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ORIGINAL PAPER

Experience of Recently Graduated Occupational Therapists in Addressing Sexuality with Their Clients

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Abstract
Health care consumers have emphasised the importance of being able to express themselves in a sexual nature, regardless of their health conditions. Unfortunately, literature based on experienced occupational therapists and students, indicates sexuality is poorly addressed, despite being a meaningful occupation. There is limited literature based on Australian experiences or the experiences of recent graduates, therefore this study aimed to explore how comfortable and prepared 11 recent graduates who studied in Australia, were in addressing sexuality, as well as the enablers and challenges experienced**.** A qualitative research design was utilized, with results demonstrating that undergraduate curricula are not adequately preparing new graduates to feel equipped with the knowledge, skills, comfort and preparedness to address sexuality. Enablers such as education, professional development and supportive workplaces, can aid to facilitate positive change in this area of practice, which may improve client outcomes.

Keywords Australian · Occupational therapy · Recently graduated occupational therapist · Rehabilitation · Sexuality · Sexual health · University curriculum

Introduction

Occupational therapy supports engagement and participation in meaningful occupations, described as everyday activities valued by people, providing them with identity and purpose [1]. International Classification of Functioning, Disability and Health (ICF) [2]

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considers following safe sex practices and maintaining relationships of a sexual nature, within the 'activities and participation' domain. Participation, described as involvement in life situations, is a focus of occupational therapy practice, positioning occupational therapists well to address client concerns related to sexuality [3, 4].

Concerns raised by occupational therapy clients, about if or how sexuality was addressed, indicate sexuality concerns were often underestimated, and there was general dissatisfaction, with how sexual concerns were addressed [5]. Having a sense of connectedness with a partner and maintaining an emotional bond was considered very important to consumers, however often conversations about intimacy did not take place, and when they did, education was limited, lacked personal context and did not address specific needs [5–8]. Furthermore, societal change has occurred in Australia, including the gay marriage legalisation in 2017 [5, 9], and this change has potentially led to more clients wanting, and now feeling able to seek support to address sexuality issues.

Sexuality has been described as gender identity, orientation, eroticism, pleasure, intimacy, reproduction, sensuality and sexualisation [10, 11]. An individual's ability to express their sexuality, such as being intimate with a partner, can often be impacted by injury, disease or disability, resulting in a negative outcome on their health, wellbeing, and occupational identity [10, 12, 13].

Since 2008, sexual activity has been considered an activity of daily living in the.

Occupational Therapy Practice Framework [1, 14]. Research, since the inclusion, is biased towards experienced occupational therapists and students [15–19]. Of the studies completed, there is a consensus that occupational therapists believe addressing sexuality is an important part of their role, particularly relating to the physical aspects of sexuality [13, 18, 20–23]. However, despite identifying this need, it does not translate to practice. Currently there is no research from an Australian perspective of how occupational therapists address sexuality in their practice. There are a limited number of international studies, which have shown sexuality being addressed. [18, 21] that reported that occupational therapists believe sexuality should be routinely addressed but this did not often occur due to a range of reasons. These included socio-cultural stigma, societal expectations that it was not important, limited resources, limited access to private space, time pressure, lower priority and lack of training, as well as perceived lack of preparedness, comfort and competence [18, 21].

Occupational therapy students in Sweden and in the USA felt unprepared, lacked the clinical and professional knowledge and competence to initiate discussions regarding sexuality, and to provide appropriate intervention, due to lack of content within the university curricula and professional placement [24, 25]. It is yet to be reported whether societal changes in Australia have resulted in changes to undergraduate occupational therapy curricula that might ensure graduates are comfortable and prepared to address sexuality. Understanding the experience of recently graduated occupational therapists, their comfort and preparedness to address sexuality with their clients would inform the development of university curricula and professional development. Exploring enablers and challenges faced by recent graduates will provide information to workplaces regarding the role occupational therapist have in ensuring client needs in the area of sexuality are met.

The aim of this study was to address these gaps by exploring the experience of recently graduated occupational therapists in Australia addressing sexuality. The study objectives were to describe their perspectives about:

- Addressing sexuality with their clients
- How comfortable and prepared they feel in addressing sexuality with their clients

- The enablers and challenges of addressing sexuality with their clients
- Whether their university curriculum prepared them to address sexuality with these clients

Materials and Methods

Research Design

A qualitative design, with a reflective thematic analysis approach, was used to provide an in-depth understanding of the participant's experience, and gain an understanding of the rationale behind behaviours, attitudes and opinions, rather than surface responses [26]. A purposive sample ensured that participants had the experience of interest and would be able to provide rich and in-depth information [27, 28]. The 'experience of interest' in this study was the experiences of participants who had completed their occupational therapy degree at an Australian university and who had six or less years of experience working as an occupational therapist, in a Victorian health care setting where there were expectations to address sexuality within their scope of practice. This study received approval from the Human Research Ethics Committee.

Participant Recruitment

Eleven participants who were recently graduated occupational therapists, with less than six years of experience, working in a range of Victorian health care settings where there was an expectation to address sexuality. Six years was chosen, in order to include participants who studied in courses potentially influenced by curricula that reflected societal change such as gay marriage legalisation in 2017 and increased openness regarding sexuality. Recruitment invitations were disseminated via an advertisement on the Occupational Therapy Australia website and to the research teams' professional contacts. Interested potential participants were emailed a Participant Information Sheet and consent form, which provided clear detail of the study's aim and procedures. Participants were assured confidentiality and anonymity and written, and verbal, consent were obtained prior to participation.

Data Collection

An interview guide with open-ended questions (Table 1) was developed to ensure consistency in the interviews while also allowing for spontaneity and elaboration of responses. Prompt questions were prepared to encourage elaboration as required [29]. The interview guide was informed by current literature and designed specifically for the study. Prior to the study the interview guide was piloted with an occupational therapist by the first author with the second and third authors present as observers. The pilot interview led to the questions being refined, in consultation with the pilot interviewee, however refined questioned were not piloted due to schedule limitations.

Semi structured interviews (60–90 min), were completed either face-to-face, or via telephone or using Skype, depending on the choice of the participants. Rapport was established by creating a safe and comfortable space for the interview to be conducted in and by allowing time for casual conversation prior to the interview commencing.

Table 1 Semi-structure interview questions

Sample interview questions
What do you see is your role in addressing sexuality as an occupational therapist?
Who else do you think should address sexuality and can you give an example of what they would do differently than an occupational therapist?
I have asked you about your role in addressing sexuality; now I would like to ask if you believe it is important that sexuality is addressed with your clients?
In your opinion, are there any areas of occupational therapy where you think it should not be addressed?
Now I would like to explore about your actual experiences addressing sexuality with your clients?
Have your beliefs or views about addressing sexuality with your clients changed since you have graduated?
Can you tell me what addressing sexuality with a client typically involves? What are some of the things that you do?
Do you feel adequately prepared to address sexuality with your clients?

All interviews were audio recorded and conducted by the first author. In the first two interviews the third author was present as an observer. The first author was a female honours occupational therapy student without experience of addressing sexuality with clients but interested in the field. The second and fourth authors have expertise in addressing and researching sexuality in rehabilitation. The third author is an occupational therapist and experienced qualitative researcher.

Data Analysis

Braun and Clark's reflexive thematic analysis approach was used, with researcher subjectivity and reflexivity central to the process was used to analyse and report on the experiences, meanings and reality of participants, as well as reflecting and understanding reality [30]. The interviews were transcribed verbatim by the first author except for three interviews transcribed by a professional transcription team. Participant codes were used to ensure anonymity of reported data. The first three researchers independently completed within, and across interview coding and then met and reached a shared understanding and they developed 20 initial themes and then refinement of these into eight themesIn the final stage of the analysis the researchers refined the themes further and agreed on five organising conceptual themes. When multiple coders participate in reflexive thematic analysis the reflective and unstructured process of discussion and sharing of experiences enables the researchers to gain an in-depth understanding of the data [30]. An audit trail, including trails of the coding process, initial theme identification, collated themes and final themes was used to ensure dependability of the findings and to ensure transparency of the researchers decision making.[30]. (Fig. 1). The first researcher maintained a reflective journal after each interview, which contributed to the audit trail, to ensure credibility of the data. Lastly, confirmability was achieved through member checking by emailing a summary of the main themes and transcripts to all participants for their feedback, whom were expected to respond with any questions or concerns. Saturation was considered reached when similar themes and ideas were noted across interviews as after 11 interviews, there were minimal new codes appearing in the data and it was agreed by the research team that saturation has been reached.

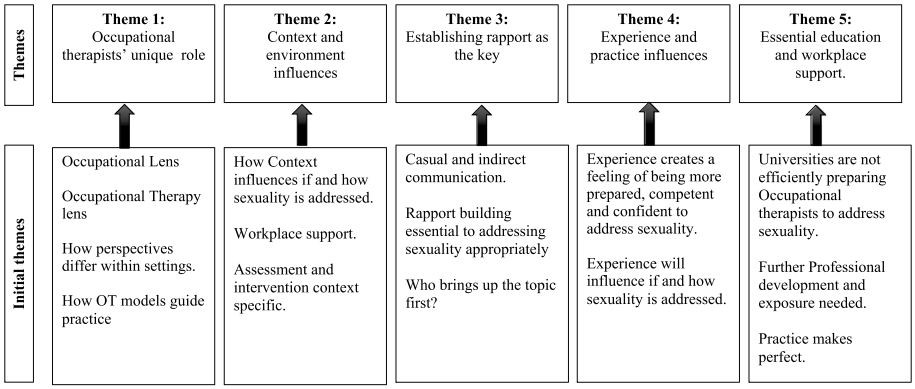

Fig. 1 Thematic analysis: audit trail of theme revision

Results

Eleven recently graduated occupational therapists (10 female) aged 21–28 years, participated in the study. They all recently graduated from Australian occupational therapy programs in Victoria, New South Wales and Western Australia and had been employed as occupational therapists from 3 months to 3 years. They were employed in a range of Australian health care settings, including metropolitan public hospitals in both acute and rehabilitation settings, private rehabilitation, private community health, aged care and mental health. Further details of demographics can be found in Table 2.

Five central organising themes related to addressing sexuality were developed through the process of reflexive thematic analysis: (i) Occupational therapists' unique role (ii) Context and environment influences (iii) Establishing rapport as the key (iv) Experience and practice influences; and (v) Essential education and workplace support.

Table 2 Demographics

	Total (%)
Gender	
Male	1 (10%)
Female	10 (90%)
Health care setting	
Public metropolitan hospital- acute	3 (27.3%)
Public metropolitan hospital- rehab	1 (9.1%)
Community setting	4 (36.4%)
Mental health	1 (9.1%)
Aged care	1 (9.1%)
Experience	
< 6 months	2 (18.2%)
6–12 months	5 (45.5%)
1–2 years	1 (9.1%)
2–3 years	1 (9.1%)
3–4 years	2 (18.2%)

Theme 1: Occupational Therapists' Unique Role.

In commencing the interviews, it was important to understand participant's views on what sexuality was and its importance to the occupational therapy profession and if it was part of their role to address sexuality, in order to have further understanding on why or why not, if and how sexuality is addressed. The interviewer provided a definition of sexuality to participants and then requested participants to provide their own definition. There was consensus that sexuality was broad and multifactorial as P3 reported it, "it means the physical act of having sex, it means sexual identity, sexual preference, sexual acts with other people, and with oneself." All participants believed it was important to address sexuality as P11 stated "for a lot of people I think that it's a huge part of their identity, all the evidence shows how important it is for health and wellbeing." Furthermore, all participants stated that occupational therapists hold a unique role in addressing sexuality as an occupation. In P5's words: "anything we need and want to do is an occupation and that is our core OT." However, several participants did differentiate that sexual activity was what they viewed as the occupation.

Most participants reported using occupational therapy conceptual models such as the Person- Environment- Occupation (PEO) [31] and The Model of Human Occupation (MOHO) [32] to guide their role in a way that was unique to occupational therapy. The models were described as facilitating understanding of the person's physical abilities, identity and spirituality, the physical and social environment, and task analysis, in relation to sexuality, as they would with any other occupation. As P2 explained: "you've got to think of any past experience, any expectations from their family, as well as culturally, and that will influence how you deliver your service." Participants highlighted that they perceived this holistic approach, looking at the client beyond their injury, disease or disability, as unique to occupational therapy. Further discussion regarding the occupational therapy role in addressing sexuality, highlighted that most participants did not have any experience in sexuality related outcome measures to assess effectiveness of intervention, but reported that this could be completed via informal conversation, and subjective feedback, using the COPM [31] Likert scales and GAS goals [33].

Participants commented that being client centered was central to their profession and as P5 explained: "it really depends on our client, I feel like as OT's we should work in a really client-centered manner and if that's the goal of our client then it is equally as important as any other goal." However, participants working in acute wards reported that although sexuality was still likely important to clients, it was often underaddressed. OT's in acute setting's, offered the opinion and possible bias, that sexuality may be less of a priority to clients due to pressing medical issues, as well as less of a priority for OTs to address due to hospital environment and discharge pressures, resulting in assessment and intervention targeting other occupations. Importantly, the participants recognised addressing sexuality as going beyond their role and requiring a multidisciplinary approach depending on the issue being raised, with P10 describing: "I think it's a responsibility of all therapists and all hospital staff to do so."

Theme 2: Context of Healthcare Setting Impacting if and How Sexuality is Addressed.

Addressing sexuality was regarded as an important part of the participant's role, however most had little experience addressing it, particularly on a routine basis. A common insight was that the workplace environment including the physical environment, priorities and pressures of the setting, client demographics and medical status, influenced the priority of sexuality being addressed. Across the various healthcare settings, time constraints, client's medical condition and hospital discharge planning determined priorities, and it was often reported that in acute settings where medical and discharge planning, sexuality was not a priority. The physical environment, including shared rooms, medical staff and family members being present, reduced privacy and confidentiality, also impacting if sexuality was addressed as P1 outlined: "I think that it's respectful to the person to have those discussions when no one else is listening." Interestingly, participants also reported that clients may have had a limited understanding of their role and would not know it was appropriate to bring it up with them.

Furthermore it was identified that the sexuality related issues and topics being raised by clients, differed amongst health care settings, and were addressed utilizing various interventions. Education, behaviour management, informal discussion, written information and social stories, were identified as some commonly used interventions. As an example, participants working with older populations, particularly with dementia, focused on managing inappropriate sexual behaviours such as masturbating in non-private places, and advocating for clients' sexual needs to be met, such as arranging a private room. Education was also part of their role, with P1 describing it as encouraging staff or family to ask "why is this person doing that, how can we look at this, making it a sexuality issue, rather than a behavioural issue." Participants working in rehabilitation or acute medical settings, reported providing education regarding adherence to surgical precautions and safe return to sexual activity, through discussion or post-surgical care booklets. In mental health and community settings, education was often delivered incidentally during intervention sessions. More particularly in community centres where participants worked with young people or clients with a disability, parents were most likely to raise concerns about their child's behaviours, which were addressed through worksheet and social stories regarding the consequences of forming safe, healthy and secure sexual relationships, particularly for those clients living with a disability or sexual related trauma.

Theme 3: Establishing Rapport as the Key

Many participants raised the issue of not wanting to offend clients, fearing they would make their clients feel uncomfortable, impacting the already built trust and their therapeutic relationship. Participants used words such as fearing it was taboo, too personal and sensitive, with P11 stating, "I feel like if I started talking to everyone about it, it would almost be like dropping bombs everywhere." This often prevented OT's from bringing up the topic of sexuality, despite valuing its importance. Furthermore, several factors, including the clinicians own personality traits as well as client factors such as age, culture or gender, often impacted if and how often sexuality was addressed. Being comfortable discussing sexuality in their own lives also influenced participant comfort raising it with their clients. As P1 outlined "I feel like I'm quite an open person and so I'd probably just ask the patient

what those beliefs or expectations were." In contrast, P2 described: "personally I don't talk about that stuff in my own personal life, so to bring it up with other people, I felt it quite challenging."

Regarding client cultural factors, P2 described that they " don't want to offend anyone because it might be in their family culture, that they just don't talk about those things." Participants commonly felt increased discomfort if they were unfamiliar with client's cultural value, however, P1 outlined that they would "make an effort to ensure that they gathered information from the client themselves about their values, beliefs and cultural norms." Age was often a factor that was highlighted to increase or decrease discomfort, discussing sexuality as an occupation. Several participated mentioned that either discussing sexuality with the opposite sex, an individual close to their own age, or significantly older than them increased discomfort, as P9 outlined "being a young male, and probably not wanting to have that conversation with a female of a similar age, and that can be uncomfortable, and not wanting to ruin that already built rapport."

A dilemma for participants was knowing that not bringing it up meant that they might not know if, or how important, it was to the client, as outlined by P8 "the reasons why there are no goals, is because we are probably not bringing up the conversation in the first place." However, if the client brought up the topic P9 stated "If they bring it up I know they're comfortable in discussing it, so probably makes the conversation a bit easier, whereas if I'm bringing it up it's always that concern that the client might not react very well to that." Participants initiating sexuality conversations occurred more commonly when client rapport was established, or during an initial assessment, however participants reported that the client was more likely to raise the issue.

An established therapeutic relationship and rapport was overwhelmingly the most important factor for almost all of the participants, influencing both comfort and preparedness to initiate or respond to sexuality issues raised by clients, and mitigate some of the personal or client factors raised above. In P4's words: "I think it would be something that we would bring up, maybe not in an initial visit, I think rapport would have to be built first for most clients, because it also depends on their personal views on sex, it can be a bit of a touchy topic to talk about." Despite feeling uncomfortable, participants highlighted that professionalism was maintained, with P2 describing a "fake it till you make it" approach.

Theme 4: Influence of Experience, Practice and Society on Comfort and Preparedness

When asked about being comfortable and prepared, participants used the terms interchangeably even though the interviewer defined them as separate terms. However, they also spoke in a way that showed the connection/relationship between the two concepts. Participant's sense of comfort and preparedness was reported to be closely linked to lack of experience, exposure, and knowledge. Most of the participants conveyed that increased confidence in their role also translated to increased confidence addressing sexuality. A combination of improved communication and rapport building skills, practise, and exposure to patient concerns in general, increased preparedness and comfort. As P6 reported "the more practise or exposure you have to any type of topic or concern, naturally the more confident you feel in addressing it for any sequential time". However, many participants also described not feeling as comfortable addressing areas of sexuality, that they were not as experienced in, or that required expert knowledge.

Some participants reported feeling embarrassed or uncomfortable when the client raised the issue as this meant they had not had a chance to prepare possible information or solutions. Although as P1 described with experience: "I've developed a lot over time, to feel more comfortable stepping away from something and saying ok thank you for sharing that I'm going to come back to that" giving them time to gather information and resources. With experience, also come improved communication skills. Some participants reported being more comfortable addressing sexuality using general questions, sandwiched or embedded into questions about self-care, continence issues or postoperative precautions, and using broad and general terms such as intimacy, relationships and sexual activity. Yet still, unless the client referred to it, it rarely went past that initial conversation.

An external societal influence, which increased exposure and awareness to addressing sexuality, was recent changes in the Australian society such as gay marriage legalisation. P6 highlighted "the gay marriage vote is a huge thing that brought it really to people's attention." The general consensus amongst participant's was that gay marriage legalisation was a significant event that may have increased societal education about gender diversity and sexuality, having resulted in this being spoken about more, including in pop culture and media. P1 described that "by seeing and hearing a lot more people speak about how they feel and their experiences online, has given me a lot more perspective to be able to ask those questions." The increased focus on sexuality related topics in media also increased the need for occupational therapists to be knowledgeable, comfortable and prepared to address concerns, and adapt their practise to societal change.

Theme 5: Essential Education and Workplace Support

In addition to experience and practice, participants reported that knowledge through further education, availability of resources and workplace support, increased preparedness to address sexuality with their clients and in turn increased their comfort. The limited knowledge and lack of preparedness lead to increased reluctance to raise these issues with clients, as there was a perceived expectation that they would need to have immediate answers.

Seven participants reported that the sexuality content of their undergraduate course did not prepare them for practice, and that contributed to their discomfort in addressing sexuality. Two were uncertain that there was sufficient content and two participants felt prepared. P9 who felt her university degree prepared her to address sexuality described a lecturer who was very passionate and provided education in lectures, and in the final year of the course, it was " in-depth in what was discussed and resources that were available." The two participants who felt prepared completed further education on sexuality during their university degree such as attending a 'sexuality and disability' expo, and professional development whilst on placement increasing their confidence to address sexuality. As P11 described "I feel like I am aware of the theory of why it's important and I'm aware of potential interventions and things particularly from going to that expo." Of the participants who were able to recall sexuality being included in their university curricula, limited details was provided as to the topics of learning, only that content was provided in a single lecture or online module, as well as one participating outlining that they had utilized a case study and included a client goal relating to sexuality.

Participants reported that university courses could be improved, by more regularly incorporating sexuality into several, or all units, which would increase awareness and better prepare students for the range of practice contexts. They recommended that future content should focus on addressing sexuality as an occupation, how different conditions may

impact sexuality, reviewing sexuality within an occupational framework and understanding the emotional and cultural aspects of sexuality.

Participants emphasised that in addition to lecture and tutorial content, that there was a need for a more practical approach such as mock interviews and role-play to learning how to conduct assessments and provide sexuality related interventions. Participants suggested that case studies specific to the range of sexual issues relevant to occupational therapy, needed to be used more extensively, as well as assessments that required students to set goals and plan intervention based on current evidence.

Six participants reported having participated in further sexuality education and training, either provided by their workplace, or accessed externally since graduating. Training focused on communication, terminology related to sexuality, professional development and presentations by experts in the field with a focus on strategies for discussion and how to promote engagement in addressing the topic. Although the participants reported that the training had improved preparedness, awareness and the expectation to address sexuality in the workplace, they still felt further training was required. P8 described "I think once we have a bit of education on how to address it, we kind of get a bit of a push and we do ask questions a bit more, but then it does drop off a bit."

They suggested they would benefit from training related to planning intervention, communicating effectively and sensitively, and supporting clients emotionally, and sharing of inter-professional and personal workplace experiences. All participants reported that the workplace professional development needed to be continuously offered to ensure availability to new staff, and that accessing external courses, where no one within the team had expert knowledge, and sharing of interprofessional and personal workplace experiences were essential.

Workplace support in the form of encouragement from management, regular workplace discussion and availability of resources, and having access to a mentor or expert in the field of sexuality also influenced comfort and preparedness. With this support, participants reported there was increased workplace awareness and expectation that sexuality would be addressed. Importantly however, P11 described their workplace to be the most significant barrier describing, "they just don't get it" and "at the moment I feel like from a facility level it's just not supported at all."

Having regular discussion formally and informally in team meetings, case conferences and supervision, were described as a means of becoming more comfortable and prepared. Knowledge also required access to resources, and that these needed to be client centred and targeting a range of different diagnoses. They reported these needed to be: available in different languages, online and hard copies, address assistive technology and include more resources to address sexual orientation and identity issues. Lastly, all participants mentioned that having prompts on the initial assessment form or a script would be beneficial to initiating the conversation, and increase accountability.

Discussion

This study aimed to explore the experiences of recently graduated occupational therapists to better understand whether they felt comfortable and prepared addressing sexuality with their clients. We sought to understand whether they felt their undergraduate university course prepared them to discuss sexuality and the enablers and challenges that influenced their practice. Overall, participants reported that occupational therapists have a unique

contribution in promoting sexuality, as an individualised meaningful occupation. However despite this, sexuality was not routinely addressed by these recently graduated occupational therapists working in a range of Australian health care settings, which is consistent with earlier findings [18, 21].

Participants felt the current content in their university degrees did not adequately prepare them to address sexuality which indicated the need for more content and changes to content delivery that were indicated in earlier studies [24, 25, 34]. This study highlighted that increased content on sexuality as an occupation needed to be added to the curricula and mode of content delivery needed to provide more opportunities to learn and apply intervention knowledge and practise of skills in how to address sexuality with clients with a range of conditions.

Participants in the study described environmental barriers such as limited resources, access to private space, time constraints, lower priority, as well as lack of training that hindered how they addressed sexuality. The barriers were similar to those identified by experienced occupational therapists in previous studies [18, 21]. The similarities imply that experience did not reduce the impact of barriers and that societal changes have not resulted in changes to their external environment [18, 21]. Given experience did not overcome some barriers such as lack of privacy there is an onus on workplaces to provide suitable environments for confidential care, where participant feel more comfortable addressing a topic that can be personal and sensitive.

A key enabler to addressing sexuality identified in this study was the workplace having an expectation that addressing sexuality was within the scope of the occupational therapy role. When there was an expectation that staff addressed sexuality it was more likely that resources, professional development, training, regular discussion and support were available and offered on a regular basis so that new staff were prepared and comfortable in addressing sexuality.

Importantly, the findings indicated that effective communication skills and having the time to establish rapport were important in determining if, and when sexuality was addressed. However, lack of knowledge, even when a therapeutic relationship had been established, resulted in the recently graduated therapists often being reluctant to raise the topic because they were not certain they would have solutions to client's sexuality related questions. These findings suggest the need for more knowledge and practical evidence-based interventions to be taught at university and a need for more opportunities to practise skills such as initiating conversations with different populations, diagnosis and areas of sexuality.

Participants also suggested that workplace initiatives such as having a script on initial assessments, training and opportunities for collegial discussion would also help increase comfort in addressing sexuality and highlight the expectation that it is addressed. No references were made to specific occupational therapy frameworks or assessment. The Annon's ex-PLISSIT Ex-PLISSIT (Extended Permission, Limited Information, Specific Suggestion, and Intensive Therapy) [35] model may be utilized within university content and within workplaces to allow therapist a means to provide explicit permission to clients to discuss any concerns about their sexuality and affirm that people are sexual beings, and to provide a framework to base intervention. Furthermore the Occupational Performance Inventory of Sexuality and Intimacy (OPISI) could also be introduced in the university and workplace context, to allow for specific occupational therapy assessment relating to the complex occupational nature of sexuality and intimacy, and once again assure the client that talking about sex or sexual related concerns, is appropriate, which may open a dialogue and allow opportunity for intervention [36].

It is hoped that such changes would facilitate the transition from student to an occupational therapist prepared and comfortable in addressing sexuality on a routine.

basis. As consumer research has indicated, when sexuality is not addressed, or not addressed at optimal levels which satisfy the consumer needs, this may impact an individuals ability to fulfil their sexual needs and maintain emotional and intimate relationships and connections with a partner, which is a highly important role [5]. This indicates the importance and priority of occupational therapists initiating the conversation about sexuality routinely and the need for focus on intimacy, relationship and emotional connection. With increased comfort and preparedness in addressing sexuality, this may improve client centred practice, better address the needs of clients and improve health and wellbeing outcomes.

Implications for future research in this field include examining university content in occupational therapy programs, further exploring how workplaces can support increase preparedness, comfort and competence in addressing sexuality with clients from various health care settings, as well as quantitative studies specifically focusing on particular health care settings, and their role in addressing sexuality.

Methodological Considerations/Limitations

The aim of this qualitative study was to understand the perspectives of recent graduates about addressing sexuality with their clients and this was achieved using a purposive sample. However, even though we sought to recruit participants with varying opinions regarding their role in addressing sexuality, as well as levels of experience doing so, it is more likely that the study attracted participants with an interest in, or strong opinions or concerns that sexuality should be addressed. Despite this possible selection bias, the results provide information of barriers towards addressing sexuality in practice. Saturation appeared to be reached, in part achieved by the focus of the research questions, but it is acknowledged that further research is needed to look in more depth at specific practice contexts and specific populations, to confirm and extend these findings. Saturation may also have been reached given that the range of experience was less than three years, even though therapists with less than six years were eligible. Further research is needed to determine if experience beyond three years but still recently graduated would alter a therapist's perceptions of preparedness and comfort in addressing sexuality. The deep competence among the authors concerning sexuality, rehabilitation and qualitative methodology is a strength to the study, likewise the methodological rigour to the research protocol. The piloting and the collaborative analysis process involving all the researchers further enhanced the quality of the results.

Conclusion

It is evident that sexuality is an important occupation to address, and occupational therapists are well positioned to do so within their role. However, newly graduated occupational therapists often felt precluded from doing so due to their own perceived discomfort and preparedness due to lack of experience, knowledge and skills. In addition, work environments often were not conducive to, or supportive of addressing sexuality.

This study highlighted the importance of maintaining an occupational focus, establishing rapport and utilizing effective communication skills to initiate conversations around sexuality. Furthermore, it emphasised the need for sexuality to be increasingly addressed in undergraduate curricula in occupational therapy and for workplaces to reinforce expectations to address sexuality.

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Declarations

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Ethics Approval All research procedures reported in this thesis were approved by the Human Research.

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Consent to Participate Informed consent was obtained from all individual participants included in the study.

Consent for Publication Informed consent was obtained from all individual participants included in the study.

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