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'That might be a bit sexy for somebody your age': Older adult sexual health conversations in primary care

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'That might be a bit sexy for somebody your age': Older adult sexual health conversations in primary care

Abstract

Background: Many older adults are sexually active and STIs are rising among this cohort. In primary care sexual health discussions are limited as healthcare practitioners commonly assume older patients aged 60+ are not sexually active or are unwilling to discuss sex. Studies have either examined patient or clinician views, but not both.

Objective: This study investigates sexual health discussions in general practice. It is unique in that it sought perspectives of different groups: older patients, healthcare professionals, and key informants.

Results: Qualitative interviews revealed that older patients expect clinicians to bring up sexual concerns, whereas clinicians prefer older patients to do so. A simple electronic solution to circumvent this impasse was suggested and discussed.

Conclusions: Older adults would like to discuss sexual concerns with their healthcare providers. Given the rising rates of STIs in later life, sexual health discussions with older patients must become part of routine care.

'That might be a bit sexy for somebody your age': Older adult sexual health conversations in primary care

Introduction

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Qualitative studies which report the lived experiences of adults aged 60 years and over show they remain sexually engaged, redefining their intimate practices beyond 'sexual intercourse' by finding unique ways to stimulate arousal and achieve orgasm[1,2]. Many older men and women face limitations to what is sexually possible due to physical changes brought about by ageing such as erectile difficulties, post-menopausal vaginal atrophy and dryness[3]. Chronic health conditions such as rheumatoid arthritis, fibromyalgia, diabetes and heart disease or some cancers[4] can also cause limitations, as can medication intake such as beta-blockers, and so on.

It is difficult to estimate how many older adults are sexually active. Large, population-based sexual behaviour studies such as the Natsal-3 (UK), the NSLHAP (USA), and the ASHR (Australia) for instance, report variability in rates of sexual activity with age [5-7]. More recent online surveys, the Sex Age & Me (Australia) and the National Poll on Healthy Ageing (USA) found rates of 72% and 40% respectively, although their age ranges differed (60 – 80+ versus 65 – 80 years) (rates for females versus males vary, see each study for more details)[8,9]. Remaining sexually active in later life is beneficial, and has been associated with several positive health and wellbeing outcomes, including increased life satisfaction and lower levels of depression and, more recently, with enhanced cognition [10,11].

While structural ageing is increasing worldwide, the numbers of older adults in the population who are single is also increasing[12] due partly to greater longevity, but also because of the growing numbers of later life divorces[13]. For instance, while Australians aged 55 and over are less likely to divorce than those who are younger, the proportion of divorces amongst couples married 20-plus years increased from 20% in 1990 to 27% in 2017[14] – prompting the Australian Institute of Family Studies to label this phenomenon as the '20-year itch'[15]. This growing trend of later life divorce is mirrored in the UK where the numbers of 'silver splicers' or 'silver separators' aged 65 and over increased by 23% for men and 38% for women from 2005-2015[16]. In the USA the so-called 'gray divorce revolution' shows the rate doubled between 1990 and 2010[17].

With the ubiquity of the internet many older adults now access online dating websites or the new smartphone dating apps to find new partners. Dating and repartnering in later life provides the opportunity to form new (and redefined) sexual relationships. The 2012 Date of the Nation Report by online dating website RSVP, for instance, found Australian baby boomers were the most likely age group to have sex on the first date or within four weeks of meeting[1,18].

STIs at older ages

Along with these new sexual relationships comes risk for contracting sexually transmitted infections (STIs)[19-22] with some researchers postulating that online dating may serve as an incubator for the spread of STIs due to the increased number of sexual meetings possible[20,21]. Certainly, the number

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of bacterial STIs (chlamydia, gonorrhoea and syphilis) amongst older Australians has increased by ~46% in the last five years[23].

The reasons for this increase appear multi-faceted and centre on a lack of sex education and sexual health literacy generally[24] in terms of the impact of ongoing sexual engagement on health and wellbeing, pleasure, the use and benefits of lubrication, addressing dysfunction, sexual aids, masturbation, consent and so on. In particular, older adults who are aged ≥60 years lack knowledge about the protection afforded by condom use[24]; with many believing they are not at risk of contracting an STI[25], although bodily changes associated with ageing can make transmission more likely to occur[22,26]. One Australian survey found younger men were more likely to use condoms than older men, who were more likely to think condoms diminished sexual interest or pleasure than their younger counterparts[27]. Among women, Australian research has found lower condom use in those aged over 40[28,29] and in those aged 60 and over[30]. It is thought this lower condom use in women is because they no longer have the need for contraception. These findings highlight the importance of providing safer sex awareness/education for older adults[22]. Older adults also have limited recent experience of negotiating with new partners about their sexual desires and practices (including use of condoms and lubrication), and this is particularly so for older women[30].

Although the incidence of STIs amongst older heterosexual Australians is relatively low compared to other groups such as 18-25 year olds or gay men, for example, testing rates in the older heterosexual population are also low in comparison. Consequently, it is likely the 'true' incidence of STIs in later life may be considerably higher[24,26,30]. Further, the factors highlighted above indicate that as the number of single heterosexual older adults in new relationships grows, so too will the future prevalence of STIs in later life[19].

The 'Catch-22' of sexual health and wellbeing discussions in the primary care setting

Older adults visit primary healthcare clinics more often than younger people[31] but, to date, their sexual health and wellbeing needs have not been covered by healthcare guidelines. For instance, the RACGP Redbook makes no mention of sexual health as a preventative health measure for adults aged 45 and over[32]. Likewise, there are very few policies which address the sexual health and wellbeing requirements of older people, beyond addressing sexual dysfunction or menopause, both in Australia or internationally[33].

Our previous research, and that of others, has also highlighted that the issue is exacerbated because older adults are known to be reluctant to talk about sex with their health practitioners[34,35]. Healthcare professionals appear just as reluctant to discuss sex with older patients[36,37], or at worse, to believe their older patients are not sexually active[35-37] and therefore, may not recognise the symptoms of STIs in their older patients[38,39]. This 'Catch-22'[40] is further compounded by the

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general lack of evidence-based sexual health and wellbeing information resources specifically designed for older patients and/or health professionals[24]. A 2011 review of the literature conducted by Hinchliff and Gott[41] found there were very few studies which examined the perspectives of general practice doctors about their patient's help-seeking behaviours. Our preliminary research found even fewer studies which combined the perspectives of both doctors *and* older patients *and* also provided a possible means to encourage such help-seeking behaviour. The purpose of the current study was to fill this gap.

Sexual Health and Ageing, Perspectives and Education (SHAPE) Project

The SHAPE Project was designed to be conducted in four complementary phases (see Figure 1); three phases have been completed to date.

SHAPE Phase 1

Our study is unique in that it sought the views and experiences of four different target groups: older patients as well as healthcare professionals (doctors, practice nurses and practice managers) about the barriers and enablers to sexual health and wellbeing discussions occurring with older patients in primary care. We also sought the views of sexual health key informants, or key informants who had developed or used digital/online health interventions. We asked whether the use of such a discussion aid could facilitate these conversations occurring in general practice settings. In all, 58 face-to-face or telephone interviews were conducted in Phase 1. The results from the healthcare professionals have been reported elsewhere[37] as have the key informant results[42].

SHAPE Phases 2-4

Phase 2 of the SHAPE Project consisted of a qualitative, co-design study with older adults to investigate the format, content and language/tone of the questions to be included in a prototype discussion tool, which was later assessed by healthcare professionals. Phase 3 of the SHAPE Project involved pilot testing of the prototype in a series of focus groups with older adults. Phase 4 will be conducted at a later stage and will further refine this intervention and then test its usability *in situ*.

Figure 1: about here

This article outlines the first comprehensive account of our Phase 1 interviews with older adults. It aims to address the gaps in the literature, by providing an overview of the barriers and enablers of sexual health discussions in primary care from older adult perspectives, as well as to provide a broad outline of a possible intervention which could be implemented in primary care clinics.

METHOD

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Recruitment

A purposive sample of older participants was recruited using a variety of means: via the SHAPE project website, advertisements in e-newsletters of a number of older adult advocacy, support and health organisations, as well as emails to professional networks/colleagues, personal networks and word of mouth (snowballing). Participants were required to be English-speaking and aged 60 or older.

Design

Semi-structured qualitative face-to-face or telephone interviews were conducted over a five month period (December 2016 to May 2017). The interview questions were designed to be non-confrontational and did not ask participants about their own sexual health or activity. Instead, they included questions regarding experiences in terms of sexual health and wellbeing discussions with healthcare professionals, in particular, doctors; whether they occurred or not; how they felt about these conversations; where the most appropriate place to conduct such conversations would be; and their views on what kind of sexual health discussion tool could be implemented to ensure these discussions occur in the future.

All participants were provided with a plain language statement and consent form containing details of the project. Participants were also provided with an information sheet containing details of support agencies should they be required, in case they felt discomforted or anxious about anything that was discussed during the interviews.

Data analysis

Interviews were digitally recorded, professionally transcribed and de-identified. Demographic data was extracted and summary statistics generated. The remaining data was coded and analysed thematically [43] in NVivo (Version 11) using the interview questions to determine baseline categories. A mixed etic/emic approach was then undertaken to the analysis, and coding/subcoding carried out in order to structure the data within research previously conducted about this subject, whilst allowing original themes to develop. Interviews were independently checked to ensure coding validity.

Ethics

Ethics approval was granted by [blinded for review] Human Ethics Sub-Committee [Approval number: blinded for review].

Results

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Twenty-one older adults aged 60 – 90+ years were interviewed. There were nine women and 12 men, with 12 participants in their 60s, eight in their 70s, and one aged 90+. Eleven rated their health as very good or excellent and 15 reported they were very or extremely satisfied with their lives (see Table 1 for sample characteristics).

Table 1 about here

All participants affirmed that sex was important to them, with one man in his 70s remarking that being sexual in later life was "as important as eating, and it's to be encouraged" (#14 male aged 70-79). Many acknowledged that how they personally defined sexual activity had changed over their life span. They wanted healthcare professionals to understand that their concept of what counted for "sex" was no longer predicated on intercourse. Other forms of sexual expression had taken a more central role once penetrative sex became less prevalent with age.

> *…you can do other things and pleasure each other in other ways [which] can actually create the intimacy that can be lost if you're not having…penile-vaginal [sex] (#6 male 60-69)*

> *One of the wonderful things about old people sex, is that there's less focus on fucking (#2 female 60-69)*

> *I think there's a misperception that once you become middle-aged, that sexuality, sexual identity, sexual practice seems to be less. However, my experience is that it's equally important (#9 male 60-69)*

Despite their ongoing interest and engagement in sexual activity, nearly all participants encountered some difficulties in talking to healthcare professionals about sexual matters. These difficulties centred on three major themes identified in the data: discouragement of sexual discussions, invalidation of sexual interest and fear of judgement.

Discouragement of sexual discussions

Our interviews with healthcare professionals indicated they preferred patient-led consultations; and they tended not to discuss sexual health and wellbeing with older patients unless the patients initiated these conversations themselves[reference blinded for review]. Nevertheless, older patients generally felt their doctors should be the ones to begin such discussions, rather than relying solely on patients to do so:

> *…that's something for the GP to bring up periodically (#2 female 60-69)*

> *I would like to think it was a professional's responsibility to initiate conversations (#6 male 60-69)*

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I think that a good doctor should be bringing it up if they think it's appropriate and not rely on the patient to bring it up (#16 female 70-79)

However, some older patients pointed out that when they did initiate discussions about sexual issues, clinician attitudes often discouraged them from pursuing the conversations further:

In the past, I've raised it and… they have been uncomfortable…. [so] I haven't pushed it any further (#10 female 60-69)

One older male's experience went beyond discouragement – he was very dissatisfied with the clinic he attended, as he felt they did not take his sexual concerns seriously:

I have tried to raise a number of sexual health issues with my doctor - actually, [many] doctors in the clinic. I just don't think they know how to deal with it [sex and ageing] effectively (#6 male 60-69)

Invalidation of sexual interest

There were examples of clinicians expressing ageist attitudes, by signalling to older patients that sex was not an acceptable topic for them to be concerned about at their age:

I said [to my GP] I was going to watch… Game of Thrones. She said 'oh no, that might be a bit sexy for somebody your age' (#1 female 60-69)

I've tried to raise my issues in the past about my libido [being] much higher than my wife's, so what am I going to do about it? [The doctor] says 'well you just have to cope' [or] 'memories, we have memories' (#6 male 60-69)

Many participants felt their sexual selves were invalidated or dismissed by their doctors, and this was particularly so for female participants.

Generally in the GP world there seems to be a view… that people – particularly women over the age of 50 – that nothing happens between the neck and the knees... [we're] still sexual beings… [it's] just a normal part of who we are (#1 female 60-69)

Some participants felt that the attitudes of healthcare professionals reflected wider societal beliefs that older people should be asexual:

People get told things – that once you reach a certain age things stop happening and you shouldn't expect to feel sexy or to have some sexual activity in your life, but I don't agree with that… Who assumes and when is it decided that we become not interested in sex anymore? What's the cut-off point? (#1 female 60-69)

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Our interviews with general practitioners (GP) illustrated this viewpoint quite starkly, as the following quotes attest [cited in Reference blinded for review]:

> *It's a bit like you don't really want to know your mum and dad have sex, you know? Because that's just gross (GP3)*

> *I suppose you grow up thinking people of that age don't have sex (GP6)*

Fear of judgement

Some older patients were reticent to bring up sexual matters with their healthcare professionals for fear of judgement. As one participant stated:

> *[There was] concern about what [the doctor's] reaction would be… knowing that the exchange would be difficult… there was probably reluctance on my part to want to [bring up sexual issues] (#16 female 70-79)*

Others noted feeling shamed for wanting to discuss sexual matters with their doctors, as though admitting to sexual interest was wrong and/or inappropriate in later life:

> *You hesitatingly bring it up in an apologetic manner and they suddenly sit back. They don't say anything. They stiffen up, and get a look on their face. Well you're going to pull back. You're not going to raise it. That's what happens… almost without a word, you are put back in your box… (#10 female 60-69)*

Some older patients felt that if sexual health was 'normalised' by being routinely addressed in regular or annual check-ups, that this would diffuse some of the discomfort associated with such conversations and, potentially, alleviate fear of judgement:

> *If it became mainstream then it'd become just 'this is my sexual health thing, I do it the same as my dental hygiene check-up' (#5 female 70-79)*

> *I think that would be good that a sexual health check-up is part of a normal health check-up (#7 male 70-79)*

Facilitating sexual health discussions with older patients

Our previous research showed that there are opportunities to create change within general practice, and that this could be achieved with an intervention to help facilitate sexual health discussions[]. Overall, most of the older patients felt that a communication support resource of some kind could be very useful for themselves, as well as for the doctors who were embarrassed to bring up sex and sexual health matters.

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If there was an instructional pamphlet or an informative pamphlet [it would make it easier to talk to my GP] (#18 male 90+)

Targeted promotion of a resource like this is certainly going to work… I see a lot of older people using iPads now (#9 male 60-69)

In designing such a communication tool some participants suggested an online resource in the form of a website could be beneficial, particularly one where a printout could be downloaded which could then be taken to healthcare consultations:

[It could be a] website [with] articles on it [with] links to further information or personal contact options - phone numbers or email addresses where you can interact more individually; and a [downloadable] form or checklist to take to the GP with you (#17 male 70-79)

What would seem to me to be most helpful would be to bring a printout for instance of the results [from the website] so you can say look, I'm bringing something, it's a sensitive area but I'd like to be able to discuss [it] - are you comfortable talking about [this]? (#14 male 70-79)

Participants were asked if they would be willing to complete a sexual health checklist, either in paper or digital format, in clinic waiting rooms, which they could then take in with them to their consultations. Most felt this could be both useful and acceptable to older patients and could provide additional information which would help frame discussions with their doctors.

I think [a checklist in the waiting room] would be good… I think that's an interesting concept [as] it puts in front of you questions that you may not think to ask yourself (#5 female 70-79)

I'd be quite happy to have in the waiting room a bit of paper about all the things you might like to talk about… part nutrition, general fitness, sexual health… (#2 female 60-69)

Confidentiality was an important consideration for some participants, however, who felt that older patients would only be willing to use such a tool if the information was kept private between themselves and their doctors. They voiced concerns about their personal information being accessible to others online or being viewed by reception staff in the clinic.

[A checklist in the waiting room] could probably be helpful, but I might be a little bit concerned about how confidential it would be (#1 female 60-69)

I don't want the receptionist to have this piece of paper that says I want to talk about sex toys or lubrication… Anything that involves creating a record, I think is potentially putting off the more vulnerable people who need [to discuss sexual health with their doctor and] who need a private communication (#2, female, 60-69)

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Overall, however, most participants felt an intervention of some kind was both advantageous and necessary, and could help circumvent the difficulties they and their doctors experienced about discussing sexual health and wellbeing.

Discussion

As other studies have found, our results show that sexual health and wellbeing are important considerations for older Australians, and that they continue to find ways to express themselves sexually beyond the penile-vaginal imperative. When bringing sexual matters to the attention of healthcare professionals in primary care clinics, however, older patients faced a number of difficulties. They were either actively discouraged from doing so or their interest in sexual matters was dismissed as inappropriate for their age. This is concerning, as it indicates that, despite research to the contrary, wider societal beliefs about the asexual older adult continue to persist – even amongst healthcare professionals.

Such a view positions sexual health and wellbeing as beyond the ageing self. The interest of older singles in finding new relationships, as well as increasing rates of STIs in later life, shows this is clearly not the case. This lack of acknowledgement of older adults as sexual beings has implications for their overall health and wellbeing. Healthcare professionals are unlikely to provide guidance about sexual difficulties or to offer advice about safer sex practices, particularly if they do not recognise the presence of STI symptoms in their older patients.

Older adults in this study felt that sexual health and wellbeing in later life should be 'normalised' as part of their ongoing, routine care, and that it could at least be included in their annual health checks. At an individual practice level this is possible, and anecdotally we have heard of some enlightened clinics putting such measures in place. However, structural limitations appear to preclude this occurring at a wider societal level. Firstly, sexual health and wellbeing in later life, not just sexual dysfunction, needs to be recognised as a legitimate part of ageing and included in government public health policies at both the Commonwealth and State level, and included, as appropriate, in the Medicare Benefits Schedule. Secondly, it needs to become embedded (i) within standard practice guidelines (i.e. the RACGP Redbook) and (ii) within healthcare professionals' education and training curriculum, including continuing education courses.

Until these occur, it is clear that sexual health and wellbeing amongst older patients will not be addressed in general practice environments without some form of intervention. The results showed that a resource in the form of a checklist – which could be either downloaded online and printed, or filled in within clinic waiting rooms and taken into consultations – would be a welcome initiative and

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could encourage/enable sexual health discussions to occur. Furthermore, it would be accepted by both older patients and their doctors[reference blinded for review]. However, issues of confidentiality would need to be addressed, to reassure patients that their privacy is preserved.

It is beyond the scope of this paper and, indeed, that of this special edition, to describe the development and testing of the prototype sexual health discussion tool. In brief, there were five topic categories ranging from common clinical questions through to questions about sexual health and wellbeing. Written in lay language and in an easily accessible format, the prototype was tested in a series of focus groups. It was generally well received and, with some modifications, will be ready for future testing. A paper describing this process in full is in the planning stages.

Strengths & Limitations

This study is limited in its generalisability by the size of the sample (small), the sampling method (purposive), and because participants were English-speaking and mostly heterosexual. However, it provides rich, descriptive and frank data of the views of a group of older adults about their experiences of sexual health discussions in primary care. Together with previous publications arising from this study, this paper fills a gap in providing an overview of barriers and enablers to these discussions, and lends weight to the literature by proposing an intervention to help ensure they occur.

Conclusion

It is clear from the results that sexual health and wellbeing continues to be important for older adults, and they would like to discuss these matters with their healthcare professionals. It is equally clear, that until such time as changes are effected which incorporate sexual health and wellbeing as part of normal ageing, and structural changes are instituted to ensure its relevancy in practice settings, sexual health discussions between older patients and healthcare professionals will not occur without an intervention of some kind.

Practice impact statement

Our study affirmed the need for healthcare professionals to facilitate sexual health discussions with older patients in primary care settings; and to consider whether STIs and safer sex practices need to be included in such discussions.

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Contribution to policy

Education is required for healthcare professionals at both the undergraduate and continuing education level addressing sexual health and wellbeing as a normal part of ageing, beyond an emphasis on dysfunction. Public health policy changes and Medicare rebates also need to be instituted to ensure later life sexual health and wellbeing are embedded as part of routine health care.

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Table 1. Sample characteristics

Characteristics	N = 21
Gender	***n***
Female	9
Male	12
Age	
60-69	12
70-79	8
80-89	0
90+	1
Retirement status	
Employed (full- or part-time)	12
Retired	9
Self-rated health	
Excellent	4
Very good	7
Good	9
Fair	1
Self-rated life satisfaction	
Extremely satisfied	3
Very satisfied	12
Satisfied	6
Relationship status	

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Married	10
Committed relationship	7
Divorced/separated	2
Widowed	2
Living arrangements	
Live alone	7
Live with spouse/partner	11
Live with friend	1
Live apart together	2
Length of current relationship (n = 18)	
≥40 years	5
30-39 years	4
20-29 years	2
10-19 years	0
5-9 years	4
1-4 years	2
<12 months	1
Not currently in a relationship	3
Computer and/or smart phone (n = 20)	
Both	19
Computer only	1
Computer/smart phone usage (n = 20)	
Several times/day	18
Once/day	2

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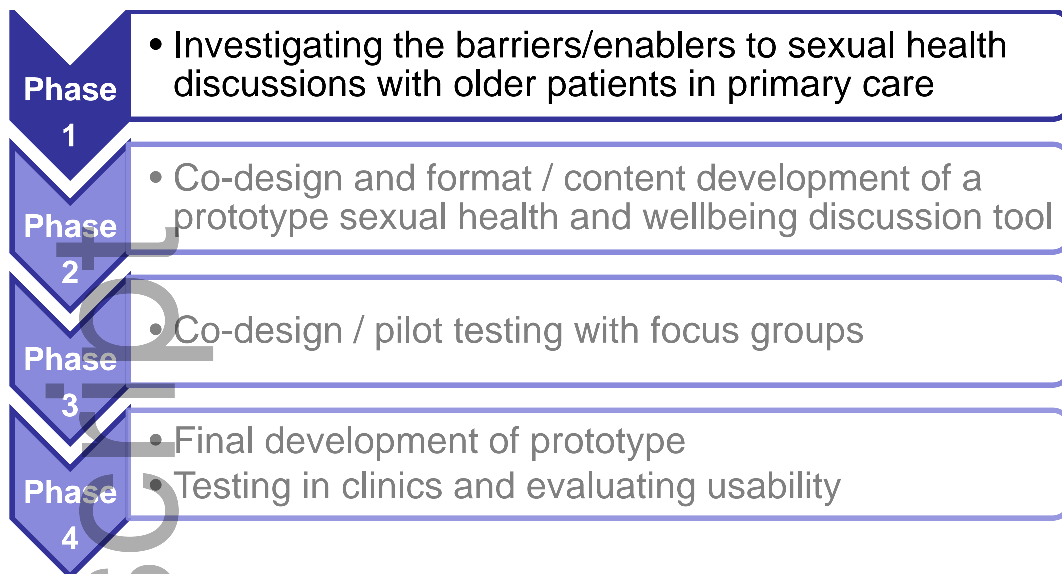

Figure 1: Outline of the SHAPE research project

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