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Article

Simulating Intimacy Without Disrobing: Teaching Relational Ethics Through Feeding and Oral Care

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ABSTRACT

Background: At least four and potentially six of the eight basic activities of daily living (ADL) described in the Occupational Therapy Practice Framework involve the patient in a naked or partially-clothed state. Preparing occupational therapy students to assist with intimate ADLs such as bathing, toileting, and dressing poses unique challenges, particularly regarding relational and ethical dimensions of care. While active learning is widely supported in occupational therapy education, little evidence describes high fidelity methods for reproducing these private states.

Methodology: This study examined an innovative feeding and oral care lab designed to replicate relational demands of intimate ADL care. The lab required second year students in a Master of Occupational Therapy program to alternate between the roles of therapist and patient while engaging in tasks such as feeding a partner and providing oral hygiene. Following the lab, 106 students across three cohorts submitted reflections which were qualitatively analyzed.

Results: Students reported significant emotional complexity in both roles. As student-therapists, they noted discomfort with proximity, bodily functions, and navigating dignity, communication, and consent. As dependent student-patients, they described vulnerability, loss of control, and embarrassment. These reflections underscore core elements of relational ethics in practice, highlighting empathy, professionalism, cultural humility, and therapeutic use of self. This lab successfully simulated the emotional aspects of intimate ADLs in an educationally appropriate, safe environment, supporting self-discovery, emotional processing, and skill development.

Conclusion: Findings suggest that high fidelity simulation should emphasize relational authenticity, and this lab experience is recommended for preparing occupational therapy students for the relational and ethical demands of intimate ADLs.

Keywords: Basic activities of daily living, active learning, occupational therapy education, relational ethics, intimate care, simulation

INTRODUCTION

At least four of the eight basic activities of daily living (ADL) listed in the Occupational Therapy Practice Framework (4th edition) involve the patient being naked (bathing/showering, toileting and toilet hygiene, dressing, and sexual activity). Another two (personal hygiene and grooming and functional mobility) may require the patient to be unclothed (American Occupational Therapy Association, 2020). The importance of preserving patient dignity and privacy during these basic, intimate ADLs has been largely recognized for decades (Whitehead & Wheeler, 2008). Adults who require assistance with toileting often feel embarrassed and undignified (Göransson, Larrson, & Carlsson, 2022; Talley, et al., 2014; Thompson, et al., 2021). Likewise, adults needing assistance with bathing and dressing experience similar emotions of anxiety and vulnerability (Holroyd & Holroyd, 2015; Oosterveld-Vlug, Pasman, van Gennip, Willems, & Onwuteaka-Philipsen, 2013; Zingmark & Bernspang, 2011). A study by Johnson, Morgan, and Jones (2023) found that oral care was viewed by older adults as a highly personal and private event; requiring assistance with this task was perceived as embarrassing and undignified (Johnson, Morgan, & Jones, 2023). Similarly, a study by Ninfa et al. (2025) focusing on the lived experiences of adults with dysphagia found that eating and swallowing difficulties were experienced as burdensome, frustrating, and embarrassing (Ninfa, Morandi, Schindler, & Delle Fave, 2025).

In healthcare education, simulation labs are frequently designed as transactional spaces where the primary objective is the mastery of technical proficiency and diagnostic accuracy (Shetti, 2024). In this type of practitioner-to-client delivery model, the learner often focuses on the clinical skill or problem in isolation, viewing the client as a passive recipient of care. However, this clinical detachment can obscure the deeply relational nature of therapeutic work. When simulation is treated merely as a performance of skills, there is risk of the imbalance of power and the moral weight of the encounter between the provider and the client being overlooked (Nimmon & Stenfors-Hayes, 2016). By grounding simulations in the framework of relational ethics, educators can move beyond technical competency to explore the ethics and the art of interaction (Bergum & Dossetor, 2005).

Prior research demonstrates overwhelming evidence supporting the effectiveness of active learning strategies in occupational therapy education, including improved clinical reasoning, skill acquisition, and learner confidence (Bingen et al., 2024; Calabrese, 2023; Feldhacker & Feldhacker, 2022). Butts et al. (2025) recommended that academic programs introduce students early in the curriculum to learning experiences that build their confidence and preparation for interacting with clients during level II fieldwork through active learning strategies. Years of focus group data consistently showed that occupational therapy students in our program wanted more opportunities to learn OT interventions for basic ADL through experiential lab activities.

Healthcare professionals experience complex psychological reactions when delivering intimate care, requiring them to manage their personal feelings about touching another person's body. Within this context, normalizing discomfort as part of training for future clinicians is viewed as a foundational element in the development of therapeutic use of self. In clinical practice, practitioners' visible discomfort may inadvertently amplify clients'

experiences of embarrassment (Buono, Nygren, & Bianchi-Berthouze, 2025; Thompson, et al., 2021).

Across all healthcare educational programs there is a need to prepare students for the emotional aspects of providing ADL assistance, including strategies to enhance the dignity and respect of patients during intimate basic ADLs (Geller, et al., 2015; Shakwane, 2024). With respect to active learning strategies, high-fidelity refers to the degree of realism of the learning experience. This may include the physical environment, the psychological impact of the scenario, and the technical demands of the task (Lavoie, et al., 2020). We found little information on evidence-based, high-fidelity active learning instructional methods for practicing basic ADLs in healthcare education.

Two active learning strategies often used in healthcare education are role-play and simulation. In role play, students act out scenarios to explore roles and practice clinical skills. Alonso-Peña and Álvarez-Álvarez (2023) found that clinical simulation in health education programs typically follows a well-defined structure with clear pedagogic objectives and sequenced stages (prebriefing, scenario execution, and debriefing), all of which are designed and facilitated by trained educators to guide learning and reflection in an ordered way involving the learner playing the role of the practitioner who is conducting the assessment or intervention on the simulated patient.

Several studies examined a type of simulation, Mask-Ed™, to train nursing students to address naked ADLs (Mainey, Dwyer, Reid-Searl, & Bassett, 2018; Reid-Searl, 2020; Reid-Searl, Eaton, Vieth, & Happell, 2011; Reid-Searle & O'Neill, 2017). Generally, this strategy involved an experienced educator portraying the role of a patient by using realistic silicone props (e.g., face mask, hands, torso with genitalia). The disguised educator acted as the patient and then provided feedback to students immediately after the simulation. The studies all reported that the use of Mask-Ed™ improved nursing students' confidence and insight when performing intimate ADLs.

Occupational therapy research related to basic ADLs tends to focus on client outcomes of interventions rather than controlled studies of educational methods to train future occupational therapy practitioners. Most studies describe occupational therapy interventions for basic ADLs in terms of observable skill performance (Canter, Loitz, Richardson, Pontes, & Katz, 2024; Khayatzadeh-Mahani, Riyahi, Amiri, & Angali, 2023; Legg, Lewis, Schofield-Robinson, Drummond, & Langhorne, 2017; Vasquez-Carrasco, et al., 2025). We found no studies describing or comparing active learning strategies in occupational therapy curricula that specifically address unclothed basic ADLs or the relational nature of the interplay between the patient and the clinician during this type of intervention. Hence, when it comes to providing instruction on clinical skills involved in unclothed ADLs such as bathing, toileting, and dressing, occupational therapy educators are faced with a unique challenge: *How can ADL instruction be provided through active learning in a realistic way that recognizes the vulnerable, intimate state involved with respect to the concept of relational ethics, within educationally appropriate guidelines?* Our answers emerged after examining students' written reflections that followed an educational experience involving a clothed ADL: a feeding, eating, and oral care lab.

METHODS

Study Design

We conducted a retrospective analysis of assignments from three cohorts. The assignments were researcher-designed reflective prompts following a lab experience for second-year Master of Occupational Therapy students nearing the end of the didactic portion of their curriculum. The lab followed a series of lectures on the basic ADLs of feeding, eating and swallowing, and oral care in the context of personal hygiene and grooming.

The lab experience combined active learning strategies of simulation and role-play. Students were told to bring two hand towels, their toothbrush, and their toothpaste to the lab. Written and verbal instructions were provided. Students thickened liquids according to the International Dysphagia Diet Standardization Initiative (IDDSI) framework (IDDSI, 2019), performed cranial nerve assessments on each other, fed each other, and brushed each other's teeth, among other guided tasks. Students took turns being a therapist and a dependent patient in a hospital bed. Immediately after the lab, students completed a reflective assignment consisting of open-ended prompts.

The lab took place in two primary areas, natural settings in which educational activities were held: an educational kitchen environment and a simulated hospital ward with 12 hospital beds. In the kitchen, students followed IDDSI guidelines for preparing and measuring the thickened consistency of orange juice, coke, and chocolate milk. Each student fashioned a cup with a nose-shaped cutout ("nosey cup") in which they poured the thickened liquids they made. They selected foods they would be fed by their lab partner from the following options: grapes, apple slices, applesauce, crackers, hard cheese cubes, cookies, baby carrots, chips, and cheese dips. Students also made a bite block from wooden clothes pins which they taped together to form a wedge.

The second part of the lab took place at the university's simulation centre. Here, the students took turns role-playing a dependent patient in a hospital bed while their lab partner acted as the student-therapist. With pre-approval, students brought the foods and liquids into this area. Student-therapists commenced this portion of the lab by performing a cranial nerve (CN) assessment (CN 5, 7, 10-12). They then fed the student-patient the food they chose for themselves and the liquid they prepared. After 15 minutes, student-therapists were instructed to clean the student-patient's mouth: on one side using the toothbrush and the bite block, and on the other side using a disposable, foam-tipped swab, a common device for oral hygiene found in hospital settings. Student-therapists used a paper cup with water to help student-patients rinse their mouth and an empty cup for spitting out the contents. After approximately 30 minutes, students switched roles. Immediately after the lab, students were instructed to complete their reflective assignments, while the experience was still fresh on their minds.

Data collection

This study was granted exemption by the institutional ethics board (Ref. No. 19-06798-XM). To ensure fidelity, the reflective prompts remained consistent for each cohort. However, the reflective questions for the assignment given to the Class of 2024 were not separated into individual prompts. Therefore, reflections were submitted as essays. Subsequent assignments for Class of 2025 and Class of 2026 required students to respond to each prompt.

Responses from all 3 cohorts were de-identified. Essay responses for Class of 2024 were analyzed by the authors, who created a spreadsheet with a column heading for each of the original 14 prompts. For each student essay, sentences or parts of sentences were extracted and categorized into the appropriate column. Disagreements were resolved through discussion. Class of 2025 assignments involved responses to each prompt (see Table 1). Data from each student assignment were extracted following the aforementioned method with the complete response (rather than a sentence or part of sentence) placed in the relevant spreadsheet column. Class of 2026 responses were collected using a survey in the learning management system, which provided results in the form of a spreadsheet. The responses for all 3 classes were combined into a single spreadsheet.

Data analysis

We conducted an inductive thematic analysis of students' perceptions to the lab by analyzing 106 assignments (39 class of 2024; 29 class of 2025; 38 class of 2026). We initially processed the spreadsheet in Microsoft 365 Copilot using the command Summarize each column to identify themes for each prompt. Most prompts had a ~90–100% response rate (n=94-106). The optional final prompt had the lowest response rate (14%, n=13). Each researcher independently reviewed the themes generated by Microsoft 365 Copilot for each prompt. This was followed by a joint discussion of identified themes to achieve consensus and enhance reliability. The themes were subsequently developed and synthesized into broader categories through iterative reflective discussions.

RESULTS

The following themes emerged from the open-response questions to the students' experience of the lab: emotional complexity and role duality, preservation of patient dignity and privacy, the centrality of communication and consent, therapeutic use of self and empathy, and cultural humility and professionalism. Statements from student assignments are provided under each theme to provide context.

Emotional complexity and role duality

Students in both the therapist and patient roles experienced a wide range of complex emotions. As student-therapists, they overwhelmingly reported feelings of awkwardness, invasiveness, and discomfort with physical proximity, especially during tasks like cleaning another's mouth or placing their hand on their fellow student's neck. At the same time, some students felt curious when performing aspects of cranial nerve assessments or palpating swallow.

> Participant 10*: "I did not enjoy this aspect of lab today at all. I felt that it was a very intimate interaction that kind of made me queasy."*

> Participant 80: *"I thought this was pretty neat. You could really feel all the structures moving to manipulate the food/drink down the throat."*

> Participant 90: *"This was a very interesting experience. I didn't realize how much the hyoid bone actually moved when we swallowed."*

As student-patients, most described feelings of vulnerability, helplessness, embarrassment, and a significant loss of control and independence. A small number of students enjoyed the experience.

> Participant 20: *"I was extremely uncomfortable having someone else cleaning my mouth."*

Participant 13: *"I felt very vulnerable."*

Participant 89: *"I felt at ease and trusted the person doing it; however, I could see how I would've been more apprehensive if I had not know the person doing it."*

Preservation of patient dignity and privacy

A major theme was the critical importance of maintaining a client's dignity during intimate tasks. Students reflected on the need to remain calm, supportive, and matter-of-fact to help normalize potentially embarrassing moments, such as spitting into a cup or drooling. The lab highlighted how easily patients can feel infantilized or ashamed when receiving assistance with basic ADLs.

Participant 1: *"In spite of my personal aversions, I understood the need to be a compassionate provider, so I attempted to work past my reluctance."*

Participant 3*: "This made me feel queasy and I had to look away for part of it."*

Participant 79: *"It felt like a very vulnerable moment to be part of, and I wanted to make sure I was calm and matter-of-fact so they didn't feel ashamed. I focused on being supportive rather than reacting, to help maintain their dignity."*

The centrality of communication and consent

Effective communication during the interaction was seen as essential for reducing anxiety and building trust. Students emphasized that seeking permission when touching sensitive areas (face, mouth, throat) must be an ongoing process, underscoring the need for continuous consent. In addition, learners recognized the heavy reliance on non-verbal communication and constant "checking in" because the patient's mouth was often occupied, limiting their ability to speak. Both of those aspects of care connect directly to the concept of relational ethics.

Participant 21*: "Working and communicating with your client to adjust your technique can go a long way and ensure the client feels dignified during the intervention."*

Participant 79: *"It felt kind of like I was intruding their personal space. I was sure to verbally assure the client of what I was doing to help calm them."*

Participant 93: *"Cleaning someone else's mouth felt like I was invading their personal space, so I wanted to be mindful and ensure they felt comfortable."*

Therapeutic use of self and empathy

The experience fostered a deeper understanding of the human experience of care. Students reported an increased awareness of the psychosocial demands of their future roles. The lab was described as a safe environment for self-discovery and emotional processing, helping students normalize discomfort before entering clinical practice.

Participant 73: *"It felt weird to feed someone else and help them drink, but it made me realize how actual patients may feel when they are receiving assistance."*

Participant 78: *"I thought it was cool to feel them swallow. I feel like now I could understand what would happen if someone had difficulty swallowing."*

Participant 84: *"I do not like spit, so I was trying to stay calm during that experience. I managed well, and I feel like it was a good opportunity to be exposed to that for the future."*

Participant 87: *"An insight I gained is that it's more difficult than I thought and it also teaches you empathy because being dependent on someone isn't fun."*

Participant 106: *"It was very intimate... I felt like they were trusting me to not hurt them and to make sure they were as comfortable as possible."*

Cultural humility and professionalism

Reflections pointed to the need for sensitivity regarding individual differences. Students noted that approach and touch must be adapted based on gender, religion, and cultural beliefs surrounding modesty and personal space. Maintaining professionalism while managing personal sensory aversions (e.g., to saliva or thickened liquids) was identified as a key skill developed during the lab.

Participant 6: *"I believe as a therapist you should take on a sense of humility, communicate respectfully, and with patience. I want to partner with my clients and empower them regardless of age, gender, sexual identity, sexual preference, religion, socioeconomic status, and etc.. My clients will be in a very vulnerable state. I want to help them regain a sense of dignity and never take that from them."*

Participant 13: *"Before spitting, I made sure no one was looking at me. I would have felt embarrassed if someone was watching me spit in front of them. It gave me a better insight on how clients must feel when they have to spit in front of others."*

Participant 88: *"I would also need to practice cultural humility by asking the client what they were comfortable with me doing, while also educating them on the importance of feeding and oral care."*

Participant 93: *"Performing these tasks with individuals who are different from me helps me practice cultural humility during therapy sessions, especially while being in their personal space."*

Overall, students provided rich reflections on the importance of empathy, cultural humility, patient dignity, and the occupational therapist's role in intimate care tasks. Many reported that this lab increased their awareness of the challenges their clients face. Students consistently expressed increased empathy for clients, especially when experiencing loss of control during feeding or oral care. Clear explanation and consent were emphasized as essential when performing intimate tasks like palpating the throat or brushing teeth.

Table 1 shows the assignment prompts and response rates.

Table 1: Assignment prompts and response rates

Prompt	N
1. Which foods were easier and which foods were harder to manage in your mouth? (not included in class of 2024)	65
2. What was it like preparing and eating or drinking thickened food or beverages?	102
3. How did you feel about feeding someone else? How did you feel about helping them drink?	101
4. What was it like to have your hand on their throat while they were eating?	99
5. How did you feel when you were being fed and given liquids to drink?	97
6. What was it like to have another person's hand on your throat to feel you swallowing?	94
7. What was it like when you were cleaning someone else's mouth?	102
8. How did you feel about having your mouth cleaned by someone else?	95
9. How did you feel about inserting the bite block into someone else's mouth?	98
10. How did you feel about having a bite block placed in your mouth?	99
11. Was there a difference between having your teeth cleaned using a brush versus a swab?	105
12. How did you feel about using a cup to spit in to clear the secretions from your mouth?	97
13. How did you feel about assisting someone to spit into a cup to clear their mouth?	96
14. After the lab, what insights did you gain regarding the role of occupational therapy in the ADLs of self-feeding and grooming? (combined with #15 for class of 2024)	106
15. How would you feel about performing these tasks with people who were different from you--different age, gender, sexual identity, sexual preference, religion, socioeconomic status, etc.? (combined with #15 for class of 2024)	38
16. (Optional) Please feel free to add any other comments about the lab that will be useful for future students who participate in this experience.	13

DISCUSSION

This study extends existing work in simulation-based occupational therapy education by demonstrating that high-fidelity learning can be achieved not only through physical realism, but through the intentional cultivation of relational and emotional complexity. Importantly, these findings suggest that fidelity in simulation should be understood not only as environmental or procedural accuracy, but as the degree to which a learning experience authentically reproduces the relational and ethical demands of practice. Viewed through a relational ethics lens, the findings highlight that preparing students for basic ADLs requires more than technical skill acquisition; it requires the development of ethical attunement to vulnerability, power, and human connection within intimate care encounters. The themes identified - emotional complexity and role duality, dignity and privacy, communication and consent, therapeutic use of self, and cultural humility - collectively illustrate how students begin to understand care as a relational, co-constructed process rather than a series of clinical tasks.

The duality of roles (acting as a caregiver and receiver of care) mirrors findings in nursing simulation literature regarding the development of embodied empathy, and our simulation demonstrated how role reversal made visible the ethical dimensions of care that are often implicit or overlooked. Through this dual-role engagement, students experienced the mutual vulnerability of the clinical encounter, shifting their focus from merely performing a task to honoring the human connection inherent in the therapeutic relationship. Further, by inhabiting the role of the patient, students moved past intellectualized empathy to an embodied understanding of the relational aspect of clinical care. The simulation served not just as a rehearsal of clinical protocols but as a site for negotiated responsibility, where future occupational therapy practitioners learned to respond to the unique presence of another person, specifically one who is vulnerable and in need. Through occupying both positions, students experienced not only what it means to perform care, but what it feels like to be the recipient of another's actions, thereby grounding ethical reasoning in lived, embodied experience.

The emotional complexity experienced by students in both roles reflects a core principle of relational ethics: vulnerability is shared, not unidirectional. While healthcare relationships are often framed as asymmetrical, with the patient positioned as vulnerable, these findings demonstrate that providers also experience uncertainty, discomfort, and moral tension. This mutual vulnerability is not a barrier to effective care; rather, it is the foundation upon which authentic, ethical relationships are built. Findings related to dignity further reinforce that dignity is not a static attribute, but something actively constructed within interaction. Students' efforts to remain calm, normalize potentially embarrassing situations, and avoid infantilization reflect an emerging awareness that dignity is upheld or compromised through moment-to-moment relational choices. From a relational ethics perspective, this positions the practitioner as an active participant in shaping the moral quality of the encounter, rather than a neutral performer of tasks.

The centrality of communication and consent represents one of the most significant contributions of this study. The themes of continuous consent and non-verbal communication illustrate a shift from viewing consent as a singular procedural event to understanding it as an ongoing, relational process. In the context of feeding and oral care, where the

patient's primary means of verbal communication may be temporarily compromised, students were required to attend to subtle cues, pauses, and embodied responses. This reliance on non-verbal communication reflects a more advanced form of ethical attunement, in which practitioners must interpret and respond to the other person in real time. In this way, consent becomes micro negotiated, with each action, such as approaching the face, offering food, or inserting a toothbrush, constituting a new request for relational entry.

Students' reflections on therapeutic use of self-highlight the internal work required to engage ethically in intimate care. Managing feelings of discomfort, curiosity, and aversion required students to regulate their own emotional responses while remaining present and supportive. Rather than suppressing these reactions, the lab created space for students to recognize and intentionally modulate them in service of the client's experience. Normalizing discomfort is a foundational component in the development of therapeutic use of self. In clinical practice, if a practitioner is visibly uncomfortable, the client's own embarrassment is amplified. This aligns with relational ethics, which emphasizes self-awareness and intentionality as key components of ethical practice. Similarly, the theme of cultural humility underscores that ethical care is always contextually situated. Students recognized that norms related to touch, personal space, modesty, and bodily exposure vary across individuals and communities. Relational ethics requires practitioners to remain open, responsive, and adaptable, acknowledging that ethical action cannot be standardized but must be negotiated within each unique interaction. Thus, this lab served as a form of exposure for the student's professional development.

While this study was initially framed in relation to unclothed ADLs, the findings suggest that the more salient construct is not physical exposure alone, but the experience of relational intimacy. Feeding and oral care, though performed in a clothed state, reproduce many of the same relational conditions as bathing, toileting, and dressing, including proximity, dependency, vulnerability, and potential for loss of dignity. Reframing the intervention around relational intimacy and ethical engagement strengthens the conceptual alignment between the learning activity and its intended outcomes and addresses a key gap in how intimate care is operationalized within occupational therapy education.

There is a notable gap in occupational therapy literature about educational strategies to train students on occupational therapy interventions for basic ADLs using realistic methods. Existing approaches tend to emphasize task performance within controlled, low-risk environments, often neglecting the relational and emotional dimensions of care. In our program, typical active learning strategies involve traditional labs such as teaching students one-handed dressing techniques or training in the use of adaptive equipment for functional mobility, grooming, feeding, and dressing. All these educational methods involve clothed role-play. We could not find information about high-fidelity instructional methods for training occupational therapy students in intimate occupations. To address this gap, we employed a design for the learning activity that used bidirectional clinical simulation, requiring students to participate as the student-therapist and the student-patient. The simulation closely mimicked other basic ADLs such as bathing, toileting, and dressing in several important ways.

In this lab, students engaged in a bona fide, hands-on basic ADL, supporting its high degree of fidelity to realistic situations encountered in occupational therapy practice. However, the fidelity achieved was not solely physical, but relational. Feeding and oral care required close proximity, direct contact, and sustained interaction with the student-patient's sensitive body areas (mouth, face, and throat). The student-therapist spent a prolonged amount of time within the student-patient's personal space. Bathing, toileting, and dressing involve sustained exposure of private body parts. These basic ADLs are all similar in that they require trust, rapport, and clear professional boundaries. Students in both roles reported complex emotions such as awkwardness, helplessness, dependence, vulnerability, and embarrassment, replicating the feelings of care providers and care receivers when engaging in naked ADLs.

Collectively, these findings suggest that relational authenticity - not physical exposure alone - is the critical mechanism through which high-fidelity learning occurs. While being fed and having one's mouth cleaned, student-patients experienced what it feels like to relinquish control: dependent, vulnerable, and childlike. This closely matches the experiences of patients who need help with bathing, toileting, and dressing. Student-therapists had to determine how to grade the activity, i.e., when to assist, when to pause, and when to step back. These moment-to-moment decisions reflect not only clinical reasoning, but ethical judgment, requiring responsiveness to the other person's comfort, readiness, and cues. In bathing and toileting, insufficient or inappropriate assistance can lead to harm (e.g., soiling, skin breakdown from poor hygiene). During the lab, the student-therapists had to determine the pace (e.g., when to feed another bite or offer hydration) and amount of assistance (e.g., pressure of the toothbrush or foam swab) to adequately and safely complete the activity. Student-patients reported discomfort having tasks done to them rather than with them in their own time. This was another aspect of the lab that closely resembled the considerations of care providers when assisting with bathing, toileting, and dressing: assistance cannot be rushed or delayed.

Handling saliva and gag reflexes during the lab experience bears similarities to dealing with body fluids during toileting. This point is particularly important as it requires the student-therapists to learn strategies to manage personal aversions while maintaining professionalism and patient dignity. For example, student-therapists had to remain calm and supportive when student-patients spat into a cup or suddenly gagged. The lab experience mirrored uncomfortable and potentially embarrassing situations encountered during naked ADLs. Care providers face similar emotional demands—remaining supportive and calm during unpleasant events, for example dealing with incontinence during bathing or assisting with toilet hygiene. Student-therapists experienced the importance of normalizing the event to preserve the dignity of the student-patient. Essentially, this aspect of the experience highlights the often-unspoken emotional labor involved in care work, which is central to relational ethics but rarely addressed explicitly in skills-based training.

Students noted that they must approach the task with sensitivity to gender, religion, and cultural beliefs. Norms around touch, exposure, and modesty vary widely with respect to gender, religion, and cultural identity during feeding and oral care. These considerations are equally critical in bathing and dressing, where modesty and cultural practices

strongly influence comfort. This reinforces the need for adaptive, person-centered care grounded in cultural humility and relational awareness.

Lastly, student-therapists emphasized the importance of communication and consent by seeking permission before touching the student-patient's face, mouth, and throat. This mirrors best practices for bathing, toileting, and dressing, where clear communication reduces anxiety. Non-verbal communication was equally important. During this lab, because student-patients' mouths were engaged, they were limited in their ability to verbally communicate with the student-therapist. The student-therapist had to rely on non-verbal cues and adjust their assistance accordingly. This required continuous explanation and narration of what they were doing and constant checking in on their comfort. In naked ADLs, consent is a continuous process, and moment-to-moment communication preserves dignity. In this way, students practiced a form of ethical mindfulness that is essential for maintaining dignity within intimate care interactions.

Overall, the lab helped students gain confidence and understand the depth of occupational therapy's role in ADLs, as evidenced in responses to the final survey question about insights regarding the role of occupational therapy in the basic ADLs of self-feeding and grooming. However, beyond confidence, the findings suggest that students developed an emerging capacity for relationally grounded practice—one that integrates technical skill with ethical awareness and interpersonal sensitivity.

Ultimately, this study suggests that high-fidelity simulation in occupational therapy education should be redefined to include relational authenticity as a core component. Preparing students for basic ADLs requires cultivating the ability to engage ethically within moments of vulnerability, power imbalance, and embodied human experience. By foregrounding relational ethics, this approach shifts the goal of education from competent task performance to ethically grounded, relationship-centered care.

CONCLUSION

Active learning through role-play and simulation, as reported in this study, resulted in a high-fidelity learning experience which fostered empathy and clinical reasoning. It exposed students to the human experience of caring, including the vulnerability, dependence, trust, and dignity involved, rather than focusing solely on task performance. The lab taught students to narrate their actions, seek consent, and respond to non-verbal cues during an ADL that they reported as "intimate". It highlighted the need to address privacy expectations. The lab revealed unexpected, uncomfortable situations that required students to exercise therapeutic use of self. It required students to simultaneously figure out how to maintain the dignity of the student-patient while managing their own sensory aversions alongside their curiosity. The lab helped students practice and normalize discomfort during basic ADLs. Students discovered that basic ADLs are not as basic as they may seem. Beyond mere task performance, assistance with basic ADLs required students to foster a therapeutic relationship, maintain client-centeredness, and consider ethical dimensions.

Limitations

In the three iterations of this lab, we did not include a debriefing session. Students' responses to the prompts served as an opportunity to individually reflect on their experiences. A collective debrief in a classroom setting would have been more beneficial in

providing students with opportunities to share their insights and learn that they were not alone in their uncomfortable experiences. Future labs will be designed to include a class-wide debriefing session. We acknowledge that our use of AI-assisted summarization at the start of our data analysis may have introduced bias related to selective emphasis which may have resulted in the potential attenuation of contextual and interpretive detail.

Implications for Occupational Therapy Education

Even though occupational therapy students standardly learn about intimate activities of daily living, they often lack opportunities to develop interpersonal skills in vulnerable occupations. A feeding and oral care lab gave students a safe and effective opportunity to explore their feelings about entering another's personal space before entering clinical practice in the field. The lab placed students in a care provider role, requiring them to take responsibility for another person's comfort, anticipate their needs, and adapt in real time. They had to obtain and continuously maintain consent, overcome awkward situations, manage their discomfort, and deal with conflicting emotions.

This lab provided a strong proxy for educating occupational therapy students to manage and perform intimate ADLs. It realistically mirrored the vulnerable state involved in basic ADLs such as bathing, toileting, and dressing, because it combined physical closeness, loss of independence, and psychosocial complexity—all hallmarks of most unclothed ADLs. Educationally, it aligned with Accreditation Council for Occupational Therapy Education (ACOTE) standards B.2.6., B.2.8., and B.3.13 (Accreditation Council for Occupational Therapy Education, 2023).

This inexpensive and straightforward lab experience is recommended for occupational therapy educators as a model for self-discovery and capacity-building with an end goal of enhancing patient care in future occupational therapy practitioners.

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