Sexual Functioning as a Topic in Occupational Therapy Training: A Survey of Programs

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To investigate the current status of sex education in occupational therapy curricula, a questionnaire survey was mailed to department chairs of 67 university programs that were either accredited or in the application process. A total of 50 programs returned usable responses. The results indicate that occupational therapy may be in a transition period: A significant minority of the respondents were either undecided about or against including sexual functioning in occupational therapy, but the majority were of the opinion that the patient's sexual functioning is an important domain of occupational therapy practice. A high percentage of programs reported that instructional time was being devoted to the basics of sexual functioning, but programs varied considerably in the amount of time allocated for this topic.

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The traditional and generally accepted aim of the occupational therapist has been to assist persons who have lost functioning because of some type of disability in becoming as independent as possible in carrying out the activities of daily living. In recent years, however, there has been a growing realization that the universe of activities necessary for independent daily living is broader than it was once thought to be, and the move for a more holistic approach has arisen (Freda, 1985; Sidman, 1977). Consequently, the profession has begun to extend its concerns from the conventional list of such activities as dressing, feeding, bathing, and cooking to less traditional areas of functioning such as sports and leisure (American Medical Association & American Occupational Therapy Association, 1983) and sexuality (Asrael, 1985; Dawe & Shepherd, 1985; Neistadt, 1986). Sexuality is often affected by disability, but seems to be infrequently dealt with by practicing occupational therapists (Conine, Christi, Hammond, & Smith, 1979; Evans, 1985), although many agree that it is an important area of concern (Conine et al., 1979; Cooper-Fraps & Yerxa, 1984; Dawe & Shepherd, 1985; Neistadt & Baker, 1978). Research by Evans (1985) has been consistent with the earlier findings of Conine et al. (1979) in suggesting that occupational therapists omit sexuality from the treatment process because of their lack of training and, more important, their uncertainty about how to relate to patients in this area.

Although sexual expression is becoming widely recognized as an important life skill and limited counseling to address decrements in this skill is frequently recommended in standard occupational therapy textbooks (e.g., Hopkins & Smith, 1983; Trombly, 1983), the extent to which currently accredited occupational therapy programs are providing their students with training in the basics of sexual functioning is not known. Because many health care professionals say they do not address the topic of sexual functioning with their patients because of their discomfort with the subject, the manner in which students are taught to deal interpersonally with clients' sexuality is also important. The purpose of this study was to address these concerns by providing descriptive information about the degree to which today's university occupational therapy programs are preparing their students to address sexual functioning as a life skill.

Method

The target respondents in the study consisted of the department chairs of all university programs in occupational therapy that were accredited as of November 1985 (n = 61). Also included were a small number of programs in the late stages of program development.
at that time \( n = 6 \). Thus, a total of 67 university programs had the opportunity to provide information.

Each program received a 60-item questionnaire and a cover letter explaining the study’s purposes. In addition to asking for descriptive information about the program (e.g., geographic location, average class size, and type of degree offered), the questionnaire items focused on current training practices in the area of sexual functioning, beliefs about who should deliver information on sexual functioning to patients, and future curriculum plans with regard to sex education.

Data were collected in the fall of 1986.

Results
Response Rate and Program Descriptions
A total of 50 usable responses were received, a response rate of 74.5%. The responding schools represented an adequate balance in terms of their geographic dispersion, with locations in the Midwest, Northeast, and Southeast represented almost equally, and the Far West and Northwest represented in small proportion. Regarding the types of degrees offered, 36 of the programs (72%) reported that they offered only the baccalaureate degree in occupational therapy, 7 (14%) reported that they offered only the master’s degree, and 7 (14%) reported that they offered both master’s and baccalaureate degrees.

Attitudes and Beliefs
The respondents generally believed that healthy sexual expression among patients is an important domain of occupational therapy practice: 32 chairs (64%) were of this opinion, but 10 (20%) said sexual functioning is not important in occupational therapy, and 5 (10%) reported being undecided on the issue. Three department chairs did not respond.

The respondents were asked to rank order a list of six kinds of health care professionals with respect to their responsibility for providing services in the area of sexual functioning. Table 1 provides a summary of these responses. For clarification and elaboration, the mean rank of each kind of health care provider was also calculated separately for respondents in favor of including sexual functioning in occupational therapy and those against it or undecided. Respondents in both groups tended to agree that doctors, physical therapists, and social workers are not primarily responsible for delivering services related to sexual functioning. As one would expect, however, respondents believing that sexual functioning is an appropriate concern of the occupational therapist tended to rank occupational therapists higher than respondents who were undecided or negative about this issue. In contrast, members of the latter group generally expressed the opinion that nurses and health educators should bear a greater responsibility for addressing patients’ sexual functioning than occupational therapists.

Program Content
Respondents also completed a number of items concerning the content of their programs, and 88% of them \( n = 44 \) indicated that formal class time was being devoted to the topic of adaptive sexual functioning.

The respondents also completed a set of items in which they were to estimate the number of hours devoted to sexual functioning in several specific formats of instruction. Responses are summarized in Table 2. The table indicates that the lecture and discussion formats were the dominant means of providing students with information and training in human sexuality. Although there was considerable variability among programs, an average of 3.5 hours of class time was devoted to sexual functioning. Eighty-two percent of the respondents \( n = 41 \) indicated that the topic was covered during either required hours (70%, \( n = 35 \)) or a mixture of required and elective hours (12%, \( n = 6 \)).

Because previous research has shown that health care professionals have considerable discomfort ap-

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Table 1
Responsibility for Providing Services Related to Sexual Functioning: Mean Ranks of Six Professional Groups

<table>
<thead>
<tr>
<th>Professional Group</th>
<th>All Respondents ( n = 47 )</th>
<th>Respondents in Favor of Including Sexual Functioning in Occupational Therapy ( n = 32 )</th>
<th>Respondents Against or Undecided About Including Sexual Functioning in Occupational Therapy ( n = 15 )</th>
</tr>
</thead>
<tbody>
<tr>
<td>Occupational therapists</td>
<td>2.61</td>
<td>2.37</td>
<td>2.83</td>
</tr>
<tr>
<td>Nurses</td>
<td>2.67</td>
<td>2.77</td>
<td>2.17</td>
</tr>
<tr>
<td>Health educators</td>
<td>2.94</td>
<td>3.30</td>
<td>2.50</td>
</tr>
<tr>
<td>Doctors</td>
<td>3.29</td>
<td>3.36</td>
<td>3.36</td>
</tr>
<tr>
<td>Physical therapists</td>
<td>4.11</td>
<td>4.29</td>
<td>4.40</td>
</tr>
<tr>
<td>Social workers</td>
<td>4.41</td>
<td>4.44</td>
<td>4.43</td>
</tr>
</tbody>
</table>

Note. Highest rank = 1, lowest rank = 6.
approaching patients on the subject of sexual functioning, an item was included to determine whether formal class time was being devoted to teaching techniques for interacting with patients on this subject. Forty of the 49 respondents answering this item (81.6%) responded affirmatively. A smaller percentage (66%) reported that class time was being devoted to the improvement of future therapists' interpersonal skills in approaching patients, but only 24% reported using desensitization exercises to reduce therapists' anxiety in approaching patients about sexual matters.

The few institutions which reported that they did not include training in sexual functioning in their curricula were asked to respond to a checklist of possible reasons for this decision. A majority (63.6%) of chairs responding to this checklist cited "lack of time" as a major factor. Only two (18.2%) indicated that sexual functioning was simply a low priority. A single respondent (9.1%) expressed the opinion that the coverage of sex "should be done elsewhere," and one other cited a combination of factors. None of the programs cited the lack of properly trained faculty as a reason for not training their students in sexual functioning.

Of the programs not currently providing training in sex education for their students, only one reported having future plans for doing so.

Fieldwork Content

The questionnaire also asked whether sexual functioning was covered during fieldwork. Of the 49 schools responding to this question, only a single institution answered affirmatively (2%). Ten of the respondents (20.4%) said no, and 38 (77.6%) did not know.

Discussion

These results indicate that the majority of the respondents believed that it was important for their students to be able to address patients' sexual functioning as a life skill. A significant minority, however, were either undecided or against including sexual functioning in occupational therapy.

In actual educational practice, a higher percentage of the programs devoted some time to teaching their students about healthy sexual functioning than would be expected given the personal beliefs of the respondents. This result may simply indicate that other faculty members in the departments were having significant input into program content. Alternatively, it may be that the occupational therapy programs were committed to providing only minimal information to their students, so that these students would be able to deal with the health care professionals responsible for providing sex education and counseling services to patients. More research is needed to clarify this issue.

With respect to both the method and the amount of instruction devoted to sexual functioning, there was little consistency from program to program. This lack of consistency probably reflects uncertainty within the profession about the role of occupational therapists in teaching clients adaptive sexual functioning. Because the profession's accreditation standards lack any specific reference to sexual functioning (American Medical Association & American Occupational Therapy Association, 1983), uncertainty and variations in program philosophy concerning the issue would be likely to occur. It may be that the profession is in a transition period with respect to its position on sexual functioning, and that greater uniformity of purpose and consistency of training will develop in the future. For the time being, however, it seems likely that an individual therapist's willingness and ability to address patients' sexual functioning will depend largely on where the therapist was trained.

These results are not unlike the findings of another recent investigation of a related group of professional therapists. Siracusano & Corbin (1986) reported wide variability in the sex education training of physical therapists. Although the respondents in the present survey indicated that occupational therapists should assume greater responsibilities for dealing with patients' adaptive sexual functioning than physical therapists, formal time spent on sex education in the occupational therapy programs surveyed was only half that of the physical therapy schools surveyed by Siracusano and Corbin (1986).

The finding that a large majority of the respondents did not know whether their students' clinical training covered the area of sexual functioning is not surprising. The respondents may not have been aware of sexuality training in the clinical setting because of a focus on areas of practice deemed more important; further, it seems likely that the diversity of fieldwork settings available to students would make it impossible for the respondents to generalize about the con-
tent of training across the various clinical settings. Again, more research is needed. It would be pertinent to know how closely department chairs monitor clinical educational experiences and whether clinical students feel adequately prepared to address matters relating to adaptive sexual functioning.

In summary, if occupational therapists wish to play a significant role in promoting healthy sexuality among their patients, then more time should be devoted to this topic in the training of future occupational therapists. Models for including sexuality counseling education in occupational therapy curricula are presently available (e.g., Neistadt, 1986), and future studies may reveal the existence of a greater amount of consistency with respect to the education of therapists in nontraditional areas such as sexual functioning. Currently, however, the inclusion of even minimal coverage of this topic in occupational therapy curricula may serve to sensitize future professionals to the need to address sexual functioning in practice or to refer patients to more highly trained professionals.

References


