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School of Occupational Therapy

Development of the Occupational Performance Inventory of Sexuality and Intimacy (OPISI): Phase One

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December, 2019

A research project submitted in partial fulfillment for the requirements of the Doctor of Occupational Therapy degree from the University of Indianapolis, School of Occupational Therapy.

Under the direction of the research advisor:

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A Research Project Entitled

Development of the Occupational Performance Inventory of Sexuality and Intimacy

(OPISI): Phase One

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By

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Acknowledgements

We wish to thank Dr. Lori Breeden, Dr. Brenda Howard, and Dr. Katie Polo for their valuable comments and input throughout the preparation of this manuscript. A special thanks to Dr. George Szasz for providing his expertise and advice during the development of OPISI and Dr. Beth Ann Walker, for her commitment, guidance, and enthusiasm throughout this experience.

Abstract

Background: The profession of occupational therapy is in need of a framework to guide practitioner understanding of the complex occupational nature of sexuality and intimacy, including assessment, intervention design, and measurement of outcomes. The purpose of this study was to define the occupational nature of sexuality and intimacy and develop a theoretical and occupation-based screen, in-depth self-assessment, and performance measure.

Method: The Occupational Performance Inventory of Sexuality and Intimacy (OPISI) was developed following DeVellis's (2017) guidelines for scale development which involved mapping the construct, generating an item pool, determining the format for measurement, and review of the initial item pool by a panel of experts.

Results: The Occupational Therapy Sexual Assessment Framework (OTSAF) was developed to define the occupational nature of sexuality and intimacy, depict how the theoretical constructs intertwine with the domain of occupational therapy, and guide scale development. The OPISI includes a self-screen, in-depth self-assessment, and an individualized measure to detect self-perceived change in ability, satisfaction, understanding, and confidence in skills and ability to improve occupational performance associated with sexuality and intimacy over time.

Conclusion: The OTSAF defines the occupational nature of sexuality and intimacy and informs the scope of practice for occupational therapy. The OPISI includes theoretical and occupation-based tools designed to adequately screen, assess, and measure performance related to the complex occupational nature of sexuality and intimacy. Formal validation is needed prior to releasing the OPISI for clinical use.

Development of the Occupational Performance Inventory of Sexuality and Intimacy (OPISI): Phase One

Sexuality and intimacy are fundamental aspects of the human experience. According to the World Health Organization (WHO) (2006), sexuality encompasses sex, gender identities and roles, sexual orientation, intimacy, and reproduction; is influenced by the interplay between psychological, biological, social, economical, political, cultural, legal, historical, religious, and spiritual factors; and is expressed in attitudes, values, beliefs, behaviors, practices, roles, and relationships. Given that sexuality contributes to a person's overall health and wellness (Fritz, Dillaway, & Lysack, 2015; Helmes & Chapman, 2012; Stanger, 2009); one can assume that sexuality and intimacy will be affected when health and wellness are compromised by an illness, injury, condition, or life stage (Isler, Beytut, Tas, & Conk, 2009; Lohman, Kobrin, & Chang, 2017; McGrath & Lynch, 2014; Stanger, 2009).

Adverse psychological, physiological, and relational consequences have been associated with illness, injury, and disability, and often result in decreased sexual satisfaction, participation, and frequency (Eglseder, Webb, & Rennie, 2018; Richards, Dean, Burgess, & Caird, 2016; Sellwood, Raghavendra, & Jewell, 2017). Societal stigma overshadowing people with disabilities may hinder positive sexual experiences (Elzehiver, 2017; Nilsson, Meyer, Koch, & Ytterberg, 2016; Sakellarious & Sawada, 2006), and internalizing negative stigma and attitudes surrounding disability and sexuality may result in decreased self-image, lower self-esteem, role loss, decreased sexual satisfaction, and depression (Eglseder et al., 2018; Richards et al., 2016; Sellwood et al., 2017). Physical limitations or impaired physiological responses involving muscle and movement functions limit engagement in sexual activities and may contribute to a decline in sexual satisfaction, performance, libido and frequency of erectile dysfunction, and

orgasm (Eglseder et al., 2018; McBride & Rines, 2000; McLaughlin & Cregan, 2005; Sakellarious & Sawada, 2006). Relational consequences associated with various conditions and disabilities noted throughout relevant literature include difficulty with initiating, engaging, and maintaining relationships (Sellwood et al., 2017). Additionally, role loss and social isolation may result from the impact of conditions and disabilities on sexuality and intimacy (Esmail, Munro, & Gibson, 2007; Richards et al., 2016). Overall, these consequences cause limitations in sexual satisfaction, performance, and frequency.

Occupational therapy (OT) helps people of all ages enhance their ability to independently participate in everyday activities and to reach their maximum level of function through engagement in purposeful interventions (AOTA, 2014; Jones, Weerakoon, & Pynor, 2005). Activities of daily living are defined as "all the things people want, need, or have to do, whether of physical, mental, social, sexual, political, or spiritual nature" (AOTA, 2014, p. S5). Within the context of human participation and function, sexuality is seen as an expression of occupational performance, which is an integral part of an individual's identity, health status, and self-image (Penna & Sheehy, 2000; Stanger, 2009). Sexuality and intimacy are considered elements of a person's occupational identity (Krantz, Tolan, Pontarelli & Cahill, 2016) regardless of the presence of a disability (Isler et al., 2009) and have long been considered factors that OT practitioners need to address (Novak & Mitchell, 1988). Although many clients identify sexual concerns as major barriers to their occupational performance (Rose & Hughes, 2018; Sakellarious & Sawada, 2006), the lack of education, experience, and comfort in addressing sexual concerns has been associated with brief discussions or a complete disregard of the issue altogether in practice (Areskoug-Josefsson, Larsson, Gard, Rolander, & Juuso, 2016).

The PLISSIT model which includes four levels: Permission (P), Limited Information (LI), Specific Suggestions (SS), and Intensive Therapy (IT), provides a systematic approach for determining the different levels of addressing sexuality and intimacy with clients (Annon, 1976). The model serves as a guide for how to request clients' permission to address sexual concerns, provide clients with general information about their concerns, give specific suggestions regarding their questions, and refer clients to a specialized therapist (Krantz et al., 2016; McAlonan, 1996; McGrath & Lynch, 2014; Weerakoon et al., 2008). Although the PLISSIT model has been heavily referenced throughout the literature as a technique to resolve conversational discomfort and enhance the client's sexual well-being (McGrath & Lynch, 2014), limitations to its use exist. The focus of the model is to assist practitioners with the discussion, not to solve problems associated with sexuality and intimacy (Rutte et al., 2015). Once permission is granted to discuss aspects of sexuality and intimacy, the client is expected to initiate the conversation, readily identify known deficits in occupational performance, and provide general information about the concerns they feel comfortable addressing (Taylor & Davis, 2007). The profession of OT is in need of a framework to help guide practitioner understanding of the complex occupational nature of sexuality and intimacy, assessment, intervention design, and measurement of performance to determine outcomes (Walker, 2019).

Multiple health professions refer to the Sexual Assessment Framework (SAF) for exploring the dynamic sexual needs of clients with a variety of injuries and disabilities (Kokesh, 2016; McBride & Rines, 2000). Dr. George Szasz developed the SAF to guide the assessment of sexual health for individuals with disabilities and was based on seven common themes found across hundreds of concerns noted in extensive interviews with individuals and couples regarding the impact of disability on sexual health in the 1970's (G. Szasz, personal

communication, November 28, 2018). The seven primary constructs of the SAF include: sexual knowledge, sexual behavior, sexual self-view, sexual interest, sexual response, fertility and contraception, and sexual activity (McBride & Rines, 2000). Walker (2019) found the SAF to be an effective guide to evaluate and understand the complex occupational nature of sexuality and intimacy. Currently, a theoretical and occupation-based assessment of the complex occupational nature of sexuality and intimacy does not exist. Thus, the purpose of this study was to create a theoretical and occupation-based screen, in-depth self-assessment, and performance measure to address the complex occupational nature of sexuality and intimacy.

Methodology

The design of this study was informed by DeVellis's (2017) guidelines of scale development and included the following steps: determining what to measure, generating an item pool, determining the format for measurement, and having the initial item pool reviewed by experts (Figure 1). Although the steps are presented here sequentially, the Occupational Therapy Sexual Assessment Framework (OTSAF) evolved throughout the study and the final model was achieved using a grounded theory approach.

Step 1: Map the Construct: The Occupational Therapy Sexual Assessment Framework

The first step in this process was to map the construct by defining the occupational nature of sexuality and intimacy. Just as the Occupational Therapy Practice Framework (OTPF) serves to describe the core tenets that serve as the foundation for understanding the practice of OT, we have developed the OTSAF to describe the core constructs of the SAF as they intertwine with aspects of the domain of occupational therapy (Table 1). As a result, three SAF constructs were modified to better reflect the tenets of OT. Specifically, the construct Sexual Behavior was renamed Intimacy, and Fertility and Contraception was renamed Sexual Health and Family

Planning. The construct of Sexual Self-View was split into Sexual Self-View and Sexual Expression. The resultant model follows a pathway from intrinsic to extrinsic. In sum, *client factors* serve to influence *performance* of relevant *occupations* that occur within an individual's *context* (Figure 1).

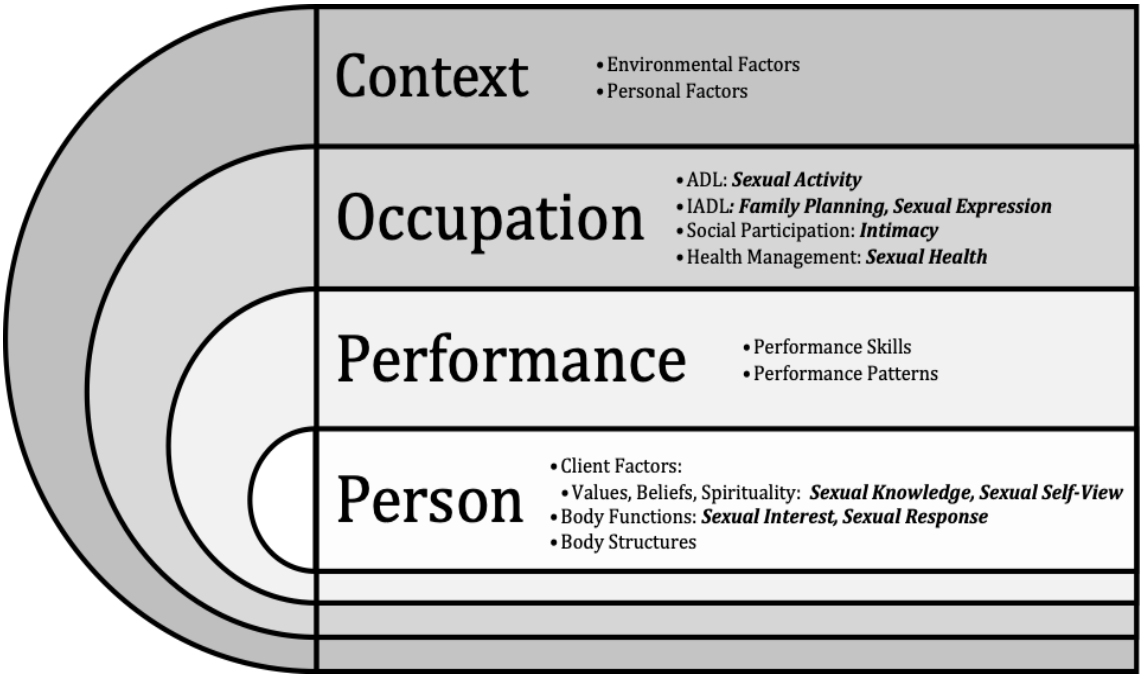
Table 1

Occupational Therapy Sexual Assessment Framework Constructs and Definitions

Construct	*Definition*
Sexual knowledge	*What a person knows, understands, believes, and values in regards to sexuality and intimacy.*
Sexual activity	*A person's ability to safely engage in sexual and/or intimate activities (alone or with another person). Sexual activities may include hugging, kissing, foreplay, masturbation, oral sex, anal sex, vaginal sex, and use of sexual toys or devices.*
Sexual interest	*A person's psychological and physiological drive, motivation, desire, or libido related to participation in sexual activities alone or with another person.*
Sexual response	*The body's physical sexual response associated with sexual activity including physiological arousal, response to erogenous zones, nipple erection, clitoral excitation, erection, vaginal lubrication, prostate release, ejaculation, and/or orgasm.*
Sexual expression	*A person's ability to express themselves as a sexual being. A person may express their sexuality and/or gender identity through behaviors, mannerisms, preferences, appearance, pronouns, political engagement, acquired tendencies, daily routines, symbolic actions, or preferred roles.*
Sexual self-view	*How a person views themselves as a sexual being and includes aspects of sexual identity, gender identity (female, male, other), sexual self-esteem (a person's comfort and confidence with how they view themselves as a sexual being), and body image (mental representation of how a person pictures themselves).*
Intimacy	*A person's ability to initiate and maintain close intimate relationships which includes the ability to give and receive affection needed to successfully interact in the role as intimate partner.*
Sexual health*	*A person's ability to develop, manage, and maintain routines for sexual health including practicing safe sex and identifying, understanding, selecting, and use of contraception.*
Family planning*	*A person's ability to develop, manage, and maintain routines associated with parenthood.*

Note. *Sexual health & family planning are combined into one section of the OPISI, but separated within the OTSAF to delineate how each aspect fits within the scope of practice for occupational therapy.

Figure 1
Model for understanding the occupational nature of sexuality and intimacy



Note: The Occupational Therapy Sexual Assessment Framework follows a pathway from intrinsic to extrinsic. In sum, a *person's* client factors, body structures, and body functions influence *performance* of relevant *occupations* that occur within an individual's *context.* ADL = activities of daily living; IADL = instrumental activities of daily living.

The person is at the center of the model as it is essential to first gain an understanding of the client factors that reside within a person that influence their perception, experience, and performance related to sexuality and intimacy. Client factors include a person's values, beliefs, spirituality, body functions, and body structures. *Sexual knowledge* and *sexual self-view* stem from one's values, beliefs, and spirituality. Sexual knowledge involves a person's understanding of how their condition, disability, illness, or injury may influence their expression of sexuality and participation in intimate activities. *Sexual self-view* incorporates the personal aspects of sexual identity, gender identity and sexual self-esteem. Just as OT practitioners consider the influence of body functions on performance of occupation, *sexual interest* and *sexual response* are considered essential body functions that influence sexual performance. Body structures also

play an important in role as they support body function and occupational engagement related to sexuality and intimacy.

Once client factors influencing participation as a sexual being are understood, it is important to consider the occupational domains of performance skills and performance patterns. Performance skills include motor, process, and social interaction skills. Motor skills are needed to interact, move, manipulate and position the body during sexual activities. Process skills are needed to identify, select, and follow step-by-step actions aimed toward successful performance of tasks associated with sexuality and intimacy. Social interaction skills serve as the foundation to *intimacy* and include skills needed during social exchange with partner(s) or potential partner(s).

Performance patterns include roles, habits, rituals, and routines that may support or hinder sexual performance and participation. Practitioners need to understand the inherent roles and patterns of behaviors reinforced by values and beliefs associated with how a person perceives themselves as a sexual being. Roles, habits, routines, and rituals are inextricably linked to *sexual self-view*, sexual identity, and gender identity. The OT practitioner can work with the client to determine whether these performance patterns support or hinder sexual participation and performance. Disruption to performance patterns in an individual's life will affect their ability to participate in intimate and/or sexual activities. Performance patterns are highly individualized which makes sexual participation and intimacy unique to the person.

Given a person's capacities, values, beliefs, skills, habits, roles, and routines, the OT practitioner must consider how these factors collectively influence participation in occupations relevant to sexuality and intimacy. *Sexual activity* is an activity of daily living (ADL) which involves a person's ability to safely engage in sexual and/or intimate activities (alone or with

another person). Sexual activities may include hugging, kissing, foreplay, masturbation, oral sex, anal sex, vaginal sex, and use of sexual toys or devices. Occupational therapy practitioners are skilled in analyzing the occupational demands of participating in daily occupations (AOTA, 2014, p. S12) to uncover the specific client factors, performance skills, and performance patterns required to participate in intimate activities such as dressing, undressing, transferring, positioning, hugging, kissing, petting, masturbating, using adult novelty products, or engaging in intercourse. Using, cleaning, and maintaining personal care items such as sexual devices is considered personal device care and is also considered to be an ADL (AOTA, 2014, p. S19).

Sexual health and family planning fall under the umbrella of the occupation health management. These occupations play a crucial role as individuals often contemplate their capacity to start a family (Walker, 2019). Occupational therapy practitioners are able to discuss and help individuals gain an understanding of how an individual's capabilities and limitations may influence performance associated with the IADL of child rearing. Similar to the IADL category of religious and spiritual activities and expression, *Sexual expression* is the way a person communicates or presents themselves as a sexual being. *Intimacy* is a clear component of the occupation of social participation as it is vital to maintain and initiate relationships with another person (Mcbride & Rines, 2000). Occupational therapy practitioners attend to an individual's involvement in activities that involve intimate interactions with others through texting, phone calls, video conferencing, social media platforms, and dating services, as well as engagement in a wide variety of interactions, displays of affection, and intimacies, which may or may not involve sexual activity (AOTA, 2014, p. S21). If leisure includes exploring and participating in activities that are intrinsically motivating and done in one's free time (AOTA,

2014, p. S21), meeting potential partners or going on dates (MacRae, 2013) may also be considered leisure occupations (Penna & Sheehy, 2000).

Lastly, OT practitioners should fully understand the context in which their client's sexuality and intimacy occurs to gain insights on their overarching, underlying, and embedded influences on engagement (AOTA, 2014, p. S28). Physical, technological, social, attitudinal, and available services play an essential role in expression of sexuality or engagement in activities relevant to sexuality and intimacy. Physical environments incorporate natural and built surroundings, as well as the objects that are in them. Elements within a person's physical environment that may influence optimal performance in related activities need to be considered. Finally, OT practitioners should pay attention to the social environment of their clients and consider the availability and expectations of those who are significant to the person, such as spouses, friends, and caregivers (AOTA, 2014).

Within personal factors of context, one's age, socioeconomic status, gender, and educational status are all part of the way one internally and externally views their sexual identity and how they express themselves. The values and beliefs within one's cultural context dictates accepted sexual practices and norms that influence personal sexual expression, identity, and activity. These factors also influence the availability of one's sexual partners and the avenues in which one has the opportunity to gain sexual knowledge, experience, and activity. The experience of sexuality and intimacy are also shaped by one's temporal context given that perceptions, expectations, participation, and performance change over time and across the lifespan. In today's society, how one interacts, expresses themselves as a sexual being, and participates in activities pertaining to sexuality and intimacy are also heavily influenced by their virtual context, whether through smartphones, computers, or social media.

Step 2: Assemble an Item Pool

Review of Existing Tools

The next task involved in this step included generating an item pool of existing items that address sexuality and intimacy (See Figure 2). This process began with using a deductive approach to generate items based on an exhaustive search of the literature and pre-existing scales (Hinkin, 1995), which revealed 31 relevant scales that addressed components of sexuality and intimacy (Table 2).

Table 2

Assessment Tools Reviewed

Assessment tool (Reference)
DASH Questionnaire (Kennedy et al., 2011)
Female Sexual Function Index (FSFI) (Rosen et al., 2000)
Functional Analytic Psychotherapy Intimacy Scale (Leonard et al., 2014)
Functional Status Questionnaire (FSQ) (Jette et al., 1986)
Life-Satisfaction-Questionnaire-9 (LISAT-9) (Fugl-Meyer, Melin, & Fugl-Meyer, 2002)
McCoy Female Sexuality Questionnaire (MFSQ) (Rellini et al., 2005)
Multidimensional Sexuality Questionnaire (MSQ) (Snell, Fisher, & Walters, 1993)
Oswestry Low Back Pain Disability Questionnaire (Alcántara-Bumbiedro et al., 2006)
Quality of Sexual Function (QSF) (Heinemann et al., 2005)
The Modified Brief Sexual Symptom Checklist for Men (BSSC-M) (Rutte et al., 2015)
The Modified Brief Sexual Symptom Checklist for Women (BSSC-W) (Rutte et al., 2015)
The Multiple Sclerosis Intimacy and Sexuality Questionnaire (Foley et al., 2013)
The Satisfaction with Sex Life Scale (SWSLS) (Neto, 2012).
Sex Effect Scale (Sex FX) (Kennedy et al., 2006)
Sexual Behavior Questionnaire (SBQ) (Macdonald et al., 2003)
Sexual Desire Inventory-2 (SDI-2) (Spector, Carey, & Steinberg, 1996)
Sexual Dysfunction Questionnaire (SDQ) (Infrasca, 2011)
Sexual Function Questionnaire (SFQ-V1) (Quirk et al., 2002)
Sexual Functioning Questionnaire (SFQ) (Smith, O'Keene, & Murray, 2002)
Sexual Interest and Desire Inventory-Female (SIDI-F) (Sills et al., 2005)
Sexual Interest and Satisfaction Scale (Siosteen et al., 1990)
Sexuality Questionnaire (Hattjar, 2012)
Participation Survey/Mobility (PARTS/M) (Gray et al., 2006)
Personal Assessment of Intimacy in Relationship (PAIR-M Questionnaire) (Thériault, 1998)
Personal Experience Questionnaire (PEQ) (Dennerstein, Lehert, & Dudley, 2001)
Pelvic Organ Prolapse/Incontinence Sexual Questionnaire-International Urogynecology Association Revised (PISQ-IR) (Rogers & Pons, 2013)
Psychotropic-Related Sexual Dysfunction Questionnaire (PRSexDQ) (Montejo & Rico-Villademoros, 2008)
Udvalg for Kliniske Undersogelser Side Effect Rating Scale (UKU) (Lingjaerde et al., 1987)
The World Health Organization Quality of Life Questionnaire (WHOQOL-100) (WHOQOL Group, 1998)
Quality of Life Enjoyment and Satisfaction Questionnaire-Short Form (Q-LES-Q-SF) (Endicott et al., 1993)

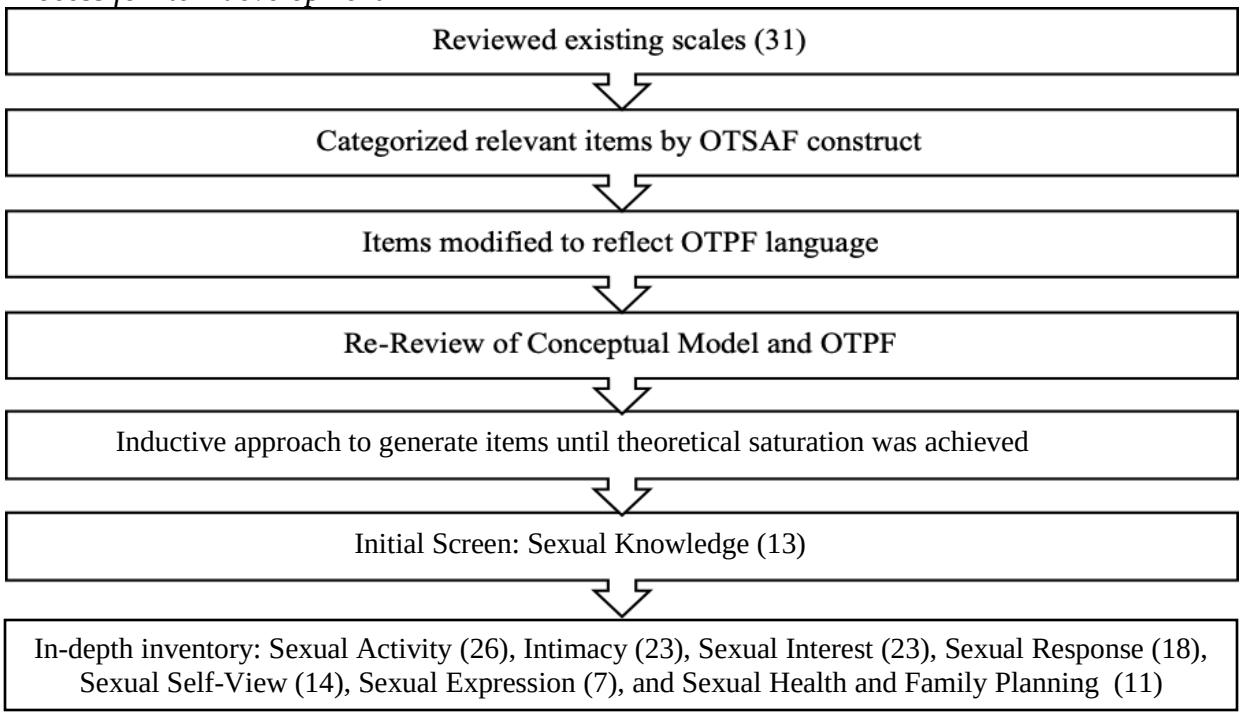
According to Henderson (2016), assembly of an item pool should involve collecting and categorizing individual items for each construct from a variety of multiple resources. Items from each scale were analyzed for applicability to the scale's purpose (DeVellis, 2017). Items found to

be relevant were then categorized depending on which construct of the OTSAF the item best reflected. The initial item pool for the in-depth self-assessment portion of the OPISI consisted of 132 items. Items were then reviewed and modified using terminology consistent with the OTPF and specifically reflect the occupational nature of sexuality and intimacy through the lens of the specific construct (see Appendix). Care was also taken to ensure that items targeted only one attribute, described a measurable behavior, were clear and unambiguous, and of relevance to the target population (Keating, Dalton, & Davidson, 2009). Reduction of items occurred when multiple items reflected the same concept, resulting in one well-constructed item.

Given the lack of scales relevant to the occupational nature of sexuality and intimacy, the next step involved a thorough conceptual analysis of the OTPF and the OTSAF to brainstorm possible occupation-based elements necessary for inclusion to adequately assess each construct. See Appendix for sample items created in this process. Conceptual analysis involved examining the OTPF and deciding what occupations, client factors, performance skills, performance patterns, contexts and environments play a role in and possibly affect one's sexuality and intimacy. Items were then generated for each construct until theoretical saturation was achieved. An inductive approach was also applied to generate items based on qualitative information regarding each OTSAF construct (Kapuscinski & Masters, 2010) obtained from interviews with individuals and couples from the target population affected by various conditions such as stroke, spinal cord injuries, and bilateral above-the-knee amputations (Walker, 2019). Following discussions regarding the global nature of the items within the category for sexual knowledge, we decided that these items would serve better as the basis for the screening tool rather than as part of the in-depth self-assessment.

Figure 2

Process for item development



Step 3: Determine the Format for Measurement

The OPISI includes a self-screen (13), in-depth self-assessment (122 possible items), and an individualized measure used by an OT practitioner to detect self-perceived changes in occupational performance associated with sexuality and intimacy over time (28 possible items). The decision to use a screening tool followed by an in-depth self-assessment was informed by the PLISSIT model. The purpose of the initial screen is to assure the client that sex is an appropriate and acceptable topic to be addressed during therapy (permission) and to gather and review information about the client to determine the need for continued evaluation and intervention (AOTA, 2014, as cited in Hinojosa & Kramer, 2014). The in-depth self-assessment was designed to provide a greater understanding of client factors that influence performance of occupations associated with sexuality and intimacy within the client's context. The OT practitioner may elect to issue the complete in-depth self-assessment to the client or tailor the

assessment to only include the categories of sexuality and intimacy identified by the client on the screen. The initial screen and in-depth self-assessment utilize a check-all-that-apply format which allows for a wide range of concerns to be covered utilizing a present or absent response approach (Hinojosa & Kramer, 2014) and does not require a high cognitive level of engagement allowing respondents the ability to cover a large number of concerns in less time (Ares et al., 2014).

Following a thorough review and discussion of the inventory, for the categories of sexuality and intimacy in which the client had concerns (sexual activity, sexual interest, sexual response, sexual expression, sexual self-view, intimacy, and/or sexual health and family planning), occupational therapists can work with the client to develop goals, plan interventions (Limited Information or Specific Suggestions), and/or make necessary referrals. A 4-item performance measure was designed for each category to quantify the client's perception of occupational performance regarding ability, satisfaction with ability, understanding of how their condition impacts performance, and confidence in their skills and ability to make necessary modifications to improve performance (self-efficacy). The OT practitioner asks the client to rate each of the relevant category of the OTSAF based on their current condition or life circumstance on a scale from 1 (no ability, satisfaction, understanding, or confidence) – 10 (highest ability, satisfaction, understanding, or confidence). This calibration process using a Likert-type scale was selected for its utility to measure beliefs, opinions, attitudes and overall quality of life (DeVellis, 2017; Krzych, Lach, Joniec, Cisowski, & Bochenek, 2018; Hinojosa & Kramer, 2014). DeVellis (2017) indicates that the Likert scale can span a wide range of constructs, which allows opportunity for graduations of responses. This adds value to the subjective questionnaire and aids in gaining essential information occupational therapists use for future intervention planning. At

follow-up, the client scores each relevant category again to determine if the intervention was effective or if the intervention plan needs to be modified (Hinojosa & Kramer, 2014).

Step 4: Initial Pool Review

A pilot study on the initial item pool gained perspective from a small sample size of individuals regarding the feasibility and application to a larger scale of audience and gather feedback on modifications needed for future validation (Leon, Davis, & Kraemer, 2011). Thirteen occupational therapists, a physical therapist, and George Szasz, renowned physician and pioneer in sexual medicine who developed the SAF in the 1970s, reviewed the initial item pool. We selected these individuals for their ability to review the overall applicability of the items to the profession of occupational therapy, establish face validity to ensure that items appear to measure the constructs they intend to measure, ensure that items were gender neutral, and that items were not discriminatory. Feedback led to changing the initial screen and in-depth assessment from Likert-type to check-all-that-apply, reordering the presentation of OTSAF constructs, and removal of certain items that did not align well with the OT scope of practice. Items were also modified based on feedback regarding item clarity, gender neutrality, inclusivity, and reading level. Overall, items for the construct Sexual Self-View were noted to be negatively worded and edits were made to better reflect client's sexual self-view concerns in a more positive light.

Discussion

Aspects of sexuality and intimacy are incorporated in every human being's daily life (Lohman et al., 2017) regardless of the presence of a disability (Isler et al., 2009). Unfortunately, many healthcare practitioners are hesitant to initiate the subject of sexuality due to personal embarrassment and belief that they would embarrass the client and clients do not bring the topic

up due to fear of embarrassing the professional (Nilsson et al., 2016). The profession of occupational therapy is in desperate need of a screen, thorough assessment, and performance measure which address the complex occupational nature of sexuality and intimacy. Such tools would serve as effective means for occupational therapists to adequately introduce, assess, and address the complex nature of sexuality and intimacy.

The Occupational Therapy Sexual Assessment Framework (OTSAF) was developed using a thorough review and combination of the OTPF and SAF core constructs. This process resulted in a model to depict how the theoretical constructs intertwine with the domain of occupational therapy. Defining the occupational nature of sexuality and intimacy served as the foundation from which to build the comprehensive OPISI. The OTSAF should inform curricular infusion, continuing education, practice guidelines, and day-to-practice.

The OPISI was created to comprehensively screen, assess, and measure performance related to the complex occupational nature of sexuality and intimacy following DeVellis's (2017) guidelines for scale development. The following steps taken thus far include: mapping the construct, generating an item pool, determining the format for measurement, and having the initial item pool reviewed by a small panel of experts. The screening tool (13 items) provides an introduction to the topic of sexuality and intimacy, the role of occupational therapy, and items relevant to sexual knowledge. The separate in-depth self-assessment (122 items) is associated with the following constructs of the OTSAF: Sexual Activity (26), Intimacy (23), Sexual Interest (23), Sexual Response (18), Sexual Self-View (14), Sexual Expression (7), and Sexual Health and Family Planning (11) (Figure 2). Once concerns are identified and goals are established, a performance measure is available to detect self-perceived changes in occupational performance associated with sexuality and intimacy over time.

Limitations in the development of the OPISI exist. The research team consisted of seven females which inherently produced a level of unavoidable gender bias regardless of attempts to gain diverse opinions and perspectives from male peers and colleagues. Although the OPISI was grounded in theory, evidence, and practice guidelines for occupational therapy, this phase of development was only vetted by a small number of individuals who served on a client-based advisory panel.

Conclusion

Formal validation of the OPISI is needed to implement this much needed screen, in-depth self-assessment, and performance measure into occupational therapy practice. Now that the occupational nature of sexuality and intimacy has been clearly defined through the development of the OTSAF, a modified Delphi technique would be an appropriate approach to collect expert opinions through consensus to validate the theoretical constructs (Linstone & Turoff, 1975). A modified Delphi technique would also be useful to obtain content validity for the OPISI (Falzarano & Zipp, 2013; Keeney, Hasson, & McKenna, 2011).

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Appendix

OPISI Item Development: Sample items

Construct	Original Item	Modified/New Original Item
Screen ***Sexual Knowledge***	How important is it for you to participate in intimacy? (Gray et al., 2006)	Sexuality and intimacy are important aspects of my life
	How important is sexuality to you now compared to before/after injury? (Siosteen et al., 1990)	
	Rather than talking about sexual activity, I'd rather receive handouts or brochures about the topic (Hattjar, 2012)	I would like to receive handouts or brochures from the occupational therapist about this topic
		I have concerns about the overall impact my condition or life stage has on my ability to safely engage in sexual and/or intimate activities (alone or with another person). Sexual activities may include hugging, kissing, foreplay, masturbation, oral sex, anal sex, vaginal sex, and the use of sexual toys or devices.
		I have concerns about the overall impact my condition or life stage has on my ability to give and receive affection needed to successfully interact in my role as intimate partner
In-Depth Inventory ***Sexual Activity***	Does your condition prevent you from enjoying sexual activities? (Dennerstein et al., 2001; Siosteen, A. et al. 1990)	My symptoms prevent me from enjoying or participating in sexual activities
	Do you experience discomfort or pain with penetration during intercourse? (Rosen et al., 2000)	I avoid participation in sexual activities that include penetration due to pain
		I experience difficulty dressing/undressing myself or my partner in preparation for sexual activities

		I worry about my ability to control my bladder and/or bowel or urinary and/or bowel symptoms during sexual activity
Sexual Interest	Are you dissatisfied with your desire to engage in sexual behavior with a partner? (Spector, Carey, & Steinberg, 1996)	I am dissatisfied with my desire to engage in sexual activities
	Have you been distressed (worried, concerned, guilty) about your level of sexual desire? (Sills et al., 2005)	I worry that my condition interferes with my overall level of sexual interest, drive, or desire
		Lack of time to participate in sexual activities interferes with my sex drive Lack of sleep interferes with my interest in participating in sexual activities
Sexual Response	Do you experience difficulty with arousal during sexual activity due to illness/injury ? (Rosen et al., 2000)	My body's physical response associated with sexual activity has changed as a result of my condition and this is a problem
	Problems with erection (Rutte et al., 2015)	I struggle obtaining an erection or maintaining it once I have initiated sexual activity
		I would like to find other means of experiencing sexual satisfaction to compensate for lack of orgasm I experience delay or difficulty achieving orgasm with masturbation
Sexual Expression		I am no longer comfortable expressing my sexual identity I worry that I no longer appear as masculine/feminine/other as I would like
		I do not feel that I am able to fulfill the roles that I associate with my gender identity

Sexual Self-View	How sexually attractive do you feel you are to your primary sexual partner? (Rellini et al., 2005)	I worry that I am not sexually attractive or appealing to my partner(s) or potential partner(s)
	Over the last 6 months feeling that my body is less attractive have interfered with my sexual activity. (Foley et al., 2013)	
	Over the last 6 months feeling less masculine or feminine due MS have interfered with my sexual activity. (Foley et al., 2013)	My condition leaves me feeling less masculine/feminine/other
		The extent of care and assistance I need leaves me feeling powerless which impacts my sexual self-esteem
		I feel that my guilt or my partner's(s') guilt regarding my condition interferes with our ability to enjoy intimacy and sexual activity
Intimacy	Are you comfortable discussing significant problems with your partner? (Leonard et al., 2014)	I am not comfortable discussing aspects of sexuality and intimacy or my sexual needs with my partner(s)
	Are you satisfied with your sexual relationships? (Jette et al., 1986)	I feel my condition prevents me from being satisfied with my intimate relationship(s)
		I have difficulty prioritizing or engaging in pleasant, loving, affectionate shared time with my partner(s)
		I find it difficult to express my sexual interest and desires in a way that my partner(s) understands
		My ability to understand, access, and use social media platforms to develop intimate relationships is limited

Sexual Health and Family Planning	I (have) (have not) consented to having sex with someone and regretted it afterward. (Hattjar, 2012)	I am concerned about my ability to protect myself from unwanted sexual advances, sexual assault, or rape I do not know how to use, forget to use, or have physical limitations that prevent me from using contraception (including ability to open packaging) as intended to prevent pregnancy or sexually transmitted infections. I feel my ability to provide care and supervision to support the developmental needs of a child may be limited My partner is hesitant to create a family with me because they will take on most of the responsibility
Performance Measure		How would you rate your sexual interest, drive, or desire? (Ability)
Sexual Interest		How satisfied are you with your current sexual interest, drive, or desire? (Satisfaction) How would you rate your understanding of how your condition or life stage influences your sexual interest, drive, or desire? (Knowledge) How confident are you in your skills and ability to make necessary changes to improve your sexual interest, drive, or desires? (Self-Efficacy)