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Physical therapy students' experiences of inappropriate patient sexual behavior: a narrative review

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Abstract

***Primary objective*:** The purpose of this study is to identify the extent to which inappropriate patient sexual behavior (IPSB) is directed toward student physical therapists (PTs) and how this phenomenon is described in the current literature.
***Review type*:** Narrative review.
***Summary of review method*:** A search of PubMed, CINAHL Plus, and Academic Search Complete was conducted using the Boolean phrase ('sexual harassment' OR 'sexual assault' OR 'inappropriate sexual behavior' OR 'sexual behavior') AND ('physical therapy' OR physiotherapy OR 'physical therapist' OR physiotherapist). After relevant articles were identified, references were searched for additional relevant material. Data and common themes were identified, extracted, and summarized.
***Primary results*:** Studies indicate that 84% to 92.9% of PTs have IPSBs directed at them during their careers. There is less information on the rate at which student PTs are targets of IPSB, but the available studies indicate 66.2% to 78% of them experience IPSB during their clinical experiences. In one study, over 22% of PT students experienced severe forms of IPSB during clinical experiences. Other studies show that student PTs and novice PTs respond to IPSB with techniques that are less effective than those used by experienced PTs. Qualitative reports indicate that student PTs feel that they and their clinical instructors are unprepared for IPSB and believe more training on the topic is necessary.
***Conclusion*:** The available literature indicates that most PT students have IPSB directed at them during their clinical experiences. Students report feeling unprepared and desire more training on this topic. Additional training may reduce IPSB.

Keywords: *sexual harassment; patient care; students; physical therapy; clinical education*

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In the 1990s, researchers began to consider the problem of sexual harassment and sexual violence directed toward healthcare workers. Much of this research focused on nurses and physicians with very little on physical therapists (PTs) and physical therapy (PT) students. A 2014 systematic review found that 39% of nurses experienced sexual harassment at some point, and patients were the most frequently identified perpetrators.[1] Compared to nurses and other healthcare workers, PTs may be at increased risk of having inappropriate patient sexual behaviors (IPSBs) directed at them due to the frequent use of therapeutic touch and extended one-on-one encounters.[2] PT students in clinical experiences are in a particularly vulnerable position as nonemployees needing to complete clinical experiences to graduate. This review seeks to examine how students experience and respond to IPSB in light of the prevalence of IPSB in PT overall.

The term 'sexual harassment' is variously defined and typically describes behaviors between employees or employees and employers.[2,3] Multiple surveys indicate that although a large percentage of PTs report having unwanted sexual behaviors directed toward them, relatively few say they have been 'sexually harassed.'[2,4] Because of this gap, many authors use 'inappropriate sexual behavior' (ISB) to refer to any 'verbal or physical act of an explicit, or perceived, sexual nature, which is unacceptable within the social context in which it is carried out.'[5] IPSB describes ISB that is committed by a patient in a healthcare setting.

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The primary purpose of this review is to identify the prevalence of IPSB among PT students. Secondary purposes include comparing student experiences to those of licensed PTs, identifying how PT students respond to IPSB, and identifying risks for experiencing IPSB. A narrative review format will be used due to the small number of available studies and to highlight common themes more effectively.

Methods

A search of PubMed, CINAHL Plus, and Academic Search Complete databases was performed on all literature published before January 2023 using the Boolean phrase ('sexual harassment' OR 'sexual assault' OR 'inappropriate sexual behavior' OR 'sexual behavior') AND ('physical therapy' OR physiotherapy OR 'physical therapist' OR physiotherapist). Articles were included in this review if they presented original data on IPSB directed toward PTs or PT students in a clinical setting. Articles were excluded if they only summarized previously reported data or if they did not report data specific to patient behaviors in the clinical setting. After the initial screening process, references of included articles were searched for additional relevant reports.

Results

The search returned 415 results, and 14 were deemed potentially relevant. After inclusion and exclusion criteria were applied, seven articles were selected for inclusion. After a reference search, one additional article was identified for a total of eight articles (Fig. 1). Characteristics of included studies are shown in Table 1.

Prevalence among PTs

Licensed PTs experience IPSB at very high rates. McComas and colleagues made the first attempt to document IPSB experienced by PTs in 1993.[2] In their sample, 92.9% of PTs experienced some IPSB during their careers, with 45.2% reporting that they had experienced severe IPSB (e.g., deliberate genital exposure or forceful attempted fondling). In the late 1990s, two studies found similar results: 85%[4] and 86%[6] of respondents reported experiencing some form of IPSB in their careers. This prevalence has been consistent across decades; in a 2017 study, Boissonnault et al.[7] found that 84% of respondents had experienced IPSB at some point in their careers, with 47% having experienced IPSB within the last 12 months. About 37% experienced severe IPSB during their careers, which included behaviors such as deliberate exposure, masturbation during a session, stalking, or forced sexual activity.

Prevalence among PT students

Although these studies illustrate the rates and types of IPSB experienced by PTs, less is known about PT students. The early studies by McComas et al.[2,8] included a sample of 68 PT students in a bachelor's degree program in Canada. The researchers found that 66.2% of students reported experiencing IPSB, with much higher incidence in the third and fourth years of training (83.3% and 75.0%, respectively). Rates of IPSB experienced by students approached those of practicing therapists, with 64.2% of students reporting mild IPSB (compared to 90.5% of therapists), 45.6% reporting moderate IPSB (compared to 76.2% of therapists), and 22.1% reporting severe IPSB (compared to 45.2% of therapists). This suggests that more than half of PTs who experience IPSB in their careers begin experiencing it before licensure. In this sample, 13 out of 68 students had patients deliberately expose their genitals to them; seven had patients make forceful attempts to touch, grab, fondle, or kiss them; four had patients proposition them for sex; and two reported patients who attempted to force intercourse. Notably, none of the licensed PTs reported patients attempting intercourse using force.

The 2017 sample collected by Boissonnault et al.[7] included PTs, physical therapist assistants (PTAs), PT students, and PTA students in the United States. The data for students were not disaggregated, but qualitative analysis revealed that IPSB remained a frequent problem for PT students. One student said, 'When I discussed my experiences with two female classmates, I found out that every one of us had been harassed on our summer internships.'

Ang et al. conducted the only study exclusively focused on PT students in 2010.[9] They surveyed 67 students in their final year of a physiotherapy bachelor's program in Australia. Although the frequency of specific behaviors was not reported in depth, 78% of students reported experiencing at least one form of IPSB. The consistently high prevalence of IPSB experienced by students across studies and in multiple countries is cause for concern.

Responses to IPSB

Several attempts have been made to document how PTs and PT students respond to IPSB. Cambier et al.[10] examined how novice therapists handled IPSB compared to more experienced therapists. They report that 95.9% of respondents used distraction to handle IPSB, 69.3% ignored it, and 66.5% used avoidance techniques such as moving treatment into public spaces. Approximately 53% reported addressing patients directly about their behavior, and 25.8% reported joking about the behavior. Respondents reported that distraction, avoidance, confrontation, behavioral contracts, transfer of care, and chaperone use were effective at reducing IPSB; ignoring and joking were ineffective and, in some cases, made the IPSB worse. More experienced clinicians were more likely to use effective strategies, and novice clinicians were more likely to use ineffective strategies.

McComas et al.[2] asked students how they responded to IPSB and found their most common response was ignoring it. Forty-seven percent of students responded to

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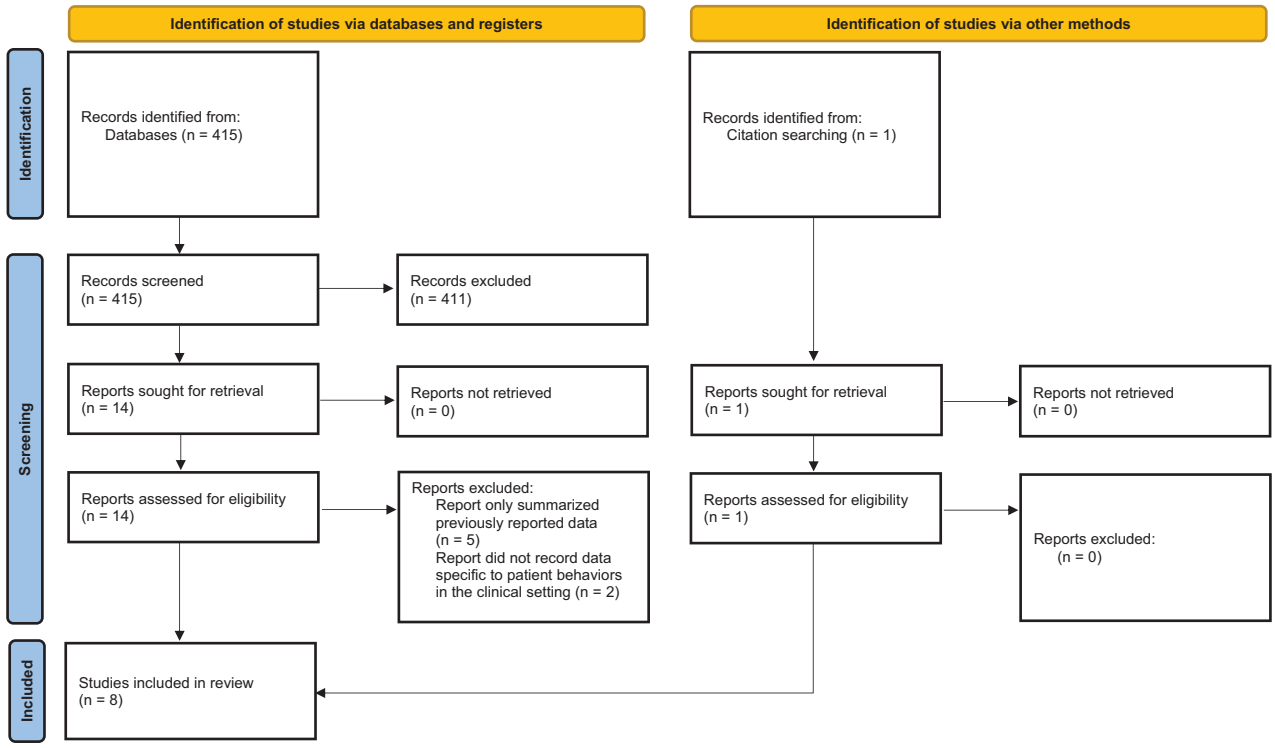

Fig. 1. PRISMA flow diagram.

Table 1. Articles included in review

Source	Number of participants	Country	Methodology	Type of instrument
McComas et al., 1993[2]	84 PTs 68 PT students	Canada	Quantitative	Survey
McComas et al., 1995[8]	84 PTs 68 PT students	Canada	Qualitative	Survey
deMayo, 1997[6]	358 PTs	United States	Quantitative	Survey
Weerakoon & O'Sullivan, 1998[4]	150 PTs	Australia	Mixed Methods	Survey
O'Sullivan & Weerakoon, 1999[11]	9 PTs	Australia	Qualitative	Semi-structured interview
Ang et al., 2010[9]	67 PT students	New Zealand	Quantitative	Survey
Boissonnault et al., 2017[7]	697 PTs 56 PTAs 132 PT students 7 PTA students	United States	Quantitative	Survey
Cambier et al., 2018[10]	282 PTs 29 PTAs 79 PT students 1 PTA student	United States	Mixed Methods	Survey

'grossly inappropriate comments' or 'brief minor touching' by ignoring compared to 28% of licensed therapists. In response to those same behaviors, 56% of licensed therapists responded by discussing the behavior with the patient directly, while only 11.8% of students did so. Students were also much less likely to address the behavior with the patient or give ultimatums to withdraw services, even in cases of 'grossly inappropriate touching.' Taken together, these studies suggest that students are much more likely to rely on ineffective methods of addressing IPSB.

Identified problems

To explain the high prevalence of IPSB in PT, many potential contributing factors have been suggested. Some

of these are likely nonmodifiable features of the PT profession; others may be addressed through planned intervention.

Features of the profession. In a qualitative analysis of IPSB, O'Sullivan and Weerakoon[11] report that the 'nature of physiotherapy practice itself with the use of touch, physical exposure and unique communication dynamics' was a commonly identified factor. In one interview, the participant stated,

> 'In general, the interactions in physiotherapy provide a false sense of intimacy. Consultations in private practice are on a one-to-one basis. They are private and involve touch. … Physiotherapists see people on a more personal level; they spend more time than doctors do with their patients. Therefore there is less distance between the physiotherapist and the patient.'

Other professions have identified similar IPSB risk factors. Notaro et al.[12] note that one-on-one encounters behind closed doors, the degree of necessary patient disrobing, physical contact during examinations, and a growing young, female workforce place dermatologists at higher risk for experiencing IPSB than other medical specialties. These same factors would well describe key features of the PT profession.

Features of individual therapists and patient populations. Provider gender is often thought to play a role in IPSB. Boissonnault and colleagues[7] identified that being a female provider and treating mostly male patients were both risk factors for experiencing any IPSB with odds ratios of 2.19 and 3.82, respectively. However, these were not significant risk factors for experiencing severe IPSB. Similarly, McComas et al.[2] found that female providers were more likely to experience any IPSB or mild IPSB, but there were no differences between genders with regard to moderate or severe IPSB. Weerakoon and O'Sullivan[4] found no significant difference between male and female experience of IPSB in any categories. Multistep regression performed by deMayo[6] identified younger age and female sex as statistically significant factors that made providers at higher risk of experiencing IPSB, but only 4% of the variation in IPSB was explained by these characteristics. Female providers appear to be at higher risk of experiencing IPSB overall, but males and females may experience moderate and severe IPSB at similar rates.

It is also frequently suggested that a significant amount of IPSB may be due to patients' cognitive impairments.[2,4,7,8,11] Boissonnault and colleagues[7] collected data on whether their respondents worked with individuals with cognitive impairments and found doing so increased the odds of experiencing mild and moderate IPSB slightly (odds ratios of 1.66 and 1.88, respectively) and of experiencing severe IPSB greatly (odds ratio of 5.48; 95% CI, 2.87-10.5). This suggests that individuals with cognitive impairments are more likely to engage in ISB toward their therapists, but it does not explicitly show it. In contrast, McComas and colleagues[2] found that respondents who worked in nursing homes and psychiatric settings experienced some of the lowest rates of IPSB (11% and 17.9%, respectively). Ang et al.[9] found similar rates of IPSB in outpatient orthopedic settings (29%) and neurological settings (36%). The only study that has directly attempted to identify what percentage of IPSB might be related to cognitive impairments found that just 7% of identified incidents could be attributed to the influence of medication or psychiatric disease.[13] Until future studies better elucidate this issue, it appears that working with cognitively impaired patients does increase exposure to severe IPSB, but cognitive impairment does not account for all incidences of IPSB.

Lack of training. Nearly two and a half decades after the first studies demonstrated high prevalence of IPSB in the PT profession, Boissonnault and colleagues[7] found that only 36% of their respondents reported receiving training in how to handle IPSB. PTs and students interviewed in qualitative studies consistently report that they wish they had more training in this area,[7,8,11] and Ang et al.[9] found that 79% of students did not feel adequately prepared to deal with IPSB.

Workplace culture. Qualitative studies often cite institutional culture as a contributing factor. O'Sullivan and Weerakoon[11] found that all but one of their participants were unaware of their clinic or institution's formal guidelines or procedures for preventing or responding to IPSB. McComas et al.[8] quote a respondent who was sexually assaulted by a patient, and upon reporting the incident to coworkers was told, 'Any lonely person needs hugs.' Boissonnault et al.[7] report that many therapists who experienced IPSB felt a similar lack of institutional support, saying, 'I was told that when patients were inappropriate with me it was "part of the job,"' and, 'My company does not support transferring care, terminating the patient, or provide support to the employee. It is also better if the company does not know because my immediate supervisor will blame it on the employee and ridicule.' The same researchers quote a student's perspective:

> 'Although I felt that my CI [clinical instructor] was generally supportive, he later said nothing when a patient's husband commented on my physical appearance. He also joined in when a patient started discussing my personal life and tried to give me dating advice. … I don't think that my CI knew that this behavior was inappropriate. He definitely didn't have enough training on the topic.'

Organizational culture has been called 'the most potent predictor of sexual harassment' in the workplace.[14] The low number of therapists who are aware of institutional

policies regarding IPSB is cause for concern. Additionally, the prevalence of reactions like, 'it's part of the job' implies that the culture in many settings enables ongoing IPSB instead of addressing it. This is a particularly dangerous combination for student PTs who have limited say in their clinical experience assignments.

Discussion

More research is needed to elucidate how PT students experience IPSB, how they can prepare for IPSB, and what interventions might mitigate the harm it causes. For now, our profession can improve awareness and education among practicing therapists and clinical instructors, improve education of PT students, and encourage bystander reporting.

The student cited by Boissonnault et al.[7] describes her CI as 'generally supportive,' but, 'I don't think that my CI knew that this behavior was inappropriate.' Her example highlights situations where patients were inappropriate, and the instructor was either silent or contributed to the behavior. Many CIs might be similarly well-intentioned but unaware of appropriate boundaries or how to react in these situations. Since just 36% of respondents in 2017 reported receiving training in how to handle IPSB,[7] and since newer PTs tend to use ineffective strategies,[10] clinical instructors are likely to be ill-equipped to support students in these scenarios. Adding IPSB training to courses for clinical instructors could improve outcomes when IPSB does occur.

Although CI training would be helpful, training students in PT programs to handle IPSB would have longer-term benefits for the profession. Not only would students be better equipped to handle these behaviors, but as they graduate and become CIs themselves, they will be able to help future students. Currently, the Commission on Accreditation in Physical Therapy Education includes no standards to cover this material. Somewhere in all our focus on patient-centered care, we might be neglecting the welfare of the clinician.

Lastly, we can work to address this issue by encouraging bystander reporting across our profession. Bystander reporting has been advocated in other healthcare professions as a way to reduce the burden on the individual who experiences inappropriate behavior.[14–16] Because students are not employees, they might lack (or perceive that they lack) some of the protections that an institution's policy affords paid staff. Additionally, they cannot resign and leave a clinic, and they often feel that their ability to graduate and take their licensure exam is dependent on a good report from their CI – a CI who may or may not be equipped to recognize appropriate boundaries or respond when they are crossed. For these reasons and others, students are less likely to report IPSB when it happens.[2] When bystanders report inappropriate behaviors, less depends on the bravery of the student. Bystander reporting has the additional benefit of validating the experience as inappropriate, which therapists and students alike may struggle to recognize.[2,4,7]

Clinical implication

IPSB is a serious problem in PT, and PT students are not insulated from it. In fact, they may be more vulnerable and less prepared to handle IPSB. The current evidence suggests that even during relatively short clinical experiences, many students are exposed to severe forms of IPSB, and they are much less likely to handle it effectively. Students and therapists consistently call for better preparation and education on the topic. Therapists, CIs, and students need to be better prepared to handle IPSB effectively so that they can protect themselves and others.

Although IPSB in PT has been reported for 30 years now, incidence has not decreased, and preparedness has not improved. When McComas and her coauthors first published their report on IPSB in PT in 1993, that edition of *PTJ* began with a letter from the editor, Jules Rothstein.[17] Addressing the topic of IPSB, Rothstein writes:

> 'This topic is brought home in alarming proportions by the study of McComas and colleagues[2] in this issue. Their data suggest that almost all of us will be exposed to inappropriate sexual behaviors from our patients – and that includes men as well as women. …
>
> The data of McComas and colleagues suggest that during our student days we may even be socialized into accepting this behavior. We may first experience this abuse as students, and, apparently, either because of our inclinations or our environments, we do very little about it. …
>
> Silence has ill served us all. The time has come for us to consider how we deal with this subject in our clinical environment. … I am not suggesting that the victims are responsible for their own abuse, but I firmly believe that each of us as members of a profession and society must consider how we have allowed these behaviors to become so common.'

If the time had come in 1993, then it is certainly past time to take this call to heart.

Limitations

This review should be interpreted within the context of several limitations. Only published literature written in English was reviewed, so relevant studies that were not indexed in the searched databases or were written in other languages were potentially omitted. The research

and composition of this paper was performed by a single author; no additional researcher was able to check the accuracy of the review process, data extraction, and conclusions. Although attempts were made to be thorough and fair with the data and analysis, the author's biases or oversights may have influenced the results. Lastly, the studies included in this review used various designs, instruments, and populations, and quality assessment was not performed. While this is typical of the narrative review format, caution should be used when applying these findings outside of the original papers' contexts.

Conclusion

The available evidence suggests that 66% to 78% of PT students experience IPSB during their clinical experiences, with many experiencing severe forms of IPSB. The majority report being unprepared for IPSB and recommend more training for students and CIs.

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