Routledge
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Sexual and Relationship Therapy

ISSN: 1468-1994 (Print) 1468-1749 (Online) Journal homepage: https://www.tandfonline.com/loi/csmt20

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To cite this article: Ateret Gewirtz-Meydan, Inbar Levkovich, Moshe Mock, Uri Gur & Liat Ayalon (2019) Promoting a discussion on later life sexuality: Lessons from sexologist physicians, Sexual and Relationship Therapy, 34:2, 193-210, DOI: 10.1080/14681994.2018.1437258

To link to this article: https://doi.org/10.1080/14681994.2018.1437258

Published online: 20 Feb 2018.

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SEXUAL AND RELATIONSHIP THERAPY
2019, VOL. 34, NO. 2, 193–210
https://doi.org/10.1080/14681994.2018.1437258

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Promoting a discussion on later life sexuality: Lessons from sexologist physicians

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ABSTRACT

This study examined factors at the structural and individual levels that can facilitate discussion of sexual matters between physicians and older patients. Fifteen physicians from differing medical specialties, who are also certified sexologists or qualified in human sexuality, were interviewed for the study. Open-coding analysis was employed, consisting of comparisons within and across interviews. Three major themes emerged: (1) *increase the visibility and importance of older adults' sexuality*, as the first step in facilitating discussion on sexual matters in later life by raising awareness of sexuality in older adults in a non-stigmatized way, (2) *increase knowledge* of medical students and physicians and provide accurate, up-to-date knowledge to older adults, and (3) *display more openness to discussing elderly sexuality* in clinical encounters, by creating an accepting atmosphere in which older patients feel comfortable discussing their sexual needs. The findings highlight that the communication between physicians and older patients needs to extend beyond practical guidance, and that ageist beliefs that assume older adults are not interested in sex should be challenged. After acknowledging older people as sexual beings, increasing the knowledge of later-life sexuality is essential, and practical guidelines for open discussions can be developed.

ARTICLE HISTORY
Received 4 July 2017
Accepted 16 January 2018

KEYWORDS
Sexual discussion; physicians; sexologists; older adults

Introduction

Sexual activity is an important component of a close emotional relationship in later life (Gott & Hinchliff, 2003b) and an important determinant of health and wellbeing of all adults. Studies indicate that older people continue to engage in various sexual practices, including vaginal intercourse, oral sex, anal sex, hand-genital stimulation and masturbation (Laumann, Glasser, Neves, & Moreira, 2009; Lindau et al., 2007; Waite, Laumann, Das, & Schumm, 2009). Although sexual problems among the older adults are not an

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inevitable consequence of aging, many older adults experience high levels of sexual dysfunction, which challenge their ability to engage in desired sexual activities (Laumann, Das, & Waite, 2008). In a study conducted among 1,491 older adults, early ejaculation (26.2%) and erectile difficulties (22.5%) were the most common male sexual problems and a lack of sexual interest (33.2%) and lubrication difficulties (21.5%) were the most common female sexual problems. The English Longitudinal Study of Ageing (N = 6,201) reported similar findings. While 39% of older men reported difficulties with erectile function, older woman reported arousal difficulties (32%) and difficulties achieving orgasm (27%) (Lee, Nazroo, O'Connor, Blake, & Pendleton, 2016). Despite the high prevalence of sexual dysfunction, older men and women report being sexually active, even in the eighth and ninth decades of life (Laumann et al., 2009; Lindau et al., 2007; Lochlainn & Kenny, 2013).Nonetheless, these dysfunctions and difficulties are often over-looked or not discussed satisfactorily with their physicians (Gott & Hinchliff, 2003a; Nusbaum, Gamble, & Pathman, 2002).

To the best of our knowledge, facilitating discussion about later-life sexuality has not been proposed to physicians who are certified sexologists or who are certified in formal education in human sexuality. This is a unique population, as in Europe with the exception of France, sexology is mainly practiced by non-physician health professionals (Giami & De Colomby, 2006). The present study presents the intersection of sexology and medicine as it examines the perceptions of physicians with certification in sexology on how to facilitate discussions about sexuality in later life with their patients.

Studies that investigated the reasons sexual matters are not often discussed found that physicians considered older people's sexuality as outside their scope of practice (Haesler, Bauer, & Fetherstonhaugh, 2016), or they equated sexuality with younger people and regarded it as less relevant to older individuals (Gott, Hinchliff, & Galena, 2004). Additional barriers to discussing sexual matters with older patients were personal embarrassment; lack of knowledge and training; lack of experience, especially in taking sexual history; low awareness and time limitations (Gott & Hinchliff, 2003a; Humphery & Nazareth, 2001). Worries about causing offense, opening a *can of worms* (Gott, Galena, Hinchliff, & Elford, 2004), personal discomfort and language barriers were noted, as well (Dyer & das Nair, 2013). Contextual/structural barriers, related to availability of secondary psychosexual services, freedom to prescribe (Humphery & Nazareth, 2001), an appropriate setting (Sarkadi & Rosenqvist, 2001), and policy guidance (Dyer & das Nair, 2013) were also cited. Other studies found that physicians do not discuss sexual matters with older adults because of ageist beliefs and stereotypes (Bouman & Arcelus, 2001; Gewirtz-Meydan & Ayalon, 2016; Macrae, 2016).

Ageist beliefs are subconscious, internalized sets of beliefs about old age and older adults that are formed and reinforced by lifetime exposure to cultural and societal messages of ageism (Levy, 2009). These beliefs can also minimize or deny the existence or value of sexuality for older persons (Gott & Hinchliff, 2003a; Henry & McNab, 2003), and consider older adults genderless, and disinterested or incapable of sexual activity (Kane, 2008).

Studies that investigated the reasons older people do not raise sexual matters with their physicians, found the most common reason was viewing a dysfunction as normal for their age (Hinchliff & Gott, 2011; Moreira, Glasser, Nicolosi, Duarte, & Gingell, 2008). Stereotypes of "asexual older people" were documented as inhibiting treatment seeking (Gott &

Hinchliff, 2003a). Older adults often viewed sex as an embarrassing topic (Gott & Hinchliff, 2003a) and felt uncomfortable talking to a physician about it (Moreira et al., 2008). Others did not think it was a medical problem or something that could be treated by a physician (Moreira et al., 2008).

While most research about discussing sexual matters in the medical setting focuses on barriers to raising the topic (Ghazanfarpour, Khadivzadeh, Latifnejad Roudsari, & Mehdi Hazavehei, 2017; Gott et al., 2004; Gott & Hinchliff, 2003a; Stead, Brown, Fallowfield, & Selby, 2003), the present study investigated factors that can facilitate discussion about sexual matters in later life between physicians and older adults. Factors at the structural and individual levels that can promote discussion are reported from the point of view of physicians from different specialties, trained in the field of sexology. The physicians' knowledge and experience in treating older adults' sexual difficulties and the interdisciplinary approach provide a unique overview on the subject (Löfgren-Mårtenson, 2015). Although most sexologists in Europe are not physicians, but rather nurses, psychologists, or marital counsellors, for example (Giami & De Colomby, 2006), the present study sample consisted only of medical physicians whose subspecialty is sexology. This enabled us to capture the complex picture of discussing sexual matters during consultations and to hear suggestions about how to improve the frequency and quality of these discussions.

Methods

Sample and procedure

The sample consisted of 15 physicians (11 men and four women) who were also certified as sexologists or have certification of formal education in human sexuality. All the physicians interviewed practiced in Israel. Their ages ranged from 45 to 80 years and their medical practice experience ranged from 15 to 45 years. Participants specialized in gynecology, family medicine, psychiatry, urology, or rehabilitation and were certified by the ISST (Israel Society of Sex Therapy), the European Society of Sexual Medicine (ESSM), the European Federation of Sexology (EFS) or the American Society of Sex Educators, Counselors and Therapists (ASSECT). Some held multiple certifications. However, only one physician (7%) reported receiving training in gerontology. Inclusion criteria for the study were individuals with an MD degree and certification in human sexuality, either through training as a sexologist or through formal education on human sexuality. Participation was not limited by age. Participants were identified through personal contacts and by using a list of certified sexologists in Israel provided by the Israel Society of Sex Therapy (ISST). At the time of the search (December 2016), 25 physicians were listed as certified sex therapists in the ISST website. All 23 (92%) physicians who posted their email address on the ISST website were approached to be interviewed for the study. It was presented to potential participants as a qualitative study about the quality of healthcare services provided to older adults (>65) regarding sexual functioning and sexual satisfaction. Fourteen physicians (60.9%) registered as certified sex therapists in the ISST agreed to participate. Subsequently, two physicians withdrew participation due to time limitations. Twelve physicians (48% of all physicians certified as sex therapists by the ISST in Israel) were interviewed for the study. An additional three interviewees were identified by personal contact: two were certified by the ISST, and one was certified by the European Committee

Table 1. Demographic characteristics of participants ($N = 15$).

Characteristic	*N*	%
Age (mean and standard deviation; years)	$M = 57$, SD = 10.25	
Seniority (mean and standard deviation; years)	$M = 27.53$, SD = 10.86	
Origin		
Israel	10	67
Other (USA, Africa, Europe)	5	33
Sex		
Men	11	73
Women	4	27
Training in gerontology		
Yes	1	7
No	14	93

of Sexual Medicine. No incentives were offered. Efforts were made to include equal representations of gender and specialties. The characteristics of the physicians who participated in the study are presented in Table 1.

Data collection

The study was funded by the Israel National Institute for Health Policy Research [grant number /2016/16] and approved by the Institutional Helsinki Committee (Protocol no. 0262-16-MMC). To explore participants' input on the factors that can facilitate an open discussion on sexual matters between physicians and older patients, data were collected through in-depth interviews at a time and place of their choosing (most often at the physician's workplace). An interview guide based on the research objectives and a systematic review of the literature was used during the discussions. The interview guide deliberately covered broad topics, because the authors aimed to uncover factors that can promote an open and free discussion regarding sexual matters between physicians and their older patients. Prior to the interview, participants were given a general statement about the rationale and aims of the study. They freely consented to participate, and could withdraw from the study at any time and refuse to answer any question. Confidentiality regarding the names of participants and their practices were assured. Interviews started in December 2016 and were completed by April 2017. Participants were interviewed individually in Hebrew. Each interview was tape-recorded and later transcribed verbatim. Interviewers were selected based on their previous experience and expertise. They received training regarding the questionnaire and interview protocol.

Data analysis

After all interviews were completed, they were transcribed verbatim and the data analyzed thematically. Initially, a line-by-line, open-coding analysis was employed (Strauss & Corbin, 1998). Saturation was achieved after seven interviews. The first two authors (AGM and IL) coded the interviews. They discussed the coding scheme and the main themes identified. Due to coders' expertise in different fields (AGM, a social worker and certified sex therapist, and IL, a gerontologist and psychotherapist), data were analyzed from broad perspectives. The themes and any conflicts between raters were discussed among all the authors, who represent additional fields of expertise (Genecology, Urology,

and Psychology). Analysis did not use preconceived codes, but allowed themes to emerge directly from the text (Creswell, 1998). Next, codes were grouped into main themes to identify variations in responses. Finally, after selected themes were identified, each was explored at the structural and individual levels. The themes identified as structural were related to governmental institutions (e.g. Ministry of Health) or the media, and are out of the scope of physicians. Individual themes were identified as those that could be performed by physicians and/or occur within medical encounters. Grouping the themes into structural and individual factors was conducted by two authors (AGM and LA). The themes were identified when comparing interviews and issues raised during the analysis of each interview. The trustworthiness of the analysis was enhanced by sharing and discussing the coding between authors.

Results

Three themes emerged: (1) the visibility and importance of older adults' sexuality. Interviewees argued that the first step to facilitating discussions about sexuality in later life is increasing awareness of older adult's sexuality, without stigmas. (2) Increasing the knowledge of medical students, physicians, older adults and society about later-life sexuality. This knowledge will empower institutions and individuals to become more active in promoting sexuality in later life. (3) Display more openness to discussing elderly sexuality. This theme refers to creating an environment in society and in medical encounters where discussing later life sexuality is accepted and older adult's sexual needs are discussed freely and openly. These themes were discussed from structural and individual perspectives.

The visibility and importance of older adults' sexuality

The first theme concerned the social invisibility of older adults' sexuality. Although most physicians agreed that the onus is on physicians to help make older patients feel comfortable discussing their sexual needs, many were not aware of older people's sexual needs and desires or that sexuality is important to them. The images of older people who spend much of their time baking cookies, knitting, or sitting in rocking chairs in front of the television, are easier to accept, than thinking of older adults as sexual beings with sexual needs and desires. The invisibility of older people as sexual beings was consistent with dominant western social norms, as interviewees described sexuality as associated with youth and beauty and irrelevant to older adults. According to interviewees, this is exacerbated by silence and avoidance in medical encounters regarding sexuality and intimacy.

> Our biggest problem is the stigma physicians have regarding older adults and the stigma older adults have on themselves. There is clear discrimination against older adults. For example, if you are an old lady and you dye your hair and have a tattoo, you are pathetic, because at your age you are supposed to sit at home and knit.

According to interviewees, physicians do not feel guilty not discussing this topic and do not necessarily feel as if they are neglecting cardinal needs of their patients, because they are not fully aware of the importance of sexuality in later life. Physicians are influenced by existing societal myths and prejudices that sexuality is unimportant for older people. As long as physicians have the mistaken belief that older adults do not have

sexual lives or interest in sex, there will be no conversations about sexuality with older adults.

> It is important for physicians from all specialties to view their (older) patients' sexuality as an important part of their lives.

The invisibility of older adults' sexuality is considered by physicians to be heightened by personal beliefs that sex becomes inappropriate at a certain age. There is a common assumption that older adults do not engage in sexual activities. Older adults who remain sexually active are labeled as socially deviant, perverted, or pathetic. In addition, the invisibility of older adults' sexuality seems to increase with age. Interviewees indicated that interest in later life sexuality is growing; however, here, later life referred to people in the sixth and seventh decades of life (women in their 50s with menopause, and men in their 60s with erectile dysfunction). Interviewees explained it might be easier for physicians to address the sexuality of men and women in their 50s, when menopause occurs, and sexual dysfunction can be addressed from a medical perspective (by prescribing phosphodiesterase-5 inhibitors; PDE5I) or hormones). Nonetheless, according to interviewees, issues concerning the old-old (people in their seventies and eighties) and the oldest-old (nineties) receive almost no attention.

Interviewees indicated that to understand the importance of sexuality in later life, sexual visibility is necessary. The extent to which sexuality can truly be termed "ageless" is reflected by extending middle age (45–65) and by including older ages, such as those in their seventies, eighties and even nineties, whose sexuality remains excluded and invisible and who are assumed to be asexual, or even anti-sexual.

> In our society, it is true we discuss sexuality more regarding menopause, at the ages of fifty or until sixty. I really didn't see much interest in sexuality at the ages of seventy…

After increasing the sexual visibility of older adults, physicians can explore the role that sexuality plays in their older patients' lives. According to physicians, sexuality is an integral part of older adults' well-being and quality of life and needs to be addressed in medical care as is any other aspect of patient health.

Interviewees emphasized that although mutual feelings of discomfort can appear among physicians and older adults, it is the physicians' responsibility to initiate and prioritize discussion regarding sexual matters and integrate it into healthcare encounters.

> It is the physician's responsibility to ask about sexual function! When you ask physicians why don't they ask, they give a lot of reasons such as, "I don't have the time, I am not a urologist, I don't want to embarrass my patient, etc." You don't have time? So, find the time! You don't need to be a urologist to ask about sexual function. You don't want to embarrass them? But you do ask about their urine and excrement…

At the structural level, interviewees discussed the lack of health system support regarding sexual health and function. According to interviewees, health systems can improve the discussion, diagnosis and treatment of sexual dysfunctions among older adults by regulating sexology as a profession and by providing sex therapy in hospitals, medical centers and geriatric institutions. They can also provide free or subsidized medication to enhance sexual function (such as testosterone replacement treatment and PDE5I) and promote the concept that engaging in sexual activity is not a privilege, but a basic right and a vital need. Compensating physicians and health maintenance organizations (HMO) that treat

or refer patients for sexual matters can convey the importance of sexuality within the healthcare system.

> The Ministry of Health needs to compensate physicians who diagnose sexual dysfunction, to compensate health maintenance organizations… it is called Quality Metrics. To check the percentage of people in each HMO who receive Viagra, or received a definition of sexual dysfunction. Why do you think mammography is such a common exam? Because it is a Quality Metric, and they check how many women in each HMO had a mammogram …Another problem is that this profession (sexology) hasn't received recognition from the Ministry of Health. Anyone could call themselves a sexologist, anyone is a specialist in sexuality…Each hospital should have a sexology clinic, and treatment would not cost additional money, that it will be part of the covered health services.

The indifference towards sexuality in later life by policy makers and the health system reflects disregard towards older adults' sexuality at the structural level. According to interviewees, the media rarely display older people as sexual, unless there is a financial motive, such as promoting a new medicine (e.g. Viagra). The portrayal of older adults in the media shapes and reflects cultural norms by displaying myths and by reinforcing negative stereotypes associated with aging (e.g. older adults as asexual and not interested in sexual intimacy in later life). In the extreme, sexuality in older age is often portrayed humorously or as a social taboo. The media have the power to promote the importance of sexuality in later life by presenting older adults expressing their sexuality in movies, shows, ads and campaigns.

> To increase social awareness, the subject needs to be presented in the media. But, if there is no financial interest, it won't be. For example, sexual function was brought up in the nineties, because they had Viagra… but for women's sexuality there is no solution, so no one brings it up… it doesn't bring in money… so then we have to wait for a star or a producer that will, once every ten years make a film about older adults' sexuality, like that beautiful movie with Diane Keaton and Jack Nicholson…

Increase knowledge

Another theme that emerged was the importance of increasing the knowledge of physicians and medical students/trainees/residents regarding sexuality in later life through courses, lectures, workshops and conferences. Some interviewees felt obligated to convey this knowledge, as it is not part of medical school curricula. According to interviewees, education programs need to address different skills and knowledge to manage sexual concerns in later life appropriately. Enhancing knowledge may not provide physicians with the full skill set needed to treat sexual dysfunction, but it will raise awareness and the comfort necessary to assess the sexuality of older adults.

> Here (in Israel), some medical schools don't teach sexuality at all. They don't have sexuality courses! A physician graduates from medical school and does not have a clue of how to ask, address, treat or even who to refer to, when a patient comes and says something like 'this medicine hurt my sexual desire'… When my grandmother moved to a new country, she went door to door selling blankets, and that is what I am doing. I go department by department (clinical departments), me and others, and we raise physicians' awareness, teaching techniques, teach how to ask questions about sexuality, teach that it is important, that older people need this…

Although physicians tried to convey the knowledge themselves, they also indicated the need for change at the structural level: in policy and training of physicians. *Sexuality and aging* should be included as a core curriculum topic. Education in this area encompasses not only basic knowledge and information regarding sexual function in later life, but also communication skills around this subject. Sensitivity in exploring the importance of sexuality among older people, recognizing how to create the space, and allow the older person to choose how much, if any, information they are comfortable disclosing regarding sexual matters, are skills that should be acquired in medical school.

> I think education is the main component. I don't think all physicians should train to be sex therapists, but raise their awareness…all the medical schools should teach basic background on sexual dysfunction. Because as people age, there are more and more sexual dysfunctions: pain, desire disorders, orgasm, etc.

Interviewees discussed the media's role in shaping and portraying sexuality in later life. The media's portrayal of older people as asexual reflects lack of knowledge about sexuality and aging among those responsible for portraying these images. The media have the potential to convey accurate knowledge on sexuality in later life by presenting the diversity of older adults and by exposing older adults to treatments for sexual dysfunctions. However, knowledge obtained from the media does not replace an open conversation with physicians, and interviewees emphasized that basing all one's knowledge on media venues can be damaging.

> Today there are a lot of sections in the newspapers, and there is the Internet and Google, and people find it very helpful. I am not against it, but don't really like it, because the answers that are given to people don't always suit the reader's problem and needs…

Display more openness to discuss sexuality among the elderly

To translate awareness and knowledge, to a significant increase in the discussion of later life sexuality, open communication regarding older adults' sexual desires, needs and dysfunctions within medical encounters and among the media and policies are needed. Openness was identified as a central aspect of communication regarding sexual matters. This theme speaks to developing a familiar, approachable relationship, between physicians and older patients that facilitates open discussion about sexual matters within medical consultations. Interviewees discussed creating a "zone of openness" in the physician's office. An area in which a patient feels free from fears and discomforts and can accept or initiate a conversation on delicate, personal matters, such as sexuality.

> The basic point is openness, from both sides (patients and physicians). Sometimes a patient would bring something up and the physician would just shut that door… they would say something like, "let's leave that for our next meeting…" That would be taking away any hope left for him.

Sexologists noted that physicians do not have to feel like they must have all the answers or all the knowledge on later life sexuality. However, they should display their ability to listen. According to one sexologist, that would sometimes be enough, or all that the patient wanted.

> You need to talk and listen. Sometimes a person just wants to talk, and there is not much to do…and if you don't know what to do, you can just refer them. (the patient)

Although most interviewees agreed that it is the physician's responsibility to initiate the conversation regarding sexuality with their patients, openness is needed from both sides to promote the issue and to talk about it freely. Interviewees recommend building a close and trusting relationship between the physician and the patient before asking older patients about sexual matters. Accordingly, sensitivity and understanding around sexuality are needed to create an open and effective discussion. Interviewees also noted that older adults have a harder time raising the discussion on sexual matters than younger adults do, and offered several suggestions for broaching the topic indirectly by using questionnaires or visible signs such as 'here you can talk about sex' or 'here you can talk about sexual dysfunctions'on the door, or put the sign on their desk.

> It is very important to be open and to have closeness, not physical of course, but emotional closeness, in order to discuss sexual matters…but first of all, openness. Then, you can gently ask 'how is your husband doing?' or 'how are things at home'? Of course, not 'how is your sex'? No! Very gently, 'how is your relationship? Intimate relationship? If there is no response, or the patient doesn't want to talk about it, ok. But if they do, they are thrilled and grateful you brought it up… again, you don't ask direct question such as 'do you have an orgasm'? it is none of my business, but gently check if they want to talk. If the physician is impatient, looking at the clock, cellphone or their computer all the time, the patent understands the visit is over and might leave without raising the problem she had in sexual function…older people grew up in a different generation. In a generation where they still think you don't talk about sex. But why suffer? With older adults, there are tools you can use, short questionnaires on sexual function you can give to men and women.

At the structural level, interviewees thought the media provide better information regarding sexuality than they once did. Awareness and sexual norms, in general, have changed, but not always for the better. However, it seems the media are open regarding younger adults and more around pathological or dangerous aspects of sexuality (e.g. sexual assaults, sexually transmitted diseases and condom use) rather than on the healthy and enjoyable parts of sexuality. In addition, openness is more common towards young adults' sexuality rather than older people's, where sexuality is presented as unidimensional and as reserved only for the young and pretty.

When physicians discuss sexual matters with their older patients, words and diagnoses may be important, but an atmosphere of trust and openness will enable patients to raise the subject. According to interviewees, physicians can obtain adequate knowledge and skills about treating sexual matters in later life, but only those who changed their perspectives, beliefs, attitudes, and values regarding older adults as sexual beings, will be able to have sufficient openness to look, listen, and consciously observe their patients to determine how best to proceed with this topic.

Discussion

This paper draws on the accounts of 15 physicians in Israel, from diverse medical specialties who are certified in sexology, to explore how to facilitate an open and free discussion about sexual matters between physicians and their older patients. "Older" was defined as a chronological age of 65+, as most developed countries have accepted this definition of "elderly" or older persons (World Health Organization, 2002). Three main themes emerged from interviews with sexologists that focused on increasing awareness,

knowledge, and openness. These themes can represent a guideline for promoting and improving the discussion of sexuality among elderly people during medical encounters.

Lack of awareness of older adults' sexuality corresponds with previous studies indicating that they are often depicted as asexual, physically unattractive, uninterested in sex, or physiologically unable to engage in sexual activity (Bouman, Arcelus, & Benbow, 2006; Gott & Hinchliff, 2003b; Walz, 2002). This invisibility is experienced by older adults as disempowering and inhibits their sexual expression (Vares, 2009). A recent study indicated that this invisibility increases with the patient's age, as physicians were more likely to discuss sexual health with patients ages 50–75 years than with patients older than 75 years, male or female (Pascoal, Slater, & Guiang, 2017). When older adults are seen as people with no sexual desires, physically unattractive and undesirable (Henry & McNab, 2003), sexuality in later life is viewed as unimportant. The assumption appears to be that there is no need to discuss this topic with older adults, as it is probably irrelevant to their lives. It is also possible that later life sexuality has been made invisible by society, the media and physicians, because of great fear of self-aging (Nelson, 2005). Viewing older people as asexual, makes it easier to distance them and create a barrier between the "young" and the "old." Other studies suggest it is not only lack of awareness, but also embarrassment (Hinchliff, Gott, & Galena, 2005; Humphery & Nazareth, 2001), fear of intrusion (Sarkadi & Rosenqvist, 2001) and worries of offending (Dyer & das Nair, 2013), cause physicians to consciously or unconsciously avoid discussing sexual matters with older patients.

On the structural level, interviewees emphasized the need to validate older adults' sexuality through standard healthcare policies. Older adults' sexual invisibility has extended to health policy and research, which often fail to address sexuality in later life (McAuliffe, Bauer, & Nay, 2007; Wallace, 2008). Perhaps when sexuality in later life is viewed as unimportant and older adults are assumed to be asexual, policy makers do not have to respond to these needs or to ensure the privacy of older adults in care facilities (Bauer, Nay, & McAuliffe, 2009; Watters & Boyd, 2017). Sexuality in later life can be promoted through policy changes, such as by regulating sexology as a profession, providing sex therapy within hospitals and medical centers, subsidizing the cost of treatment and drugs to enhance sexual performance and compensating physicians and HMOs for referrals or for providing treatment for sexual dysfunction.

At the individual level, the importance of sexuality is demonstrated by viewing the subject as an important issue to broach. A conversation regarding sexual matters should be initiated with the understanding that its importance to the individual and the ways he/she chooses to express it vary widely, and there is no single correct or clearly defined manner in which sexuality in later life should manifest (Hillman, 2008). According to interviewees, questions about sexual history and function should be an integral part of the intake procedure and viewed as an important component of overall health care. Routinely asking patients about sexual functioning or problems can provide opportunities for guided discussion regarding these topics (Hillman, 2008). In addition, most participants agreed that it is the physician's responsibility to do so. However, for health professionals to perform this task appropriately, they must be equipped with accurate knowledge, and not rely on ageist beliefs, myths and misperceptions to inform clinical practice.

Studies indicated time limitations and lack of training as factors that might prevent discussion of sexual matters (Dyer & das Nair, 2013; Gott et al., 2004; Gott & Hinchliff, 2003a; Humphery & Nazareth, 2001; Mellor et al., 2013). In the present study,

interviewees argued that it is a matter of prioritizing sexuality on the structural and individual levels and maintaining non-ageist perceptions about sexuality in later life. While most physicians acknowledge the importance of managing sexual health issues, they also recognized that they rarely prioritize them (Gott et al., 2004). The low priority given to sexual dysfunction in older people is also influenced by wider policy (Gott et al., 2004) and the assumption that sexual wellbeing is not the priority of patients during treatment (Stead et al., 2003). Underpinning these assumptions, might be physicians' lack of awareness to inquire about their patients' sexuality (Balami, 2011; Bouman & Arcelus, 2001) or to offer an unbiased diagnosis, treatment plan, or prognosis (Gewirtz-Meydan & Ayalon, 2016). Finally, interviewers noted ageist stigmas physicians have regarding older adults' sexuality. Ageist myths and stereotypes about late-life sexuality have often been cited as a reason for the lack of sexual health discussions between physicians and older patients (Allen, Petro, & Phillips, 2009; Bauer, McAuliffe, & Nay, 2007; Bouman & Arcelus, 2001; Gott et al., 2004; Lindau et al., 2007; McAuliffe et al., 2007), but these could be lessened by increased education and training programs (Villar, Celdrán, Fabà, & Serrat, 2016).

In the present study, increasing physicians and medical students' knowledge about sexuality in later life (through educational programs, workshops, conferences and lectures) is suggested as a means of promoting open dialogue and meeting the needs of older patients in a more useful and effective way, on a structural level. Knowledge of sexuality in later life among primary care physicians was found to be insufficient (Dogan, Demir, Eker, & Karim, 2008; Mahieu, Van Elssen, & Gastmans, 2011; Snyder & Zweig, 2010) and resulted in feelings of inadequacy when discussing sexual health with their patients (Humphery & Nazareth, 2001).

On the individual level, interviewees recommended education programs to increase physician's skills and awareness in terms of identifying and addressing sexual dysfunction among older patients. Proper education would enable physicians to be responsive to the needs of their individual patients rather than to stereotypes of older people (McAuliffe et al., 2007). Education is also valuable in diagnosing the problem and determining whether to refer the patient to a psychosexual medical specialist, counselling psychologist or urologist/gynecologist (Gewirtz-Meydan & Ayalon, 2016; McAuliffe et al., 2007).

However, both physicians and older patients should receive education about sexuality in later life. Older adults have a relative lack of formal knowledge about sexual functioning and physiology, because scientific sexual information was not readily available or widely discussed when they were young (Bouman, Arcelus, & Benbow, 2007). Lack of information might have detrimental effects on sexual function. Many older men and women do not know how to improve sexual function and are reluctant to ask for information, or are unfamiliar with where to obtain help. Providing information during medical encounters is an important factor in enabling patients to initiate discussions about their sexual health concerns, and patients consider this information valuable and useful (Gott et al., 2004; Stead et al., 2003).

On the structural level, although sexual content is prevalent in the mass media, and appears to have increased over the past two decades, sexuality in later life still has limited representation (e.g. Hurd Clarke, Bennett, & Liu, 2014). Sexuality in older age is usually presented in the media to promote medication to enhance sex (Hartley, 2006) or from a unidimensional perspective, in which sexual activity is reserved for people who are aging well, are physically attractive and active (Gewirtz-Meydan & Ayalon, 2017; Wada, Hurd

Clarke, & Rozanova, 2015). Advertisers and the media continue to associate sexuality with attractive youth, which reinforces the image that older adults should be *sexually retired* (Bauer et al., 2007, p. 64). It is important for the media to portray sexuality in later life realistically, acknowledging the heterogeneity of sexual experiences in later life. In the present study, interviewees hoped the media would not view this subject as taboo, but would present it from a positive, joyful perspective.

The third theme that emerged from the interviews was the need for physicians to display openness regarding sexually related matters. Awareness and education cannot proceed without demonstrating openness to discussing sexually related issues. Sexologists recommended creating an accepting atmosphere during clinical encounters, in which older patients can feel recognized, with their sexual needs seen as legitimate. Sarkadi and Rosenqvist (2001) believe physicians need to have increased openness and the often-cited *permission* attitude (Wallace, 2008) to legitimize discussion of sexual issues during clinical consultations. In the present study, interviewees recommended that physicians routinely ask their patients about sexuality directly, but discreetly. This proactive style can be beneficial to some patients, as it indicates their physician is open to discussing questions about sexual matters (Hinchliff & Gott, 2011).

Even after dealing with feelings of discomfort and personal embarrassment, sexuality still might be a sensitive topic. Therefore, interviewees noted that it is important for physicians and patients to have basic levels of trust and closeness. This finding corresponds with other studies reporting that when a certain level of trust is established and support is given, patients were more comfortable discussing sexuality (Mahieu et al., 2011; Mellor et al., 2013; Wallace, 2008). However, not all people want to discuss sexuality, and this must be respected (McAuliffe et al., 2007). For patients who have a difficult time discussing sexuality, interviewees suggest giving out questionnaires to identify sexual dysfunctions (e.g. Rosen, Brown, Heiman, & Leib, 2000; Rosen et al., 1997). These can be used to help diagnose and to provide a baseline against which to monitor changes in symptoms and response to therapeutic interventions (Hackett, 2017).

Limitations

Although this study provides important insights on factors that can facilitate discussion of sexual matters between physicians and older adults, several limitations should be considered. A total of 15 physicians participated in the study. Although all physicians registered in the ISST and others registered in the SSAECT, EFS ESSM were approached, only 15 agreed to participate in the study, and this may indicate a bias for a sample of physicians that this subject is important for them. The research was based in Israel, and therefore may not reflect the opinions of physicians from other countries. Thus, generalization to other ethnic groups (e.g. Asian or Latino cultures) should be undertaken with caution, and potential bias must be acknowledged. However, the study included physicians with varied sociodemographic characteristics and specialties.

Contribution and future research directions

The current study had several strengths. While most research regarding the discussion of sexual matters in the medical setting focused on barriers to raising the topic (Gott et al.,

2004; Gott & Hinchliff, 2003a; Stead et al., 2003), the present study investigated factors on the structural and individual levels that can facilitate the discussion of sexual matters between physicians and older patients. While most studies investigated physicians with no background or training in sexuality (e.g. Gott et al., 2004; Humphery & Nazareth, 2001), this study voices the ideas of physicians from various specialties with training and experience in the field of sexuality. In addition, although most participants stated they have no formal education in gerontology, they obtained significant knowledge on aging autodidactically and have gained considerable experience through years of practice with older populations.

Additional research is needed to expand the knowledge on how to facilitate the discussion of sexuality between older patients and physicians, rather than focusing solely on barriers to this discussion. Further research is suggested to identify differences in attitudes between physicians who were "older adults" themselves (i.e. age 65–80) versus those who were younger adults, and between different areas of medical expertise. Finally, the nature of medical encounters, of healthcare consumption, and methods of acquiring medical information and advice have changed dramatically in the last decades. The Internet has become a popular venue for searching for medical advice and care among older adults, also (Baker, Wagner, Singer, & Bundorf, 2003; Diaz et al., 2002). Further research exploring how sexuality in later life is discussed online is needed.

Recommendations

On the individual level, physicians can include sexuality-related questions and prioritize sexuality-related issues during intake. Prominent signs calling to raise these subjects (e.g. on the clinic wall or desk) or reading materials and questionnaires given to patients, can increase older adults' level of comfort in discussing these issues. Physicians should ask questions, but more importantly- listen. If they build trust and emotional closeness with their patients and confront their own embarrassment and feelings of incompetence, they should be able to discuss sexually related issues more freely.

On the structural level, it is recommended that sexology should be recognized as a profession, and sex therapy subsidized and provided in hospitals and medical centers. Physicians and HMOs that treat or refer sexually related issues to experts should be compensated. Medical schools should educate students on sexuality of older people through courses, lectures, and workshops. Finally, the Ministry of Health should organize conferences and sponsor campaigns to reduce ageist beliefs regarding older adults' sexuality and convey accurate knowledge and information.

Conclusion

The findings of this study indicate that perceiving sexuality in later life as important, obtaining knowledge, and openness are essential components of having unrestricted discussions on sexual matters with older patients. However, changing the communication dynamics between physicians and older patients needs to extend beyond practical guidance and ageist beliefs that assume older adults are not interested in sex. When older people are viewed as sexual beings, practical guidelines for an open discussion can be implemented.

Acknowledgment

Acknowledgment: We wish to thank The Israel National Institute for Health Policy Research (NIHP) for supporting this research.

Disclosure statement

No potential conflict of interest was reported by the authors.

Funding

This work was supported by the Israel National Institute for Health Policy Research (NIHP)[grant number 16/2016/].

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