



Sexuality after stroke:

SOX guidelines for interdisciplinary practice

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6/1/2014



Acknowledgements

We would like to thank the following project researchers who participated in the Sexuality after Stroke (SOX) Program for their commitment to improving services for stroke clients, as well as their contribution toward the development of this resource:

Claire Stewart, Speech Pathologist. Ballarat Health Services; Susie Leech, Neuro Social Worker. Caulfield Hospital; Katy Meltzer, Clinical Psychologist. Caulfield Hospital; Dr. Jane V Khoo, Clinical Neuropsychologist. Caulfield Hospital; Daphne Van Pagee. Occupational Therapist, Angliss Hospital, Eastern Health; Dr Shannon Scratch. Clinical Neuropsychologist. Angliss Hospital, Eastern Health; Dr. Helen Pechlivanidis. Senior Clinical Neuropsychologist. Angliss Hospital, Eastern Health; Rebecca Nicks. Senior Clinician Occupational Therapist. Inpatient Rehabilitation. Royal Melbourne Hospital. Royal Park Campus; Dr Nina Zhang, Rehab Consultant. Inpatient Rehabilitation. Royal Melbourne Hospital, Royal Park Campus; Christine Cowan. Inpatient Rehabilitation. Royal Melbourne Hospital, Royal Park Campus social worker; Anita Brown-Major, Occupational Therapist. Royal Melbourne Hospital, Royal Park Campus social worker; Phyllis Virgona, Case Manager Home Rehab Southern Health; Anne Cattermole, Senior Occupational Therapist, Home Rehab Southern Health; Katie Dye. Occupational Therapist. Frankston Community Rehabilitation Centre. Peninsula Health; Vatt Sounthakith, Physiotherapist. Peninsula Health; Sarah Murphy. Occupational Therapist. Western Health. Western Health; Belinda Woods. Western Health. Senior Clinician Occupational Therapist. Community Based Rehabilitation. Williamstown Community Rehabilitation. Western Health; Anne Renshaw. Clinical Nurse Consultant, Western Health

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Suggested citation

Barrett, C and Whyte, C. (2014). Sexuality after stroke: SOX guidelines for interdisciplinary practice. Australian Research Centre in Sex, Health and Society, La Trobe University. Melbourne

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Background

This Guide was developed as part of the Sexuality after Stroke (SOX) Program facilitated by the Australian Research Centre in Sex, Health & Society at La Trobe University in collaboration with the Victorian Stroke Network. The SOX Program supports clinicians through the practical steps involved in providing stroke clients and their partners with information on sexuality.

The SOX Program generated significant discussion about 'whose role it is' to provide stroke clients and their partners with information on sexuality. The Program was underpinned by a belief that all disciplines have a role to play in this area. Furthermore, that addressing sexuality after stroke requires an interdisciplinary approach. Therefore, this Guide was developed to generate discussion and debate about the roles of each discipline and to encourage interdisciplinary approaches to sexuality after stroke.

Defining sexuality

The SOX Program was underpinned by a broad understanding of sexuality. The World Health Organisation's definition of sexuality was provided to Program participants to encourage a focus 'beyond sex':

Sexuality is a central aspect of being human throughout life and 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, behaviours, practices, roles and relationships. While sexuality can include all of these dimensions, not all of them are always experienced or expressed. Sexuality is influenced by the interaction of biological, psychological, social, economic, political, cultural, ethical, legal, historical, religious and spiritual factors (World Health Organisation, 2006 p. 5).

The SOX approach addresses myths about asexuality and ageing and the importance of including stroke clients who are lesbian, gay, bisexual, transgender or intersex (LGBTI).

The importance of sexuality after stroke

Changes to sexuality after stroke can have a significant impact on quality of life (Thompson & Ryan, 2009) and these changes are more likely to be psychological, rather than physical (Buzzelli, di Francesco, Giaquinto & Nolf, 1997). Despite the importance of sexuality, opportunities to address sexuality after stroke have infrequently been addressed (Green & King, 2010; Kautz & Secrest, 2007; Tamama, Tamam, Akil, Yasan & Tamam, 2008) with suggestions it is the most neglected of all the parameters that determine quality of life after stroke (Chadwick, Saver, Biller & Carr, 1998).

The failure to address sexuality after stroke has been attributed to the lack of education for clinicians (McLaughlin & Cregan, 2005). Additionally, while stroke clients may want information on sexuality they may also be too embarrassed to ask staff for it (Kautz, 2007). To address this gap there is a need to explore the experience of clinicians addressing sexuality ([McLaughlin & Cregan, 2005](#)) and identify strategies to improve services. The experiences of clinicians participating in the SOX Program informed the development of the Interdisciplinary Guide.

Evidence of the need to address sexuality after stroke has been documented by the National Stroke Foundation. The NSF is a not-for-profit organisation that aims to reduce the impact of stroke on the Australian community. This includes working with health professionals to promote evidence based practice, particularly through a set of Guidelines for Stroke

Management (2010). The Guidelines includes a specific guideline (8.5) that addresses sexuality after stroke by stating that: *stroke survivors and their partners should be offered the opportunity to discuss issues relating to sexuality with an appropriate health professional; and written information addressing issues relating to sexuality post stroke* (National Stroke Foundation, 2010). To assist in achieving this guideline, the NSF has developed an information sheet on sexuality and relationships (National Stroke Foundation, 2012).

The NSF monitors compliance with the Guidelines by auditing medical records in stroke services. In 2010 an audit of 100 hospitals and 2,985 admissions identified that only 12% of stroke survivors were provided with information on sexuality (National Stroke Foundation, 2010). Two years later an audit of 111 eligible hospitals and 2,821 stroke rehabilitation admissions found that compliance had risen to 17% (National Stroke Foundation, 2012). While there is significant scope for improvement, it is important to recognise the leadership provided by the NSF in relation to sexuality. The development of a national guide and fact sheet about sexuality and the monitoring of compliance with the guideline may be unrivalled in disability and aged care services

To address this gap the SOX Program sought to build the confidence and capacity of clinicians in the Victorian Stroke Network to implement Guideline 8.5, to provide clients and their partners with written information addressing sexuality after stroke and the opportunity to discuss issues relating to sexuality. The SOX Program involved research, education and the development of resources, including this interdisciplinary Guide.

Interdisciplinary practice

The SOX Program is underpinned by the principle of interdisciplinary practice. It acknowledges that providing information on sexuality after stroke is the responsibility of all disciplines and that there is no discipline more important than others. The development of a Guide to Interdisciplinary Practice and strategies for interdisciplinary communications were critical to achieving this. Interdisciplinary practice in this context recognizes that each discipline makes a unique contribution to client care and that bringing these unique contributions together, through interdisciplinary communication, enables collective wisdom to be developed to address sexuality after stroke.

About the Guide

The Guide was developed in consultation with participants of the 2013 SOX Program. It is not intended to be prescriptive. The Guide was developed to generate discussion and is likely to be most effective when it is localised to the specific function of an organisation or services and to the unique needs of each service or team. The Guide includes the five key components:

- 1) A definition of sexuality
- 2) Rationale for the SOX Program
- 3) Suggested roles for each discipline
- 4) Strategies for interdisciplinary communication

For each discipline we have provided a brief overview of some of the components of the code of practice/conduct that relate to sexuality. Then, we present some of the issues that might be encountered and a description of the suggested role.

The SOX Program identified nine interdisciplinary team members who have the capacity to address sexuality after stroke. This includes: clinical neuropsychologists, clinical

psychologists, dietitians, medical officers, nurses, occupational therapists, physiotherapists, social workers and speech pathologists.

Participants of the SOX Program were invited to identify the potential issues related to sexuality that they might encounter in their work and then consider the role of their discipline. This approach was undertaken to encourage participants to think about what needed to happen from the perspective of the stroke client, rather than be locked into conversations about the 'territory' of their discipline.

We also invited participants to consider the code of conduct (or similar) for their discipline, to reaffirm the links to addressing sexuality. While few codes made specific reference to sexuality there were broader conceptual links.

In the following section we present the nine disciplines addressing first any links between their code of conduct and the importance of addressing sexuality. Next, potential issues relating to sexuality after stroke that they may encounter are listed and then the roles are also presented.

Interdisciplinary roles

Clinical Neuropsychology

Code of practice

The Australian Psychological Society Limited Code of Ethics (2007) notes *that Psychologists regard people as intrinsically valuable and respect their rights, including the right to autonomy and justice. Psychologists engage in conduct which promotes equity and the protection of people's human rights, legal rights, and moral rights. They respect the dignity of all people and peoples.* People who have had a stroke have the right to autonomy over decisions about their sexuality.

Psychologists avoid discriminating unfairly against people on the basis of age, sexuality, gender, disability, or any other basis proscribed by law. Strategies to address sexuality need to be accessible to stroke clients of all ages, abilities, sexual orientations and gender identities.

Potential issues encountered

COGNITIVE CHANGES

1. Fatigue – patients may tire quickly during mental and physical effort, have reduced tolerance and ability to cope, and become irritable easily
2. Slowed speed of processing – it may take longer for a patient to perform a task, to get ideas together and respond, or to be unable to keep track of lengthy conversations and instructions
3. Attention / Concentration – a patient may have difficulty sustaining attention, lose track of what they are thinking/doing, appear not to listen, miss details, be unable to cope with more than one thing at a time, be easily distracted and get bored easily.
4. Visual / Sensory Inattention (Neglect) – the patient may be experiencing a lack of awareness of their needs and the position of their body in space
5. Memory – the patient may experience difficulty remembering strategies negotiated with intimate partner, including for safety during intimacy. This may also impact on the patient's role as a romantic partner in a relationship. The patient may also have difficulty learning new things.
6. Abstract reasoning – the patient may have rigid and inflexible thinking and this can impact on their ability to understand complex issues in their relationship, difficulty reading body language, facial expression and imagination.
7. Problem-solving, planning, organizing – the patient may have difficulty working out solutions to problems, be unable to generate new ideas, have a disordered approach to problem solving. They may have difficulty implementing safe sex precautions and may have difficulty using contraceptives reliably.

BEHAVIOUR AND PERSONALITY CHANGES

8. Self-monitoring – the patient may be verbose and keep talking when others are no longer interested. They may not realise that they are dominating conversations.
9. Lowered frustration or tolerance / reduced self-control – these factors may create stress within relationship. The patient may lose their temper quickly or become physically/verbally abusive.
10. Behavioral disinhibition, problems with impulse control – the patient may experience an increase in sexual desire, they may want to increase the frequency and amount of public displays of affection and touching, which their partner may not be comfortable with.
11. Adynamia / reduced drive – the patient may experience a decreased sexual desire / libido or may lose the capacity to initiate intimacy or affectionate acts

12. Egocentricity – the patient may not consider consequences of their behaviour on partner, be unable to ‘put themselves in someone else’s shoes’, appear selfish to others
13. Emotional lability - laugh and cry inappropriately, change moods quickly
14. Perseveration / Rigid inflexible thinking – the patient may talk about the same topic repeatedly, return to the preferred topic when doing something else
15. Reduced social skills – the patient may interact poorly with others because of all the above problems, lose their ability to relate well with others and not pick up the usual social cues / body language

Role

1. Assessment of cognition and changes in behaviour or personality and develop strategies to maximize function
2. Education of patient and partner about how cognition and behavior can impact on participation in intimacy
3. Educate about changes to roles and identity
4. Provide education for other team members on cognitive function and strategies to promote recovery
5. Strategies and training regarding cognition and management of problems experienced by the patient, their partner (or staff)
6. Advocacy, normalizing sexual expression
7. Provide adjustment counseling
8. Discuss grief and loss
9. Treatment Planning Meeting – guiding team in understanding the neuropsychological underpinning impacting on patient’s sexuality

Clinical Psychology

Code of practice

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Psychologists avoid discriminating unfairly against people on the basis of age, sexuality, gender, disability, or any other basis proscribed by law. Strategies to address sexuality need to be accessible to stroke clients of all ages, abilities, sexual orientations and gender identities.

Potential issues encountered relating to sexuality after stroke

1. Anxiety about intimate relationships
2. Adjustments to changed body image
3. Changes to self-identity
4. Adjustments to changing role in relationship
5. Changes in relationship dynamic
6. Emotional adjustments
7. Grief and loss
8. Apathy and loss of initiation
9. Impulsivity
10. Dealing with feelings of anger or frustration
11. Managing anxiety about another stroke
12. Managing anxiety about effect of stroke on sexual functioning
13. Depression
14. Sexual problems - need to access sex therapist.

Role

1. Establishing sessions to take a comprehensive history and assess issues related to sexuality post stroke
2. One on one counseling to provide patient support
3. Facilitate discussion around emotionally adjusting to changes in body image, intimacy, sexual functioning, sexual role and identity, relationship issues
4. Provision of couple therapy to assist stroke patients and their partners to talk about their fears and adjust to changes
5. Identify whether additional interventions are required by the team to treat mood
6. Disseminate psycho educational material (written and verbal) to patients and their carers both in individual sessions and groups to communicate the message that patients and their carers that they are welcome to discuss sexuality
7. Invite patient to raise questions about sexuality as part of their broader psych education
8. Help patient to work through issues of loss and grief around their sexuality
9. Help carers to optimally cope with changes in their relationship/intimacy
10. Differentiate depression as a cause of sexual difficulties from other pathology or relationship issues
11. Look at cognitive strategies for managing anxiety and depression
12. Provide sex therapy or access to a sex therapist if technical information on sexual intercourse is required

Dietitian

Code of practice

Dietitians Association of Australia Code of Practice (May 2013) states *ppractitioners will ensure provision of non-discriminatory service provision regardless of age, colour, gender, sexual orientation, religion, ethnicity, race, and mental or physical status.*

Potential issues encountered

1. Fatigue due to reduced nutrition – reducing capacity to engage in intimacy
2. Need for nasogastric or PEG – presence of the tube or the pump may create anxiety for patient or partner in relation to intimacy or create difficulty accessing social activities
3. Difficulty lying flat due to reflux
4. Low EFT (access to dietician) so dietician may not be present at all case conferences
5. Energy and fatigue levels
6. Changes to body image
7. Loss of weight
8. Weight gain
9. Incontinence

Potential issues encountered

1. Assessment of nutritional status to determine how to build patient's energy and reduce fatigue
2. Provide education to the patient about how to turn off or disconnect the pump when required
3. Provide education for the patient on how to manage tube feeding when accessing social activities
4. Recommend strategies to promote bowel and bladder control
5. Weight control strategies to promote positive body image
6. Advice regarding eating to boost energy levels
7. Advice on the importance of food and human/social connection

Medical

Code of practice

Good Medical Practice: A Code of Conduct for Doctors in Australia (2009) notes that *good medical practice is patient-centred involving an understanding that each patient is an individual and unique*. This includes understanding the patient's experience related to sexuality after stroke. *Doctors should encourage and support patients to be well informed about their health and work together in partnership to address needs and reasonable expectations*. Ensuring patients are well informed about sexuality after stroke is one such example. *Good medical practice means upholding the duty to the patient and not discriminating on medically irrelevant grounds, including race, religion, sex, disability*. Strategies to address sexuality need to be accessible to stroke clients of all ages and abilities.

Potential issues encountered

1. The impacts of:
 - a. physical changes on sexual activity and intimacy
 - b. stroke on self-esteem and body image
 - c. the stroke on mental health (anxiety or depression)
 - d. mental health on intimate relationships and libido
 - e. fatigue on intimacy and sexual function
 - f. diminished erectile function
 - g. vaginal dryness on sexual function
 - h. spasticity on intimacy
 - i. decreased motivation on intimate relationships
 - j. urinary catheters on sexual function and activity
 - k. urinary incontinence on self-esteem and intimacy
 - l. pain on mobility and intimacy
 - m. reduced physical impairment on intimacy
2. The management of contraception
3. Issues related to reproduction
4. The patient or their partner's questions about sexuality eg:
 - a. When it is safe to resume sexual activity/intimacy?
 - b. Will sexual activity induce another stroke?
 - c. What are the side effects of medications on libido or sexual functioning?
 - d. What are the effects of physical changes on sexual activity?
5. The importance of addressing sexual safety
6. Changes to sexual behavior – reduced libido or hypersexuality
7. Challenges having sensitive, personal conversations:
 - a. On a busy ward round
 - b. In an open ward
 - c. Using an interpreter service
 - d. At the last minute before weekend leave
8. Issues may be raised as an outpatient
9. Bedside rounds – lack of confidentiality and time
10. Competing priorities

Role

1. Alleviate fear
2. To provide written information (National Stroke Foundation Fact Sheet) or other information that patients and their partners can read when they are ready
3. Raise the opportunity to discuss sexuality and make it clear to patients that it is okay to talk about their issues

4. Assess issues early on, during admission to rehab stages, to enable management strategies to be developed
5. To provide sexual education and support to the patient and their partner
6. To influence the development of practice guidelines and checklists to ensure that sexuality is not omitted from patient care
7. To ensure outpatient follow up and support to help patient to integrate back into social roles – particularly in relation to their intimate relationship
8. To ensure that medications are reviewed and optimize healthy sexuality and discuss adverse effects
9. To ensure that pain management is effective to ensure that pain does not inhibit intimacy
10. To ensure that patients are aware of the effects of medications on their libido
11. To monitor anxiety and depression and provide appropriate interventions
12. Refer the patient to other team members, specialists if required – including a sex therapist if required (and available)
13. Provide patients with information about the safe return to sexual activity
14. To provide patients and their partners with information about reproductive issues
15. Discuss contraception for younger clients

Nursing

Code of practice

Code of Professional Conduct for Nurses in Australia (2008) requires that nurses *support the health, wellbeing and decision making of people requiring or receiving care*. Providing information on sexuality after stroke is an important way of supporting patient decisions about sexuality. Nurses are also required to: *respect the dignity, culture, ethnicity, values and beliefs of people receiving care and treatment*. Building the capacity of nurses to address sexuality after stroke can assist in ensuring that nurses are able to explore the values about beliefs of stroke patients about their sexuality. The Code also identifies that nurses ensure that quality of care is not compromised on the basis of age or sexuality - strategies to address sexuality need to be accessible to stroke clients of all ages and sexual orientations.

Potential issues encountered

1. Assessment of patient mood to determine depression or anxiety
2. Observation of partner dynamic
3. Patient responses to physical changes
4. Patient concerns about intimate relationship
5. Patient concerns about changed physical appearance
6. Assessment of continence
7. Management of wounds: odour, exudate that might effect intimacy
8. Effectiveness of pain management
9. Assessment of any changes to sexual expression such as hypersexuality
10. Lack of privacy

Role

1. To invite the patient to discuss how they feel about their changed body
2. To provide the patient with the opportunity to discuss how the stroke has effected them & their intimate relationship
3. To invite the patient to discuss any relationship issues with counselor
4. To provide a comprehensive continence assessment and implement strategies to promote continence to ensure that incontinence is not a barrier to intimacy or rebuilding self esteem
5. To identify and report any problematic mood such as depression or anxiety
6. To promote wound healing to ensure that painful, exudate or smelly wounds are not a barrier to intimacy
7. To conduct effective pain assessment and monitoring to ensure that pain is not a barrier to mobility, particularly in relation to intimacy
8. To provide private time for patients and their partners to hold hands, kiss, touch, have personal conversation
9. To identify and report any sexual disinhibition

Occupational therapist

Code of practice

The Occupational Therapists Australia Code of Ethics 2001 requires its members to discharge their duties and responsibilities, at all times, in a manner which professionally, ethically, and morally compromises no individual with whom they have professional contact, irrespective of that person's position, situation or condition in society. The code notes that occupational therapists have a responsibility always to promote and protect the dignity, privacy, autonomy, and safety of all people with whom they come in contact in their professional practice.

Occupational therapists shall not discriminate in their professional practice, on the basis of ethnicity, culture, impairment, language, age, gender, sexual preference, religion, political beliefs or status in society.

Potential issues encountered

1. Undertake observation of functional tasks/task analysis
2. Patient experiencing difficulty managing continence
3. Difficulty identifying comfortable physical positions for intimacy
4. Difficulty with self-grooming
5. Fatigue resulting in diminished interest in intimacy
6. Difficulty with perceptions of space – particularly in relation to intimate contact with partner
7. Reduced vision, difficulty renegotiating cues during intimacy
8. The impact of reduced sensation on intimacy
9. The impacts of pain on intimacy
10. The difficulty achieving social access – dating, social events

Role

1. Address environmental and physical barriers – eg. Equipment needs, body positioning
2. Discuss cognitive, psychological barriers
3. Explore changes of roles and participation regarding sexuality
4. Education regarding the effects of sexuality and discuss strategies and resources
5. Provide opportunities to discuss changes in roles, social participation/dating
6. Education to partners/carer stress issues
7. Source equipment including sex aids or provide patient with information on where to source this
8. Provide physical demonstrations regarding safe positions for intimacy
9. Conduct environmental assessment of home, including bedroom and make recommendations for safe intimacy
10. Discuss strategies for energy conservation during intimacy and more broadly to make time for partner
11. Discuss social media use, internet dating (work with family etc. around cognitive risks)
12. Discuss strategies for accessing the community, dating and other social events
13. Discuss career retraining and the effects of changed role on sexuality
14. Provide limb therapy to maximize patient limb use

Physiotherapist

Code of practice

The Australian Physiotherapy Association Code of Conduct (2008) notes that *physiotherapists respect the rights, needs and dignity of all individuals and strive to develop and implement service delivery which enhances the status of the community and promotes social justice*. This section of the Code could be applied to the rights of stroke clients to information on sexuality after stroke. The code also notes that physiotherapists: *respect people's individuality and will not deny access to people on the basis of age, ... sexual preference or health status*.

Potential issues encountered

1. Diminished physical fitness, endurance and capacity for sexual activity
2. Decreased physical ability to participate in social activities, dating etc.
3. Decreased strength, balance and mobility creating difficulties engaging in life with partner, intimate activity and returning to work
4. Fatigue
5. Falls
6. Reduced pelvic floor strength - incontinence
7. Difficulty achieving comfortable, safe positions for intimacy
8. Altered perception or spatial awareness creating issues of safety and anxiety around contact with intimate partner
9. Reduced physical strength and flexibility creating difficulties in intimacy with partner
10. Sensory impairments eg. hypersensitivity and associated unwillingness to engage in intimate activity such as hugging, stroking, foreplay
11. Reduced sensation creates difficulty responding to touch and intimacy
12. Pain on movement

Role

1. Work with the patient to build their mobility
2. Support the patient to identify safe positions for intimacy
3. Discuss strategies to improve body spatial awareness
4. Exercises to improve flexibility and endurance
5. Strategies to prevent falls from bed, during transfers
6. Liaise with partner to identify safe positions
7. Monitoring the effects of movement on pain
8. Educating patient about non pharmaceutical strategies to manage pain associated with movement
9. Provide sensory retraining and desensitization
10. Discuss strategies for adapting to/compensating for reduced sensation
11. Assess the effects of physical capacity on self esteem
12. Assess the impacts of physical changes on body image
13. Assist in building client stamina and physical endurance
14. Build pelvic floor
15. Improve pain management
16. Improve balance – reduce falls

Social work

Code of practice

Australian Association of Social Workers Code of Ethics (2010) notes that the social work profession: *promotes social change, problem solving in human relationships and the empowerment and liberation of people to enhance wellbeing*. The reference to human relationships and wellbeing can be applied to the provision of information on sexuality after stroke. Other parts of the Code refer to social workers aim to: *empower individuals, families, groups, communities and societies in the pursuit and achievement of equitable access to social, economic, environmental and political resources and in attaining self-determination, self-management and social and emotional wellbeing*. The Code also makes note of Social workers respect for diversity.

Potential issues encountered

1. Changes to patient body image
2. Changes to self esteem
3. Changes in role in intimate relationship
4. Difficulty socializing
5. Complexity of intimate relationship – prior to stroke (including domestic violence)
6. Lack of knowledge about stroke and related fear
7. Tension arising from different expectations of patient and intimate partner
8. Depression and anxiety
9. Patient desire to explore sexual functioning post stroke
10. Patient concerns about reproductive capacity
11. Changing role of intimate partner – to carer

Role

1. Invite patient to talk about how the stroke has affected their self-esteem and body image
2. Invite patient to discuss how the stroke has affected their intimate relationship
3. Assess mood for depression or anxiety
4. Provide information on stroke to reduce anxiety
5. Discuss recovery with patient and partner to promote shared expectations
6. Provide emotional support, education and counseling to patients and families or partner about sexuality and relationships
7. Discuss what sexuality and intimacy means to patient
8. Invite the patient to discuss their sense of grief or loss
9. Provide refer on to counseling, psychology services. Explain to team the impact of these factors on rehab
10. Acknowledging and validating change in role
11. Sourcing and raising awareness of support services

Speech pathology

Code of practice

The Speech Pathology Australia Code of Ethics 2000 notes the fundamental professional values and responsibilities of its members are to: *respect the unique dignity of each individual, and their intrinsic rights. ... and seek to protect the individuality and rights of clients through advocacy, professional skills and interventions.* This section of the Code could be applied to the rights of clients to access information on sexuality after stroke. The Code also notes that Speech pathologists will ensure that clients are not unfairly discriminated against on the basis of gender, sexual preference.

Potential issues encountered

1. Difficulty expressing themselves and their needs relating to sexuality with the treating team
2. Difficulty having conversations with intimate partner
3. Difficulty having social conversations – engaging socially, dating
4. Difficulty using social media, difficulty with computer skills
5. Changes in cognition affecting capacity to communicate relating to sexuality
6. Impulsive behavior or verbal indiscretion that may result in relationship tensions
7. Pragmatics of conversation
8. Changes to body image, resulting in reduced self-esteem and fear of rejection by partner
9. Dealing with grief and loss of the client and their partner
10. Role changes in their intimate relationship
11. Difficulty managing saliva – impact on partner desire for intimacy
12. Oral praxis, reduced control of mouth muscles – impact on capacity to kiss
13. Clients may disclose needs to speech pathologist because therapy takes place in private area.

Role

1. Establish and encourage a communication system to convey messages concerning sexuality
2. Encourage facial expression and gesture to express basic needs and wants or complex ideas/needs concerning sexuality
3. Encourage the development of aphasia friendly education resources that encompass sexuality
4. Ensure the re-iteration of information about sexuality for the patient and their intimate partner
5. Work with the OT to redevelop computer skills to promote social engagement
6. Work with neuropsych to identify and respond to cognitive deficits and develop strategies with patient and intimate partner
7. Discuss strategies to improve saliva management
8. Discuss strategies to reduce oral praxis and enable patient to rebuild capacity to kiss
9. Identify strategies to manage communication fatigue

Strategies for interdisciplinary communication about sexuality

Participants of the SOX Program were invited to brainstorm strategies that they might utilise in their organisation to facilitate interdisciplinary communication related to sexuality after stroke. The following strategies were identified.

- 1) Provide team members with a copy of the SOX Interdisciplinary Guide and discuss:
 - a. How they feel about what they have read
 - b. What they agree with/disagree with
 - c. How confident they feel in their role
 - d. How comfortable they feel in their role
- 2) Discuss sexuality at team meeting – as a domain.
- 3) Discuss individualised care plans at team meetings and set goals related to sexuality
- 4) Identify functional goals – that are client centred (what does the patient want?)
- 5) Invite team members to help gather resources for sexuality education
- 6) Establish an interdisciplinary working party to address sexuality
- 7) Update the resource kit for patients to include information on sexuality
- 8) Put sexuality on the agenda at Quality Assurance Meetings
- 9) Include items related to sexuality in the quality plan – engage the support of senior staff
- 10) Include sexuality in interdisciplinary professional development opportunities
- 11) Make sexuality a part of patient goals
- 12) Include questions on sexuality on the intake assessment form – to encourage discussion of patient goals related to sexuality
- 13) Include goals related to sexuality in the goals menu options
- 14) Include information on sexuality in staff orientation
- 15) Discuss sexuality at handover, follow up discussion, flag goals and make a checklist
- 16) Discuss sexuality on the ward rounds
- 17) Put issues related to sexuality in the doctors diary – so they are discussed
- 18) Discuss sexuality at the clinical review meeting – review the goal sheet
- 19) Amend the stroke checklist to include sexuality as an item to be discussed with patients
- 20) Include sexuality as a topic in the stroke education topic form
- 21) Include information on sexuality in the stroke orientation folder about: “what staff need to discuss”
- 22) Put sexuality on the agenda for discussion at the stroke committees
- 23) Add sexuality as a topic to the interdisciplinary goal setting form
- 24) Include sexuality in the Action Improvement Meeting for senior staff to ensure their support (and education)
- 25) Develop a poster for the unit/service inviting staff to talk about sexuality
- 26) Put poster on the importance of talking about sexuality in the staff toilets (and patient toilets)
- 27) Include sexuality in the Rehab planning days
- 28) Include sexuality in the initial (comprehensive) assessment.

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Codes of practice

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http://www.psychology.org.au/Assets/Files/Code_Ethics_2007.pdf

Dieticians Association of Australia Code of Practice May 2013 available from
<http://daa.asn.au/for-the-public/about-daa/professional-standards/>

Good Medical Practice: A Code of Conduct for Doctors in Australia (2009) available from
<http://www.medicalboard.gov.au/Codes-Guidelines-Policies.aspx>

Code of Professional Conduct for Nurses in Australia (2008) available from
<http://www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/Codes-Guidelines.aspx>

The Occupational Therapists Australia Code of Ethics 2001 available from
<http://www.otaus.com.au/onlinestore/free-resources/occupational-therapy-australia-national-code-of-ethics>

The Australian Physiotherapy Association Code of Conduct (2008) available from
http://www.physiotherapy.asn.au/DocumentsFolder/The_APA_Governance_Code_of_Conduct_2008.pdf

Australian Association of Social Workers Code of Ethics (2010) available from
<http://www.aasw.asn.au/document/item/740>

Speech Pathology Australia Code of Ethics 2000 available from
<http://www.speechpathologyaustralia.org.au/about-spa/code-of-ethics>