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Addressing Occupational Therapy Practitioners’ Knowledge and Attitudes about Older Adult Sexual Health and Sexual Activity through Continuing Education

Robin Lynn Chilton

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Addressing Occupational Therapy Practitioners’ Knowledge and Attitudes about
Older Adult Sexual Health and Sexual Activity through Continuing Education

A Doctoral Capstone

Presented to

The School of Medicine and Health Sciences
Department of Health, Human Function, and Rehabilitation Sciences
George Washington University
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of the Requirements for the Degree
Occupational Therapy Doctorate

by
Robin Lynn Chilton
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Keywords: occupational therapy, sexuality, older adult, knowledge, attitude
CAPSTONE COMMITTEE

Capstone Advisor: Jennifer Weaver, PhD, OTR/L, CBIS

  Associate Program Director, Post-Professional Occupational Therapy Doctoral Program
  Department of Health, Human Function, & Rehabilitation Sciences
  School of Medicine & Health Sciences
  George Washington University

Capstone Content Expert: Roger Ideishi, JD, OT/L, FAOTA

  Director, Occupational Therapy Programs
  Professor of Occupational Therapy
  Department of Health, Human Function, & Rehabilitation Sciences
  School of Medicine & Health Sciences
  George Washington University

Capstone Content Expert: Sarah Doerrer, PhD, OTR/L, CHT, CLT

  Adjunct Faculty Member, Post-Professional Occupational Therapy Doctoral Program
  Department of Health, Human Function, & Rehabilitation Sciences
  School of Medicine & Health Sciences
  George Washington University
ABSTRACT

Background: There is very little research examining how specific education about older adult sexual health and sexual activity may improve occupational therapy practitioners’ knowledge and attitudes towards geriatric sexuality. Research is also limited as to how knowledge about older adult sexual health and sexual activity is applied in clinical practice. Therefore, it is important to investigate to what extent education in older adult sexual matters impacts occupational therapy practitioners’ knowledge, attitudes, and clinical practice.

Objective: To examine and explore occupational therapy practitioners’ knowledge, attitudes, and clinical practice in the areas of older adult sexual health and sexual activity.

Study Design: Sequential explanatory mixed methods.

Participants: Occupational therapy practitioners practicing in any setting who have experience working with older adults.

Methods: Participants completed a pretest using the Aging Sexual Knowledge and Attitudes Scale (ASKAS), viewed an online educational course on the topic of older adult sexuality, and then completed a posttest ASKAS. The pretest posttest data was examined for normality, correlation, and whether there was a statistically significant difference in knowledge and attitudes. A convenience sample of subjects from the online educational course were selected to participate in a 30–40-minute semi-structured interview to explore the experience and perceptions of occupational therapy practitioners regarding older adult sexual health and sexual activity in their clinical practice. Thematic analysis of the qualitative interview transcripts followed an inductive holistic approach using in-vivo and emergent coding to create categories that described the participants’ experiences and perceptions.

Results: Forty-four occupational therapy practitioners completed the online educational course
and ASKAS pre- and post-test. Statistically significant improvement in pretest posttest scores for knowledge (p<.001), but the attitude change scores (p=.198) did not show a statistically significant improvement on the ASKAS using the Wilcoxon Sign Rank Test with a significance value of <.05. Qualitative findings described the occupational therapy practitioners’ lack of knowledge and experience, personal and cultural influences, and clinical priorities regarding older adult sexuality in their health care practice.

**Conclusions:** Continuing education regarding older adult sexual health and sexual activity had a positive effect on the occupational therapy practitioners’ knowledge, but not on the attitudes section of the ASKAS. The online educational course and interview process prompted the therapists to reflect on their implicit bias surrounding sexual matters for older adults. The lack of existing education available on the topic of older adult sexuality for occupational therapy students and practitioners presents a significant need for increased content and clinical experience in this area.
Acknowledgments

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Addressing Occupational Therapy Practitioners’ Knowledge and Attitudes about Older Adult Sexual Health and Sexual Activity through Continuing Education

Introduction

Many older adults find that sexuality and sexual relations remain an important, and often central part of their interpersonal and intimate relationships, and quality of life (Traeen et al., 2017). By the year 2050, the number of adults aged 65 and older is estimated to reach 83.7 million, increasing the need for community-based health and wellness services that address sexual satisfaction in this age group (Ortman et al., 2014; Scott et al., 2012). Human sexuality has been associated with health benefits and longevity and is increasingly being recognized as an important aspect of quality of life throughout the lifespan (Killinger et al., 2014).

Elderly who reported regular sexual activity tended to have higher levels of life satisfaction, improved self-esteem and understood sex as a pleasant encounter as compared to their peers who were not engaging in sexual activity (Park et al., 2016). Previous literature by Park et al (2016) did not define sexual activity. According to research conducted by Killinger et al. (2014) sexual activity included touching and caressing, masturbation, and sexual intercourse; those who reported sexual activity at least once per month were considered sexually active. A total of 242 participants (113 women and 129 men) were surveyed and overall, 159 (65.7%) were sexually active, and 110 of 151 (72.9%) sexually active participants engaged in intercourse; the majority of sexually active adults (104 of 158, 65.4%) reported performing sexual activity at least once per week (Killinger et al., 2014). Similar to Killinger et al.’s (2014) definition of sexual activity, the Occupational Therapy Practice Framework (OTPF): Domain and Process (4th Edition) (AOTA, 2020) considers sexual activity as an activity of daily living (ADL) and
defines it as “engaging in the broad possibilities for sexual expression and experiences with self or others (e.g., hugging, kissing, foreplay, masturbation, oral sex, intercourse)” (p. S19).

The OTPF includes acts of intimacy, which have also been shown to possess health benefits including increased longevity, less cognitive decline and dementia with aging, greater resistance to infectious disease, and better prognoses when facing chronic life-threatening illnesses (Cohen & Janicki-Deverts, 2009). According to Syme (2014) sexual partnership, frequent sexual expression, engaging in a good quality sex life, and interest in sex have been positively associated with increased relaxation, decreased pain sensitivity, improved cardiovascular health, lower levels of depression, increased self-esteem, and better relationship satisfaction. “Practitioners must keep an open attitude and encourage this healthy practice” (Syme, 2014, p. 35). In order to understand what is known about occupational therapy practitioners’ knowledge, attitudes, and clinical practice regarding older adult sexuality, a thorough literature review was conducted.

**Literature Review**

Assessment and discussion of occupational therapy practitioners’ knowledge-level, personal attitudes and/or the amount of clinical intervention provided to older adults in the area of sexual health and sexual activity were the topics examined from peer-reviewed articles for this literature review. Information from each of these areas was needed to support the research questions. The following databases were searched: ProQuest, PubMed and CINAHL from the earliest possible date available to the present date. Key words include occupational therapy, sexuality, older adult, education, knowledge, and attitude. It was discovered in completing this literature review that this is a very specific and narrow topic with sparse research. The use of only occupational therapy practitioners limited the scope significantly. Due to minimal evidence
in occupational therapy, additional disciplines such as nursing and social work were also reviewed.

**Knowledge of Sexual Activity and Aging**

Although sexuality is an important part of health, quality of life, and general well-being, it tends to be disregarded or ignored in the geriatric population (Nusbaum et al., 2004; Syme, 2014). Some health care professionals express worry about addressing sexuality with older adults due to a lack of knowledge and embarrassment (Olatayo et al., 2015; Syme 2014). Although occupational therapy considers sexual health and management as part of its practice, lack of knowledge of sexual health related to disease and disability, cultural diversity, age, and sexual orientation is reported by therapists (Areskoug-Josefsson & Fristedt, 2017).

McGrath and Lynch (2014) explored perceptions of occupational therapists in addressing sexual activity in a rehabilitative setting for older adults using a qualitative exploratory design. One theme that emerged was perceived competence, and confidence to address sexuality. None of the occupational therapists had received training either as an undergraduate student or as qualified therapist that related to sexuality in later life. The participants all expressed a willingness to address the concerns of their clients relating to their sexual needs; however, most participants reported feeling anxious about their ability to respond appropriately to these concerns.

Occupational therapy programs should provide instruction on older adult sexuality so future therapists will approach this ADL in clinical treatment in a knowledgeable and sensitive manner (Goldstein-Lohman & Aitken, 1995). In addition, research on older adult sexuality is also necessary: “much must still be learned about the impact of behaviors, habits, and illness on sexuality among older adults” (Killinger et al., 2014, p. 263). Ongoing research should address
awareness that sexuality is important to the human experience, regardless of age, and health care providers need to assist older adults in addressing these unmet needs (Killinger et al., 2014).

**Attitudes Towards Sexual Activity and Aging**

Syme (2014) suggests that health care providers must understand their own attitudes and beliefs towards sexual activity in the geriatric population while identifying any barriers that may prevent them from providing support in this area. Many stereotypical beliefs are held by health care providers in regard to sexuality in the geriatric population: older adults are asexual, society discourages sexual activity amongst the elderly, and the geriatric population is too overwhelmed by their health burdens (Olatayo et al., 2015; Syme 2014). In addition, research has revealed negative attitudes among staff at long-term care facilities toward residents' sexual expression (Nusbaum et al., 2004).

A study conducted by Thompson et al. (2014) assessed and compared young adults’ implicit and explicit attitudes toward older adult sexual expression and it yielded mixed results. The explicit self-report demonstrated positive attitudes of young adults towards older adult sexuality, while implicit measures showed a bias against sexual expression in the elderly (Thompson et al, 2014).

Even-Zohar and Werner (2018) examined ageist beliefs, attitudes and knowledge related to older adult sexuality among nursing and social work students. Resulting data indicated nursing students had more conventional attitudes towards the sexuality of their geriatric patients. Participants expressing ageist beliefs showed a positive correlation with more conservative attitudes towards older adult sexual activity. A negative correlation showed that with increased conservative attitudes towards older adult sexuality there was decreased knowledge about sexuality in older adults. Overall, results indicated the need for the development of educational
programs regarding sexuality for healthcare students, as knowledge is considered intrinsically related to attitudes. Educational programs should include practical training sessions and more knowledge on later-life sexuality, which can contribute to positive attitudes regarding older adults’ sexual needs. It is important for students to acknowledge that sexual identity and activity are integral parts of older adults’ well-being and may be part of successful aging. “Educating students regarding sexual changes that occur with age and in the field of gerontology can challenge negative stereotypes and myths that are established at a young age, and lead to positive changes in attitudes towards aging and sexuality in later life” (Even-Zohar & Werner, 2018, p. 386)

**Bringing Knowledge About Sexual Activity with Older Adults to Occupational Therapy Practice**

Geriatric occupational therapy practitioners should make addressing the ADL needs of patients to include sexuality a treatment priority because health care practitioners are in a position to contribute to the education and intervention with the elderly about sexual matters (Goldstein-Lohman & Aitken, 1995). Consequently, a majority of occupational therapists reported low levels of awareness, knowledge and/or confidence in addressing sexuality with their clients, and sexuality was not addressed during their everyday practice (Hyland & McGrath, 2013). The rationale for not addressing sexuality with older adults was due to lack of knowledge and training, fear of causing offense, and the clients’ age. “Education and training for occupational therapists should focus on changing attitudes towards sexuality and people with disabilities, as well as providing information on occupational therapy interventions in this area” (Hyland & McGrath, 2013, p. 73). As the population continues to age, healthcare professionals must acknowledge the importance of sexuality and be prepared to be involved in sexual health
management and care. “Education is needed to improve perceived competence and confidence in addressing sexuality with older adults” (McGrath & Lynch, 2014, p. 651).

Culture also had a major influence on the occupational therapist’s practice as discussing sexuality was considered “taboo,” and would be inappropriate to raise the topic of sexuality with an older person, as such discussion was likely to cause offense, anxiety, or embarrassment (McGrath and Lynch, 2014). Some occupational therapists believed they could damage their professional reputation if they began to address sexuality as part of rehabilitation because it is not a topic that is frequently addressed by any member of the health care team. Finally, resource limitations, particularly time, prevented the participants from addressing sexuality with older adult clients (McGrath and Lynch, 2014). Participants perceived that they had to focus on basic ADLs for hospital discharge and discussing sexual concerns was an unrealistic option for clinical practice in the hospital setting.

**Gap in Literature**

It is unclear to what extent healthcare professionals are prepared to address sexual concerns identified by older adults, and many continue to be reluctant to respond to this population’s concerns relating to sexuality (McGrath & Lynch, 2014). According to Lichtenberg (2014), sexuality and sexual needs in older adults remain a neglected area of clinical intervention, particularly in medical care and rehabilitation, as well as with older adults who live in long-term care facilities. Although the occupational therapy profession has recognized sexual expression as being an important part of the human experience, and identified its unique role in addressing sexuality, little progress has been seen in clinical practice (Eglseder et al., 2018). Because there is reluctance for occupational therapy practitioners to address older adult sexuality, education in this area is also lacking.
There is very little research that has examined how specific education in the area of older adult sexual health and sexual activity improves occupational therapy practitioners’ knowledge and attitudes towards geriatric sexuality. The first step to making an impact on addressing sexual health and sexual activity in older adults is to improve the occupational therapy practitioner’s knowledge about older adult sexual activity and sexual health. Therefore, it is important to understand to what extent education in older adult sexual matters impacts occupational therapy practitioners’ knowledge, attitudes, and clinical practice in this area.

**Purpose of the Study**

The primary purpose of this study was to provide an online educational course in the area of older adult sexual health and sexual activity to increase occupational therapy practitioners’ knowledge and improve their attitudes related to sexual health and sexual activity within the geriatric population. The secondary purpose was to increase the application of knowledge to clinical practice by occupational therapy practitioners as related to sexual matters with the elderly.

**Methodology**

This sequential explanatory mixed methods research study was designed to measure and explore occupational therapy practitioners’ knowledge, attitudes, and clinical practice in the areas of older adulthood sexual health and sexual activity before and after completing a two-hour online education course about older adult sexuality. The study used sequential timing with the quantitative methods being implemented in the first phase and the qualitative methods following in a second phase. Data was collected and analyzed, the findings were integrated, and inferences were drawn using both the quantitative and qualitative approaches into a single mixed methods
study. The main premise was that the combination provided a better understanding of the research question than either method on its own (Creswell & Plano Clark, 2011).

The paradigm of this study is interpretivism in which the qualitative strand is predominant over the quantitative strand (Corcoran, 2017). The researcher constructs a reality of how the occupational therapists experience and perceive their knowledge, attitudes and clinical practice with older adult sexuality based on the subjective reports of multiple participants. Finally, the methodology, or approach to inquiry, is primarily qualitative, but also uses some quantitative methods (Corcoran, 2017).

**Research Questions**

**Quantitative question.** Will occupational therapy practitioners completing a two-hour online educational course addressing older adult sexual health and sexual activity increase their knowledge and attitudes related to sexuality within the older adult population?

*Hypothesis I (quantitative).* Occupational therapy practitioners who complete a two-hour online educational course addressing older adult sexual health and sexual activity will have decreased scores from pretest to posttest (demonstrating improvement) on the knowledge section of the Aging Sexuality Knowledge and Attitudes Scale (ASKAS).

*Hypothesis II (quantitative).* Occupational therapy practitioners who complete a two-hour online educational course addressing older adult sexual health and sexual activity will have decreased scores from pretest to posttest (demonstrating improvement) on the attitude section of the Aging Sexuality Knowledge and Attitudes Scale (ASKAS).

**Qualitative question.** What are the experience and perceptions of occupational therapy practitioners who work with older adults regarding sexual health and sexual activity in their clinical practice?
Mixed method question. In what ways do the interview data about occupational therapy practitioners' knowledge, attitudes, and clinical practice regarding older adult sexual health and sexual activity help to explain the quantitative results about these areas as reported on the pretest to posttest Aging Sexuality Knowledge and Attitudes Scale (ASKAS) results?

Theoretical Model

This study uses the knowledge to action (KTA) theoretical framework which consists of two distinct but related phases: knowledge creation and action. The aim of this framework is to provide support for planning and managing implementation of knowledge (Ramos-Morcillo et al., 2020). Each phase involves several components which overlap and can be iterative; action phases may be carried out sequentially or simultaneously and knowledge creation phases may impact the action phases.

During the knowledge creation phase, empirically based research is combined into products and tools for clinical application. The creation phase components include: 1) knowledge inquiry, 2) knowledge synthesis, and 3) tools and products. The creation phase was used in this study to guide the development of an online educational course for occupational therapy practitioners to learn about older adult sexual health and sexual activity. The product, an educational webinar, contains educational material and information that can increase the knowledge level of the participants about sexuality in the geriatric population so they can bring it to their clinical practice.

The knowledge action phase develops a process for knowledge implementation, that represents the activities needed for knowledge to be applied in clinical practice (Field et al., 2014). The action cycle is responsible for knowledge implementation through multiple components including: 1) identifying the problem and selecting available knowledge, 2) adapting
recommendations to the local setting and context, 3) assessing barriers to and facilitators of knowledge use, 4) planning and executing implementation, 5) monitoring knowledge use, 6) evaluating outcomes to determine implementation success, and (7) developing strategies to sustain knowledge utilization (Graham, et al., 2006).

Three components of the action phase were addressed in this study. A problem was identified during a thorough literature review (see Gap in Literature). Information was adapted and tailored to occupational therapists at the same time that information about older adult sexuality was synthesized during the knowledge creation phase resulting in an educational webinar. Adaptations were made to the delivery method of the course so that it was delivered both synchronously and asynchronously to meet the scheduling needs of more participants. To understand whether the online educational course impacted the occupational therapy practitioners’ knowledge and attitudes regarding older adult sexuality, participants completed a survey. To further understand the barriers specifically to using knowledge about older adult sexuality in occupational therapy practice, qualitative interviews were conducted with participants who received the educational webinar.

Methods

Study Participants

The study participants consisted of licensed occupational therapists and occupational therapy assistants from any setting who had current or previous clinical practice experience with older adults. Additional inclusion criteria required the participants to have access to an electronic device (e.g., computer, tablet, smart phone) and internet access. Exclusion criteria included health care professionals who were not licensed occupational therapy practitioners and the inability to demonstrate basic skills required to access online learning and survey platforms.
Student occupational therapy and occupational therapy assistants were eligible to view the online educational course but could not participate in the pretest and posttest due to their limited clinical experience.

**Recruitment and Sampling**

Participants were recruited via email, social media, and word-of-mouth. Information about the research study and online course were sent via email including an attached flyer to all licensed occupational therapists and occupational therapy assistants in the state of Ohio. In addition, flyers were posted on more local Facebook pages such as the Cleveland State University *Occupational Therapy Fieldwork Educators* page, and national pages such as *OT After Dark*, *OT Treatment Ideas and Information*, and *Geriatric OT/PT Treatment Ideas*. Snowball sampling was also used as individuals were asked to forward the flyer to their colleagues and occupational therapy network.

**Ethics**

All participants provided informed consent prior to completing research activities. Further, all participants were eligible to receive either two continuing education credits (CEUs) from the Ohio Occupational Therapy, Physical Therapy, and Athletic Trainers Board and/or two professional development units (PDUs) from the National Board for Certification in Occupational Therapy (NBCOT) when the participants completed the pretest, online educational course, and posttest.

**Online Educational Course**

A two-hour short course was developed to focus on three main constructs: 1) knowledge of sexuality and aging, 2) attitudes towards sexuality and aging, and 3) bringing this knowledge-to-practice in the older adult population. The course was designed as part of the knowledge-
creation phase of the KTA. The goal of the course was to deliver it synchronously and asynchronously so that the webinar was adapted to meet the needs of the occupational therapy practitioners. Knowledge was synthesized and adapted to the occupational therapy perspective to improve their knowledge and attitude in the area of older adulthood sexual health and sexual activity.

The course was iteratively developed for three years for the purpose of occupational therapy education, and recently modified and updated for a doctoral course. It covered sexual health in the normal aging process, how to approach clients about sexuality, and intervention ideas and strategies based on diagnosis and disability. Content was delivered via PowerPoint slides with an associated lecture, and time for questions and answers throughout the course.

**Quantitative Study**

The quantitative study used a pretest posttest study design to examine whether knowledge and attitudes about older adult sexual activity and sexual health improved with an educational intervention. The pretest and posttest for this study used an outcome measure, the Aging Sexual Knowledge and Attitudes Scale (ASKAS), which is designed to measure two realms of sexuality: 1) knowledge about changes (and non-changes) in sexual response in advanced age in males and females, and 2) general attitudes about sexual activity in the aged (White, 1983).

**Data collection.** Participants interested in the study reached out to the student investigator. Participants were provided with a link to complete a demographic intake questionnaire and the pretest ASKAS through the Research Electronic Data Capture (REDCap) platform (Harris, Taylor, Minor, et al., 2019; Harris, Taylor, Thielke, et al., 2009). Participants were given a link to access the online educational course, which was presented synchronously through the Zoom platform. Participants who could not attend the synchronous course were
given a link to a recording of the course and had one week to view it asynchronously. Directly after the course was completed, participants were given a link to complete the posttest ASKAS. All quantitative study data was collected and managed using REDCap, a secure, web-based software platform designed to support data capture for research studies, hosted at George Washington University (Harris, Taylor, Minor, et al., 2019; Harris, Taylor, Thielke, et al., 2009).

**Outcome measure: Aging sexual knowledge and attitudes scale (ASKAS).** The ASKAS was designed for use in assessing the impact of group or individual interventions in the area of older adult sexual health and sexual activity, such as in a pretest/posttest process (White, 1983). The assessment consists of 61 total items and takes 20-40 minutes to complete. Knowledge about sexual changes and non-changes that may or may not be age related are evaluated using 35 true/false/don’t know statements (White, 1983). Attitudes towards sexual behaviors in older adults is evaluated using 26 statements on a 7-point Likert-type scale indicating the degree of agreement or disagreement with the particular item (White, 1983).

The ASKAS knowledge and attitude sections receive a composite score. Knowledge scores range from 35 (indicating more knowledge) to 105 (indicating less knowledge). Attitude scores range from 26 (indicating a less permissive attitude) to 182 (indicating a more permissive attitude) (White, 1983). A decrease in scores from pre-test to post-test demonstrates improvement such that the participant has more knowledge or a less permissive attitude.

The reliability of the ASKAS has been examined in several studies with different types and sizes of samples with the reliability coefficient for split-half, alpha and test-retest ranging from .90 to .97 for measuring knowledge, and .72 to .96 for measuring attitudes (White, 1983). Studies on validity of the ASKAS report significant changes in scale scores following sexual education intervention, and significant relationships of sexual behavior to the Likert-type scale.
scores which follow predicted directions (White, 1983). This assessment was found to be reliable and valid for pretest/posttest use (White, 1983).

**Analytic procedures.** Data were downloaded from REDCap into an excel spreadsheet. Total scores for the knowledge and attitude sections of the ASKAS were calculated for both the pretest and posttest according to standardized procedures. The change in knowledge and attitude scores were calculated for each participant. Each participant’s total and change scores for knowledge and attitude were entered into the IBM SPSS Statistical Software Version 28.

Descriptive statistics were calculated using SPSS. The Shapiro-Wilk test for normality was conducted. If data were normal, SPSS software would be used to conduct a Pearson’s correlation to measure of the strength of the association between the pretest and posttest data. A t-test for dependent means would examine whether there was a statistically significant difference between the pretest and posttest scores for both the knowledge and attitude sections of the ASKAS. If the data were non-normal, non-parametric equivalents would be conducted such as the Spearman’s correlation and Wilcoxon Sign Rank Test.

**Qualitative Study**

After completing the quantitative data analysis, the qualitative strand was introduced to help explain the initial quantitative results. A phenomenology approach was used to describe the experiences and perceptions of occupational therapy practitioners who work with the geriatric population regarding their clinical experiences addressing older adult sexual health and sexual activity (Creswell & Poth, 2018). The purpose of the qualitative study was to further understand barriers to knowledge use (KTA: Assessing barriers to and facilitators of knowledge use) (Graham et al., 2006).
**Data collection.** Participants were sampled from the therapists that completed the quantitative study and were only recruited for the qualitative study if they were willing to be contacted for the interview as indicated on the pretest or posttest. Criterion sampling was used to achieve variety in performance on the knowledge and attitude sections of the ASKAS (Creswell & Poth, 2018).

Once participants were contacted and continued to indicate interest in participating in the qualitative study, a mutually convenient time was confirmed to review the consent. The interviews were all scheduled and conducted within two weeks of the participants completing the online educational course. Once informed consent was provided by the participant, the qualitative study consisted of a 1:1 semi-structured interview with the doctoral student via the Zoom platform. The semi-structured interview guide included questions about previous and current knowledge and clinical experiences with older adult sexual matters; feelings about the topic and obstacles faced when addressing it; and types of additional education on this subject matter that would be beneficial. Multiple follow-up probing questions were included so that the interviewer could gain a deeper understanding of the participants’ responses. Participants were provided an opportunity to provide additional comments and ask questions. All semi-structured interviews were audio-recorded.

**Analytic procedures.** Audio recordings were transcribed verbatim using the Rev.com transcription service. Transcripts were downloaded, deidentified, matched with the participants’ pretest/posttest number, and renamed according to their quantitative subject identification number (e.g., Therapist #3, Therapist #6). De-identified transcripts were securely stored in a GWU Box folder that was only shared with study team members.
Thematic analysis of the de-identified transcripts was used to identify, analyze, and report patterns within the data (Braun, 2006). Thematic analysis was used to organize and describe the data set in rich detail (Braun, 2006). Transcripts were read multiple times prior to coding. Analysis used an inductive approach indicating the categories identified were strongly linked to the data. Data was coded without trying to fit it into a pre-existing coding frame, or the researcher’s analytic preconceptions (Braun, 2006). Open holistic coding was used where initial codes were in-vivo representations of the data for the initial transcripts (Saldana, 2016). These in vivo codes were analyzed to produce final codes that could be applied across the remaining transcripts, while remaining open to emergent codes. Codes were then grouped into categories that described what the participant experienced and how they had experienced it (Creswell & Poth, 2018).

Trustworthiness is a concept used to evaluate the rigor of qualitative research (Lincoln & Guba, 1985). Trustworthiness includes four strategies: credibility, transferability, dependability, and confirmability, which serve as alternatives to the conventional, quantitative measures for quality such as internal validity, external validity, reliability, and objectivity (Lemon & Hayes, 2020). Credibility refers to “truth of the data or the participant views, and the interpretation and representation of them by the researcher” (Cope, 2014, p. 89). Credibility of the analysis was established through triangulation of data sources, methods, and investigators (Creswell & Poth, 2018). Direct quotes from the participant were triangulated with their ASKAS survey. Transferability refers to “findings that can be applied to other settings or groups” (Cope, 2014, p. 89), and “a qualitative study has met this criterion if the results have meaning to individuals not involved in the study and readers can associate the results with their own experiences” (Cope, 2014, p. 89). Descriptive information about each study participant is provided as well as the
research context to enable readers to assess the findings as being appropriate and transferable to their own clinical practice (Cope, 2014). Dependability refers to “the constancy of the data over similar conditions” (Cope, 2014, p.89). Research is considered dependable if the study findings are replicated under similar conditions with similar subjects” (Cope, 2014). During the coding process, another researcher reviewed the codes and categories. Clear descriptions and research processes were carefully documented so the study can be replicated by other researchers. In the discussion, we describe this study’s results with previous research. Finally, confirmability is “the researcher's ability to demonstrate that the data represent the participants' responses and not the researcher's biases or viewpoints” (Cope, 2014, p.89). Confirmability was established by including rich, thick quotes from the participants’ interviews that depict each emerging category (Cope, 2014; Creswell & Poth, 2018).

Results

Demographic Data for the Quantitative Study

The demographic data for the study participants is detailed in Table 1. A majority of the participants were female occupational therapists, with five of the 44 participants being male, and only three of the 44 were occupational therapy assistants. Hospitals (acute care and acute rehab) were the primary practice setting for 30% of the participants while 16% practiced in skilled nursing facilities. However, 36% selected the “other” option which included academia, schools, geriatric psychiatric facilities, private practice, and areas within the community. Two of the participants indicated they were retired (Table 1). For the 50% of the participants who had previous education in older adult sexual health and sexual activity, 47% indicated it was included in their occupational therapy education, while 30% reported learning about it through continuing
education selected independently or provided at work, and 23% responded being self-taught or receiving extra education during their field work (Table 1).

**Table 1**

*Participant Characteristics for the Total Sample in the Quantitative Study*

<table>
<thead>
<tr>
<th>Participant Characteristics (n=44)</th>
<th>Totals n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age in years, mean (SD)</td>
<td>39.18 (12.48)</td>
</tr>
<tr>
<td>Gender</td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>5 (11.36)</td>
</tr>
<tr>
<td>Female</td>
<td>39 (88.64)</td>
</tr>
<tr>
<td>Type of OT Practitioner</td>
<td></td>
</tr>
<tr>
<td>Occupational Therapist</td>
<td>41 (93.18)</td>
</tr>
<tr>
<td>Occupational Therapy Assistant</td>
<td>3 (6.82)</td>
</tr>
<tr>
<td>Number of Years in OT Practice, mean (SD)</td>
<td>11.88 (12.44)</td>
</tr>
<tr>
<td>Primary Practice Setting</td>
<td></td>
</tr>
<tr>
<td>Hospital</td>
<td>13 (29.55)</td>
</tr>
<tr>
<td>Acute</td>
<td>8 (61.54)</td>
</tr>
<tr>
<td>Acute Rehab</td>
<td>5 (38.46)</td>
</tr>
<tr>
<td>Home Health</td>
<td>3 (6.82)</td>
</tr>
<tr>
<td>Skilled Nursing Facility</td>
<td>7 (15.91)</td>
</tr>
<tr>
<td>Assisted Living Facility</td>
<td>1 (2.27)</td>
</tr>
<tr>
<td>Long-Term Care Facility</td>
<td>1 (2.27)</td>
</tr>
<tr>
<td>Outpatient</td>
<td>3 (6.82)</td>
</tr>
<tr>
<td>Other</td>
<td>16 (36.36)</td>
</tr>
<tr>
<td>Currently working with the geriatric population</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>29 (65.91)</td>
</tr>
<tr>
<td>No</td>
<td>15 (34.09)</td>
</tr>
<tr>
<td>Number of years worked with geriatric population, mean (SD)</td>
<td>9.39 (9.68)</td>
</tr>
<tr>
<td>Previous education received in the areas of older adult sexual health and sexual activity</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>22 (50.00)</td>
</tr>
<tr>
<td>No</td>
<td>22 (50.00)</td>
</tr>
<tr>
<td>How education was received</td>
<td></td>
</tr>
<tr>
<td>OT Program</td>
<td>14 (46.67)</td>
</tr>
<tr>
<td>Self-Selected Continuing Education</td>
<td>5 (16.67)</td>
</tr>
<tr>
<td>At Work</td>
<td>4 (13.33)</td>
</tr>
<tr>
<td>Self-Taught (books, videos)</td>
<td>6 (20.00)</td>
</tr>
<tr>
<td>Other</td>
<td>1 (3.33)</td>
</tr>
</tbody>
</table>
Quantitative Study Results

Descriptive statistics. The knowledge and attitude sections of the ASKAS were compared after participants (n=44) received a two-hour online educational program about older adult sexual health and sexual activity using a one group pretest and posttest design. The knowledge section pretest scores ranged from 40 to 79 while the posttest range was from 35 to 48. On average the study participants performed better on the knowledge section of the ASKAS after the educational intervention (M=39.66, SD=2.35) compared to before (M=54.39, SD=10.77) with a difference between the means of -14.72 (SD=10.28). The attitude section pretest scores ranged from 26 to 91 while the posttest range was from 26 to 78. Participant performance on the attitude section of the ASKAS improved after the educational intervention (M=36.32, SD=9.53) compared to before (M=41.07, SD=16.28) with a difference between the means of -4.75 (SD=14.12) (Tables 2 and 3).

Table 2

Descriptive Statistics and Variance (n = 44)

<table>
<thead>
<tr>
<th>Section of ASKAS</th>
<th>Type of Test</th>
<th>Mean</th>
<th>Variance</th>
<th>Standard Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Knowledge</td>
<td>Pretest</td>
<td>54.39</td>
<td>113.32</td>
<td>10.77</td>
</tr>
<tr>
<td>Knowledge</td>
<td>Posttest</td>
<td>39.66</td>
<td>5.41</td>
<td>2.35</td>
</tr>
<tr>
<td>Attitude</td>
<td>Pretest</td>
<td>41.07</td>
<td>258.98</td>
<td>16.28</td>
</tr>
<tr>
<td>Attitude</td>
<td>Posttest</td>
<td>36.32</td>
<td>88.67</td>
<td>9.53</td>
</tr>
</tbody>
</table>
Table 3

*Change in Mean from Pretest to Posttest ASKAS (n = 44)*

<table>
<thead>
<tr>
<th>ASKAS</th>
<th>Mean Change</th>
<th>Standard Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Knowledge Pretest and Posttest</td>
<td>-14.73</td>
<td>10.28</td>
</tr>
<tr>
<td>Attitude Pretest and Posttest</td>
<td>-4.75</td>
<td>14.12</td>
</tr>
</tbody>
</table>

**Shapiro Wilk test for normality.** In completing the Shapiro Wilk test for normality, all data in the knowledge and attitude sections’ pretests and posttests had a significance value <.05, indicating that the data is not normally distributed (Table 4).

Table 4

*Shapiro-Wilk Test for Normality (n=44)*

<table>
<thead>
<tr>
<th>Section of ASKAS</th>
<th>Type of Test</th>
<th>Statistic</th>
<th>Df</th>
<th>Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Knowledge</td>
<td>Pretest</td>
<td>.94</td>
<td>44</td>
<td>.016</td>
</tr>
<tr>
<td>Knowledge</td>
<td>Posttest</td>
<td>.89</td>
<td>44</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Attitude</td>
<td>Pretest</td>
<td>.80</td>
<td>44</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Attitude</td>
<td>Posttest</td>
<td>.83</td>
<td>44</td>
<td>&lt;.001</td>
</tr>
</tbody>
</table>

p = .05 level of significance

**Spearman’s rank correlation test.** Due to the non-normal data, a Spearman’s Rank Correlation Test was used to test the strength of the relationship between the pretest and posttest scores of both the knowledge and attitude sections of the ASKAS. The Spearman’s correlation coefficient for the knowledge relationship is .31 (p<.05) indicating the score on a participant’s knowledge pretest has a weak correlation with their posttest score (Table 3). In addition, the Spearman’s correlation coefficient for the attitude relationship is .50 (p<.05) indicating the score
on a participant’s attitude pretest has a moderate correlation with their posttest score (Spearman’s correlation, n.d.) (Table 5).

Table 5

Spearman’s Rank Correlation Test

<table>
<thead>
<tr>
<th>Paired Samples (n=44)</th>
<th>Correlation</th>
<th>Sig. One-Sided p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Knowledge Pretest and Posttest</td>
<td>.31</td>
<td>.020</td>
</tr>
<tr>
<td>Attitude Pretest and Posttest</td>
<td>.43</td>
<td>.002</td>
</tr>
</tbody>
</table>

p = .05 level of significance

Wilcoxon sign rank test. Using a Wilcoxon Sign Rank Test with a significance value of <.05, the knowledge change scores demonstrated statistically significant improvement (p <.001), but the attitude change scores did not show a statistically significant improvement (p = .198) (Table 6).

Table 6

Wilcoxon Signed Ranks Test (n=44)

<table>
<thead>
<tr>
<th>Pair</th>
<th>Z</th>
<th>Sig. Two-Sided p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Knowledge Pretest and Posttest</td>
<td>-5.71</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Attitude Pretest and Posttest</td>
<td>-1.29</td>
<td>.198</td>
</tr>
</tbody>
</table>

p = .05 level of significance
Qualitative Findings

Five participants from the quantitative study also completed the interview (Table 7). From the five transcripts, three major categories reflecting the experience and perceptions of occupational therapy practitioners who work with older adults regarding sexual health and sexual activity in their clinical practice emerged from the data: 1) lack of knowledge, 2) personal and cultural influences, and 3) limited treatment time to address sexuality. Each of these categories will be explored in more depth.

Table 7

Participant Characteristics for the Total Sample in the Qualitative Study (n=5)

<table>
<thead>
<tr>
<th>Therapist</th>
<th>OT or OTA</th>
<th>Primary Practice Setting</th>
<th>Years in Practice</th>
<th>Years Practiced with Geriatric Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>OT</td>
<td>Hospital – Acute Care</td>
<td>&lt;1</td>
<td>&lt;1</td>
</tr>
<tr>
<td>2</td>
<td>OTA to OT</td>
<td>Skilled Nursing Facility</td>
<td>36</td>
<td>20</td>
</tr>
<tr>
<td>3</td>
<td>OT</td>
<td>Academia</td>
<td>19</td>
<td>19</td>
</tr>
<tr>
<td>4</td>
<td>OT</td>
<td>Academia</td>
<td>10</td>
<td>10</td>
</tr>
<tr>
<td>5</td>
<td>OT</td>
<td>Assisted Living Facility</td>
<td>17</td>
<td>15</td>
</tr>
</tbody>
</table>

Lack of knowledge. This category refers to the degree in which the occupational therapists interviewed in this study felt that they were prepared and/or had experience in addressing sexuality with their older adult clients. All five therapists expressed that they had little to no previous education regarding older adult sexuality prior to participating in the online educational course. Only one participant had received a lecture on this topic during their formal occupational therapy education and another participant through a professional development course. Although it was not directly addressed in their occupational therapy program, one
therapist learned about older adult sexuality through a fellow student’s capstone project.

Therapist 3 stated “And I personally, until I did your webinar, I don't think I ever really had any education on it [older adult sexual health and sexual activity].”

I don't think I've had any [education in older adult sexual health and sexual activity]. I don't even recall learning it, both times I went back to school for OT. I don't recall it being talked about. So, it was talked about in the physical dysfunction, but not having specifically to do with elderly. No, I haven't had any, yours [online educational course] is the first. (Therapist 2)

Of the five interviewees, only one had addressed any type of sexual matters in their clinical practice with an older adult client. Another participant described that a physical therapy assistant addressed a mutual client’s sexual issues. Although some participants had been presented with the opportunity to approach the topic, they chose not to pursue it due lack of experience. Upon further reflection, each of the participants indicated a situation where, in hindsight, they felt they should have opened a discussion with their client about sexuality.

But I didn't necessarily have the depth of knowledge in relation to the barriers or even some of the techniques or opportunities out there for OTs to help older adults with sexuality type intimacy occupations, and I hadn't ever addressed it as a clinician.

(Therapist 4)

And I could see now where that [addressing older adult sexual health and sexual activity with a client] probably could have been added to my assessment. I could think of that really many times when I've worked with my elderly, if I would have included that [addressing older adult sexual health and sexual activity with a client] as one of my
questions or asked if they had any concerns about that. Definitely, I could see where I should have done that. (Therapist 3)

Participants were unanimous in agreeing that sex was a meaningful occupation defined in the Occupational Therapy Practice Framework and should be taught in educational programs. They concurred it was an important topic for occupational therapy practitioners to understand and discuss. Each therapist believed that sexuality should be addressed with clients regardless of their advanced age. Some of the participants communicated anxiety about not being more proactive in asking their clients questions or “opening the door” to discuss sexuality. All therapists reported feeling better prepared after taking the online educational course, but one stated that they would not feel confident in addressing sexuality with their older adult clients until they had more experience this is area. Therapist 4 stated “Yeah, I feel better prepared. I don't know the confidence would be there yet, I feel like confidence comes with practice for me. I feel prepared to address it [older adult sexual health and sexual activity].”

It just brings it [addressing older adult sexual health and sexual activity with a client back to the forefront of your mind. Like, oh, this [addressing older adult sexual health and sexual activity] is definitely a concern. This is definitely something we should address, we should ask. (Therapist 5)

**Personal and cultural influences.** Another category that emerged amongst the participants was how personal experiences and cultural influences effected their clinical practice regarding sexual health and sexual activity with older adults. If a participant had limited personal involvement in sexual or intimate relationships, they reported they were less likely to discuss this subject with their clients. Therapist 4 stated “But I don't know why, maybe it's my own personal
limited experience, but I hadn't really even thought about that sex and sexuality and masturbation
and things like that as something that older adults partake in."

I think the main thing I had been thinking about when I thought about my personal
clinical experience with it [sexual health and sexual activity] was perhaps how my lack of
personal experience impacted that [addressing sexual health and sexual activity.
(Therapist 3)

Other therapists described cultural beliefs where sex was to be restricted to married
couples which led to a perceived decreased need for sexual intervention with non-married
individuals and discouraged them from addressing sexuality with all elderly clients. One
therapist indicated that the interview led her realize that she had a bias regarding sex, and they
would have to put those biases aside to appropriately interact with clients. Some felt
uncomfortable because discussing this topic with older adult clients reminded them of speaking
to close relatives, such as grandparents. Being shy or hesitant to bring up the subject unless it’s
introduced by the client was another issue. Finally, one therapist had a personal belief that sexual
matters were private and, therefore, had never considered discussing them with clients.

I may be turning red. This [sexual health and sexual activity] is something in my personal
life I don't talk about a whole lot. As I said, personally I was raised to believe sex is
for marriage, so I did not personally experience it until I was married, which was in my
mid to late 30s. So, my lack of personal experience, I think was a barrier as well, but
what contributed to the comfort with it as well. I think those were things, lack of
education and comfort with it, including my own lack of experience. (Therapist 3)
And I guess never really thought of myself as having a bias regarding sex I guess, but in a way I do. And it's important that I know, and I can be more prepared to put those aside and appropriately interact with the client. (Therapist 3)

**Addressing sexuality is not a priority.** Each of the participants reported that addressing sexual health and sexual activity had not been a priority in their previous clinical practice. Time was limited in some practice settings, and other issues were considered more important. One therapist who worked on a hospital’s acute care unit reported having less than 30 minutes to spend with each client. Most often their client was never seen again by them after their initial meeting, so a lot of information had to be covered in a very short amount of time. Another reason sexual health and sexual activity were not a priority of the occupational therapists was because they felt the need to address more basic ADL issues that would be required for the client to return home, such as self-care and toileting. They believed that a client’s sexual needs were something that could be dealt with “down the road.” A participant expressed concern that some occupational therapists are “shutting down” their older adult clients’ opportunities to approach the topic of sexuality. It was also reported that other medical professionals, such as doctors and nurses, had no concern about the client’s sexual issues.

I think in my setting, the biggest limitation is time. We don't spend a lot of time with patients at the hospital. If, it's acute, it's usually something that they're there for short term. So, as I said, I might be only seeing them once and then they leave the next day. So, I think timing is my biggest barrier addressing that sort of thing [sexual health and sexual activity], because the concern in the acute setting is usually those basic ADLs and mobilization. (Therapist 1)
Maybe my thought process was that there's these pressing things for them to be able to get home and be independent, and those were the most pressing things for me to address. So that might be part of it, that my focus was solely on the physical part of getting home. (Therapist 4)

**Discussion**

Occupational therapy practitioners who completed a two-hour online educational course addressing older adult sexual health and sexual activity had decreased scores from pretest to posttest (demonstrating improvement) on the knowledge section of the ASKAS but did not have decreased scores (demonstrating little to no improvement) from pretest to posttest on the attitude section of the ASKAS. The experiences and perceptions of the occupational therapists who work with older adults described a lack of knowledge regarding sexual health and sexual activity for older adults, personal and cultural factors influenced the therapy practitioners’ perceptions of addressing sexuality in clinical practice, and addressing sexuality was not a high priority in clinical practice. It is important to explore what this means for clinical practice in terms of the barriers that continue to exist and what changes can be made to bring knowledge about older adult sexuality to practice within the occupational therapy profession.

One area that arose during the interviews when the participants were describing personal experiences and perceptions regarding older adult sexuality was their own implicit bias. An implicit bias or attitude is an “involuntary and effortless responses to stimuli occurring outside of conscious awareness” (Thompson et al., 2014, p. 261). These differ from explicit attitudes which describe the perspectives that individuals are able to acquire consciously and report willingly and openly; explicit attitudes typically only partially resemble implicit attitudes (Thompson et al.,
Research suggests that implicit attitude measures are more predictive of behavior outcomes than are explicit measures in prejudices and disability biases, which can pertain to older adults (Thompson et al., 2014). Two of the interviewees in this study reported that the more they participated in the interview discussion, the more they came to understand that they held a stronger implicit bias against older adult sexuality than they had initially realized or expressed. Some practitioners held personal beliefs (e.g., sex should not occur outside of marriage) pertaining to sexual expression that prevented them from being completely open to assisting older adults with their sexual concerns. Personal beliefs are one important factor that may explain why attitude scores did not change significantly on the ASKAS. Although the participants increased their knowledge scores and expressed explicit thoughts of wanting to have more permissive attitudes, they may be held back by their implicit biases. Addressing implicit bias surrounding sexuality will be an important component to address in future educational opportunities.

Participants showed a statistically significant improvement in the knowledge scores on the ASKAS after completing the online educational course. These results were similar to those in Steinke’s (1997) study where knowledge scores on the ASKAS showed a statistically significant increase from pretest to posttest by 10 nurses who participated in an older adult sexuality course. The improvement on the knowledge section may be explained by the fact that 50% of the occupational therapy practitioners had no previous education on older adult sexual health or sexual activity. Participants from the qualitative study reported learning from the course what happens sexually in the normal aging process, how to approach their clients about sexuality, as well as information about sexual positioning and adaptive equipment. Each of the five interviewees reported that the education they received was important and beneficial to them.
They discussed feeling “more prepared” to approach their older adult clients about sexuality and to work with them to provide appropriate interventions. Although this study was unable to obtain information about how the interview participants will apply their knowledge in future clinical practice, nurses in the Steinke (1997) study reported including the newly acquired knowledge and strategies in their interactions with elders. Future research on the application of knowledge regarding older adult sexuality in occupational therapy practice is warranted.

The categories that emerged regarding the occupational therapists’ experiences and perceptions regarding older adult sexual health and sexual activity (lack of knowledge, personal and cultural influences, and addressing sexuality is not a priority) were similar in scope to the qualitative themes discussed in the McGrath and Lynch’s (2014) study. Prior research explored occupational therapists’ perspectives on addressing sexuality in the context of rehabilitation services for older people and they developed three themes: 1) perceived competence and confidence to address sexuality, 2) socio-cultural expectations relating to sexuality, and 3) the impact of resources regarding the inclusion or exclusion of sexuality from rehabilitation (McGrath & Lynch, 2014). Barriers to addressing older adult sexuality are very similar across the two countries (United States and Ireland) and both studies show clinicians unable to integrate education about older adult sexuality into clinical practice. The barriers are not new, novel, or surprising, but rather, expected, and necessary to overcome. The KTA framework can be used to facilitate knowledge translation for continuing education about older adulthood sexuality by including the best available knowledge, using educational and other transfer strategies that are known to be effective, and training of health professionals for the enhancement of practice, education, administration, and research (Graham et al., 2006). Although education is provided to practitioners more iterative strategies are needed because they are still hesitant to address older
adult sexuality. Trying something that may fail, and then learning from failures and successes to try again, is key to this process.

**Implications for Occupational Therapy**

It is clear from the literature and this research study that occupational therapy practitioners do not have a strong knowledge base, permissive attitude or clinical application of older adult sexual health and sexual activity. Knowledge was increased after completing the online course, therefore, more education is needed on this topic through occupational therapy program curricula, continuing education opportunities, or independent study. It is also important for occupational therapy practitioners to be aware of and understand implicit biases that they may have about older adulthood sexuality. This may be done through further assessments such as the Implicit Association Test (IAT) to assess attitudes towards sexuality among older adults (Thompson et al., 2014). The IAT was created to measure automatic associations (i.e., preferential responses) between counterbalanced target stimuli by using a number of response discrimination tasks (Thompson et al., 2014). Providing elderly clients with a safe and supportive environment in which they can discuss sexual health, expression, and experiences, as well as understanding the information to educate them about common sexual concerns and functioning in older adulthood is imperative.

**Study Limitations**

This study had three main limitations. The sample was relatively homogenous to occupational therapists with limited input and insight from occupational therapy assistants. This reduced the varied perspectives between practitioners, particularly in relation to clinical application as occupational therapy assistants provide most treatment interventions. Another was the lack of a control group and/or comparator educational intervention, so it is unknown if
viewing the online educational course was responsible for the increased knowledge. The third limitation was the timeframe of the interviews. All were conducted within two weeks of the participants completing the online educational course. Participants spoke about their prior experiences with older adult sexuality because they did have a significant amount of time to apply any knowledge learned from the course.

**Areas for Future Research**

Another way to address older adult sexual health and sexual activity and bring the knowledge to clinical practice would be through the development and implementation a community of practice using the building capacity process. This would involve bringing together occupational therapy practitioners to explore knowledge-to-practice; specifically, the application of current literature and research on the value of addressing sexual activity with older adult clients in occupational therapy evaluation and intervention. A community of practice (CoP) is a group of individuals who come together with a common concern about an area of practice and interact regularly to learn, problem solve, share resources, and develop new ways of practicing (Bazyk, et al., 2015; Wenger et al., 2002). The building capacity process is a systematic approach aimed at integrating new knowledge and research into a community of practitioners so that situated learning takes place resulting in innovative practice. The CoP process recognizes the differences in practice settings and relevance of barriers that may be common or unique to different situations/settings. It serves as a model to promote knowledge translation in order to develop change leaders--those who wish to lead others to change practice that will address their common concern using the best evidence (Bazyk et al., 2015).
Conclusion

This study yielded mixed results. Although occupational therapy practitioners demonstrated an increase in knowledge about older adult sexual health and sexual activity after completing the two-hour online educational course, their attitudes remained relatively unchanged. Attitudes surrounding older adult sexuality is a gap in clinical practice and research in the occupational therapy profession. Addressing this deficit through continuing education and the development of a stronger knowledge base and comfort level with older adult sexual matters is necessary. In addition, occupational therapy practitioners must be aware of their own implicit bias towards this topic and how it may be influencing their attitudes and practice. Sexual activity is a lifelong need and should no longer be considered a low priority for occupational therapy practitioners, nor dismissed as unimportant or irrelevant.
References


