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Sexual Health of Older Patients: Attitudes and Perceptions of Healthcare Providers

Abstract

Background: Recent research has demonstrated an alarming rate of sexually transmitted diseases (STDs) among sexually active heterosexual individuals > age 40 years . Literature suggests that healthcare providers give minimal attention to the sexual health of their older patients and admit to decreased confidence and comfort in broaching the subject of sex with these patients and may not include STDs in a list of differential diagnoses when patients present with uro-genital or other symptoms. Objective: To explore healthcare providers' perceptions, awareness, and level of comfort in managing their older patients' sexual health. Older patient : individual > age 40 years Methods: Ten health care providers participated in focused guided interviews. Themes, interactions, and sequences in conversations were examined. Results: All of the practitioners indicated sexual health of older patients to be an important aspect of healthcare, but agreed the barriers to discussion with their patients were lack of time in a patient encounter, age and gender of the practitioner, length of time in practice for the practitioner, lack of appropriate education of the practitioner and perceived lack of medical priority. Conclusions: Further research is warranted for this population and increased educational opportunities should be presented to practitioners to decrease barriers to dialogue with their older patients concerning sexual health.

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Abstract

Background: Recent research has demonstrated an alarming rate of sexually transmitted diseases (STDs) among sexually active heterosexual individuals \geq age 40 years. Literature suggests that healthcare providers give minimal attention to the sexual health of their older patients and admit to decreased confidence and comfort in broaching the subject of sex with these patients and may not include STDs in a list of differential diagnoses when patients present with uro-genital or other symptoms.

Objective: To explore healthcare providers' perceptions, awareness, and level of comfort in managing their older patients' sexual health. *Older patient*: individual \geq age 40 years

Methods: Ten health care providers participated in focused guided interviews. Themes, interactions, and sequences in conversations were examined.

Results: All of the practitioners indicated sexual health of older patients to be an important aspect of healthcare, but agreed the barriers to discussion with their patients were lack of time in a patient encounter, age and gender of the practitioner, length of time in practice for the practitioner, lack of appropriate education of the practitioner and perceived lack of medical priority.

Conclusions: Further research is warranted for this population and increased educational opportunities should be presented to practitioners to decrease barriers to dialogue with their older patients concerning sexual health.

Keywords: Older adult, sexual health, STDs, Diffusion of Innovation Theory

Although there is an abundance of information surrounding the sexual health of men and women aged 15-40 years old, there is a paucity of literature concerning STDs and the sexual health of older persons (Bodley-Tickell et al., 2008; Levy, et al, 2007). There is no doubt that the population of the United States has begun to age rapidly, increasing the number of older patients and affecting how practitioners manage sexual health care in this population. In addition to chronic illnesses, this group of older adults experience many life changes including widowhood, divorce, and infidelity, all of which can affect their sexual health.

Background and Significance

Though research on sexually transmitted diseases (STDs) among older adults is limited, Bodley-Tickell et al. (2008) found that the rate of STDs doubled in less than a decade for persons 45 years and older. Their retrospective study of 445 cases from 1996-2003 revealed a 127% increase in STD diagnoses, which can represent a considerable burden in healthcare dollars as it has been estimated that STDs are responsible for \$6.5 - \$15 billion annually in direct and indirect healthcare costs (Chesson et al. 2004; Lin et al 2008). Conversely, other literature identifies an incorrect stereotype of older adults being neither sexual, nor having an interest in sex (Steinke, 1994) and some authors found that while older adults considered sexual expression to be a very important aspect of life, sexual health was rarely discussed by their healthcare providers (Nusbaum, Singh, & Piles 2004). Gott et al (2004) explored this concept with primary healthcare providers who identified provider-embarrassment, sparse formal education and decreased patient-provider encounter times as barriers to discussion of older patient's sexual health. The documented rate of STDs in the older population coupled with the lack of patient-practitioner dialogue contributes to the lack of awareness of health risks in this age group potentially neglecting an area of healthcare in patients.

Review of the literature

While a complete medical history, including a sexual history should be incorporated into a healthcare visit for patients over 40, a review of the literature has demonstrated that many primary healthcare providers often neglect this aspect of a patient's care. As a result, the recognition and consideration of STD diagnoses in this older population may be missed (Bodley-Tickell, 2008; Caffrey & O'Neil, 2007; Gott, 2001; Gott, Galena, Hinchliff, & Elford, 2004; Gott, Hinchliff, & Galena, 2004; Levy et al, 2007; McAuliffe, Bauer, & Nay, 2006; Wimberly et al, 2006; Zagaria, 2008). As the population ages, chronic health conditions, such as hypertension and diabetes may assume priority over patients' sexual concerns, but according to the Centers for Disease Control and prevention (CDC, 2008), 13% of newly diagnosed AIDs patients are over the age of 50 years. The literature also indicates that many older adults do not actively protect themselves from STDs because they were unaware of their personal risk for acquiring these infections (Abel & Werner, 2003; Aral & Ward, 2005; Bardsley, & Miller, 2004; Billy, Grady, & Sill, 2009; Ford, Jaccard, Millstein, Williams & Donnelly, 2002;). Studies also show that health care providers may be uncomfortable discussing patients' sexual histories, as they may not have been educated regarding effective interview methods for introducing this topic (Gott, Hinchliff, & Galena, 2004).

Evidence exists to demonstrate that older people do engage in sexual relationships, with the majority of older adults (ages 57-85) considering sexuality to be an important part of life and in their relationships (Zagaria, 2008). Gott et al (2001) also noted that the majority of individuals aged 50-90 are sexually active, and in fact, 15% had more than one partner.

Researchers have noted that seeking treatment for sexual problems was often delayed by older persons due to lack of information about the diseases and by the assumption that these may

be a normal part of aging (McAuliffe, Bauer, & Nay, 2007). In addition to the negative stigma associated with STDs (Lichtenstein, Hook, & Sharma, 2005; Liu, Detels, Ma, Yin, & Li, 2003), there also is a negative stigma associated with the idea that an older individual is in fact, sexually active, sometimes being portrayed as predatory when sexual satisfaction issues are described (Gott, 2001; Lichtenstein et al., 2005)

The CDC (CDC, 2011) currently recognizes reportable sexually transmitted diseases as Chlamydia, Gonorrhea, Syphilis, AIDs and HIV. As HIV and AIDs frequently are tested anonymously, the reported cases of these two STDs may not be indicative of the actual disease burden. There is no mandatory reporting of HPV, herpes, trichomoniasis, scabies, molluscum contagiosum, chancroid, granuloma inguinale, or Hepatitis C infections. Many of these infections and their modes of transmission are unfamiliar to the older population, as noted by Levy et al (2007). Xu et al (2001) further noted that the lack of tangible statistics on these diseases contributes to the lack of attention paid to the issue of sexual health and STDs in older individuals by healthcare providers and researchers alike.

Findings from several qualitative studies suggested that providers do not discuss sexual health topics with their older patients as often as these patients would like (Bodley-Tickell et al., 2008; Caffrey & O'Neil, 2007; Levy et al, 2007; McAuliffe, Bauer, & Nay, 2006; Wimberly et al, 2006). In a randomized study married couples aged 67 to 99 years, Smith and Christakis (2009) reported an increased rate of STDs among men in the first year of widowhood. The authors also suggested that providers should be proactive in discussing sexual health with their older patients (Smith & Christakis, 2009). In a qualitative study of 20 male and female participants, Abu-Rajab et al (2009) identified themes that may help to direct the patient care pathway for STD care. "Life stage and risk behavior" was identified as a theme when the stage

of “single again” led to more open relationships and higher risk behavior for STDs. The theme of “risk perception” was noted to contribute to the acquisition of STDs as individuals associated cleanliness and non-infection with “knowing” the partner, even if only through acquaintances. Operationalization of the second theme in Abu-Rajab’s study, “intended personal strategies to prevent infection or re-infection”, may help providers to identify their patients’ beliefs and intentions for further risk and prevention behaviors. Even after being diagnosed with an STD, many participants in this study continued to assume non-infection with higher familiarity of partners (Abu-Rajab et al., 2009). In view of these findings, recognizing individual patients’ perceptions could help direct providers to educate patients about the prevention of STDs re-infection.

All of the studies supported the value of healthcare providers discussing sexual health with their older patients notably so, because negative stigma and shame have long been associated with STDs (Idso, 2009, Holmes et al., 2008, Lichtenstein, Hook, & Sharma, 2005), recognizing the sensitivity of the issues and creating a sense of security by using a non-judgmental and sensitive approach to history taking is essential for both provider and patient (Andrews, 2000). Andrews also noted that the initial discomfort experienced by providers might be alleviated by giving patients a questionnaire to complete before the appointment begins. This allows for the patient to consider his/her level of comfort, as well as to give the provider an idea of the patient’s concerns and his/her risk factors for acquiring an STD. Nussbaum et al (2004) found that respondents wanted their providers to bring up the subject of sexual health, and wanted them to be knowledgeable about diagnosing and treating STDs. In a quantitative study of 102 patients, Berrios et al (2006) noted that a trusting relationship with the health care provider was responsible for improved health outcomes based on increased patient satisfaction

with health care, improved compliance with treatments, increased use of preventive care services, and better quality of life for patients. Fifty-seven providers taking part in a qualitative study by Gott et al (2004) agreed that although the providers played an important role in patient's sexual health, they themselves did not initiate discussion with their older patients

Purpose

The purpose of this study was to explore healthcare providers' perceptions, awareness, and level of comfort regarding their older patients' sexual health. *Older patient* was defined as an individual over the age of 40 years.

Theoretical Framework and Model

The diffusion of Innovation Theory model was used for its applicability to the clinical issue of sexual health in the older population and the theoretical assumption that sharing and creating information through communication enhanced a mutual understanding of an issue (Rogers, 1997). The innovation or idea that is perceived as new, in this instance, the need for sexual healthcare in the older patient, was adopted at different rates based on several variables and is influenced by an individual's social system.

Methods and Design

After Institutional Review Board approval, participants were recruited via letter of invitation explaining the project and the voluntary nature of participation. Informed consent was obtained immediately prior to starting the focused interviews. The investigator explained that the risks associated with taking part in this interview related to loss of time spent during completion of the interview, potential for feelings of distress, and discomfort associated with disclosing personal perceptions related to management of sexual health for older patients. Each participant was assigned a numeric identifier to preserve anonymity. Inclusion criteria consisted

of nurse practitioners, physician assistants, and physicians who work in primary care settings, (ie., family practice, internal medicine, and women's health), males and females, age range 24 years to 60+ years, able to read and speak English, willing to participate, and willing to sign an informed consent. *Exclusion Criteria* consisted of licensed personnel from non-primary care settings and unlicensed personnel, unwillingness to participate, and unwillingness to sign an informed consent.

The study setting was neutral; located in a private and informal meeting room, easily accessible to participants, and geographically removed from health care providers' offices and clinical settings. Data were collected through focused individual interviews. Initial interview questions were derived from a previous qualitative study conducted by Gott et al (2004) with the primary author's permission. The investigator facilitated each interview which was tape-recorded, and lasted from 30 to 50 minutes. Following each interview, the investigator wrote a summary of statements and impressions derived from the interview. The interviews were transcribed verbatim and reviewed individually by the authors who then discussed their findings to develop common themes identified.

Data Analysis

Transcriptions of recorded interviews, field notes, debriefing notes, and verbatim comments were analyzed. Issues central to analysis included ascertaining whether an issue constituted a theme or a strongly held viewpoint of one or two members; determining whether the same issues arose in more than one interview; discovering whether differences in individual characteristics accounted for differences, observing whether similar issues emerged at multiple points across interviews (Polit & Beck, 2011).

Following the initial review of the transcripts and identification of preliminary themes, the investigator contacted participants and offered them the opportunity to review their interview summary for accuracy and completeness. Each participant agreed with the initial themes and overall analysis.

Results

The sample consisted of 10 practicing healthcare providers, (MD, DO, PA, and NP) in diverse practices in rural upstate New York. The sample was indicative of the general provider population with a busy practice and mix of patients, many of whom are aging and dealing with numerous diagnose, both acute and chronic. The healthcare providers interviewed consisted of five nurse practitioners, two physician assistants and three physicians ranging in ages of 30-59, and an average practice of over 20 years experience. One practitioner had less than one year experience.

All providers voiced the belief that sexual health in the older population was an important component of health care and should be approached routinely. When asked what role they played in the sexual health of their older patients, one participant explained “I think it’s just as important as their spiritual health, their mental health, it’s another part of that person.”

The idea of comprehensive health was discussed by many participants from the perspective of patient education, which was seen as an important tool in a health care provider’s ability to affect care. Although one third of the participants reported that treatment of STDs was a large part of their practice, nearly half indicated prevention was the key component in their role as providers. As one participant explained “Prevention. That’s the hallmark of primary care. You use the other ways to enforce your message, but if you can prevent a disease, you can continue to have a patient who has a better health outlook.” All participants expressed active involvement in

managing their patients' healthcare and provider involvement in the sexual health of older patients was reflected in discussions regardless of their training, although some did identify barriers to patient-provider discussion of sexual issues. The recurring themes were: (1) time: "there's just not enough", (2) lack of medical priority: "opening the can of worms", (3) "what education in training"? (4) age and time in practice: "for a provider more IS more", (5) gender: the quiet undercurrent affecting dialogue, and (6) provider responsibility: "It's not my job".

Time: There's just not enough

All but one participant reported the amount of time it might take to manage a sexual issue, as well as a lack of time in an appointment frame as a barrier to discussing sexual health with their older patients. Noting a patient rarely comes to an appointment specifically for sexual issue, one participant stated "We don't have a lot of time and sexual health can take a lot of time, if you open that can of worms you know, these are real issues for real people in their day to day life." Another participant responded "I think that most healthcare providers do not like to address sexual health whatsoever. I don't think they want to open that can of worms." Another participant said "many times, sexual issues in primary care are connected to psychological issues which take a lot more time, so if my schedule will allow it, I will get into it, but there are days when there literally just isn't time." The practitioners seemed very aware of the time parameters involved in routine patient care and though a few did make time to schedule specific follow-up appointments with their patients to explore sexual health concerns, most did not address the subject at all. Several participants used patient intake forms asking basic questions concerning sexual health, but the forms were frequently used during yearly visits, and were not comprehensive in nature, asking only if the patient had any concerns about their sexual health. The overall opinion of adding a discussion concerning sexual health with older patients during a

routine encounter was described by one participant who said: “I think it’s right there, you don’t want to ask the question, you don’t have enough time to deal with the answers.” This comment appeared to reveal the time management issues faced by all providers.

Lack of medical priority: Opening the can of worms

Closely associated with the lack of time in a patient encounter, the lack of priority of sexual health during a patient-provider appointment was discussed by several participants. “At this point in time, I see my patients as a chronic disease, they need follow-up, they need prevention, they need to stay out of the hospital.” Another participant stated: “I’m trying to deal with getting their A1c under control and their lipids. I just pay attention to those things and don’t even hint at anything else.” Chronic disease seemed to take precedence over sexual health discussion for this participant who said: “If there was an issue, I wouldn’t have a problem bringing it up but that’s usually not a topic that we discuss at all, just, again, time limited, trying to get their diabetes under control, their blood pressure.” Each of these respondents identified a common chronic disease process that took a higher priority over a discussion of sexual health. This omission might be an indicator of the participants’ belief that sexual health is not relevant to this age group, or that it is an emotional issue, rather than a physical issue, and therefore not contributory to a patients’ physical health. However, that as the interviews progressed, several participants voiced the opinion that many times chronic disease and sexual health are inter-related and therefore this topic should be broached by the practitioner during a patient encounter.

What education in training?

Many participants identified a lack of formal education in their original programs of professional study. One participant reflected “I don’t think for the older, I don’t think that’s part, at least when I was taught. It’s not taught, when it comes to adolescent health, that’s when its

brought up, I don't remember getting any adult sexual type stuff.” Another participant related a similar perception by saying “I don't know how universally it's broached in medical school, it's kind of taught, it's kind of assumed you'll know this by osmosis.” A third participant explained “the only training we got was our rotation in women's health, we were taught about the physiology of issues, but just a regular course or training in sexual health with the older population? Nope.” All participants, regardless of background, mentioned the lack of education specific to older populations and sexual health. As the interviews progressed and the subject of CE specific to the sexual health of older adults, the majority of participants expressed a need for this type of CE while also admitting they would most likely not attend if offered. As one participant put it, “I think if providers were aware of the statistics, they might be more proactive. I do think that is where CMEs come in, but I think it would depend on what else was being offered at the time.” Again, this was identified by a participant who related: “If you put it up against congestive heart failure management or dermatology for the general practitioner? I feel like I would go to the derm one, sorry (laughs).” These statements appear to relate to the previous themes in which the practitioner must choose their most useful educational opportunity within the parameters of time and medical priority.

Not only was there a marked lack of formal training in sexual healthcare for older patients, only one participant expressed any interest in further educational opportunities. Caffrey and O'Neil (2007) recommended revising medical education to increase practitioners' ability to explore sexual issues with their older patients ensuring that STDs are addressed appropriately and effectively.

Age and time in practice: For a provider, more IS more

Even with limited formal education related to sexual health in the older population, participants expressed that gender, age and time in practice affected the dialogue. In this respect, all agreed that increased time in practice as well as age of the provider increased their level of comfort when discussing sexual health with a patient. "I graduated medical school at 35 so I wasn't perceived by my patients as this kid, and so it was, that was definitely an advantage I had." This practitioner explained that patients took him more seriously if he appeared more mature, and spoke more to the comfort of the patient rather than the practitioner. A second participant agreed, saying "I think a little gray around the sideburns gives more validity to a provider, I am taken more seriously than a younger doctor would be." Still thinking of the patient's level of comfort, a different idea concerning age arose for a participant who considered the actual age difference between patient and provider to be an issue: "I think it's always more uncomfortable to talk about it when you're younger than the patient." She went on to explain "I always worry what their response is going to be, which is the other barrier, are they going to be insulted, are they going to be intimidated, are they going to be like 'why are you asking me these questions'?" Most of the participants discussed the need to be respectful in any health related discussion with older patients, and felt that they would be taken more seriously if they were perceived as an older practitioner.

Although increased time in practice seemed to correlate with a provider's comfort in discussing sexual health with patients, it also introduced the concept that less time in practice could be a barrier to dialogue. This theme was expressed by a participant who noted; "The newness of practice might be a barrier, it probably is, once I know my comfort stage, I'll usually go right in." Although this provider had been in practice less than one year, the idea was

nevertheless expressed by a participant with several years' experience who noted "I think maybe the fact that I was new to practice rather than my age, might have made a difference."

Gender: The quiet undercurrent affecting dialogue

Gender was an unexpected identified barrier, with most providers leaning toward more open dialogue with those patients whose gender was the same as the provider. As one participant explained, "When you talk about embarrassment, that's more embarrassing for me because I don't feel that educated myself in male health, let alone aging male health. That's not my area at all." A third of participants stated they could approach either gender to discuss sexual health, though they were most comfortable with same gender encounters. One clearly felt gender was a barrier to discussion when she explained: "For me as an individual on a scale of 1 to 10, I would be about a 3, I'm not real interested in men's sexual health." Though it was an incidental theme identified in the interviews, gender still was an important finding contributing to the continued sensitivity of the subject of sexual health, and none of the participants voiced any concerns with sexual orientation of their patients.

Provider responsibility: It's not my job

Many participants also seemed to consider the sexual health of their patients as the responsibility of other providers. The most common fallacy was that older women continue to have sexual health care provided by a gynecologic (GYN) specialist. When queried about the sexual health of their patients, one participant responded: "65 and above, I would usually tell them that they need to continue seeing their GYN just because there are certain things that need to be taken care of at least once a year by the GYN." Another remarked: "It's also not really an issue for women since they see their GYNs." This revealed a lack of awareness of patients' needs as they age, in addition to a lack of awareness of insurance parameters as women age.

With the Medicare regulations, women are no longer covered for yearly preventative exams if they are not deemed medically warranted. A quarter of the participants routinely referred patients to other providers, “I would absolutely refer a male patient out to someone who would be more interested and thereby helpful to him in regards to sexual health.” Another participant was reluctant to accept referrals from other providers just for Women’s health saying: “Long ago I decided I would not become the Pap-queen, I take care of the whole patient.”

Awareness of a patient’s health needs is a primary component in being able to address that need. The majority of the participants in this study reported a lack of awareness of the need for sexual healthcare in the population in question. One participant voiced her increased awareness in this way “I think it's more so into my 70 and 80 year olds that I would not, it didn't even dawn on me until they came in together, he was having some issues and they wanted to fix it.” This participant seemed to have separated the older age group into “older” and “much older” and poses possibilities of why patients aged 40-50 are seen as sexually active and the ages later than that are not assessed for sexual health issues. This separation and awareness of the clinical issue also was introduced by another participant who stated “40s or 50s it might be something of concern, with the 70s or 80s they’re more settled, more like the grandmother type.” These statements possibly allude to a lesser awareness of the clinical need for sexual healthcare in a patient over the age of 65 or 70 and the stereotype that people who fall into this age group are not in need of sexual healthcare.

The majority of participants routinely discussed sexual function with their older patients when prescribing a medication that might have side effects affecting their sexual performance or enjoyment. In this respect, there did not seem to be a delineation of “older” and “much older” patients. As one participant related “If it's an anti-hypertensive, it's going to affect erectile

dysfunction, I would mention that and certainly with some of the SSRIs, it's pretty common so I do bring that up and I let them know.” A second noted “you put a person on a beta blocker, it's a male patient, I will tell them you may have some erectile dysfunction with this.” The trend of addressing sexual health when in conjunction with medical interventions, seemed due more to medical appropriateness than the age of the patient. This also may reflect practitioners’ prioritization of medical needs and the possible assumption that sexual health was not a medical need.

Discussion

The sample was representative of the general healthcare provider population with a busy practice and mix of patient demographics, including many aging patients with multiple disease processes. The practitioners interviewed showed a high level of awareness of their older patients’ need for sexual healthcare and although all of the providers voiced the belief that sexual health in the older population was important and should be routinely approached by the health care provider, the majority of them did not initiate this dialogue. The barriers identified were both personal and professional, mirroring many of the findings noted in previous studies which had identified a lack of time in a patient encounter and provider discomfort.

According to the practitioners, most felt fairly comfortable in discussing sexual health with their older patients, although the majority felt more comfort when the patient was of the same gender as the provider. Many of the participants seemed unaware of this bias until asked by the interviewer. This finding highlights the sensitive and personal nature of sexual health. An interesting finding was that none of the participants identified discomfort discussing sexual health with older homosexual or bisexual patients in relation to gender. Many participants actually were members of the age group being studied. Gender bias may be explained by the fact

that because practitioners are more aware of their own personal aging issues, they themselves may be more familiar and comfortable having dialogue with same sex patients

These findings speak, in part, to the “not my job” theme. Many participants expressed not addressing sexual health because they either assumed another provider, such as GYN, was addressing patients’ needs, or because they routinely referred the patient to a specialist. Review of interview transcripts revealed some participants referred to a specialist or different provider for reasons of gender and supposed comfort of the patient.

Other personal and professional premises introduced by the participants were age of the provider and the length of time in practice. More time in practice equated to increased awareness and comfort in discussing all aspects of care of patients including sexual health in the older group, and is congruent with the aging members of the healthcare profession in general. Increased exposure to patients and their needs enable practitioners to tailor treatment and care; experience has long contributed to improved care and outcomes as a practitioner’s comfort level increases. Strengthening this theme were findings from the interview with the participant who had less than one year in practice. Demographically in the 50-59 age group, this provider still identified a low level of comfort in discussing sexual health with those patients of an opposite gender, those who were the same age or older. The age of the provider also contributes to the theme, as many of the participants noted that, as they aged, they were more comfortable with patients’ sexual health concerns and assumed the patients would be more open to them. This could be because an older provider might be considered more experienced or because they might be more aware of the patients needs. The generalization that an older-appearing provider might be taken more seriously by a patient, or be more trusted, especially in relation to sexual health spoke to the comfort to the provider as well to that of the patient.

The phrase “opening a can of worms” was repeated by a third of the participants in this study, and is the title of a study in which Gott et al (2004) identified similar findings. Particularly in relation to patient encounters, lack of time was the most common theme identified as an issue when sexual health concerns were raised, and the majority of participants seemed to feel helpless that future changes in healthcare would change this. As a layered theme, participants felt there was not enough time in an encounter to address sexual health, but also expressed the assumption that sexual health in an older patient required a lot of time and was not a medical priority when compared to other more chronic disease processes. This theme was further reinforced by the practitioner with less than one year of experience who did not identify lack of time in an encounter as a barrier to dialogue, nor did the practitioner routinely discuss sexual side effects of medications with patients.

When education was addressed, most participants not only did not have formal education specific to the older age group and sexual health, they also candidly expressed reluctance to attend a CE offering if it was competing with a more medically relevant topic. All providers expressed high interest, indicating that if presented in an appropriate manner, a CE course would be well attended and would help sensitize providers to the topic of elder sexual health.

Implications for Practice

Incorporating the goals set forth by the CDC, USPTFS, and Healthy People 2020 to reduce the transmission of STDs and improve the overall health of the population, health care providers are responsible for awareness of their patients’ sexual health and must be able to initiate sensitive and clinically appropriate dialogue to competently and holistically care for their patients. It has been shown that practitioners do not ask about the sexual practices of their older patients, thereby missing an opportunity to facilitate a patient’s understanding of their own

sexual health. Many themes noted by participants strengthen the idea that dialogue about sexual health was not being initiated during patient encounters. Although the majority of participants recognized the importance of discussing sexual health with their older patients, they identified many barriers to doing so. By including sexual health on the agenda of patient encounters, health care providers have the ability to increase positive patient outcomes and decrease direct and indirect medical costs related to STDs and other sexual concerns. In relation to Diffusion of Innovation Theory, the interview of the practitioners also served as an intervention, introducing an innovation that was adopted by some of the participants readily, highlighting the potential for CE to be successful in changing clinical practice of healthcare practitioners to incorporate provider-patient dialogue in care of older people.

Limitations

Limitations include the small sample size, and narrow demographic characteristics of the sample. The issue of instrument change, where there is an unintentional change in the interview technique, and value imposition where the interviewer imposes personal reaction to responses contribute to the limitations of the study. As the interviewer also was the investigator, another limitation may be the interviewer's female gender which may have affected the interview responses, as gender was identified as a barrier to discussion of sexual health with patients.

Conclusion

As the population ages, the health concerns of this group are varied and changing. Discussion of sexually-related problems is a part of routine health care for younger populations, and since sexuality may continue well after the age of 40, it is prudent for primary care providers to continue this dialogue (Andrews, 2000). Studies indicate that the older population is sexually active, and is at risk for STDs, which can negatively affect their health and contribute to

complications of chronic illnesses. *Preventive care is one of the hallmarks of Healthy People 2020*; and sexual behavior is one of the ten leading United States health indicators (Healthy People 2020). This standard is further upheld by the U.S. Preventive Services Task Force (USPSTF), which stated that prevention of STDs is important to overall population health (USPSTF, 2010). Results of research also have demonstrated that healthcare practitioners are influential in educating the population about risk (Idso, 2009). Healthcare providers' ability to incorporate appropriate sexual health histories and dialogue with older patients has the potential to decrease healthcare costs and improve clinical outcomes.

Findings from this study revealed that the majority of interviewed practitioners agreed that sexual health among older patients is a legitimate topic in healthcare, although the awareness of that patient need did not always result in action by the practitioner. Action and the practitioner's comfort level were affected by variables both personal and professional. These findings were consistent with previous studies and also follow the Diffusion of Innovation theory demonstrating how enhanced communication over time increases the rate of adoption. Several participants stated, after their interviews, that they would be more proactive in this area. To that end, recommendations include the need for increased educational opportunities for providers in the form of CE, formal training, in-services, increased dialogue among practitioners and increased participation by practitioners. In this way, routine inclusion of dialogue about sexual health will result in improved outcomes in the health of older patients.

References

- Abel, T., & Werner, M. (2003). HIV risk behavior of older adults. *European Journal of Public Health, 13*, 350-352.
- Abu-Rajab, K., Scoular, A., Church, S., Connell, J., Winter, A., & Hart, G. (2009). Identifying opportunities for sexually transmitted infection prevention: analysis of critical points in the care pathways of patients with gonorrhoea. *International journal of STD & AIDS, 20*, 170-175.
- Andrews, W. C. (2000). Approaches to taking a sexual history. *Journal of Women's Health & Gender-Based Medicine, 9* (Supplement 1), S21-S24.
- Aral, S. O., & Ward, H. (2005). Modern day influences on sexual behavior. *Infectious Disease Clinics of North America, 19*, 297-309.
- Berrios-Rivera, J. P., Street, R. L., Garcia Popa-Lisseanu, M. G., Kallen, M. A., Richardson, M. N., Janssen, N. M., ... Suarez-Almazor, M. E. (2006). Trust in physicians and elements of the medical interaction in patients with rheumatoid arthritis and systemic lupus erythematosus. *Arthritis & Rheumatism, 55*(3), 385-393.
- Billy, J. O., Grady, W. R., & Sill, M. E. (2009). Sexual risk-taking among adult dating couples in the United States. *Perspectives on Sexual and Reproductive Health, 41*(2), 74-83.
- Bodley-Tickell, A. (2008). Increase the Radar for STDs in Seniors. *Contraceptive Technology Update, ()*, 106-108.
- Caffrey, N., & O'Neil, D. (2007). Sexuality and health among older adults in the United States. *New England Journal of Medicine, 27*, 2732-2733.
- Centers for Disease Control and Prevention. (n.d.). <http://www.cdc.gov>

- Chesson, H. W., Blandford, J. M., Gift, T. L., Tao, G., & Irwin, K. L. (2004). The estimated direct medical cost of sexually transmitted diseases among American youth, 2000. *Perspectives on Sexual and Reproductive Health, 36*(1), 11-19. doi: Retrieved from
- Ford, C. A., Jaccard, J., Millstein, S. G., Bardsley, P. E., & Miller, W. C. (2004). Perceived risk of Chlamydial and Gonococcal infection among sexually active experienced young adults in the United States. *Perspectives on Sexual and Reproductive Health, 36*(6), 258-264.
- Gott, C. M. (2001). Sexual activity and risk taking in later life. *Health and Social Care in the Community, 34*(8), 541-544.
- Gott, M., Galena, E., Hinchliff, S., & Elford, H. (2004). "Opening a can of worms": GP and practice nurse barriers to talking about sexual health in primary care. *Family Practice, 21*(5), 528-536.
- Gott, M., Hinchliff, S., & Galena, E. (2004). General practitioner attitudes to discussing sexual health issues with older people. *Social Science & Medicine, 58*, 2093-2103.
- Henderson, Z., Tao, G., & Irwin, K. (2005). Sexually transmitted disease care in managed care organizations. *Infectious Disease Clinics of North America, 49*1-511.
- Holmes, K. K., Sparling, P. F., Stamm, W. E., Piot, P., Wasserheit, J. N., Corey, L., ... Watts, D. H. (2008). *Sexually transmitted diseases* (4th ed.). New York: McGraw Hill Medical.
- Idso, C. (2009). Sexually transmitted infection prevention in newly single older women. *Journal for Nurse Practitioners, 5*(6), 440-446.
- Levy, B. R., Ding, L., Lakra, D., Kostead, J., & Niccolai, L. (2007). Older persons' exclusion from sexually transmitted disease risk-reduction clinical trials. *Sexually Transmitted Diseases, 34*(8), 541.

- Lichtenstein, B., Hook, E. W., & Sharma, A. K. (2005). Public tolerance, private pain: stigma and sexually transmitted infections in the American Deep South. *Culture, Health & Sexuality*, 7(1), 43-57.
- Lin, J. S., Whitlock, E., O'Connor, E., & Bauer, V. (2008). Behavioral counseling to prevent sexually transmitted infections: a systematic review for the U.S. Preventative Services Task Force. *Annals of Internal Medicine*, 149, 497-512.
- Liu, H., Detels, R., Ma, E., Yin, Y., & Li, X. (2003). Sexual activities of patients with STDs in the interval between noticing symptoms and presenting for treatment. *AIDS Patient Care and STDs*, 17(9), 453-459.
- McAuliffe, L., Bauer, M., & Nay, R. (2006). Barriers to sexual expression in the older person: The role of the health professional. *2007 The Authors*, 69-75.
- Nusbaum, M., Singh, A., & Pyles, A. (2004). Sexual healthcare needs of women aged 65 and Older. *Journal of the American Geriatric Society*, (), 117-122.
- Polit, D. F., & Beck, C. T. (2011). *Nursing research: generating and assessing evidence for nursing practice* (9th ed.). Philadelphia, PA: Wolters, Kluwers, Lippincott, Williams Wilkins.
- Smith, K. P., & Christakis, N. A. (2009). Association between widowhood and risk of diagnosis with a sexually transmitted infection in older adults. *American journal of Public Health*, 99(11), 2055-2062.
- Steinke, E. (1994). Knowledge and attitudes of older adults about sexuality and ageing: a comparison of two studies. *Journal of Advanced Nursing*, 19, 477-485.
- U.S. Department of Health and Human Services. (2010). *Healthy People 2020*. Retrieved from <http://www.healthypeople.gov/2020/default.aspx>

- US Preventative Service Task Force. (2010). [http://:www.healthcare.gov](http://www.healthcare.gov)
- Williams, E., & Donnelly, J. (2002). Older Americans and AIDS: Some guidelines for prevention. *Social Work, 47*, 105-111.
- Wilson, M. G. (2006). Sexually transmitted diseases in older adults. *Current Infectious Disease Reports, 8*(1), 139-147. doi: Retrieved from
- Wimberly, Y. H., Hogben, M., Moore-Ruffin, J., Moore, S. E., & Fry-Johnson, Y. (2006). Sexual history-taking among primary care physicians. *Journal of the National Medical Association, 98*(12), 1924-1929.
- Xu, F., Schillinger, J. A., Aubin, M. R., St.Louis, M. E., & Markowitz, L. E. (2001). Sexually transmitted diseases in older persons in Washington state. *Sexually Transmitted Diseases, 28*(5), 287-291.
- Zagaria, M. (2008). Sexual activity and STDs among seniors. *U.S. Pharmacist, 1-7*.