and intimacy. As evident by the pre-survey results, half of OT clinicians did not feel they had adequate knowledge on sexuality and intimacy as it applied to patient care. Therefore, this subfolder included evidence-based research articles and evidence-based intervention strategies on sexuality and intimacy. As OT clinicians expressed desire for diagnosis specific resources, the content focused on evidence-based literature including: TBI, stroke, amputation, and SCI. The PowerPoint presentations on sexuality and intimacy, developed for scheduled OT in-services, were also included in this subfolder for reference.

Resources for OT clinicians are intended to promote evidence-based practice methods when addressing sexuality and intimacy in OT practice. Robinson et al. (2011) discussed the shortcomings of therapists when providing intervention on sexuality and stated, “occupational therapists...need to identify the client’s specific needs and problems and allow this to direct the intervention provided” (p. 16). While the OT clinicians desired diagnosis specific resources, it should be noted therapists were encouraged to approach sexuality and intimacy through a functional lens considering specific needs, rather than simply providing resources based on deficit. In addition, the Sexual Assessment Framework was utilized as a guide for development of content, which reflected the following: Sexual Knowledge; Sexual Behavior; Sexual Self-View; Sexual Interest; Sexual Response; Fertility and Contraception; and Sexual Activity (Kokesh, 2016). Educational materials were included within these areas of sexual assessment to

ensure a theoretical approach to evidence-based resources for OT clinicians. This approach intended to supply resources through a holistic, client-centered view.

In-Services for OT Clinicians. Educational in-services for OT staff were scheduled to increase knowledge and comfortability regarding addressing sexuality and intimacy in OT practice. Fronek, Kendall, Booth, Eugarde, & Geraghty (2011) conducted a 2-year follow-up study measuring changes in comfort, knowledge, and attitudes of healthcare professionals after a 1-day educational session on sexuality and SCI. Researchers found participants involved in the training experienced improvements in confidence, knowledge, and comfortability with addressing sexuality with clients. The healthcare professionals involved in the study placed the importance of addressing sexuality as equivalent to bowel and bladder issues after the educational session and expressed a desire for in-services and regular updates to maintain knowledge (Fronek et al., 2011). With respect to these findings, two in-service topics were covered, and a total of 4 in-services were held. In an effort to educate both full-time and part-time OT staff, the two in-service topics were each presented twice to educate all OT staff. The first in-service focused on addressing sexuality and intimacy in OT practice. Components included: stigma and disability, literature findings, results of the needs assessment, feedback from former patients, value of holistic practice methods, sexuality and the role of OT in relation to patient care, and an in-depth description of DCE implementation components. The second in-service covered sexuality and intimacy and the OT process in greater detail. Diagnosis specific intervention methods for TBI, stroke, amputation, and SCI were a main focus. Additionally, a case study was presented and discussed in the lecture to provide an interactive experience. It was critical to model a holistic approach to this in-service, as it was an opportunity for OT clinicians to practice addressing sexuality and intimacy. Each session was 45 minutes. Thirty minutes were

designated for the lecture portion, while the last 15 minutes were devoted to discussion and reflection. Once both educational in-services had been presented, the post-survey was distributed to OT clinicians. Occupational therapy clinicians were notified of the post-survey through an e-mail, which was attached as a word document. Verbiage of this e-mail outlined criteria to participate in the post-survey, which stated only those who completed the pre-survey should participate. Respondents were given one week to complete the post-survey. Following the allotted time period, pre-survey results were then compared to post-survey results to measure level of effectiveness of educational in-services. Measurable survey components included: level of comfortability, education, knowledge, attitudes, confidence, current practice methods, and barriers to addressing sexuality in OT practice.

Patient Support Groups. Patient education was provided through leading support groups on sexuality and intimacy. Community Rehabilitation Hospital has monthly support groups for individuals with stroke, amputation, TBI, and SCI. Results from the needs assessment indicated patients were interested in attending support groups on sexuality and intimacy after injury. Support groups benefit the individual "by normalizing the experience of recovery and increasing the survivors self-efficacy through education and resource sharing, support groups have the potential to strengthen the survivor's coping…" (Trauma Survivors Network, 2018, para 1). Therefore, the student investigator led four interactive diagnosis specific support groups on sexuality and intimacy, addressing common concerns after injury. To respect the first stage of the recognition model, all support group participants were notified of the group content in advance via monthly flyers. The monthly flyer listed the student investigator as a guest speaker and offered a brief description of intended topic information. Feedback from the survey guided presented content, as themes from the open-ended questions were generated based on diagnosis.

In regards to sex, participants recovering from stroke inquired about desire, relationship changes, and safety after stroke. One individual with TBI was concerned about desirability and performance post injury. Those with SCI were concerned about bowel and bladder control, level of injury and impact on sexuality, and the caregiver role. Those with amputation worried about self-esteem and body image. Group dynamics and limits were respected, as thorough discussions with the Program Lead, who typically leads the support groups, were held prior to the group. The Program Lead offered personal insight and requested content on sexuality and intimacy be presented directly or indirectly, pending the dynamic of group members. A handout on sexuality and intimacy after injury was created prior to each group with respect to the diagnosis. Handout content discussed components of sexuality including societal stigma, sexual expression, common concerns, and links to online resources. These handouts were distributed during each support group session. Relevant research and resources were intently reviewed in preparation for the group session. Outlines with information on sexuality and intimacy, as well as discussion questions, were created as a tentative guide for each group session. Each support group began with formal introductions. Beyond this, groups were non-structured, as the members were welcome to partake in an open discussion throughout the group. Conversation on sexuality and intimacy varied, from discussing body image and self-esteem to positioning and adaptive equipment. Post-satisfaction surveys were distributed after each group for support group members to fill out. The post-satisfaction survey included a smiley face scale and prompted group members to offer one like, one dislike, or any additional comments about the group. This created a mechanism to measure satisfaction and improve content as directed by suggestions and feedback.

Advocating for the Role of OT. There were no formal means of addressing sexuality at Community Rehabilitation Hospital prior to development of the sexual recovery program. Therefore, advocating for sexuality to be integrated in practice and designated to the role of OT required leadership and professionalism. Significant research on addressing sexuality and intimacy in the rehabilitation process was vital, as these evidence-based literature findings offered a window of opportunity to educate OT staff on the significant need to address the topic in therapy. This was further supported by findings of the needs assessment, as former patients of the rehabilitation process expressed concern with sexuality post injury. Presenting these findings to OT staff in a professional manner allowed the student investigator to expand on effective communication strategies through conducting informal meetings and providing staff education during educational in-services. Leading patient support groups also required professional communication through advocating for the role of OT and addressing concerns within the scope of OT practice. These components of implementation further developed leadership skills and improved confidence in relation to educating on sexuality and intimacy and OT practice.

Results/Outcomes

Implementation strategies were devised to bridge the gap in holistic service delivery, regarding addressing sexuality and intimacy in OT practice, through program development. The sexual recovery program was the first formal means of addressing sexuality and intimacy at this site. Therefore, formative and summative measures were utilized as quality improvement (QI) strategies to measure effectiveness of implementation components and determine program success (Bonnel & Smith, 2018).

Outcome Tools

Formative evaluations were intended to provide ongoing feedback on strengths and weaknesses throughout the implementation process, whereas summative measures offered overall feedback on effectiveness of the process as a whole (Tatian, 2016). Kringos et al. (2015) suggested, "awareness, attitude, knowledge of and understanding performance data were all essential facilitators for the implementation of QI interventions" (Kringos, et al., 2015, p. 9). Efforts to modify the approach and content of sexual recovery programming were influenced by feedback gleaned throughout the implementation process. Formative evaluations included post-satisfaction surveys distributed after each support group, as well as informal feedback from OT clinicians during the discussion period after each in-service. In addition, the pre-post survey distributed to OT clinicians was utilized to measure change in perceptions regarding addressing sexuality and intimacy in OT practice. Components of the implementation process as a whole were depicted through specific goals for program development. These goals represented the summative program evaluation and were presented in the GAS. Formative evaluations throughout the implementation process, in conjunction with a summative evaluation at the end of the process, allowed for meaningful interpretation of program development outcomes.

Feedback from OT Clinicians. One of the main aspects of the sexual recovery program was to provide education to OT clinicians in relation to the role of OT in addressing sexuality and intimacy in the rehabilitation setting. Ultimately, the OT clinicians were responsible for consistently integrating sexuality and intimacy in OT practice upon the departure of the student investigator. Therefore, advocating for the role of OT while addressing this area of practice was vital to ensure sustainability of programming. Education of OT staff was achieved through the two in-services, which focused on specific needs of OT clinicians as identified in the needs

assessment. The primary goal of the in-service format was to increase comfortability, knowledge, and confidence in OT staff when addressing sexuality and intimacy in OT practice. At the cessation of each educational in-service, there was a 15-minute discussion period intended for OT staff in attendance to provide feedback on content, pose questions, and discuss integration of sexuality and intimacy in OT practice. Overall, OT clinicians were receptive of in-service content and verbalized understanding the need for integrating sexuality into OT practice. One OT clinician in particular commented on the shift in her attitude regarding the topic. Originally, she felt addressing sexuality was not feasible. However, after the first in-service, she expressed those views had changed, and she was more open to the idea of incorporating sexuality in practice. As a group, OT clinicians brainstormed practical approaches to integrating sexuality into OT practice. Some discussed threading the topic in existing diagnosis specific education groups, while others proposed sexuality and intimacy as a topic to be added to the discharge form. Nevertheless, OT clinicians were seeking a method of accountability to discuss sexuality during rehabilitation. While distribution of the MAT is one form of accountability, this discussion period offered OT clinicians the freedom to openly discuss ideas and provide feedback to be considered for improving implementation components.

Pre-Post Survey Results. Occupational therapy clinicians who participated in the pre-survey were invited to partake in the post-survey at the end of the final in-service. The survey was designed to measure effectiveness of in-service content in regards to influencing level of comfortability, knowledge, attitudes, confidence, current practice methods, and perceived barriers related to addressing sexuality in OT practice. Post-survey data were analyzed in the exact manner as outlined for the pre-survey results. There were a total of 10 OT clinicians (90.9%) who participated in the post-survey. Results indicated level of confidence addressing

sexuality and intimacy with clients increased, as the majority of OT clinicians agreed to feeling confident in abilities (60%, n=6). This was an improvement from pre-survey results, which found 50% (n=5) disagreed and 40% (n=4) strongly disagreed to feeling confident. In regards to frequency of addressing sexuality, post-survey findings indicated the majority of OT clinicians addressed the topic once a year or more (40%, n=4) or never (30%, n=3). These results differed from pre-survey findings, which indicated the majority of OT clinicians never addressed sexuality in practice (54.55%, n=6). In the initial survey, OT clinicians strongly disagreed to incorporating components of sexuality into intervention sessions at a higher rate as compared to the post-survey. While the pre-survey found 80% (n=8) of OT clinicians strongly disagreed to incorporating into intervention, the post-survey indicated 40% (n=4) strongly disagreed and 30% (n=3) neither agreed nor disagreed.

Perceived barriers to implementing sexuality in OT practice did not greatly differ from pre-survey to post-survey. Knowledge continued to be the largest perceived barrier to implementation, followed by priority and time, comfortability, and support. Priority and time were both the second highest perceived barriers to implementation. However, OT clinicians agreed to having adequate knowledge on sexuality at a higher rate on the post-survey as compared to initial findings. The majority of OT clinicians on the post-survey either agreed (40%, n=4) or neither agreed nor disagreed (40%, n=4) with having adequate knowledge, while half of OT clinicians (50%, n=5) strongly disagreed with this statement on the initial survey. Post-survey findings indicated the majority of OT clinicians either agreed (30%, n=3) or strongly agreed (30%, n=3) sexuality is essential to address in this practice setting, and participants agreement with OT clinicians being the designated healthcare provider to address the topic greatly increased. Initially, respondents were impartial to OT clinicians assuming the role of

addressing sexuality in the healthcare setting (70%, n=7). However, after partaking in implementation components, the majority of OT clinicians either agreed (40%, n=4) or strongly agreed (30%, n=3) with OT clinicians being the designated healthcare provider to address the topic. Level of comfortability addressing sexuality improved across all components (Figure 1). The majority of OT clinicians were comfortable providing resources (7.7), discussing resources (6.9), and initiating the conversation (6.3) at a higher rate than indicated on the pre-survey. Comfortability also improved in relation to educating on adaptive equipment utilized for sexual intercourse (5.1), incorporating scenarios into therapy sessions (4.5), and leading a support group (3.7).

These findings suggest sexual recovery programming positively influenced OT practice methods at Community Rehabilitation Hospital. Perceived level of comfortability, knowledge, attitudes, confidence, and current practice methods improved after participation in educational in-services on addressing sexuality and intimacy in practice. These implementation components did not greatly influence perceived barriers, as knowledge, time, and priority remained the greatest barriers to addressing sexuality in OT practice. However, OT clinicians indicated a higher level of agreement with having adequate knowledge and confidence addressing sexuality as compared to pre-survey results.

Support Group Participation. Patient education was the second area of focus for the sexual recovery program. Leading four diagnosis specific support groups on sexuality and intimacy was the main mode of accomplishing this vision. Seven participants attended the support group for individuals with amputation. Two of these participants were spouses of the individual with amputation, and one participant was an OT student. Six participants attended the support group for individuals with TBI. One of these participants was a caregiver and another

participant was a spouse. There were a total of 9 participants in the support group for individuals with stroke. Two of these participants were undergoing the rehabilitation process as inpatients at Community Rehabilitation Hospital, six participants were former patients, and one participant was a PT student from a local university. Six participants attended the support group for individuals with SCI. Two of the members were former patients, while four of the participants were therapy students from a local university. Two of the four therapy students in attendance from a local university were familiar with the student investigator, which posed a potential conflict of interest. Therefore, these two students were the only participants of the SCI support group who did not complete a post-satisfaction survey. All participants from the support group for individuals with stroke and TBI completed the post-satisfaction survey, while six members of the support group for individuals with amputation participated in the survey. The counts described do not include the Program Lead, who was present for each session, or the student investigator, who led each session.

It should be noted the presence of therapy students offered the ability to provide education within the realm of sexuality and intimacy as related to the rehabilitation process. As discussed, sexuality and intimacy are not traditionally included in curricula of academic programs; therefore, this was a unique opportunity to present the topic of sexuality and intimacy within the context of disability to therapy students who have the power to impact future practice methods.

Post-Satisfaction Survey Results. Support group members completed post-satisfaction surveys at the end of each session. The post-satisfaction surveys were anonymous and format consisted of a smiley face scale, as well as three open-ended questions. Open-ended questions asked support group members to describe one like and one dislike about the session, while the

last question offered support group members the option to convey any additional comments regarding the session. Overall, support group participants rated positive feelings toward the sessions on the post-satisfaction survey. There were a few participants who rated the session with a neutral smiley face. One support group member disliked that the session was too early, as noted on the post-satisfaction survey. The context of this comment is unknown, though the student investigator speculated the feedback was in reference to the participant's recovery process. It is possible the participant was not ready to discuss sexuality and intimacy, which displays the importance of recognizing the individualistic nature of this topic. Another participant commented it would have been beneficial to have a nurse practitioner present to answer questions about medications. During each session, a brief discussion about medication side effects and impact on sexuality took place. Participants were notified in-depth discussion and medication recommendations were outside the scope of OT practice. In regards to aspects of the session support group members liked, feedback included: the fact sexuality was discussed at all, talking about a taboo subject, getting information on the topic, discussing a topic of importance, and not feeling embarrassed during the session. Others commented on the dynamic, stating they liked the open, honest, and relaxed nature of the session. A few of the support group participants requested more sessions on sexuality and intimacy and wished to review the references listed on the handout in a future session, noted in the additional comment portion of the post-satisfaction survey.

Goal Attainment Scale. The goals developed for the sexual recovery program aligned with the implementation process. In reference to goal formation for the GAS, Turner-Strokes (2009) suggested "three to five goals" as adequate (p. 364). Three goals were definitively outlined for sexual recovery programming and may be referenced in detail per Appendix B.

Successful integration of programming was achieved across implementation components and measured by the level of attainment at the end of the implementation period. Goals were rated on a 5-point scale, and achievement was dependent upon whether the expected level of outcome was reached, exceeded, or not fully met (Turner-Strokes, 2009). The 5-point scale has ratings from -2 (much less than expected) to +2 (much more than expected). Goal composition for integration of sexuality and intimacy included: holding interactive in-services for OT clinicians, leading support groups for former patients, and developing resources and a screening tool to be utilized at the site. For the purpose of sexual recovery programming, goals of holding interactive in-services and leading support groups resulted in a 0 score, indicating these goals met the expected level of outcome. The goal related to resource development and creation of a screening tool scored +2, indicating this goal exceeded expectations and was met much more than expected. Refer to Appendix B for a detailed outline and explanation of goals.

Sustainability of Sexual Recovery Programming

Each component of implementation was intended to equip OT clinicians with necessary support and mechanisms for addressing sexuality and intimacy in OT practice. Sustainability of sexual recovery programming is at the discretion of each OT clinician. The foundation has been set, complete with education on sexuality and intimacy, integration of the MAT and sexuality questionnaire as a means to consistently initiate the topic, establishment of accessible sexuality resources, and discussion of the needs identified by former patients. These strategies were intended to advocate for the need to address the topic and offer a solution to professionally integrate sexuality and intimacy into OT practice methods. The Director of Rehabilitation Services demonstrated significant support for addressing sexuality and intimacy at this site, through both verbal and written communication with OT clinicians, which reinforces the need to

sustain programming. Recommendations for monthly discussions on sexuality and intimacy, as well as an annual in-service presentation were made to the Director of Rehabilitation. An open style format for discussions was suggested, which included a proposed lunch and learn designed for OT clinicians to review an evidence-based article on addressing sexuality in healthcare. Discussions would encourage an open dialogue among OT clinicians to review evidence-based findings in a group format to remain up to date on current issues and address changing needs. The student investigator is hopeful OT clinicians will continue to acknowledge the importance of addressing sexuality within OT practice and make a consistent effort to honor the values of the OT profession through provision of holistic and client-centered care.

Discussion

Sexual recovery programming was intended to address sexuality and intimacy as it pertained to the divide between current OT practice methods and provision of client-centered care. The notion of client-centered practice aligns with Vision 2025 of AOTA (2018) which states, “occupational therapy maximizes health, well-being, and quality of life for all people, populations, and communities through effective solutions that facilitate participation in everyday living” (p.19). As addressing sexuality and intimacy are often stigmatized and neglected areas of OT practice, sexual recovery programming served as an opportunity to positively influence OT practice methods and promote client-centered care at Community Rehabilitation Hospital.

Creating a mechanism, guided by theory and evidence, for OT clinicians to consistently initiate the topic of sexuality and intimacy with patients was a main priority of the sexual recovery program. Establishing the MAT, providing the sexuality questionnaire, and educating OT clinicians through educational in-services provided an avenue to advocate for the importance of threading sexuality and intimacy into OT practice methods. These components promote

initiating the conversation early on during patient recovery, to ensure patient concerns regarding sexuality and intimacy are not neglected. With respect to this newly designed, systematic approach to addressing sexuality in OT practice, patients have the opportunity to openly discuss concerns and receive professional guidance within the scope of OT practice.

Limitations

The relatively small sample size of both OT clinicians and former patients limited generalizability of findings. The small response rate must be considered, as only 7.34% (n=21) of former patients and 36.67% (n=11) of OT clinicians completed the initial surveys for the needs assessment. Response rate may have been impacted by the sensitive nature surrounding the topic of sexuality and intimacy. With respect to the nature of the topic, participant bias may have been present, as those with positive feelings or interest in sexuality and disability may have been more likely to participate. As a result, survey findings may not have represented perceptions of OT clinicians and former patients as a whole. In addition, attendance of diagnosis specific support groups was also relatively low, which may have been influenced by the stigma surrounding sexuality and disability. Support group members may not have felt comfortable discussing sexuality and intimacy in a group format, which may have limited amount of patient education achieved. Consequently, participant bias may have impacted post-satisfaction survey results, as support group members in attendance may have been eager or interested in discussing sexuality and intimacy. With consideration of these limitations, future research should expand inclusion criterion to include patients with a variety of diagnoses and compare OT practice methods regarding sexuality and intimacy across a variety of practice settings to expand level of participation and improve generalizability of findings.

Professional Communication

Establishing the sexual recovery program from the ground up required development and utilization of effective communication skills. Communicating evidence-based research findings to OT staff and presenting survey findings in a relatable manner was the first step to advocate for the need. Communication was achieved through written and verbal communication. Email was utilized as a method to inform OT staff on upcoming meetings and provide updates on the progress of program development. Interaction with OT clinicians was threaded throughout the implementation process, including holding informal meetings and presenting educational in-services. Educating former patients also required professional communication. The handouts distributed each support group session represented written communication, while discussion was guided through verbal cueing to encourage member participation. Essentially, the student investigator aimed to normalize the conversation and desensitize OT clinicians and support group members to the taboo nature of the topic. Whilst working to achieve this intention, the student investigator developed self-confidence in regards to addressing sexuality and intimacy in OT practice.

Need for Advancement

As implicated by the results of the sexual recovery program, establishing a professional and theoretical basis to address sexuality and intimacy within the scope of OT practice is attainable. Sexual recovery programming created an intentional means of consistently addressing sexuality and intimacy in OT practice. Though integration of sexuality and intimacy was achieved at Community Rehabilitation Hospital, similar methods should be explored and pursued in additional practice areas. The need for furtherance and advancement of routinely addressing sexuality and intimacy, within the OT profession as a whole, is indisputable. Electing to exclude

sexuality and intimacy from the healthcare environment inadvertently devalues a fundamental aspect of the identity of individuals served. As demonstrated by evidence-based literature findings and results of the needs assessment, failure to address the topic deprives patients from exploring the occupation of sexuality and intimacy (Sakellariou & Simó Algado, 2006a). OT clinicians have the power to bridge this gap in healthcare provision and positively influence practice methods simply through honoring the client-centered principles of the OT profession. AOTA (2018) encourages OT clinicians to promote positive change stating, “Think big: No other profession is like OT. Be comfortable being a trail blazer” (p. 19). This process begins with declaring freedom from the societal chains and stigmatization surrounding sexuality and disability.

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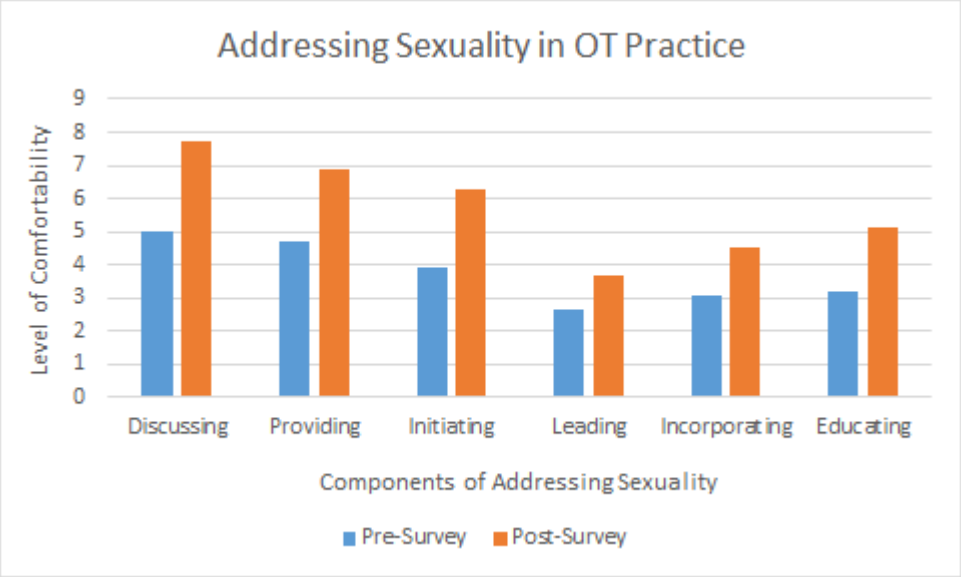

Figure 1. Comparison of pre-post survey results for OT clinician perceived level of comfortability with addressing sexuality in OT practice.

Appendix A

Meaningful Activity Tool

This tool is designed to identify activities that are meaningful to you in everyday life, so you are prepared to participate in these after recovery. Please **circle** any meaningful activities that apply to you.

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1. Household Management
- Cleaning/Shopping
- Laundry
- Bills

2. Pet Care
- Feeding
- Walking
- Grooming

3. Outdoor Activities
- Gardening
- Driving
- Other: _____

4. Exercise
- Yoga
- Gym
- Other: _____

5. Hobbies
- Journaling
- Reading
- Other: _____

6. Games
- Playing cards
- Board Games
- Sports

7. Meal Preparation
- Cooking
- Baking
- Hosting

8. Community Outings
- Movies
- Restaurants
- Appointments

9. Sexuality & Intimacy
- Dating
- Relationships
- Sex

10. Communication
- Social Media
- Texting/Phone
- E-mail

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Appendix B

GOAL ATTAINMENT SCALE

Level Of Attainment	**Goal 1:**	**Goal 2:**	**Goal 3:**
-2 Much less than expected *(Present Level)*	Did not educate OT staff through providing interactive in-service regarding addressing sexuality and intimacy in OT practice.	Educate clients on sexuality and intimacy, within the scope of OT practice, through holding 2 or less interactive support groups.	Did not create and provide resources on sexuality and intimacy for staff and clients to utilize.
-1 Somewhat less than expected *(Progress)*	Educate OT staff through providing 1 interactive in-service regarding addressing sexuality and intimacy in OT practice.	Educate clients with disabilities on sexuality and intimacy, within the scope of OT practice, through holding 3 interactive support groups.	Create and provide resources on sexuality and intimacy through resources on the t-drive and updated handout materials for staff and clients to utilize.
0 Expected level of outcome *(Annual Goal)*	**Educate OT staff through providing 2 interactive in-services regarding addressing sexuality and intimacy in OT practice.**	**Educate clients with disabilities on sexuality and intimacy, within the scope of OT practice, through holding 4 interactive support groups**.	Create and provide resources on sexuality and intimacy through resources on the t-drive, updated handout materials, and development of a screening tool for staff and clients to utilize.
+1 Somewhat more than expected *(Exceeds annual goal)*	Educate OT staff through providing 3 interactive in-services regarding addressing sexuality and intimacy in OT practice.	Educate clients with disabilities on sexuality and intimacy, within the scope of OT practice, through holding 5 interactive support groups.	Create and provide diagnosis specific resources on sexuality and intimacy through resources on the t-drive, updated handout materials, and development of a screening tool for staff and clients to utilize.

+2 Much more than expected *(Far exceeds annual goal)*	Educate OT staff through providing 3 or more interactive in-services regarding addressing sexuality and intimacy in OT practice.	Educate clients with disabilities on sexuality and intimacy, within the scope of OT practice, through holding 6 or more interactive support groups.	**Create and provide diagnosis specific resources on sexuality and intimacy through support group outlines, resources on the t-drive, updated handout materials, and development of a screening tool for staff and clients to utilize.**