Using the Extended PLISSIT model to address sexual healthcare needs

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Nursing Standard; Nov 22-Nov 28, 2006; 21, 11; ProQuest Nursing & Allied Health Source
pg. 35

Summary

Sexual health is a holistic concept which encompasses much more than the prevention of infections and unwanted pregnancy. This article defines sexuality and sexual health before discussing the nurse’s role in identifying and meeting patients’ sexuality and sexual health needs. The Ex-PLISSIT model is proposed as a useful tool for nurses working in primary care to address sexuality and sexual health.

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Keywords

Community nursing; Nurse-patient interaction; Primary healthcare; Sexual health; Sexuality

Sexuality and sexual health defined

The World Health Organization (1975) defines sexual health as the ‘integration of somatic, emotional, intellectual and social aspects of sexual being, in ways that are positive, enriching, and that enhance personality, communication and love’. The more recent Royal College of Nursing (RCN 2000) definition of sexual health is not dissimilar: ‘the physical, emotional, psychological, social and cultural wellbeing of a person’s sexual identity, and the capacity and freedom to enjoy and express sexuality without exploitation, oppression, physical or emotional harm.’

The freedom to enjoy and express sexuality does not necessarily involve sexual behaviour, as sexuality is expressed in how we dress, how we feel about ourselves, our relationships with others and how we communicate with those around us. Stuart and Sundeen (1979) state that: ‘Sexuality is an integral part of the whole person. Human beings are sexual in every way, all the time. To a large extent human sexuality determines who we are. It is an integral factor in the uniqueness of every person.’

Health is a matter of perception in that each person defines health differently. In the same way, sexual health is subjective. To one person, sexual health might mean freedom from infection; to another, sexual health is about feeling comfortable and secure in a relationship. For others, sexual health involves a positive self-image and a sense of feeling ‘at one’ with oneself (Davis and Taylor 2006). These examples incorporate social, psychological, spiritual and cultural factors but do not preclude physical aspects of sexual behaviour.

NURSING STANDARD

The nurse’s role

Pearson et al (1996) advise nurses to explore ‘those aspects of sexuality relevant to the current

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need for nursing. The decision about which aspects are relevant should rest with the patient. However, research shows that patients do not voice their concerns about sexuality and sexual health because they prefer nurses to raise the subject first (Waterhouse and Metcalfe 1991, Waterhouse 1996, Gott and Hinchliff 2003). Savage (1987) argued that any illness, disease process or treatment has the potential to impinge on an individual’s sexuality or sexual health. Van Ooijen and Charnock (1994) suggested that ‘the important issue is for the topic to be on the agenda at all times, and for nurses to realise that sexuality definitely falls within the remit of holistic nursing care’. This view is supported by the RCN (2000), which described meeting individuals’ sexuality and sexual healthcare needs as ‘an appropriate and legitimate area of nursing activity’.

Nurses are fearful of not being able to respond to the sexual health issues raised by patients (Stokes and Mears 2000). This has resulted in nurses waiting for patients to initiate discussion. Gott et al’s (2004) study of 22 GPs and 35 practice nurses in Sheffield identified primary care health services as the first point of contact for patients with sexual health concerns. This was seen as particularly important for ‘middle-aged’ and ‘older’ patients (ages not stated), who were considered to be less likely to access services such as genitourinary medicine (GUM) and family planning clinics. Despite this, the practice nurses and GPs stated that they did not initiate discussion on sexual health issues with patients as a matter of routine.

This study found that barriers to discussing sexual health with patients were based on the practitioners’ belief that certain patients would be less likely to want to talk about sexual health (Gott et al 2004). Such patients were considered by the GPs and practice nurses to be from black and ethnic minority groups, those whose sexual identity and/or sexual practices were other than heterosexual, and those of middle and older age. It is significant that practitioners who had discussed sexual health with patients stated that this had not been their experience, illustrating the effect of stereotypes in restricting nursing practice.

**The Ex-PLISSIT model**

The Ex-PLISSIT model is an extension of the much-used PLISSIT model. The PLISSIT model was developed by Annon (1976) for use by practitioners in meeting the sexuality and sexual healthcare needs of patients. The acronym PLISSIT signifies the four levels of intervention—Permission, Limited Information, Specific Suggestions, and Intensive Therapy. As the level of intervention increases, greater knowledge, training, and skills are required (Seidl et al 1991).

Unlike the linear PLISSIT model, where practitioners are able to progress from one level to the next, a key element of the Ex-PLISSIT model is Permission-giving as a core feature of each of the other stages (Figure 1). All interventions with patients should begin with Permission-giving; therefore, the stages of Limited Information, Specific Suggestions, and Intensive Therapy are underpinned by Permission-giving (Davis and Taylor 2006).

Other features of the Ex-PLISSIT model include the requirement to review all interactions with patients, and the incorporation of reflection as a means of increasing self-awareness by challenging assumptions (Davis and Taylor 2006). The elements of reflection and review are discussed more fully later in this article.

**Permission-giving stage** The assessment process is the first step in addressing the patient’s sexual health needs. Unless nurses are willing to introduce the topic, they will be unable to identify the patient’s needs (Guthrie 1999). Explicit Permission-giving during this assessment provides patients with the opportunity to voice...
their concerns. Unless the Permission-giving is explicit, patients will not know that this is what the nurse is offering. It is insufficient for nurses to say ‘do you have any other questions?’ or ‘is there anything else that you want to ask?’ Nurses may feel that they have provided opportunities for a patient to express concerns about sexual health but patients cannot know that it is appropriate to raise issues relating to sexuality and sexual health if nurses have never discussed the subject with them. When patients are not aware that they can discuss sexual health issues, or are reticent or embarrassed to do so, the onus is on the nurse to give explicit permission.

Some opportunities for Permission-giving occur before any interaction between the patient and the healthcare professional. The waiting room and practice newsletter are ideal places to advertise the services available and to provide reassurance about confidentiality. Specific reference to young people’s right to confidentiality is crucial because teenagers may be reluctant to disclose information that they perceive would be shared with their parents. The practice leaflet and posters in waiting rooms are also a means of illustrating an inclusive, responsive environment where the diversity of patients’ health needs is recognised. This can be demonstrated through, for example, positive images of young people, gay men and lesbians, as well as older people.

It is, however, not enough to provide information in the form of posters and leaflets. For patients who do not wish to discuss these matters, this may well meet their needs. Nurses cannot distinguish those who wish to discuss their sexuality or sexual health needs from those who do not unless the matter is discussed on an individual basis. There are numerous opportunities available in primary care for Permission-giving. It is important to recognise the opportunities available that are not directly related to sexual behaviour. Some of these are outlined in Box 1. Services listed in Box 1 can be provided by community nurses in clinic settings and in patients’ homes.

Nurses working in primary care regularly ask patients personal questions regarding bowel habit and the menstrual cycle. Lawler (1991) suggests that when nurses overcome their embarrassment in relation to sexuality, they also give patients permission not to be embarrassed. As indicated earlier, unless healthcare professionals raise the matter of sexual health, many patients will not.

Examples of questions that may enable patients to voice their sexuality and sexual health concerns are suggested in Box 2.

It is important to recognise that by giving patients permission to discuss sexuality, nurses are at the same time giving them permission to decline. Any reluctance that the nurse detects can be clarified by asking the person: ‘Would you like to talk about this?’

If patients appear uncomfortable or embarrassed, it should not be assumed that they do not wish to discuss the matter further. Patients may be reflecting nurses’ own embarrassment. It is helpful to ask questions such as: ‘Would you like to talk about this further?’ or ‘Is now a good time for you?’ Nurses in a busy clinic could suggest that the patient makes a longer appointment on another occasion so that more time can be given to the discussion.

Whether or not patients choose to discuss their sexuality or sexual health at any given consultation, further Permission-giving is required from the nurse so that patients are aware they can discuss issues at future consultations, if they wish.

Nurses may be concerned about ‘opening a can of worms’ (Gott et al 2004) and may therefore be reticent about providing opportunities for patients to talk about their sexuality or sexual healthcare needs. However, for many patients, permission to express their concerns and being given the therapeutic space to try to understand their feelings is sufficient intervention from the

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**Box 1**

**Opportunities for Permission-giving in primary care**

- New patient registration
- Well man/woman checks
- Adolescent clinics
- Cervical smear appointments
- Contraception checks
- Pregnancy and postnatal checks
- Following a myocardial infarction or stroke
- Suture removal or dressings following surgery
- Travel clinics
- Chronic disease management and long-term conditions
- Continence clinics
- Discussions with patients before insertion of a urinary catheter
- Discussion with patients when weighing up the advantages and disadvantages of bringing a bed downstairs, or introducing a pressure-relieving mattress

**Box 2**

**Examples of Permission-giving questions**

- People with (a specific condition) often experience sexual difficulties, such as loss of desire or problems with enjoyment. How have you been affected?
- Many people are concerned about how this condition and/or treatment might affect their sexuality. What is your experience?
- What happens when you and your partner try to make love?
- How has your health affected you as a couple? Has it affected your sexual relationship? Would you like to talk about this?
nurse (Irwin 2000). This requires ‘the humility to be able to listen without needing to know, to take the risk of hearing without the certainty of answers’ (Clifford 1998).

**Limited Information stage** The Limited Information stage of PLISSIT and Ex-PLISSIT reflects the important role of the nurse as a source of information. At this stage, information should be given about the impact of illness on sexuality and the effects of treatments on sexual function. Some of the pharmacological effects on sexual function are listed in Boxes 3 and 4. Providing patients with this information about their medication indicates that sexuality is an important aspect of nursing practice. It also normalises any drug-related sexual health concerns that patients may have.

During the Limited Information stage, nurses have an important role to play in clarifying misinformation, dispelling myths and giving factual information in a limited manner. This may involve providing leaflets or directing a patient to a particular website. Examples of useful websites are listed in Box 5.

Box 6 provides further examples of Limited Information. Addressing the Permission-giving level first ensures that the information meets the specific needs or concerns of the individual. If this level is not addressed initially, the information given will be too general and not effective (Davis and Taylor 2006). For example, if the limited information given to a post-menopausal woman focuses on vaginal dryness, it will not meet the needs of a woman who regularly has anal intercourse. It is essential that nurses provide information that is relevant, rather than giving information that is based on assumptions about the patient’s sexual preferences. It is also important that nurses do not assume that individuals will feel able to disclose all their issues and concerns at once (Davis and Taylor 2006).

**Specific Suggestions stage** At this stage, a problem-solving approach is needed to address an individual’s particular problem. Some examples of Specific Suggestions made in response to concerns or problems are outlined in Table 1. Carter et al. (1998) provide further examples of common medical problems leading to sexual difficulties and possible solutions. For example, difficult arthritic pain and stiffness can be overcome by experimenting with different sexual positions and adequate pain relief before sexual activity.

The Specific Suggestions stage needs to address all aspects of sexuality and sexual health rather than only focusing on sexual behaviour. For example, a patient may feel anxious that her partner will not find her attractive following surgery. This anxiety may reflect the patient’s own sense of loss, for example, after a mastectomy or hysterectomy, and may therefore relate to how she perceives her femininity and attractiveness. Specific Suggestions need to be tailored to address an individual’s specific needs and, for this woman, may focus on body image, make-up and clothing.

**Intensive Therapy stage** Intensive Therapy is the most advanced stage of both the PLISSIT and Ex-PLISSIT models. While many nurses working in primary care have contraceptive expertise, few have sufficient training to provide Intensive Therapy in other areas of sexual health. It is essential that practitioners identify services to which patients can be referred (Box 7).
Irwin (2000) lists sources of specialist help for psychosocial problems that include sexual dysfunction clinics, as well as psychosocial counselling. This is accessible through many family planning and GUM clinics, as well as being provided (for a donation) by the charitable organisation Relate. A list of psychosocial counsellors is available from the British Association for Sexual and Relationship Therapy at www.basrt.org.uk

**Reflection and review**

The impact of stereotypes on nursing practice, as indicated by Gott et al (2004), serves to highlight the need for reflection and review. Unlike the PLISSIT model, the Ex-PLISSIT model incorporates reflection and review following all interventions. These elements in Ex-PLISSIT are crucial in ensuring not only that nursing practice meets the needs of each patient, but also that the nurse continues to learn and develop.

For effective review, the nurse needs to seek the patient’s perspective (Box 8). This, by its nature, involves further Permission-giving. Review not only occurs at the end of a consultation, but also takes place at future consultations. For example, the nurse could ask: ‘When we last spoke, you mentioned... and we discussed... How has this been since then?’ Through the review process, the nurse ensures further Permission-giving, which enables patients to discuss their concern or problem further, should they so wish.

It is important that, as nurses, we reflect on our own attitudes and how these might affect the service we provide. Nurses are unable to give effective care if patients perceive disapproval or judgement. Carter et al (1998) provide some useful questions that nurses should ask of themselves when considering with which patients they find it easier to discuss sexual health:

- When did a patient last disclose that they were in a same-sex relationship?
- Which consultations make me feel awkward or embarrassed?
- When did any patient last express concerns of a psychosexual nature?

By considering how often patients disclose issues of a sensitive nature, Carter et al (1998) suggest

**BOX 6**

**Examples of Limited Information**

- After an operation (or with a stoma), some people find that wearing a silky negligee/pyjamas helps them feel more feminine/masculine and more sexually attractive to their partner.
- Some people with muscle spasm or abdominal wounds find some sexual positions more comfortable than others.
- It is not unusual for people to misinterpret their partners even after many years together. Talking about how you feel is really helpful.
- It is not uncommon for women/men to be apprehensive about vaginal intercourse after having a baby. You may want to explore other ways of showing love and affection or sexual activities other than full intercourse until you both feel more comfortable.

**BOX 7**

**Reasons to refer patients to other services**

- If the issue is beyond the competence of the nurse
- Rape or sexual abuse
- Psychosocial problems should be referred to a psychosexual therapist
- Relationship problems should be referred to a relationship counsellor

**TABLE 1**

<table>
<thead>
<tr>
<th>Problem or concern</th>
<th>Specific Suggestions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Angina or fear of heart attack during sexual activity</td>
<td>Take angina prophylaxis before activity. Avoid a large meal before sexual activity. Partner to take a more active role</td>
</tr>
<tr>
<td>Sexual activity provoking an asthma attack</td>
<td>Use inhaler before sexual activity</td>
</tr>
<tr>
<td>Muscle spasm from multiple sclerosis (MS) interfering with intercourse</td>
<td>Experiment with different sexual positions, for example, female with MS entered by her partner (or sexual aid) from behind</td>
</tr>
<tr>
<td>Hemiplegia impeding sexual activity</td>
<td>Affected person to lie either on back or side with the unaffected side uppermost</td>
</tr>
<tr>
<td>Discomfort or pain on intercourse</td>
<td>Use of lubricants. Consider full range of sexual activities</td>
</tr>
<tr>
<td>Sexual intercourse with a catheter <em>in situ</em></td>
<td>Sip the catheter. For men: fold the catheter along the shaft of the penis and then apply a condom. For women: tape the catheter to the abdomen. If this causes excessive clitoral stimulation, alter the position of the catheter</td>
</tr>
<tr>
<td>Perception that masculinity or femininity have been affected by the illness</td>
<td>Discuss what masculinity/femininity means to the individual. Identify what enhances these feelings</td>
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</tbody>
</table>
that nurses consider how their own attitudes may affect patients. Through reflection, any issues can be identified and addressed. This reflection can occur alone or with peers. Clinical supervision provides opportunities for nurses to reflect on their practice, explore their feelings, challenge any assumptions and develop confidence (Bond and Holland 1998). This may highlight the need for further education on sexuality and sexual health.

**Conclusion**

This article has emphasised the holistic nature of sexual health and highlighted the integral nature of sexuality in determining the uniqueness of each individual, regardless of his or her age. Sexuality and sexual health are not only expressed through sexual relationships, but also influence how we dress, how we feel about ourselves and our social relationships with others.

The Ex-PLISSIT model is a useful framework for nurses working in primary care to meet the sexuality and sexual healthcare needs of patients. Ex-PLISSIT is an extension of Annon’s (1976) PLISSIT model, which identifies four levels of intervention: Permission, Limited Information, Specific Suggestions, and Intensive Therapy. Unlike the original PLISSIT model, Ex-PLISSIT expects nurses to not only give patients permission to discuss sexual health and express any concerns, but also to reflect on their interventions. This involves open dialogue with patients, seeking their involvement in reviewing interactions, so that their individual needs are met.

Unless nurses working in primary care are willing to introduce the topic of sexuality, they will be unable to identify or address patients’ needs. The Ex-PLISSIT model clarifies the nurse’s role in identifying and addressing the sexuality and sexual health needs of patients. The model provides a framework for nurses and other healthcare professionals to establish the stage with which they feel most comfortable, to identify and meet patients’ needs with confidence. The reflection and review elements are essential parts of this model, enabling practitioners to reflect on their experiences and, as a result, to increase their self-awareness and extend their knowledge base. Nurses are encouraged to be proactive in addressing the sexuality and sexual health needs of all patients, regardless of their age.

**References**


Stuart GW, Sundeen SJ (1979) *Principles and Practice of Psychiatric Nursing*. CV Mosby, St Louis, MO.


