Talking about post-injury sexual functioning: The views of people with spinal cord injuries—A qualitative interview study

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Abstract

Aim: This study aimed to explore perceptions of people with spinal cord injuries regarding the information they received during their rehabilitation programme on post-injury sexual functioning.

Background: Spinal cord injury is a traumatic, life-altering event that is associated with loss of motor and sensory function and sexual impairment. Existing evidence suggests that sexual issues are poorly handled during the rehabilitation phase of the patient’s journey.

Design: A descriptive qualitative design was utilized in this study.

Methods: Twenty-nine people with spinal cord injury participated in qualitative in-depth interviews between November 2017 and April 2018, and data were analysed using the Burnard (1991) thematic analysis framework.

Results: Some participants indicated they were sexually inactive prior to their spinal cord injury. They testified that they had not received information on post-injury sexual functioning. Many participants who received post-injury information on sexual functioning reported dissatisfaction with the content and timing of this information.

Conclusion: Personal conversations between spinal cord injured patients and dedicated members of the interdisciplinary health team can enhance the quality of rehabilitation care and patients’ satisfaction with rehabilitation care. Nurses are central clinicians in the rehabilitation programme of spinal cord injured patients and should engage in individually designed conversations about post-injury sexual functioning.

KEYWORDS
interdisciplinary communication, interview, nursing, patient care team, qualitative research, rehabilitation, sex education, spinal cord injuries

Summary statement

What is already known about this topic?
- Spinal cord injury causes significant disturbances of sexual functions and sexuality with potential serious implications for sexual relationships.
Sexual health issues are considered important aspects of holistic care but are not routinely addressed in health-care settings.

Spinal cord injuries units provide rehabilitation for people with spinal cord injuries.

What this paper adds?

- There are multiple barriers to providing high-quality information on sexual functioning within the rehabilitation setting, associated with personal, clinician and systems-related factors.
- Determinations regarding individualized plans for sexual health conversations must be collaborative with the patients and possibly their family members, considering the individual views of patients regarding the best timing, content and most appropriate method for such interventions.
- The experiences and views of people with spinal cord injury are diverse and probably culturally dependent, and there are inherent risks associated with stereotypical attitudes to sexual behaviour and age.

The implications of this paper:

- Spinal cord rehabilitation services must respond to the identified unmet needs of people with spinal cord injury regarding education on sexual functioning.
- Multidisciplinary teams that utilize a holistic approach designed collaboratively with the individual with spinal cord injury will have the best potential for success.
- To be able to successfully realize rehabilitation standards, clinicians must be immersed in techniques and strategies that motivate and guide them in discussing sexual functioning and other sexual health-related issues.

1 | INTRODUCTION

The World Health Organization (2013) defined spinal cord injury (SCI) as damage to the spinal cord resulting from trauma, disease or degeneration. The annual global incidence of SCI has been estimated at between 250,000 and 500,000, of which approximately 55% are traumatic (Donovan et al., 2017). It is estimated that 50,000 people are living with SCI in the United Kingdom (Spinal Injuries Association, 2020).

SCI is a traumatic, life-altering event that is often associated with loss of motor and sensory function as well as sexual impairment (Choi et al., 2015). Individuals are faced with devastating loss and an abundance of new information that can cause extreme stress and anxiety (Hess & Hough, 2012). Literature suggests that concerns associated with sexual functioning are poorly handled during the rehabilitation phase of the patient’s journey (Donovan et al., 2017), and although sexual functioning is an important aspect of holistic care (Bodner, 2011), it is not routinely (Gianotten et al., 2006) nor adequately (Evans, 2013; New & Currie, 2016) addressed in healthcare settings.

People with SCI are faced with a lengthy rehabilitation process with life-changing physical adaptations imposed by the injury. While initially reliant on clinicians within an unfamiliar hospital environment, a prolonged rehabilitation phase supported by family and professional carers in their own homes or other rehabilitation settings ensues. Rehabilitation aims to minimize disabilities and assist individuals to work towards recovery of activities and maximum participation in society. Although sexuality is acknowledged as a key domain in health that is important for well-being and quality of life, many rehabilitation professionals find sexual issues difficult to address with patients (Simpson et al., 2012).

Awareness of sexual functioning issues in people with SCI increased in the 2000s and is reinforced by publications emphasizing the importance of sexual function as a component of the individual’s rehabilitation process (Hartshorn et al., 2013). Individual injury-related and personal factors combine with clinician-associated and health-care systemic factors to influence post-injury adjustment to sexual functioning. Barriers to the provision of education on sexual functioning include limited staff knowledge and skills, staff discomfort, cultural issues and perceptions of clinicians that the expertise lies somewhere else (Choi et al., 2015; Julia & Othman, 2011; Othman & Engkasen, 2011; Parker & Yau, 2012).

Education on sexual functioning (such as genital arousal, ejaculation and orgasm) should be integral to the rehabilitation programme as maintaining a healthy sex life after SCI is important to many
individuals (Hartshorn et al., 2013; Othman & Engkasian, 2011; Saif et al., 2013).

SCI impacts the sexuality of men and women differently. In men, erectile dysfunction and infertility have merited considerable attention in the literature (Spinal Injuries Association, 2014). As women’s ability to become pregnant and deliver a child is largely unaffected following SCI, other aspects of women’s sexual functioning are often assumed unaffected and resulting in less focus on research into women’s compared with men’s sexual functioning after SCI (Celik et al., 2014; Cramp et al., 2015; Iezzoni et al., 2015; Singh & Sharma, 2005).

It is recommended that effective and holistic rehabilitation is best provided within specialist centres that aim to care for and support people to live a fulfilled and independent life (National Health Service, 2015). NHS England (2014) emphasized that the rehabilitation process, defined as ‘... the restoration, to the maximum degree possible, of an individual’s function and/or role, both mentally and physically, within their family and social networks and within the workplace where appropriate’, is a shared activity between the person, his or her family and interdisciplinary team members. Although excellent examples of collaborative rehabilitation services had been reported to them, Wessex Strategic Clinical Networks (2015) noted that clinicians and service users across the United Kingdom reported that rehabilitation services did not meet service users’ needs.

The opportunities for people with SCI to live productive lives have increased greatly with the development of medical (intracytoplasmic sperm injection [ICSI] and surgical vas aspiration of semen [VASAP]) and information technology (Spinal Injuries Association, 2014). Rehabilitation programmes designed by SCI specialist centres should have such advances in technology imbedded in their rehabilitation practice. This study aims to use qualitative methodology to add to the evolving evidence base.

2 | METHODS

2.1 | Aim

The aim of this study was to explore perceptions of people with spinal cord injuries about the information they received during their rehabilitation programme on post-injury sexual functioning.

2.2 | Design

A descriptive qualitative design was chosen. ‘The goal of qualitative descriptive studies is a comprehensive summarization, in everyday terms, of specific events experienced by individuals or groups of individuals’ (Lambert & Lambert, 2012) and can improve our understanding of human beliefs, perceptions, motivations, intentions and behaviours (Parahoo, 2014). The methodology is presented in accordance with the Consolidated Criteria for Reporting Qualitative Research (COREQ) (Tong et al., 2007) (Table 1).

2.3 | Participants

The study was conducted at a single centre SCI Unit in Northern Ireland that provides intensive rehabilitation for people with SCI. The unit covers a population of 1.6 million people. To be included, participants

- had to have an SCI;
- be minimum 18 years old;
- have participated in the centre’s rehabilitation programme; and
- deemed medically fit to participate in the study by their consultant.

Participants were excluded if they were unavailable during the data collection period. A total population purposive sampling approach was implemented, commonly used when the population is small or difficult to access (Etikan et al., 2016).

2.4 | Data collection

Data were collected through individual face-to-face in-depth interviews between November 2017 and April 2018, guided by an interview framework consisting of open-ended questions focused on major concepts synthesized from the literature (who presented the information, content of the information). The major concepts were agreed within the research team, and the duration of interviews ranged from 45 to 60 min. To enhance truthfulness of the interpretation of the narrative data, probes such as ‘In what way?’, ‘What do you mean by that?’ and ‘Can you give an example?’ were used by the interviewer when required. Rigour of the data collection process was enhanced as interviews were audio recorded and a reflexive diary was employed. Validation of findings were assured as transcripts were returned to participants for comments or corrections, and themes were agreed within the research team. The voice of participants is clearly heard in Section 3 where multiple direct quotations from participants are used to illustrate their views.

2.5 | Ethical considerations

All participants were given a participant information sheet and a consent form. A date and time for the interview were arranged with individuals who consented. The study was approved by a UK National Health Service research ethics committee, a university research ethics filter committee and the Research Governance Department at the participating health and social care trust.
| Domain 1: Research team and reflexivity |
|----------------------------------------|
| **Personal characteristics**            |
| Interviewer/facilitator: SN             |
| Credentials: BSc, RN                    |
| Occupation: Ward sister, MSc student    |
| Gender: Female                          |
| Experience and training: Basic MSc research training but had extensive clinical experience of interviewing patients about clinical matters |
| **Relationship with participants**      |
| Relationship established: As ward sister on the ward, a relationship was established prior to study commencement with most of the participants |
| Participant knowledge of the interviewer: All participants knew the researcher was the ward sister and that she was doing her MSc. This was explained in the participant information sheet and invitation letter also |
| Interviewer characteristics: The interviewer was the ward sister on the spinal unit and had a key interest in the topic and was the instigator of the study and refined the focus |

| Domain 2: Study design |
|------------------------|
| **Theoretical framework** |
| Methodological orientation and theory: The methodological orientation was underpinned by a descriptive qualitative, exploratory philosophy and the Burnard (1991) 14-stage thematic content analysis framework |
| **Participant selection** |
| Sampling: Purposive |
| Method of approach: Face-to-face |
| Sample size: 29 |
| Non-participation: Two individuals declined participation, giving no specific reason |
| **Setting** |
| Setting of data collection: Ward setting, confidential clinical room |
| Presence of non-participants: None other than the participants and the interviewer |
| Description of sample: Participants were sampled from a single specialist spinal centre within the United Kingdom, participants’ age ranged from 18 to 96 years, included females and males, and sampling took place between November 2017 and April 2018 |
| **Data collection** |
| Interview guide: A brief overview of topics explored is provided, along with examples of probes used by the interviewer to facilitate exploration of the topic. The interview schedule was not pilot tested but was agreed within the research team |
| Repeat interviews: Repeat interviews were not carried out |
| Audio/visual recording: Interviews were audio recorded |
| Field notes: Field notes were gathered during the interviews to facilitate reflexivity |
| Duration: 45–60 min |
| Data saturation: Data saturation could not be ascertained |
| Transcripts returned: Transcripts were returned to participants for comment and/or correction |

| Domain 3: Analysis and findings |
|---------------------------------|
| **Data analysis** |
| Number of data coders: The interviewer also coded the data |
| Description of the coding tree: A coding tree was not described |
| Derivation of themes: Themes were derived from the data |
| Software: Data management software was not used |
| Participant checking: Participants provided feedback on the findings |
2.6 | Data analysis

The qualitative interviews were transcribed verbatim and analysed using the Burnard (1991) 14-stage thematic content analysis framework. Analysis involved reading and re-reading the transcripts and taking notes on emerging themes from each interview, and data were prepared, reviewed and categorized into broad themes. Where appropriate, data from the reflexive diaries, which captured non-verbal aspects of the interviews, were merged with the respondents’ narrative to ensure a truthful representation of the experiences of the respondents. To enhance dependability, the transcripts and subsequent analysis were triangulated by one additional research team member to validate themes. Data were member checked against each participant enhancing credibility and confirmability of the findings.

3 | RESULTS

Thirty-one individuals were invited to participate from a total of 43 people that were discharged from the rehabilitation centre during the data collection period. Participants’ age ranged from 18 to 96 years. Two individuals declined to participate. Nine participants reported they had received information on sexual functioning during their rehabilitation programme or at outpatient appointments; however, all 29 participants expressed their views and experiences on the topic. Five broad themes emerged from the data, illustrated by the participants’ own voice: It’s a very essential part of my life

3.1 | It’s a very essential part of my life

Some participants explained that they were not sexually active prior to their injury due to marital status, age or pre-existing illness, and their perceptions reflected such personal contexts.

   ... I’m divorced for the past twenty years. Because of my illness ... I never enjoyed it ... just went along with that sex thing. (Female Patient A)

3.2 | I wasn’t told anything

Most participants reported that they had not received information on sexual functioning as part of their rehabilitation programme, with some indicating this was acceptable to them.

   No ... I wasn’t told anything, why are they supposed to talk about things like that? (Male Patient F)

   ... you are the first person to ask me about that. I didn’t talk about it or want to talk about it, so I didn’t ask anything. (Female Patient B)

TABLE 1  (Continued)

| Domain 3: Analysis and findings |
|-------------------------------|
| Reporting                     |
| Quotations presented          | Participants’ quotations were used to illustrate the themes, and each quotation was identified using a synonym patient descriptor |
| Data and findings consistent  | Findings are consistent with the data |
| Clarity of major themes       | Major themes are clearly presented in the findings |
| Clarity of minor themes       | There is description of some diverse cases, but minor themes were not identified |

... essential part of my life ... to know what changes there would be. (Male Patient C)

I really need to know what is going on. (Female Patient C)

Participants who had been sexually active prior to their injury affirmed that restoring their sexual function was a key priority for them and actively sought information on sexual functioning from staff in the rehabilitation centre or online.

... it’s a very essential part of my life, I wasn’t told anything, I’m happy enough. One-to-one, face to face, is the best way to go and The timing was right for me.

I never married and never had sex. (Female Patient B)

I’m too old for sex ... that’s important for the young ones. (Male Patient A)

It should be up to the patient to ask if he wants to know about these things. (Male Patient E)

I don’t think they should be talking about these things, don’t think there’s a need for it. We are here to learn to walk. (Male Patient F)
Some participants suggested their age may have influenced the education on sexual functioning from some staff members, hinting at age discriminatory attitudes.

Most of the people here are all of an age where I don’t think they, or me, require sex education ... I’m sure the staff think the same. (Male Patient G)

They probably looked at me and thought that auld [old] doll is too old for that. (Female Patient E)

A range of individuals provided information on sexual functioning.

Yeah, the consultant mentioned a little bit about sensation, feeling, periods and birth control. (Female Patient C)

Peer support worker [charity worker who visits the centre two days a week] mentioned it, then my social worker ... said speak to your consultant. (Male Patient C)

3.3 | I’m happy enough

Some participants reported that receiving information on sexual functioning was not a priority for them during rehabilitation and they had no interest in discussing these issues; other needs were more important.

It was the last thing on my mind at that time, I was more interested in walking again. (Female Patient F)

Never really thought about it, sex never entered my head in the beginning, ... [the consultant] mentioned it ... said ... would talk about it when I came up for outpatient appointment. (Male Patient H)

Other participants were content not receiving information on sexual functioning.

I wasn’t given any information ... a short discussion at the end of my family meeting, but only because I asked. I would have liked ... more information on how my injury would impact on my sex life. (Female Patient I)

I wasn’t given the full range of everything ... specific to my injury. (Male Patient D)

3.4 | One-to-one, face to face, is the best way to go

Most participants affirmed that one-to-one discussions with a nurse was their preferred method of receiving information on sexual functioning.

One-to-one, face to face is the best way to go. (Male Patient C)

The only way to discuss that sort of thing would be in private, with a nurse probably. (Female Patient D)

Other participants indicated they would prefer group sessions as they would feel less embarrassed discussing such issues within a group; they could simply listen and hope that someone else would ask the questions they wanted answered.

I think group sessions are the best way ... people feel more comfortable ... you are not under pressure to talk. Other people asking questions can encourage others to talk. (Female Patient J)

The group might be good if you didn’t want to speak ... get answers to the questions you want to know with someone else asking ... just listening. (Male Patient J)

Groups, everyone gains from conversation. (Female Patient H)

Some participants considered that information leaflets would be helpful to consolidate the verbal information they had received.

Yes, leaflets would be good, I like reading ... could take these home and read them when I have more time. Support groups would be good, I could contact them when I’m at home. (Female Patient I)

I like to look at leaflets and have a contact number of a support group to contact if I need to. (Female Patient F)

The use of digital versatile discs (DVDs) to present information on sexual functioning was not considered appropriate by participants.
DVDs would be too sterile. (Male Patient C)

Would not want a DVD lying around for everyone to see. (Male Patient K)

Other participants liked the option of discussing these issues with a peer support worker and some mentioned a book on the life stories of SCI people given to them by a peer support worker.

... was the only one to mention sex to me and ... gave me a book ... I took it home to read. Suppose until you have an injury you don't think about these things, so the book was good to get. (Male Patient J)

I liked talking to ... and ... gave me a book about life stories of people with spinal cord injury, I like reading that sort of thing. (Female Patient F)

3.5 | The timing was right for me

Participants who had received information on sexual functioning suggested these issues be introduced in hospital and followed up during outpatient appointments.

Yeah it was fine ... not too invasive. Peer support worker was very good ... mentioned it in a casual manner. (Male Patient C)

Doesn't make any difference when it was given out as long as it is. (Male Patient D)

Yes, it was just right for me. Some other people might not like talking about sex, but I don't mind. I would like to talk about it again at the six-week review when I have been home for a while. (Male Patient L)

Some participants intimated they were not ready to receive information on sexual functioning during their inpatient rehabilitation programme and suggested that the best time to discuss this was at the 6-week outpatient review appointment.

Yes, the timing was right ... me being quiet and backward, awkward. It's good to know that I can talk about this ... as out-patient ... would be better then. (Male Patient J)

It wasn't just the time for me. It was mentioned gradually throughout my stay, it was there if I wanted it. (Female Patient J)

I would like to get home ... back to normal ... at six-week review appointment, might have some questions then. (Female Patient F)

The least preferred times to present information on sexual functioning was during the medical ward rounds or as part of family meetings, with participants citing their own or their partner's embarrassment.

One-to-one talk would be less awkward than on the ward rounds with all the student nurses or medical students— it doesn't make you feel comfortable. I would like a talk with [a senior nurse] rather than the family meeting. (Male Patient D)

I didn't like to bother you all on the ward rounds ... a lot happier when I got to speak to [a senior nurse] on my own. (Female Patient C)

Don't like the idea of the consultant, me and my husband at ... the family meeting, he is quiet and would be embarrassed. (Female Patient J)

In a comfortable, quiet, private environment—not at ... the family meeting, don't know how my husband would feel about that. (Female Patient F)

4 | DISCUSSION

This study aimed to explore the views of people with SCI on the education on sexual functioning they received during their rehabilitation programme. Key findings suggest that many (but not all) people with SCI believe that information on sexual function post-injury is important, best facilitated through one-to-one personal discussions between the person with SCI and a professional. Our respondents have confirmed that information on post-injury sexual function is not systemized within the rehabilitation programme but is sporadic and contingent on particular professionals and other key workers with a particular interest in such information provision.

The people in this study who were sexually inactive prior to their SCI due to marital status, age or pre-existing illness suggested that education on sexual functioning was unnecessary. Such views would be consistent with a culture in Ireland of traditional values and religious beliefs on sexual activity outside marriage and between older people (Catholicismehome.org, 2021; The General Synod of the Church of Ireland, 2016; Wallace, 2012) but are contrary to much existing literature that affirms that education on sexual functioning are of paramount importance to people with SCI and should be treated as a priority during rehabilitation (Abramson et al., 2007; Hartshorn et al., 2013). In our study, such views were offered by participants who were sexually active prior to their injury, validating that
sexual functioning was important to them, and many actively sought information on sexual functioning. Discussions about sexual functioning (and other aspects of sexual life) appear to be neglected by multidisciplinary rehabilitation teams within spinal rehabilitation centres (Burch, 2008; Fritz et al., 2015).

The timing of the provision of information on sexual functioning has received considerable attention in the literature, much of this literature advocating that such information should be introduced during the inpatient acute rehabilitation stage of the patient’s journey (Saif et al., 2013). However, the discrepancy in our respondents’ views regarding best timing for this education is also reflected in the literature (Fritz et al., 2015). Not all individuals are ready to embrace information on sexual functioning during inpatient rehabilitation, in which critical needs such as mobility, hypothesized to belonging to physiological needs in Maslow’s model, take priority (Moreno et al., 2017). For these individuals, sexual educational needs, matching love and belonging needs in Maslow’s model, could be better situated within their outpatient review appointments (Abramson et al., 2007; Hess & Hough, 2012). This is indeed reflected in some of our respondents’ narrative. Other literature recommends a 6-month post-injury time frame for information on sexual functioning; nevertheless, the challenge for clinicians is to appreciate how individuals’ needs change over time so that each individual’s preferred time for education on sexual functioning is ascertained and addressed appropriately (Moreno et al., 2017). Some participants in our study indicated that they wanted information on sexual functioning introduced during their inpatient rehabilitation and further enhanced at their subsequent outpatient appointments. Existing evidence suggests that a majority of people with SCI do not receive sexual functioning education at any stage during or after their acute rehabilitation (inpatient) programme (Burch, 2008). Our study adds to existing evidence by recommending individualized exposure to key sexual functioning messages during inpatient rehabilitation with detailed follow-up during clinic appointments (Lombardi et al., 2010).

Existing evidence has testified that people with SCI report poor satisfaction with the provision of information on sexual functioning within rehabilitation programmes (New et al., 2016), and some participants in our study corroborate this dissatisfaction. Poor quality information provision can have devastating effects on people’s marriage and sexual relationships (Abramson et al., 2007; Consortium for Spinal Cord Medicine, 2010; Hess & Hough, 2012; Events, 2013; Gianotten et al., 2006).

In our study, many respondents reported satisfaction with information provided, confirming that needs prioritization is highly individual amongst people with SCI. Person-centred interventions must reflect the different needs between men and women (Hartshorn et al., 2013; Stoffel et al., 2018; Tong et al., 2007) and also between people with traumatic versus non-traumatic SCI (Moreno et al., 2017). As the quality of programmes on education on sexual functioning and the regularity of their implementation are so inconsistent, rehabilitation services’ ability and capacity to respond to such evolution of sexual needs require thorough scrutiny and evaluation.

The detrimental effects of SCI can reduce quality of life by changing or restricting frequency and content of sexual functioning (Pakpour et al., 2016). In our study, participants of both genders indicated they wanted more information on how their individual SCI would impact on their sexual function. Although most participants preferred to discuss sexual functioning in one-to-one conversations with a senior nurse, group sessions were favoured by others, reinforcing the importance of individualizing information sharing to mirror the needs of the individual. Education on sexual functioning should be provided by qualified health professionals who have appropriate knowledge and experience (New & Currie, 2016). The training of such clinicians needs careful consideration as there is limited evidence on what constitutes the best education format or content (Elliott & Quéré, 2018).

Embarrassment, privacy and confidentiality emanated as key reasons why participants did not want sexual functioning addressed during the ward round or during family meetings. This embarrassment was sensed implicitly during the interviews as some participants initially only answered in one or two words. As time lapsed and they became comfortable with the conversation, their embarrassment eased, and they started to express their views openly. Our data recommend one-to-one conversations, at least initially, as this allows clinicians to evaluate the readiness of individuals to engage with sexual functioning matters with a view to design personalized education plans (Celik et al., 2014). Group sessions may be introduced at a later stage, as some respondents indicated a preference for this. However, it is important to remember that clinicians’ style of presentation, body language, attitude, subject knowledge and personal discomfort can influence patients’ receptiveness, confidence, amount of disclosure and level of satisfaction with information received on sexual functioning (Consortium for Spinal Cord Medicine, 2010; Hess & Hough, 2012; Simpson et al., 2012).

### 4.1 Study limitations

The arguments presented in this discussion must be interpreted within the limitations of the study. The data were collected from a single centre within one region of the United Kingdom, with participants embedded in the cultural and religious norms of this region, which potentially reduces transferability to other regions of the United Kingdom and other countries in the world. As all participants had been treated by clinicians at the spinal centre and participated in the centre’s rehabilitation programme, participants may have felt a moral obligation to provide more positive, or at least less negative, views than those representing their true feelings. The initial reluctance by respondents to provide detailed responses during interviews may be an indication of this. As such, it was difficult to ascertain if data saturation occurred.

### 5 Conclusion

Our study confirms that high-quality education on sexual functioning is not consistently provided to people with SCI. Satisfaction from
people with SCI is variable, but there is evidence of good quality interventions provided by individual rehabilitation team members that were highly rated by individuals. Determinations regarding individualized plans for sexual functioning conversations must be collaborative with individuals and, in some cases, their family members, considering the individual’s views about the best timing, content and method for such interventions. Sexual functioning conversations should be undertaken by clinicians trained for such conversations, while acknowledging personal and cultural factors that may inhibit or enhance the quality of such conversations. There are multiple barriers to providing high-quality information on sexual functioning within the rehabilitation setting, associated with personal, clinician and systems-related factors. The experiences and views of people with SCI are diverse and probably culturally dependent, and there are inherent risks associated with stereotypical attitudes to sexual behaviour and age, which may create considerable challenges to educational programmes that aim to inform and support normalization of sexual activities for people living with SCI.

Spinal cord rehabilitation services must respond to the identified unmet needs of people with SCI regarding education on sexual functioning. Rehabilitation is an essential component of quality health-care services and is an investment for the future with benefits for individuals and society alike.

Considering our findings in the context of existing research, it is concluded that co-designed educational plans between clinicians, immersed in techniques and strategies that motivate and guide them in discussing sexual functioning and other sexual health-related issues, and the person with SCI may have the greatest potential for success. Such rehabilitation plans may be realized through the implementation of culturally sensitive, evidence informed conversations.

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CONFLICT OF INTEREST
The authors declare no conflict of interest.

AUTHORSHIP STATEMENT
Both authors confirm that they meet the authorship criteria and are in agreement with the content of the manuscript. SN and VM made substantial contributions to conception and design, analysis and interpretation of data. SN collected the data. SN and VM drafted the manuscript and revised it critically for important intellectual content. SN and VM gave final approval of the version to be published and have participated sufficiently in the work to take public responsibility for appropriate portions of the content. SN and VM have agreed to be accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved.

DATA AVAILABILITY STATEMENT
Due to the risk of breach of confidential and sensitive personal information, the data in this study cannot be shared.

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