

UNIVERSITY OF **INDIANAPOLIS**

SCHOOL OF OCCUPATIONAL THERAPY

Sexual Misconduct and Inappropriate Client Sexual Behavior
in Occupational Therapy: A National Survey

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December 12, 2024



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

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A Research Project Entitled
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By

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12/13/24

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The authors have no declarations of financial support. This research was self-funded for participant incentives.

Abstract

Importance: This study examines inappropriate sexual behavior within occupational therapy, addressing a significant gap in understanding sexual misconduct and inappropriate client sexual behavior (ICSB) in the profession.

Objective: To investigate the perceptions of inappropriate sexual behavior within occupational therapy in the United States.

Design and Setting: Investigators adapted a survey developed by Roush et al. (Roush, 2015). Data were collected in July 2023.

Participants, Outcomes, and Measures: Investigators surveyed occupational therapy practitioners and students who completed at least one Level II Fieldwork rotation. Investigators recruited through Facebook groups, AOTA social media platforms, and direct recruitment.

Results: Among 356 respondents, 69% of females and 41.5% of males reported experiencing ICSB. The majority (96.6%) considered relationships with current clients unethical, yet 54% believed relationships with former clients could be appropriate after 6-12 months. Seventeen percent admitted sexual attraction to a client, 6.1% reported having had a relationship with a current client, and 16.3% reported knowing a colleague who had had a relationship with a current client. Females reported experiencing greater sexual harassment from clients than males; and males reported engaging in romantic or sexual relationships with current clients significantly more frequently. Qualitative data revealed six themes: ICSB on a continuum, non-consensual sexual misconduct, context of ICSB, response to ICSB, consensual sexual relationships, and recommendations for future action.

Conclusions and Relevance: Sexual misconduct and inappropriate sexual behaviors occur frequently within occupational therapy, underscoring the critical need for professional guidelines and intervention strategies.

What This Article Adds: This study highlights the significant ethical challenges related to sexual misconduct and ICSB within the occupational therapy profession. Findings from this study may inform professional guidelines, continuing education, and instructional resources to inform and support current and future occupational therapy practitioners.

Keywords: sexual misconduct, occupational therapy, inappropriate client sexual behavior, sexual behavior

Sexual Misconduct and Inappropriate Client Sexual Behavior in Occupational Therapy: A National Survey

Sexual misconduct and sexual harassment cause issues in healthcare practice by breaking professional boundaries, compromising trust, and causing trauma for the client and career-ending consequences for the practitioners (Surgenor, 2019). Breaking sexual boundaries within a therapeutic relationship could be a one-sided or mutual occurrence (Roush, 2015). The therapeutic relationship is a professional bond founded on trust (Bismark, 2020).

Services delivered by the practitioner should not take on a sexual tone; however, close contact, removal of clothing for treatment, and prolonged treatment periods can increase the practitioner's risk of experiencing inappropriate client sexual behavior (ICSB) (Ang, 2010); (deMayo, 1997).

The frequency and consequences of sexual misconduct in occupational therapy in the United States have been under-researched. Studies in physical therapy have indicated that one-third to one-half of all physical therapists have experienced inappropriate sexual behavior from patients (Cambier, 2018); (Roush, 2015). Research has suggested a high frequency of sexual attraction originating from professional relationships (Cooper, I., & Jenkins, S., 2008); (Roush, 2015). A recent study examined sexual harassment within the context of occupational therapy graduate programs (Proffitt, 2024), but there have been no similar studies examining sexual misconduct by the practitioner and ICSB of clients in occupational therapy since 1999 (Schneider, 1999).

This exploratory mixed-methods study investigated the perceptions of inappropriate sexual behavior within occupational therapy in the United States. Inappropriate sexual behavior has occurred in the form of practitioner sexual misconduct toward clients or ICSB toward practitioners. Secondary purposes include comparing the relationship between perceptions of

inappropriate sexual behavior and demographic variables and a qualitative exploration of experiences of inappropriate sexual behavior and sexual attraction in practice.

Sexual Misconduct Defined

The American Occupational Therapy Association's (AOTA) 2022 Model Occupational Therapy Act classifies sexual misconduct as “engaging in or soliciting a sexual relationship, whether consensual or nonconsensual, while an Occupational Therapist or Occupational Therapy Assistant/client relationship exists with that person” or “making sexual advances, requesting sexual favors, or engaging in physical contact of a sexual nature with patients or clients” (American Occupational Therapy Association, 2022). Sexual misconduct can occur in various situations where there is an imbalance of power. This includes interactions between a client and a practitioner, a supervisor and a supervisee, or a student and a faculty member. In each of these situations, the individual in a position of authority has a responsibility to maintain professional boundaries. Even in cases of consensual relationships, sexual misconduct still exists. Service recipients are in a vulnerable position due to a power differential that exists, where healthcare practitioners possess the knowledge and expertise that the client needs, rendering consent not applicable to the situation (DuBois, 2017).

The therapeutic relationship is a one-way relationship that exists for the sole benefit of the client; any attempt by the practitioner to benefit themselves or meet their own needs is a breach of the therapeutic relationship and ought not to occur (Taylor, 2020). Sexual misconduct, including consensual relationships with persons who trust the occupational therapy practitioner (OTP) to implement the plan of care, can cause irreparable damage to the therapeutic relationship. Similarly, in academic or workplace environments, there are power imbalances present between students and faculty, administrators and employees, and supervisors and subordinates. These power differentials create environments conducive to abuse and harassment

taking place, which can negatively impact the victim's personal and professional development (Proffitt, 2024).

Inappropriate Client Sexual Behavior Defined

ICSB has been defined as, “a verbal or physical act of an explicit or perceived sexual nature which is unacceptable within the social context in which it is carried out” (Ang, 2010). Clients commonly demonstrate ICSB through verbal and nonverbal communication (Adler, 2021); (deMayo, 1997); (Kettl, 1993). Verbal ICSB has included, but was not limited to, sexual innuendos, sexual harassment, a client making a sexual remark about the practitioner, and sexually offensive jokes (Adler, 2021); (Draucker, 2019); (deMayo, 1997); (Schneider, 1999); (Clari, 2020); (Kettl, 1993). Alternately, the most common forms of nonverbal communication have been inappropriate touching, obscene gestures, suggestive sounds, sexual abuse, and sexual assault (deMayo, 1997); (Schneider, 1999); (Clari, 2020); (Kettl, 1993) and may include other inappropriate behaviors as well.

Prevalence of Sexual Misconduct Notifications

Limited research has been conducted on the prevalence of sexual misconduct in healthcare professions. Previous research included limitations of small sample sizes, underreporting, and insufficient clarity regarding the types of sexual misconduct (Bismark, 2020); (Cooper, I., & Jenkins, S., 2008); (Clemens, 2021).

Roush et al. (2015) and Cooper and Jenkins (2008) surveyed registered physiotherapists from five states within the United States and Australia, respectively, and found that a significant number of physiotherapists had been sexually attracted to a patient at some point. Roush et al.'s (2015) study reported that 42.5% of physiotherapists indicated they experienced sexual attraction to a patient. Cooper and Jenkins' (2008) found that 74% of male physiotherapists indicated they had been sexually attracted to a patient compared to 41% of female physiotherapists. Sexual

attraction alone is not misconduct; however, these feelings of attraction toward a patient could lead to sexual misconduct.

Cooper and Jenkins (2008) found that 21% of male physiotherapists reported dating a former patient compared to 16% of female physiotherapists. Similarly, 7% of male practitioners reported they dated a current patient compared to 4% of female practitioners. This preliminary data suggests that male practitioners are more likely to date current and former patients. There has been a lack of clarity and differing opinions surrounding the boundaries and tolerance of dating a former client within therapy professions. Therefore, practitioners have not had guidelines for making decisions about engaging in romantic relations, specifically with former clients.

Complaints against healthcare professionals have given some indication of the prevalence of sexual misconduct. In professional counseling, out of the reported ethical complaints resulting in disciplinary action, 9.0% were for sexual relationships with clients (Wilkinson, 2019). In the United States, out of physicians with any type of report in the National Practitioner Data Bank, approximately 1% were sexual misconduct reports (AbuDagga, 2016). Cooper and Jenkins (2008) found that physiotherapists in rural and private sectors were more likely than physiotherapists in urban and public sectors to find it acceptable to engage in a sexual relationship with a patient. While Proffitt et al. (2024) looked specifically at sexual harassment within occupational therapy academia, authors did not provide insight into its prevalence. No previous research on the prevalence of sexual misconduct committed by OTPs in the United States was found.

Prevalence and Impact of Inappropriate Client Sexual Behavior

Compared to sexual misconduct, there has been more literature and data on ICSB. Healthcare students reported experiencing sexual harassment in the clinical setting 40% of the

time (Kettl, 1993). In nursing settings, the prevalence of sexual harassment was found to be 53.4% (Clari, 2020). Additionally, 84% of physical therapists and physical therapist assistants reported experiencing ICSB during their careers (Cambier, 2018). In rural and outpatient settings, the roles of physiotherapists and students had less clearly defined professional boundaries, which led to higher incidences of ICSB (Ang, 2010). Schneider et al. (1999) found that, in most instances, practitioners experienced ICSB in settings where a client had a cognitive or psychosocial performance component deficit or a combination of both. Home health care has been an under-researched practice area in occupational therapy for ICSB. Clari et al. (2020) stated, “home-care sector presents particular risks for healthcare workers because clients’ homes expose healthcare workers to a relatively uncontrolled work environment” (p. 2). The authors found that most clients receiving home care were terminally ill, disabled, or had dementia, where the client's physical and mental states were compromised and could lead to more inappropriate behaviors. The lack of ability to manage safety in the environment of clients’ homes has led to uncertainty for both the client and practitioner (Clari, 2020).

Gender differences between practitioners and clients could have been noted as correlating with the occurrence of ICSB. There has been limited demographic data on the populations committing ICSB. Schneider et al. (1999) found that men were committing 98.2% of ICSB in their sample. Other factors that have played a role in increasing the risk of occurrence of ICSB throughout a practitioner’s career include working in direct patient care, working with patients with cognitive impairment, being female, treating primarily men, and being under the age of 40 (Cambier, 2018). Therefore, the practitioner's perceptions of ICSB's impact and frequency could differ from person to person depending on gender, setting, and patient population.

Unwanted sexual behaviors in verbal or nonverbal communication have negatively impacted the practitioner professionally and personally. The effects have been most noticeable in

the aspect of physical and mental health (Draucker, 2019) & (Clari, 2020). Negative impacts of ICSB have included but have not been limited to insomnia, fatigue, headaches, stiffness, high stress, depression, shame, anxiety and anguish, anger, post-traumatic stress disorder, and poor quality of life (Draucker, 2019) & (Clari, 2020). The implications of ICSB have affected the practitioner's work performance in the form of burnout, dissatisfaction, poor work quality, distraction, lack of motivation, resignation from work, and, in the cases of students, taking time away from school or considering dropping out (Draucker, 2019) & (Clari, 2020).

Sexual Misconduct Guidelines and Regulations

The boundaries and regulations regarding sexual misconduct in healthcare practice have not been clear. In many cases, disciplinary action has not been taken due to underreporting, poor enforcement of regulations, or the general lack of clear regulations and boundaries (Surgenor, 2019). Consequently, what constitutes sexual misconduct, and its repercussions has been held as subjective, and, in many cases, the responsibility of the persons and/or organizations involved to decide and enforce. In New Zealand, the Health Practitioners Disciplinary Tribunal (HPDT) held that factors that affected the type and extent of disciplinary action taken included “the level of exploitation and coercion; power and knowledge imbalances; vulnerability factors of the practitioner and the patient; timing of the relationship; and type of professional services provided” (Surgenor, 2019). When disciplinary action was taken, 22.9% of disciplinary action involved license suspension, followed by 16.2% involving license revocation (AbuDagga, 2016).

Cooper and Jenkins (2008) revealed that age was the most significant factor in the action taken to report a colleague for sexual misconduct. They found that younger physiotherapists were more likely than older physiotherapists to report a colleague to the Physiotherapists Registration Board or APA National Professional Standards Panel (Cooper, I., & Jenkins, S.,

2008). Rather than reporting the incident, older physiotherapists who were made aware of sexual misconduct were more likely to speak with the accused colleague and get back to the patient or suggest the patient write to an appropriate disciplinary body (Cooper, I., & Jenkins, S., 2008). This difference in reporting could be due to generational differences in education or perceptions of sexual misconduct.

According to the American Occupational Therapy Association (AOTA) Occupational Therapy Code of Ethics (the Code), practitioners are not to “engage in sexual activity with a recipient of service, including the client’s family or significant other, while a professional relationship exists” (American Occupational Therapy Association, 2020a). The Code also prohibits engaging in “dual relationships or situations in which an occupational therapy professional or student is unable to maintain clear professional boundaries or objectivity” (American Occupational Therapy Association, 2020a). Lastly, the Code prohibits “...sexual harassment of any individual or group” (AOTA, 2020a, p. 9). While the Code explicitly states that sexual activity should not occur, AOTA can only enforce the Code through sanctions on AOTA membership (AOTA, 2020a). The State Licensing Boards govern the ability to practice occupational therapy, and there are no consistent guidelines from state to state as to what constitutes actionable sexual misconduct (AOTA, 2024). For example, should there be a waiting period after a therapeutic relationship ends before an OTP can be romantically involved with a former client? To what extent is the OTP required to explain interventions with physical touch before performing them?

In addition to AOTA membership sanctions and state licensure actions, employers and organizations maintain policies and can enact disciplinary actions upon employees, including termination of employment (AbuDagga, 2016). These rates of disciplinary actions and processes for decision-making at the organizational level are not found in the literature for the field of

occupational therapy. As a result, there is no consensus available on what constitutes a sexual misconduct violation, nor clear guidance on what should be done when it occurs. It is unclear if and how existing guidelines are enforced in different settings and facilities.

Managing ICSB

Practitioners have been uncomfortable when ICSB has arisen and have not known how to manage the behaviors. Jones et al. (2005) used a 19-item survey to gauge undergraduate occupational therapy students' (OTs) comfort in scenarios where ICSB was prevalent. They found that more than half the students had reported on 10 of the 19 scenarios that they would feel uncomfortable handling these situations. The most common strategies used by practitioners to address ICSB include verbal redirection/distraction, setting limits, education about client relationships, physical intervention, ignoring the behavior, and joking with the behavior (Kettl, 1993); (Cambier, 2018). Cambier et al. (2018) found that physical therapy practitioners with ten years or less of experience were more likely to ignore or joke about inappropriate client sexual behavior compared to more experienced practitioners (75.2% vs. 60.5% and 31.6% vs. 17.2%, respectively).

Professional Boundaries

Professional boundaries can be legal, ethical, or organizational guidelines and exist with the purpose of ensuring a safe and respectful environment between professionals and clients. Unlike professional boundaries that usually originate from the human resource department, sexual boundaries are defined through sexual misconduct policies or can be established between persons in an academic, clinical, or workplace environment (Health and Care Professions Council, n.d.). OTPs' perceptions of sexual boundaries and what constitutes sexual misconduct in practice have not been studied recently in the United States or abroad.

In the context of academics, Title IX is in place to protect faculty and students from sexual harassment at their academic institutions (U.S. Department of Justice, n.d.). Similarly, supervisors and supervisees are protected from sexual harassment in the workplace under Title VII of the Civil Rights Act of 1964 (U.S. Equal Employment Opportunity Commission, n.d.) While, each organization, university, or company may have their own policies and guidelines, when it comes to sexual harassment and misconduct, these federal protections are in place in order to keep individuals safe.

Summary

Based on the available literature, ethical problems related to sexual misconduct and ICSB have been pervasive within occupational therapy in the United States. There is a clear need to learn more about OTPs' experiences and perceptions regarding sexual misconduct, ICSB, and the outcomes of inappropriate sexual behavior enacted by the practitioner or client. Findings from this study may contribute to more specific guidelines within occupational therapy, continuing education courses addressing sexual misconduct and ICSB, and instructional resources to inform and support current and future OTPs.

Method

In this mixed methods exploratory study, researchers investigated the perceptions, experiences, and demographic factors impacting sexual misconduct and inappropriate client sexual behavior in occupational therapy within the United States using an original online survey distributed through Qualtrics (2020).

Ethics

This study was approved as Exempt by the Human Research Protection Program Institutional Review Board of the University of Indianapolis (Study #01856). Participants

completed an informed consent question as the first question of the survey. A trigger warning was included in the recruitment materials stating that participants “may experience emotional discomfort or recall distressing situations.” This trigger warning was repeated in the informed consent document, and participants were told they may choose to not answer a question or withdraw from the study at any time.

Recruitment

The researchers recruited participants through social media using an infographic with a survey link. Recruitment materials included an incentive of inclusion in a drawing for one of five \$50 Amazon gift cards. The research team sought out occupational therapy-based Facebook groups and asked permission from group moderators to distribute the survey link via the Facebook group “wall.” The criteria for Facebook group recruitment included being occupational therapy-based, willingness to participate in research, frequency of posting, and number of members. Investigators posted within six Facebook groups with 145, 200 members as of July 2023. Additionally, researchers collaborated with AOTA to post the recruitment infographic on AOTA’s social media platforms. Finally, with AOTA’s permission, the primary investigator invited audience members who attended a session on sexual boundaries in occupational therapy at the AOTA Inspire 2023 Conference to participate in the study. These audience members provided their email addresses by scanning an on-screen QR code which led them to a Google Form. Due to social media use, investigators were unable to calculate the response rate.

Instrument

Quantitative

Investigators adapted a survey with permission from Roush et al. (2015), originally modified from Cooper’s studies (Ang, 2010); (Cooper, I., & Jenkins, S., 2008); (Cooper, 2010). See Appendix A for survey questions. The researchers modified demographic questions, nominal

questions, and vignettes from the Roush et al.'s 2015 survey to be more relevant to occupational therapy and used gender-neutral language (e.g., changed “she/he” pronouns to “they/them” and changed “therapeutic massage” to “myofascial release”). Fifteen questions measured the frequency of encounters with ICSB and sexual misconduct that participants had experienced or someone they knew had experienced. These were rated on a nominal scale of: “Yes,” “No,” “Not Applicable,” or “Other: please write in.” Nine vignettes measured the practitioners' self-reported perceptions of sexual misconduct on a 5-point Likert-type scale. Four faculty members previewed the survey and provided comments prior to launching the survey; investigators edited the survey based on their feedback.

Qualitative

Investigators included three open-ended questions in the survey for participants to convey their subjective experiences with ICSB, sexual misconduct, and any additional comments (see Appendix A). Investigators formulated these questions based on personal communication with an OTP regarding their experience and perception of sexual misconduct and ICSB. Once investigators sorted responses by type of comment, they placed comments into categories consisting of context, consensual relationship, non-consensual misconduct, response to ICSB when reported, and recommendations for future action. Researchers created themes and identified comments that best exemplified each category.

Procedures

Data collection occurred from July 1, 2023, through August 1, 2023, and researchers collected no identifying information. Participation was voluntary, with no mandatory questions. Respondents consented to participate before beginning the survey by reading an Informed Consent Document (ICD) and clicking on “I voluntarily consent to participate in this research study survey.” Respondents had the option to download the ICD. At the end of the survey,

participants were given the opportunity to provide their email address to be entered in a drawing for one of five Amazon \$50 gift cards. Investigators selected gift card winners using a random number generator. The primary investigator self-funded and distributed the gift cards. Prior to data analysis, the researchers removed survey responses that they determined to be from bots. Responses were removed based on unfeasible completion times, failure to pass the bot detection rating (CAPTCHA™), and illogical or incomplete responses.

Data Analysis

Data were entered into the Statistical Package for the Social Sciences © (SPSS) version 26. The researchers utilized descriptive statistics to discuss the characteristics of the participants and percentages and counts for survey responses. Inferential statistics, including Kruskal-Wallis and chi-square, determined relationships between variables of inappropriate sexual behavior and demographic variables. Investigators employed a phenomenological approach for qualitative analysis and formed themes to interpret OTPs experiences with inappropriate sexual behavior in practice. Prolonged engagement with the data and discussion among investigators continued until agreement was reached. Investigators then created a figure based on the findings.

Results

The purpose of this exploratory mixed methods study was to investigate the perceptions of inappropriate sexual behavior in occupational therapy, including practitioner sexual misconduct and ICSB toward practitioners, using a Qualtrics (2020) survey.

Participants

After cleaning the data, the valid number of participants was 356. The gender breakdown consisted of: Males: 56 (15.7%), Females: 295 (82.9%), and Other: 5 (1.4%). Titles those participants held at the time of this survey consisted of: occupational therapist (OT): 253 (71.1%), occupational therapy assistant (OTA): 56 (15.7%), and OTS: 47 (13.2%). Regions of

the U.S. where the participants practiced were; Midwest: 95 (27.4 %), Northeast: 60 (17.3%), South: 113 (32.6%), and West: 79 (22.8%). The mean number of years in practice was 6-10 years.

Vignettes

Table 1 contains results pertaining to the frequency, mean, and standard deviation for responses to sexual boundaries discussed within Vignettes #1-8 on a 5-point Likert scale. Each question posed a different hypothetical scenario. Half of the Vignettes (#2, 3, 4, and 6) had a mean response of 4, “This behavior is wrong,” followed by a quarter of the Vignettes (#1 and #5) with responses between “This behavior is wrong,” and “I don’t know if this is right or wrong.” Respondents scored Vignette #7 and Vignette #8 with means between the categories of, “I wouldn’t do this, but I wouldn’t criticize anybody who did.”

Table 1: Frequency, mean, and standard deviation for responses to sexual boundary vignettes 1-8

Vignettes	n(%) Mean (±s.d.)*
1. After an occupational therapy practitioner performs myofascial release on a client, the client says they are feeling much better. The occupational therapy practitioner replies that they are too and it would be the client’s turn to give the massage to the occupational therapy practitioner the next time.	356 (100) 3.67 (1.12)
2. An unmarried occupational therapy practitioner is the only occupational therapy practitioner in a small rural town and meets one of their clients socially on a number of occasions; they develop a sexual relationship. The practitioner continues to provide the client with ongoing care for a chronic condition.	356 (100) 4.05 (1.03)
3. An occupational therapy practitioner has a sexual relationship with a client while continuing to act as the occupational therapy practitioner and as an occupational therapy practitioner to the client’s children, and on occasions to the client’s spouse. The occupational therapy practitioner has made the acquaintance of the family through their position as an occupational therapy practitioner.	354 (99.4) 4.29 (1.03)

4. An occupational therapy practitioner invites a client to meet them at a bar after work for a drink. A sexual relationship develops, and the occupational therapy practitioner continues to provide occupational therapy treatment to the client.	355 (99.7) 4.16 (1.03)
5. An occupational therapy practitioner is invited by their sibling to be the occupational therapy practitioner for a semi-professional volleyball team. They agree, and a few weeks later they accepted an invitation to go on a date with one of the team members.	356 (100) 3.29 (1.12)
6. An occupational therapy practitioner supervising a final-year occupational therapy student offers to help the student study out of normal working hours. A sexual relationship develops while the student remains under the supervision of that occupational therapy practitioner.	355 (99.7) 4.27 (1.00)
7. An occupational therapy practitioner runs into a former client at the supermarket; it has been six months since the client was being treated by the practitioner. The client asks the occupational therapy practitioner to go out to dinner, and the occupational therapy practitioner accepts the invitation.	354 (99.4) 2.08 (1.00)
8. An occupational therapy practitioner runs into a former client at the gym; it has been two years since the client was being treated by the practitioner. The client invites the occupational therapy practitioner to a concert because they have an extra ticket. The occupational therapy practitioner accepts the invitation.	354 (99.4) 1.75 (0.94)

*Scale: 1 = This is OK & I might do it if the circumstances are right; 2 = I wouldn't do this, but I wouldn't criticize anybody who did; 3 = I don't know if this is right or wrong; 4 = This behavior is wrong; 5 = This behavior is so wrong that the occupational therapy practitioner should be barred from practice. Range of scores were 1-5

Table 2 contains Vignette #9, which is a multiple-select vignette of the courses of action participants endorsed in response to a hypothetical, possible inappropriate sexual misconduct by an OTP colleague. All of the participants in this survey engaged in this question, with a majority choosing option F., “Advise the client that she should file a complaint by writing to the appropriate disciplinary body” (65.7%), and G., “Comfort the patient” (54.8%). Few respondents chose options A., “Do nothing” (1.1%), and B., “Assure the client she must have misinterpreted whatever your colleague did” (4.2%).

Table 2: Courses of action participants endorsed in response to a hypothetical, possible inappropriate sexual misconduct by an occupational therapy practitioner colleague

Course of action	Endorsed n (%)
A. Do nothing.	4 (1.1%)
B. Assure the client she must have misinterpreted whatever your colleague.	15 (4.2%)
C. Inform the client that this is something she should personally take up with your Colleague.	40 (11.2%)
D. Offer to talk to your colleague and then get back to the client.	46 (12.9%)
E. Offer to arrange a meeting to discuss the incident between the client, your colleague, and yourself.	70 (19.7%)
F. Advise the client that she should file a complaint by writing to the appropriate disciplinary body.	234 (65.7%)
G. Comfort the patient.	195 (54.8%)
H. Inform Law Enforcement of the incident.	168 (47.2%)
I. Report the occupational therapy practitioner to the American Occupational Therapy Association.	133 (37.4%)
J. Report the occupational therapy practitioner to the State Licensing Board.	169 (47.5%)

Practitioner Opinions

Investigators asked participants 11 questions pertaining to reports of romantic or sexual involvement in the workplace. Table 3 contains results of those who responded “yes” for each item. The highest response was for question 10, “Have you ever been sexually propositioned or harassed by a client?” with a total of 102 (22.8%) responses. The lowest response was for question 3, “Have you ever engaged in a romantic or sexual relationship with someone after the therapeutic relationship ended?” with a total of 22 (10.1%) responses.

Table 3: Comparison of participants’ reports of romantic or sexual involvement in the workplace by demographic groups using chi-square

Item	Yes, n(%)	Yes, GENDER n(%)	Yes, YEARS IN PRACTICE n(%)	Yes, TITLE n(%)
Have you ever been sexually attracted to a client? n = 352	61(17.3)	Male: 22(41.5) Female: 39(13.3)	Student through 5 years: 19(10.2) 6 through 15 years: 26(26.8) 15+ years: 16(23.2)	OT: 38(15.1) OTA: 16(29.1)

Item n responding	Yes, n(%)	Yes, GENDER n(%)	Yes, YEARS IN PRACTICE n(%)	Yes, TITLE n(%)
				OTS: 7(15.2)
Have you ever engaged in a romantic or sexual relationship with someone while you were in a therapeutic relationship with them? n = 344	61(6.4)	Male: 16(30.2) Female: 6(2.1)	Student through 5 years: 6(3.3) 6 through 15 years: 15(16.1) 15+ years: 1(6.4)	OT: 13(5.2) OTA: 5(10.0) OTS: 4(8.9)
Have you ever engaged in a romantic or sexual relationship with someone after the therapeutic relationship ended? n = 345	22(10.1)	Male: 22(41.5) Female: 13(4.5)	Student through 5 years: 9(4.9) 6 through 15 years: 23(24.2) 15+ years: 3(4.4)	OT: 20(8.1) OTA: 10(19.2) OTS: 5(11.1)
Have you ever engaged in a romantic or sexual relationship with someone who supervised you at the time (for example, a boss, a faculty member)? n = 348	28(8.0)	Male: 15(28.3) Female: 13(4.5)	Student through 5 years: 12(6.5) 6 through 15 years: 15(15.6) 15+ years: 1(1.5)	OT: 19(7.6) OTS: 9(17.0) OTS: 0(0.0)
Have you ever engaged in a romantic or sexual relationship with someone who was subordinate to you or reported to you at the time (for example, a supervisee or employee, a student)? n = 342	29 (8.5)	Male: 19(36.5) Female: 10(3.5)	Student through 5 years: 11(6.1) 6 through 15 years: 17(17.9) 15+ years: 1(1.5)	OT: 17(6.9) OTA: 9(17.6) OTS: 3(7.0)
Are you aware of a colleague who engaged in a romantic or sexual relationship with a current client	57(16.3)	Male: 19(35.8) Female: 38(13.3)	Student through 5 years: 23(12.5) 6 through 15 years: 24(24.7) 15+ years: 10(14.7)	OT: 42(16.9) OTA: 10(18.2)

Item n responding	Yes, n(%)	Yes, GENDER n(%)	Yes, YEARS IN PRACTICE n(%)	Yes, TITLE n(%)
or their family member? n = 349				OTS: 5(11.1)
Are you aware of a colleague who engaged in a romantic or sexual relationship with a former client or their family member? n = 349	93(36.6)	Male: 21(39.6) Female: 72(24.8)	Student through 5 years: 36(19.4) 6 through 15 years: 35(36.8) 15+ years: 22(32.4)	OT: 69(27.6) OTA: 14(26.4) OTS: 10(21.7)
Are you aware of a colleague who engaged in a romantic or sexual relationship with someone who supervised them at the time (for example, a boss, a faculty member)? n = 349	69(19.8)	Male: 19(37.3) Female: 50(17.1)	Student through 5 years: 28(15.2) 6 through 15 years: 28(28.9) 15+ years: 13(19.1)	OT: 49(19.8) OTA: 10(18.2) OTS: 10(21.7)
Are you aware of a colleague who engaged in a romantic or sexual relationship with someone who was subordinate to them or reported to them at the time (for example, a supervisee or employee, a student)? n = 347	69(19.9)	Male: 17(33.3) Female: 52(17.9)	Student through 5 years: 31(16.7) 6 through 15 years: 25(26.9) 15+ years: 13(19.1)	OT: 48(19.4) OTA: 12(23.1) OTS: 9(19.1)
Have you ever been sexually propositioned or harassed by a client? n = 350	102(22.8)	Male: 22(41.5) Female: 197(67.5) Other: 3(60)	Student through 5 years: 111(60.0) 6 through 15 years: 62(63.9) 15+ years: 49(72.1)	OT: 171(67.9) OTA: 27(51.9) OTS: 24(52.2)
Have you ever been sexually propositioned or harassed by someone	102(28.8)	Male: 16(29.1) Female: 84(28.6)	Student through 5 years: 43(23.0) 6 through 15 years: 41(41.4) 15+ years: 18(26.5)	OT: 79(31.3) OTA: 17(30.9)

Item n responding	Yes, n(%)	Yes, GENDER n(%)	Yes, YEARS IN PRACTICE n(%)	Yes, TITLE n(%)
accompanying a client? n = 354		Other: 2(40)		OTS: 6(12.8)
Have you ever been told by a client that your touching or treatment was sexually inappropriate? n = 347	25(7.2)	Male: 16(30.8) Female: 9(3.1)	Student through 5 years: 10(5.4) 6 through 15 years: 14(14.6) 15+ years: 1(1.5)	OT: 13(5.3) OTA: 8(15.1) OTS: 4(8.5)

*Significant ($p \leq .05$)

Table 4 contains the results of the participants' responses regarding thoughts of when it might be an appropriate time to have a romantic/sexual relationship with a current or former client, supervisor/supervisee, or professor/student. The most frequent response for the time after the therapeutic relationship to begin a romantic or sexual relationship with a former client was 6 months, with 113 (31.7%) selecting this option. The most frequent response for time after the student-professor relationship for beginning a romantic or sexual relationship for beginning a romantic or sexual relationship was 12 months, with 93 (26.2%) selecting this option. The most frequent response for time after the supervisor-supervisee relationship for beginning a romantic or sexual relationship was "immediately after," with 122 (34.4%) selecting this option. For each of the three potential relationships, the specific time frame selected with the least frequency was, "While still in therapeutic relationship." with percentages of 3.4% and 5.3%.

Demographic Comparisons

Cronbach's alpha for vignettes 1-8 (Table 1) in this sample was .827, indicating high scale reliability (Laerd Statistics, n. d.). Scores from vignettes 1-8 were then totaled. Investigators then analyzed the total of vignettes 1-8 by demographic group. Table 5 contains the results of these comparisons. Females, those who reported their gender as "other," and those

working with older adults scored the vignettes as significantly more concerning than those in other demographic groups. Practitioners with 6 to under 15 years in practice scored the vignettes as significantly less concerning than those practicing as OTSs to OTPs with under 6 years' experience, and OTPs who had practiced more than 15 years. Comparisons by regions, urban/suburban/rural areas, and by settings were not significant.

Table 4: Thoughts on when a romantic or sexual relationship is ok (n=356)

When is it ok?	While still in therapeutic relationship n (%)	Immediately After n (%)	6 months n (%)	12 months n (%)	Never n (%)	Other n(%)
After therapeutic relationship	12 (3.4)	72 (20.2)	113 (31.7)	80 (22.5)	63 (17.7)	16 (4.5)
After student-professor	12 (3.4)	76 (21.4)	71 (20.0)	93 (26.2)	89 (25.1)	14 (3.9)
After supervisor-supervisee	19 (5.3)	122 (34.4)	74 (20.8)	81 (22.8)	53 (14.9)	6 (1.7)

Table 5: Vignette total scale and comparisons to demographic groups with Kruskal-Wallis (n=348)

Demographic Items	Significance*	Direction and Adjusted Significance Between Groups**
Gender	<.001*	Male > female: .000* Male > other genders: .006*
Years in Practice	.016*	OTS to 5 year vs. 6 years to 15 years: .066 OTS to 5 years vs. 15+ years: 1.000 6 years to 15 years vs. 15+ years: .023*
Title	<.001*	OTA to OT: .000* OTA to OTS: .001* OT to OTS: 1.000
Populations	.014*	Across the Lifespan to Children & Youth: .846 Across the Lifespan to Adults: .868 Across the Lifespan to Older Adults: 1.000 Children & Youth to Adults: 1.000 Children & Youth to Older Adults: .038* Adults to Older Adults: .032*

*Significance level set at $p \leq .05$. Items of significance are marked with an asterisk.

**Pairwise comparisons with Bonferroni correction.

Investigators examined demographic groups with statistically significant differences between their vignette responses and reports of romantic or sexual involvement in the workplace (see Table 3). A significantly higher percentage of males reported romantic or sexual involvement or awareness of others having sexual or romantic involvement in the workplace, but a significantly higher percentage of females reported sexual harassment in the workplace. Practitioners in practice 6 to under 15 years reported a significantly higher percentage of romantic or sexual involvement or awareness of others having sexual or romantic involvement in the workplace than OTSs under 6 years and OTPs practicing 15+ years. OTAs reported being sexually attracted to a client and having a sexual or romantic relationship with a supervisor at a significantly higher percentage than OTs or OTSs. OTs and OTAs reported experiencing sexual harassment at a significantly higher percentage than OTSs.

Qualitative Results

Figure 1 depicts the themes found through qualitative analysis. The first theme explored the continuum of behaviors that constitute ICSB. This continuum included innuendos, direct comments, actions, and assaults. Other themes included the context of ICSB, consensual sexual relationships, non-consensual sexual misconduct, response, and survey recommendations for future actions. Qualitative comments called for more support and education regarding

inappropriate sexual behavior.

<p>ICSB ON A CONTINUUM</p>	<ul style="list-style-type: none"> • Innuendo- <i>"This would be better if you were in bed too... minus the scrubs"</i> • Direct- <i>"Asked me to meet him on my lunch hour for sex"</i> • Action- <i>"Patient pulled down his pants in the middle of the session and began pleasing himself while he asked for oral sex"</i> • Assault- <i>"He pulled me inside, blocked the door, groped me, and said he could rape me whenever he wanted."</i> 	<p>NON-CONSENSUAL SEXUAL MISCONDUCT</p> <p>Most commonly reported context:</p> <ul style="list-style-type: none"> • Faculty preying on students • Supervisor on other staff • Team discomfort • Staff on client • Abuse of power <p><i>"While supervising OTD students working on their capstones I had multiple students tell me about a faculty member that propositioned them for threesomes with his wife."</i></p>
<p>CONTEXT OF ICSB</p>	<p>Most commonly reported context: setting, intervention, cognition, bystanders, and gender.</p> <ul style="list-style-type: none"> • ICSB from male clients toward female practitioners • Older adult male clients • Cognitive deficits (eg. TBI, dementia) • Inpatient rehab, SNF, acute care, home <p><i>"Given the nature of our treatments, men in particular feel the need to comment on what we are doing. In particular, many clients have asked me to "come sit on their lap"</i></p>	<p>RESPONSE</p> <p>Most commonly reported responses to ICSB:</p> <ul style="list-style-type: none"> • OTP handles behavior (addresses client directly) • supervisor handles behavior • moving forward, 3rd party remains in room during sessions • legality • no response <p><i>"[my boss] implied that I needed to get thicker skin"</i></p>
<p>CONSENSUAL SEXUAL RELATIONSHIPS</p>	<p>Most commonly reported consensual sexual behaviors of OTPS that may be perceived as sexual misconduct:</p> <ul style="list-style-type: none"> • Faculty and student • Fieldwork educator and student • Supervisor and supervisee • OTP and client <p><i>"I know an OTR who had a sexual relationship with a patient 2 months after the therapeutic relationship ended"</i></p>	<p>SURVEY RECOMMENDATIONS FOR FUTURE ACTION</p> <p>Most commonly reported context:</p> <ul style="list-style-type: none"> • Need for Open discussion • Better reporting • Need for education • Clearer guidelines for timeframes • safety of OTP during functional mobility and transfers <p><i>"More attention should be paid to the formulation and implementation of laws, regulations, and codes of conduct."</i></p>

Figure 1: *Qualitative Themes*

Discussion

The purpose of this exploratory mixed-methods study was to investigate participants' perceptions and experiences with inappropriate sexual behavior in practice. Investigators meet this purpose by surveying OTPs and OTSs in the United States. Investigators captured the participants' experiences through quantitative and qualitative responses.

According to the Occupational Therapy Practice Framework (OTPF), sexual activity as an ADL is within occupational therapy's scope of practice (American Occupational Therapy Association, 2020b). Despite the OTPs' responsibility to address sex, there is a concern that it is not being addressed due to lack of appropriate education regarding sexuality and intimacy (Walker, 2020). The lack of education and awareness surrounding this topic might contribute to the differing opinions on guidelines and perceptions of sexual misconduct noted in this study. With increased attention on sexuality in occupational therapy practice, there is a need for practitioners to maintain consistent professional boundaries to avoid sexual misconduct and

manage ICSB to ensure ethical conduct and protect patients and practitioners from misunderstandings and inappropriate behavior (Cooper, I., & Jenkins, S., 2008).

The comparison of the present study to Roush et al. (2015) revealed related results in significance for gender differences. In both studies, males experienced more instances of being sexually attracted to a patient, romantic or sexual involvement with a current patient, and being told by a patient that their touching or treatment was sexually inappropriate. Both studies also indicated females reported experiencing ICSB occurrences more frequently than males.

The increased concern among different genders for behaviors in the vignettes, may be linked to a higher sensitivity to ICSB among female participants, as they reported experiencing ICSB more frequently than male participants in this study (Table 3). The variation in concern between practitioners with different years of practice was unexpected to the researchers; further research should be conducted in this area. In total, differences in level of concern between demographic groups of this study could be attributed to increased willingness to discuss sexuality and professional boundaries from individual experience and exposure to these topics.

Roush et al. (2015) reported a higher “yes” percentage for romantic and sexual involvement in the workplace than the present study, which could suggest that norms and societal perceptions have shifted in the intervening decade since Roush et al.’s (2015) study. Despite this difference, there were many similarities in responses for the nine vignettes when compared with Cooper and Jenkins (2008), whose study included the first six vignettes, and Roush et al. (2015), whose study included all nine of the vignettes. Participants rated the wrongness of the vignettes similarly, aside from vignette five being most commonly rated as (1)= This is OK and I might do it if the circumstance were right in Cooper and Jenkins (2008) study compared to (3)= I don’t know if this is right or wrong for Roush et al. (2015) and the present study. In vignette 9, Roush et al. (2015) and this present study found agreement in

significant results for the most and least selected course of action. The consensus between these two studies on vignette 9 suggests there is agreement across healthcare professions (i.e., occupational therapy and physical therapy) when considering severely egregious sexual misconduct. However, behaviors with former clients and relationships beginning through client connections are considered a gray area. More ethical guidance is needed regarding these gray areas.

Most of the participants indicated six to 12 months would be an appropriate amount of time to wait to pursue a romantic or sexual relationship following the therapeutic or academic relationship. For supervisor and supervisee relationships, most participants reported it is acceptable to engage in romantic or sexual relationships immediately after the professional relationship ends. Further discussion within the profession is needed to establish consensus regarding romantic and sexual relationships following termination of the professional relationship.

Implications for practice, education, and research

Currently, there are no guidelines in occupational therapy in the United States for establishing professional boundaries for the time frames of starting a romantic relationship and following a therapeutic relationship within the occupational therapy profession. The majority of participants from this study support a minimum of 6 months after the therapeutic relationship ends to begin a romantic relationship (Table 4). These findings may inform the time frames for guidelines for appropriate conduct within the field of occupational therapy. However, in the qualitative themes of recommendations for future action (Figure 1), participants reported it was important to consider the context when determining acceptable time frames, including prior power imbalances, vulnerabilities, community culture, and length of treatment relationships. Existing guidelines are ambiguous across states, settings, and facilities, leading to confusion

about appropriate reporting and responding procedures (Roush, 2015). Occupational therapy practitioners would benefit from techniques to redirect clients when ICSB is experienced. Specifically, qualitative comments/respondents include scripting phrases for responding to ICSB when working with clients who exhibit a lack of inhibitory control. For the safety and well-being of practitioners, employers need to empower practitioners through clear procedures for responding to ICSB such as putting a tiered system in place for future care or transfer of care following the ICSB occurrence(s).

There is limited relevant research on the number of notifications or reports of sexual misconduct in healthcare professions in the United States. Unlike Australia (Bismark, 2020), the United States does not regulate reports of misconduct by health practitioners on a national level. Instead, professional state licensing boards are notified of misconduct and have the governance to respond how they see fit. Participants commented that certain populations, like students, women, and those with disabilities, are disproportionately impacted by sexual misconduct. Occupational therapy practitioners would benefit from advocacy on a state level for clear procedures on reporting sexual misconduct and the resulting response from licensing boards. Limited guidance is available on what constitutes a sexual misconduct violation in the field of occupational therapy and its consequences. OTPs would benefit from standard guidelines/a code of conduct similar to the American Psychological Association (2017), that states an appropriate duration of time after cessation of therapy to begin a sexual relationship.

Further research areas include ICSB and sexual misconduct in more specific settings, such as home health care (Clari, 2020). It is recommended that future studies related to ICSB and sexual misconduct include a demographic question on race to analyze its relevance. The qualitative responses from this study can indicate topics for further research. For example, participants discussed experiencing ICSB when working with patients with cognitive deficits

such as those with traumatic brain injury or dementia. There is research on this topic in the pharmacology field (Accetta, 2023); however, further research is needed in the field of occupational therapy. Further research is required to inform educational materials that can be integrated into the occupational therapy ethics curriculum to expose OTSs to guidelines for ICSB and sexual misconduct before entering into practice. A longitudinal study regarding OTP's experiences of inappropriate sexual behavior over time could further elucidate the prevalence of sexual misconduct and ICSB in occupational therapy. Additional longitudinal studies could examine the effectiveness of education and other interventions in reducing the occurrence of and trauma from inappropriate sexual behaviors.

Limitations

The demographics obtained in this study may not accurately represent the population of OTPs in the United States. This study was based on Roush et al.'s (Roush, 2015) questionnaire, which did not include race in the demographic questions. Therefore, race was omitted from the demographics section of the survey. Respondents were obtained through social media from direct recruitment and snowball sampling, which could have introduced self-selection bias and reduced the sample's representativeness. Additionally, recruitment methods resulted in an unknown response rate and an inability to collect responses of those who do not use social media. Using social media introduced the opportunity for AI-powered bots to respond to the survey. Human error during the data cleaning process may have resulted in bot responses remaining in the data and legitimate responses being removed, which may have skewed the study's results.

Conclusion

The purpose of this study was to investigate the perceptions of inappropriate sexual behavior within occupational therapy in the United States, with secondary purposes to explore

the relationship between perceptions of inappropriate sexual behavior and demographic variables; and to explore experiences of sexual misconduct and ICSB in practice. Results indicated that ICSB and sexual misconduct do occur with regularity in occupational therapy practice, with perceptions that these occurrences are problematic, and that OTPs should take responsibility for protecting their clients and maintaining professional boundaries. This study contributes to the limited body of literature on sexual misconduct and ICSB in occupational therapy and highlights the need for more attention to this topic. Further research is indicated to reduce the prevalence and impact of inappropriate sexual behaviors in occupational therapy practice.

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Appendix A

Survey