Addressing sexuality post-stroke: can targeted implementation change practice ?

Margaret McGrath

Sandra Lever

Emma Power

Stroke FOUNDATION

InformMe

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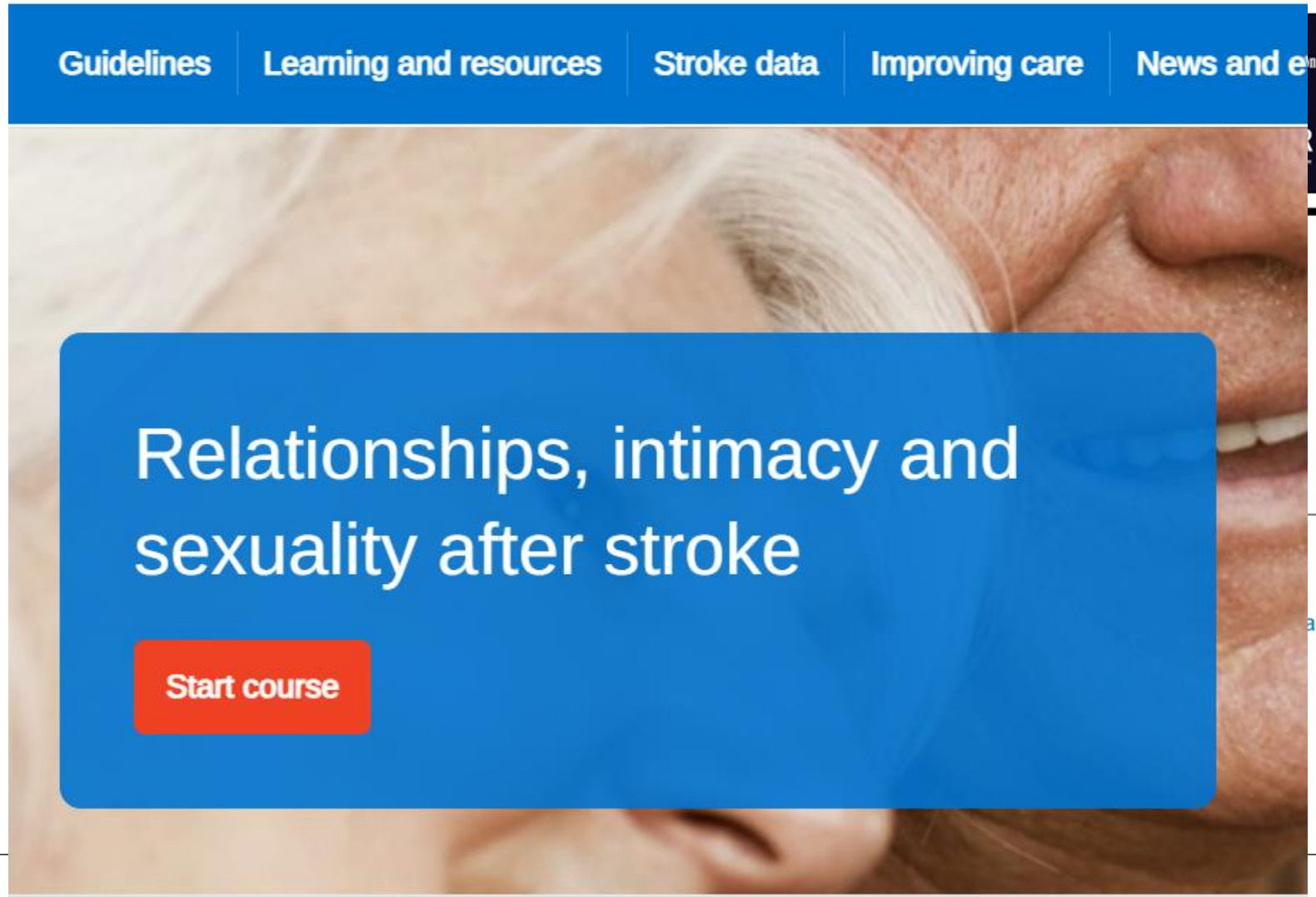


Sexuality

Central to being human

Broader than sexual activity

Individually experienced and expressed

Can change over time

Sexuality is a **central** aspect of being **human throughout life** that encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction. Sexuality is **experienced** and **expressed** in thoughts, fantasies, desires, beliefs, attitudes, values, behaviour, practices, roles and relationships. Sexuality is also i**nfluenced** by the interaction of biological, psychological, social, economic, political, cultural, ethical, historical, religious and spiritual factors *(WHO, 2002)*

What do we know about sexuality and stroke ?

Sexual dysfunction and dissatisfaction are common for people living with stroke & reduces QOL (McGrath at al, 2019; Jackson et al., 2016; Lew-Starowicz & Rola, 2014)

People living with stroke would like **health professionals to provide information and support about sexuality** to them and/or their partners (Lever, 2017, Byrne et al., 2013).

Sexuality is **rarely addressed by professionals** within rehabilitation services (Byrne et al., 2013; McGrath et al., 2019 Kokay et al. 2023).

Pt record audits **show less than 25% of stroke survivors receive best practise care** (Stroke Foundation, 2020)

All members of the MDT need to be prepared to address relationships, intimacy & sexuality (RISS)

Education & training alone is insufficient to change practise (McGrath et al, 2021)

Current study

- A research implementation protocol for supporting health professionals in NSW metro & rural inpatient stroke rehabilitation services to address relationships, intimacy and sexuality as well as the **preliminary** results of this study.

1. What are the barriers and enablers to implementing clinical guidelines related to sexuality after stroke?
2. Does a tailored implementation strategy improve:
    - Number of stroke survivors who are provided with permission to discuss relationships, intimacy and sexuality by members of the stroke rehabilitation team
    - Number of stroke survivors who are provided with limited information about relationships, intimacy and sexuality by members of the stroke rehabilitation team
    - Stroke rehabilitation clinicians' self-reported knowledge, skills and comfort in addressing sexuality after stroke ?

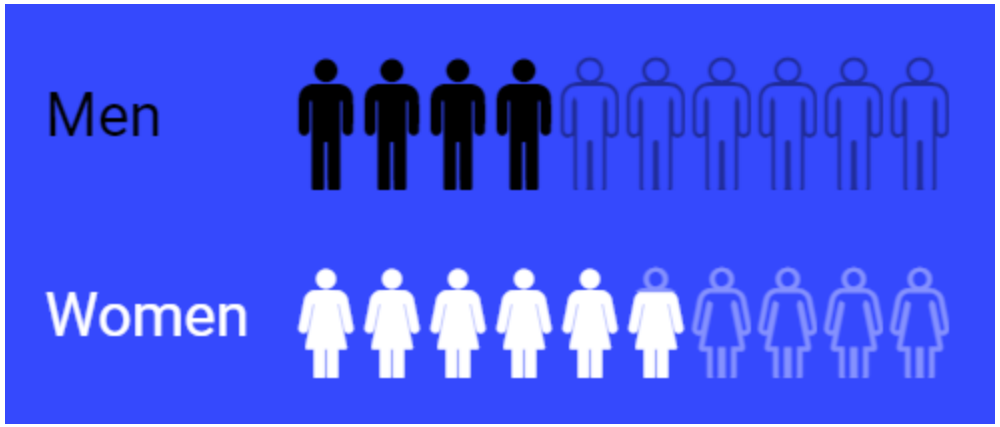
Methods

Pre & post data collection

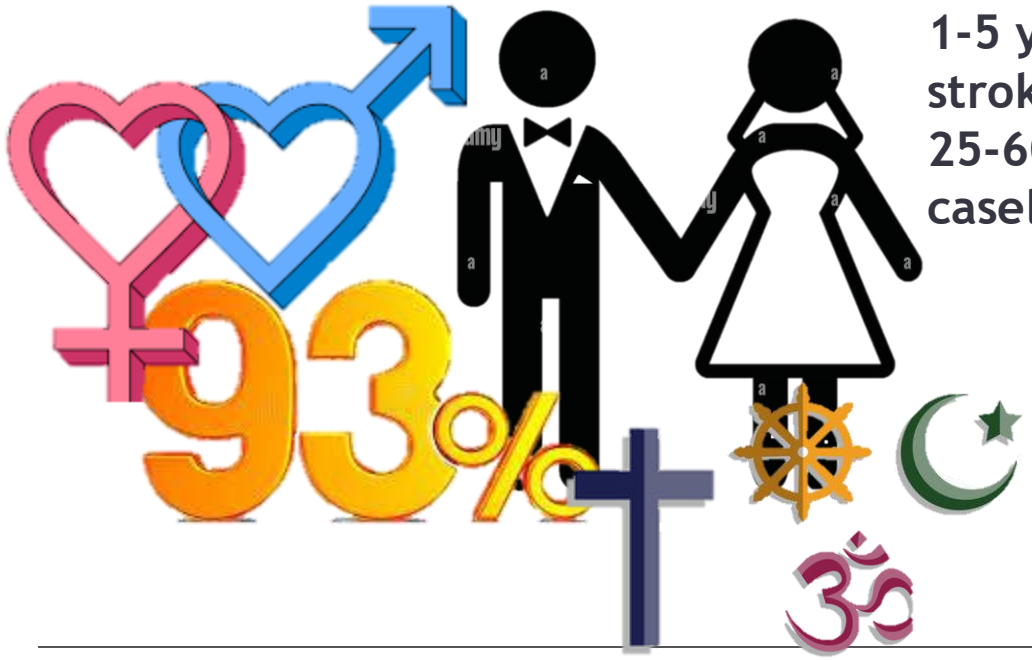
- Medical Record Audit –
- Clinician Survey– knowledge, comfort, attitudes and practice
- Focus groups/ interviews to identify barriers and enablers to clinical guidelines implementation

Implementation strategies

- Tailored to each site based on analysis
- Co-designed and implemented with key champions to ensure sustainability



Mean Age
39.7
SD 11.5



1-5 yrs in stroke rehab
25-60% caseload stroke

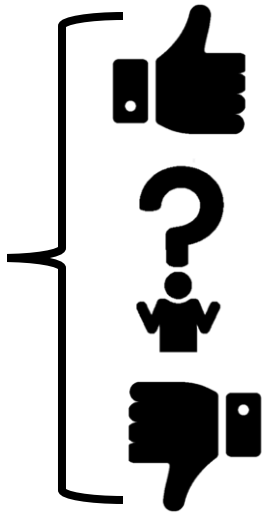
- n=23 33.8%
- n=15 22%
- n=9 13.2%
- n=6 8.8%
- n=6 8.8%

Knowledge, Comfort, Approach and Attitude towards Sexuality Scale (KCASS)

Scale (Min- Max Score)	Knowledge (13-52)	Comfort (20-80)	Approach (5-20)	Attitudes (5-20)
Physician	29.2(8.7)	31.5(15.7)	7.9 (3.9)	6.4(1.9)
Nurse	25.4(10)	46(24)	11.6 (6.3)	9 (3.6)
PT	27 (8.6)	52.3(21.5)	13.1(5.6)	9.7(3.3)
OT	21.7(7.3)	57.3(23.6)	14.3(6.1)	8 (3.1)
SP	29(6.3)	46.7(15.1)	11.7(4)	7(2.2)
Psych	24.5 (9.5)	56.7 (21.4)	19.3 (1.2)	6 (1)
SW	24 (0.1)	50(11.3)	12.5(3.5)	5.5(0.7)
Total	26.5(8.6)	47.3(21)	11.9(5.5)	8.5(3.2)

LET'S TALK ABOUT IT: SEXUALITY

Should we ?



n=58 85.3

n=8 11.8

n=58 2.94

Have stroke survivors asked ?

Never	61	89.7
At least once	1	1.5
1 -3 times	3	4.4
Prefer not to say	3	4.4

Direct Conversation

Direct Conversation

Never	Occasionally	Sometimes	Frequently
61 89.7%	1 1.5%	3 4.4%	0
57 83.8%	6 8.8%	2 2.9%	1 1.5%

Why not ?

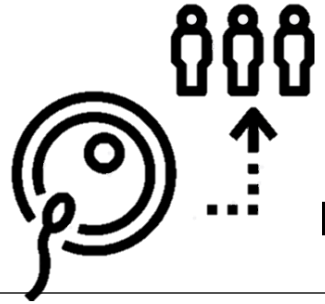
- Stroke survivors have not asked questions about sexuality (n=7)
- Not part of my role / within the scope of my practice (n=6)
- Sexuality is not a concern/relevant for stroke survivors (n=6)
- Sexuality is not a priority in stroke rehabilitation services (n=5)
- I am uncomfortable asking stroke survivors about sexuality (n=5)
- No opportunity to develop my knowledge and skills (n=5)
- I think other professionals do this(n=1)
- Sexuality is a private taboo topic (n=1)
- I am a young clinician (n=1)

n=7

n=5

LET'S TALK

SEXUALITY



n=1

n=1

What do clinicians perceive as barriers and facilitators to addressing sexuality after stroke ?

Domain	Barriers	Facilitators
1. Knowledge	26	10
2. Skills	12	7
3. Social/Professional Role and Identity	44	18
4. Beliefs about Capabilities	77	25
5. Optimism	39	18
6. Beliefs about Consequences	51	22
7. Reinforcement	8	2
8. Intentions	37	21
9. Goals	10	4
10. Memory, Attention and Decision Processes	0	1
11. Environmental Context and Resources	25	28
12. Social influences	44	3
13. Emotion	29	5
14. Behavioural Regulation	4	12

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Barriers: Beliefs about Capabilities and Beliefs about Consequences

Perception that very few team members were likely to be able to address sexuality Feeling unprepared to address sexuality	I say for myself because I don't know a lot about it I feel really awkward raising it because I don't know anything about what to say
Believing that not everyone had the capacity to address sexuality	I think it's not for everyone
Sexuality is not a priority in the context of stroke rehabilitation	Inpatient rehab we focus on transfers, mobility ADLS, communication so it doesn't' really sit within that frame
Sexuality is a taboo and patients may be offended; raising the topic could lead to misinterpretation and cause problems	It could be perceived that you're coming onto them It could be very shocking very distressing

Facilitators: Environmental Context & Resources Beliefs about Capabilities

Patient information resources support staff to feel confident to address sexuality	The Stroke Foundation leaflet yes that's very helpful we give it to everyone
Staff have good relationships with patients and can identify times for private conversations	Its' always easy enough to go in and see what's a good time that they won't be interrupted
Specialist follow up care is available	I know there's a couple of clinics we can refer to
My professional training supports these discussions	It went ok like we just kind of like brainstormed through it and I was able to help with positioning
Being comfortable managing /tolerating discomfort	I've never felt I think threatened or needed to escalate but yea I mean I've I can tolerate that type of thin

Implementation Strategy	Description	Suggested implementation	Behavior Change Technique
Goal setting	Individual team member sets personal goals re addressing sexuality	Team/buddy check in to monitor progress	Self-monitoring
PLISSIT model to guide practice	Stepped approach to guide clinicians in increasing comfort / confidence	Start at working at the level of permission and limited information	Graded task – starting with the easy task
PLISSIT model to guide practice	Stepped approach to guide clinicians in increasing comfort / confidence	Key champions provide permission and limited information statements	Increased skills problem solving decision making goal setting
		Onward referral pathways documented	Increased skills problem solving decision making goal setting

Implementation Strategy	Description	Suggested implementation	Behavior Change Technique
Managing potential problems	Identify potential risks to addressing sexuality and plan to mitigate	If X then Y plan in place to manage negative responses/ challenging questions/ higher level of need	Coping skills
Confidence to discuss sexuality	Opportunity to practice asking questions and responding to queries	Role play Sample scripts to support permission and limited information	Rehearsal
Managing self	Increasing own belief in capability to address sexuality	Self affirmation statements to support completing task Positive MMENOMIC	Self talk

Emerging considerations

- Differences between professional groups
  - - is it within scope of practice ?
  - - am I prepared and capable ?
  - - motivation to change behaviour ?
- The power of the role model
  - Role models can exert positive or negative influence
  - Do what I do not what I say
- Organizational support – is it real ?

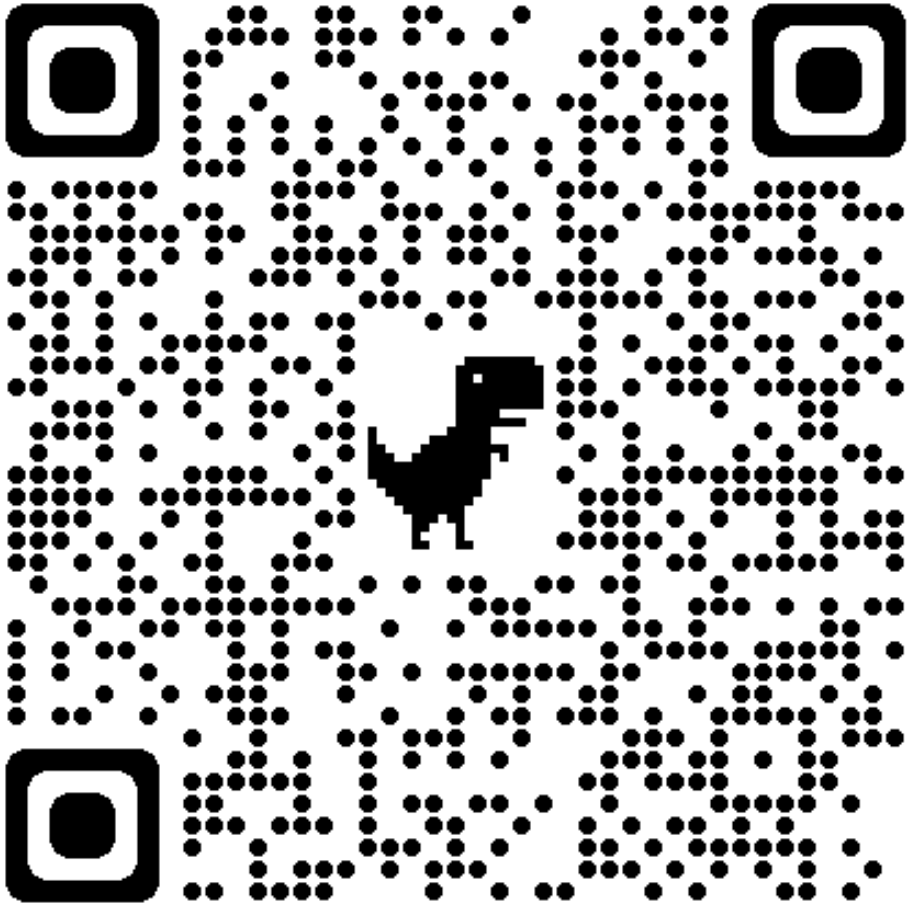
Addressing sexuality post-stroke: can targeted implementation change practice ?

- Change is slow
- Influence of service factors cannot be underestimated
- Barriers are well established and tricky to shift
- Commitment and openness of service leaders is critical
- Genuine acknowledgment that people with disability value this topic
- Values clarification – what do we really mean when we say person centred care ?

UCC Coláiste na hOllscoile Corcaigh University College Cork, Ireland
NSW GOVERNMENT Health Northern Sydney Local Health District
THE UNIVERSITY OF SYDNEY
UTS UNIVERSITY OF TECHNOLOGY SYDNEY

Stroke Foundation Education Module

- Power, E., Lever, S. & McGrath, M. (2023). Relationships, intimacy and sexuality after stroke. [online]
- Available from https://informme.org.au/learning-modules/relationships-intimacy-and-sexuality-after-stroke
- Free for health professionals to use



For stroke survivors

- Ask questions of health professionals – most are operating on a if it's important they will ask model of care
- Ask directly – indirect conversations are easier to sidestep
- Lots of web-based resources are available scan QR code for some good examples
- Be specific as much as possible

Keep in touch

- Margaret McGrath

  @OT_Ireland

  margaretmcgrath@ucc.ie

  - Sandra Lever

    @SandraLever63

    Sandra
  - Emma Power

    @dr_epower