

Being Ex-PLISSIT: Addressing Visible Difference and Intimacy with Patients

Introduction

Having previously discussed the possibility that appearance altering conditions may impact upon the intimate and sexual lives of some patients (Sharratt, 2015), Nick Sharratt from the Centre for Appearance Research looks more closely at the Ex-PLISSIT (Davis and Taylor, 2006) model of interaction which may be deployed in discussing this potentially sensitive topic.

Four Key Words

1. Psychology
2. Appearance
3. Visible difference / disfigurement
4. Sex and intimacy

Abstract

Whilst visible differences may impact upon intimacy and sexual activity, it can be difficult for healthcare professionals to raise these issues with patients. Offering patients the opportunity to engage in discussions relating to visible difference and intimacy may be of therapeutic value. To help facilitate these discussions healthcare professionals can consider adopting the EX-PLISSIT (Davis & Taylor, 2006) model of interaction. This incorporates guidance for everyday clinical consultations where intimacy and sexual relationships may be relevant topics of discussion. The latter stages of the models remain subject to practical limitations that may undermine their utility.

Visible Differences, Intimacy and Healthcare Professionals

Any condition or feature that differentiates an individual's appearance from the norm may be considered a visible difference. The psychosocial difficulties with which they are sometimes associated, such as social anxiety, reduced quality of life and social avoidance have previously been introduced in these pages (see Sharratt, 2015). The capacity for visible differences to adversely affect an individual's intimate relationships and sexual activity were also discussed. As was emphasised, this may occur via the perceptions and judgements of others and by influencing an individual's own capacity to initiate, maintain, engage in and enjoy intimate relationships. Diminished self-perceived attractiveness, lowered self-confidence and fear can lead to avoidance of intimate situations.

The Code for Nurses and Midwives (Nursing and Midwifery Council, 2015) requires that patients' physical, social and psychological needs are addressed. Sex and intimacy may, however, be a challenging subject to broach especially within a clinical setting that may act to desexualise the patient (Dixon and Dixon, 2006). Similarly, a healthcare professional may need to exercise their clinical judgement and consider the best interests of their patient in determining whether to discuss visible difference and intimacy.

The PLISSIT and Ex-PLISSIT Models

In instances when a healthcare professional does feel able to address intimacy and sexual activity with a patient who has a visible difference, they may find it helpful to employ the PLISSIT model (Annon, 1976) or its revision, Ex-PLISSIT (Davis and Taylor, 2006). This is a stepped-care model with its origins in psychosexual therapy and its use has been advocated in providing interventions for appearance concerns (Clarke et al, 2014).

The steps within the Ex-PLISSIT model are:

- (i) Permission-giving
- (ii) Limited Information
- (iii) Specific Suggestions; and
- (iv) Intensive Therapy.

As a stepped-care model the needs of the patient will dictate progression within the framework with each descending level being associated with greater patient need and requiring greater knowledge, training and skill on the part of the healthcare professional. The competencies of the healthcare professional delimit their involvement and help identify when onward referral is required.

Hordern (2008) argues that the original PLISSIT model does not offer the shared opportunities for reflection and negotiation that characterise a patient centred approach. The Ex-PLISSIT model (Davis and Taylor, 2006) incorporates a continual cycle of review and reflection at each stage to ensure the needs of the patient are met and to facilitate the continued professional development of the practitioner. The model proposes non-linear movement between the four levels with Permission-giving being central and permeating all interactions.

(i) Permission-giving

Within the Ex-PLISSIT model (Davis and Taylor, 2006) permission-giving must be explicit as practitioner silence may be interpreted as signalling that it is not appropriate to discuss sex and intimacy (Taylor and Davis, 2007). This permission-giving is ongoing and underpins subsequent communications. It includes giving the patient permission to talk about sex and intimacy but not compelling them to do so, creating a private, dignified and safe environment within which they can do so, utilising inclusive language that contains no implicit assumptions or value judgements and sensitively incorporating the topic into related conversations (Davis and Taylor, 2006). A conversation about sleeping arrangements could, for example, be augmented with by considering the subject of sexual activity.

Permission-giving extends to healthcare professionals taking steps to normalise and legitimise patients' thoughts, feelings and behaviours. Annon (1976) believes that many patients wish to know that their experiences are not unusual and for this to be

communicated by a knowledgeable professional. Sometimes this reassurance of normality and permission to think, feel and behave is sufficient to meet the patient's needs and so the therapeutic value of these interactions must not be underestimated (Taylor and Davis, 2006).

McInnes (2003) provides examples of how permission may be communicated and proposes the use of various techniques to help achieve this. These include reassuring the patient that the topic is routinely addressed, deploying generalising and normalising statements and confirming these with relevant statistics. Open ended questions can then be employed to link the professional's introduction to the topic with the patient's opportunity to speak freely about what is important to them.

As Permission-giving underpins the Ex-PLISSIT model all healthcare professionals should be comfortable engaging at this level, including General Practitioners and Practice Nurses (Clarke et al, 2014).

(ii) Limited Information

The provision of limited information refers to the provision of information that is directly relevant to the concern of the patient. This information may include details of relevant support groups and resources. Changing Faces (2013), for example, offers a range of materials to support people with disfiguring conditions, including a two part guide entitled 'Intimacy, Love and Relationships.'

Whilst no resource can be fully comprehensive and the Changing Faces (2013) material centres primarily on developing new relationships, being aware of such organisations and their materials enables a healthcare professional to offer useful resources to their patients. As Davis and Taylor (2006) insist, these should not be considered a panacea and follow up questions can be asked at a later date to provide the patient with the opportunity to discuss any concerns.

Clarke et al (2014) surmise that all healthcare professionals working with target groups can be expected to engage at this level. This will include nurses and doctors that regularly encounter those with visible differences.

(iii) Specific Suggestions

This stage can involve taking a more detailed history from the patient, identifying the challenges they face and exploring their aspirations and expectations. Specific suggestions are used to offer more focussed, tailored support. Interventions at this level require identifying goals, designing a strategy to achieve them and assessing its effectiveness. They can include social skills training (Clarke et al, 2014). Within the sphere of intimacy this could include focussing on social skills and situation

management to overcome specific difficulties that a patient may disclose. For example, a single patient with a difference that is not ordinarily visible as it is concealed by clothing or in some other way may benefit from focussing on the scenario where they make a new or potential partner aware of their altered appearance.

This approach is presented as being within the realm of Occupational Therapists and Clinical Nurse Specialists working with a population who may be affected by visible difference (Clarke et al, 2014). The need for onward referral therefore becomes increasing likely at this stage. In light of this it is necessary for healthcare professionals to ensure that they are aware of the available referral pathways.

(iv) Intensive Therapy

Engagement at this level would involve the provision of specialist psychological therapy such as Cognitive Behavioural Therapy or Acceptance and Commitment Therapy and fall primarily within the domain of Clinical Psychologists (Clarke et al, 2014). Dedicated specialist support for people with a visible difference is, however, rare. The Outlook Service based within North Bristol NHS Trust and specialises in providing psychological support to those with visible difference but is the only such NHS service. Existing NHS Psychology services may be overburdened and under-resourced and the professionals working within them may lack specialist knowledge. Similarly, there are no interventions focussing on intimacy designed for people with visible differences that can be accessed remotely. Access to the third and fourth levels of the Ex-PLISSIT model thus depends largely upon the nature and availability of local services.

Whilst the Ex-PLISSIT model may provide a useful framework to facilitate interactions between HCPs and patients at the stages of Permission and Limited Information, its utility is necessarily limited by the availability of specialists able to operate at the more intensive levels. In light of this, the imperative to develop materials to assist practitioners in effectively addressing intimacy and visible difference at all stages within the model and in assessing those that may benefit from onward referral is thrown into sharp relief.

Four Summarising Key Points

1. Visible differences can present patients with psychosocial challenges, including difficulties with their intimate and sexual life.
2. Discussions relating to intimacy and visible difference may be challenging for healthcare professionals.

3. Adopting the Ex-PLISSIT model of interaction may facilitate clinical discussions, may increase the utility of these discussions and ensure patients are referred to specialist services when appropriate.
4. Opportunities for more intensive therapy are limited so the development of specific guidance and interventions may benefit healthcare professionals and patients.

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