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Communicating with older adults about sexual issues: How are these issues handled by physicians with and without training in human sexuality?

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Abstract

Although sexuality is an important part of health and emotional well-being throughout the entire life cycle, including during old age, little is known about how physicians discuss or approach the topic of sexuality during later life. The present study examined the perspectives of two groups of physicians toward discussing sexuality with older patients: 17 physicians who did not have any training in human sexuality and 21 physicians who were certified as sex therapists. The interviews underwent thematic content analysis to identify and code major themes and patterns. Qualitative analysis of the interviews yielded three main themes: (a) discourse between physicians and older adults regarding sexuality, (b) diagnosing sexual dysfunction among older adults, and (c) treating sexual dysfunction among older adults. Physicians who were not trained in sex therapy did not regularly ask their older patients about sexual functioning and/or problems with sex, tended to diagnose sexual problems from a medical perspective, and offered medication as the main treatment for sexual problems. Physicians trained as sex therapists felt more comfortable discussing sex-related issues with their older patients and diagnosed sexual problems from a medical, social, dyadic and psychological perspective. Although they offered their older patients a greater variety of medication-oriented interventions than those without training in sexuality, they did not rush into such interventions and instead emphasised the importance of the psychological and relational aspects of sex. The present study highlights the importance of human sexuality training for physicians and points out the effects of such training on the discourse, diagnosis and treatment of sexual concerns in later life.

KEYWORDS

aging, health aging, physicians, sexuality

1 | INTRODUCTION

Sexuality is an important part of health and emotional well-being throughout the entire life cycle, including during old age (American Association of Retired Persons, 2010; DeLamater, 2012; Kasif & Band-Winterstein, 2017). Nevertheless, despite its importance and despite the evident changes that take place in sexual functioning during this period, little is known about how physicians discuss or approach the topic of sexuality during later life (Latif & Diamond, 2013; Levkovich, Gewirtz-Meydan, Karkabi, & Ayalon, 2018; Shifren, Monz, Russo, Segreti, & Johannes, 2008; Taylor & Gosner, 2011). More specifically, little is known about how physicians discuss sex-related issues with older adults. Because sexual concerns and difficulties are more likely to increase with age, this topic is important (Træen et al., 2017).

Although psychological factors such as depression and anxiety can influence sexual functioning at any age, these factors become more prevalent with ageing (Gregorian et al., 2002). Life events such as retirement, the death of a loved one, the lack of a partner or the lack of privacy upon moving to an institution are some of the factors that can interfere with sexuality among older adults (Sinković & Towler, 2019). In addition, physiological and emotional states as well as morbidity are also related to sexual function in old age (Kontula & Haavio-Mannila, 2009; Lindau et al., 2007).

Research shows that primary care physicians are expected to address the sexual health concerns of older adults (Hughes & Wittmann, 2015). Yet, in a qualitative study conducted among 53 patients aged 60 and over, patients reported that upon consulting their physicians about sexual matters, they were met with disparaging or dismissive responses (Fileborn et al., 2017). Responses of this nature increase with patient age, as physicians are more likely to discuss sexual health with patients between the ages of 50 and 75 than with those over 75 (Pascoal, Slater, & Guiang, 2017). Studies among primary care physicians point to a number of barriers to discussion of sexual issues, including lack of time, lack of communication skills, lack of confidence and the desire to avoid this topic (Dogan, Demir, Eker, & Karim, 2008; Dyer & das Nair, 2013; Fileborn et al., 2017; Levkovich et al., 2018). Indeed, findings have indicated that healthcare professionals tend to believe that sexuality in old age falls outside their area of expertise (Haesler, Bauer, & Fetherstonhaugh, 2016; Levkovich et al., 2018) or that they do not have sufficient knowledge to discuss this topic (Dogan et al., 2008; Mahieu, Van Elssen, & Gastmans, 2011; Snyder & Zweig, 2010). A qualitative study among 15 general practitioners (GPs) and six practice nurses in Australia showed that the GPs had several constraints to discussing sexual health related to their perceptions that their older patients either did not have sex or were not interested in addressing this topic (Malta et al., 2018). Another study assessed the content and context of physician–patient discussions of sexual health during periodic health exams among 483 adults aged 50–80 years (Ports, Barnack-Tavlaris, Syme, Perera, & Lafata, 2014). Approximately 50% of the exams included some discussion of sexual health, but only 10% of patients were specifically asked if they were sexually active. Physicians initiated discussion of sexual health topics 83.3% of the time, usually while taking the patient's history (69.7%) or during the physical exam (22.9%) (Port et al., 2014). When physicians do discuss sexuality with older adults (i.e. if the older adult brings up a problem), they tend to talk about symptoms, prevalence, medication and other patient illnesses that may be related to the sexual problem (Levkovich et al., 2018). Very few physicians examine intimacy and marital relations as a potential part of the problem. Studies have shown that proposed treatment for sexual problems in men entails mostly drug therapy. In contrast, only a small number of family physicians indicated that they discussed the couple's sexual expectations and/or difficulties or attempted to reduce the stress associated with intercourse (Berger, 2017; Haesler et al., 2016; Levkovich et al., 2018; Levkovich, Gewirtz-Meydan, Karkabi, & Ayalon, 2019).

What is known about this topic:

- Sexuality is an important part of human health and well-being in old age.
- Barriers to discussing sexual concerns are physicians' lack of time, lack of communication skills and wish to avoid the subject.
- Formal education in human sexuality can broaden physicians' understanding of how medical conditions and medications can impact sexual function in old age.

What this paper adds:

- This study provides an understanding of the differing attitudes towards sexuality in old age between physicians who have been trained in human sexuality and those who have not.
- Physicians who were not trained in human sexuality tended not to initiate discourse on the subject.
- Physicians who received such training viewed intimacy and marital relations as integral to their diagnosis.

1.1 | Previous training in human sexuality

Formal educational settings around the world provide training in human sexuality. For example, the European Society for Sexual Medicine (ESSM), the Israel Society of Sex Therapy (ISST), and the American Association of Sexuality Educators, Counselors and Therapists (AASECT) all offer courses for the study of human sexuality. These courses cover a wide range of sexual medicine and clinical sexology topics, such as sexual development, the psychology and physiology of sexual response (desire, arousal and orgasm), and the examination, treatment and management of sexual dysfunction (Löfgren-Mårtenson, 2015). They also provide specific knowledge on aging and sexuality and broaden the understanding of how different medical conditions and medications can impact sexual function (Giami & De Colomby, 2006; Wallace, 2008). Training in human sexuality in formal academic education programmes provides the essential background for developing clinical experience and research. This training also sets the standard of care in sexual medicine and increases the quality of treatment for sexual issues. These courses are designed to teach experienced scientists and healthcare professionals the essentials of sexuality, thus paving the way towards effective clinical practice that treats the patient as a whole person. In Israel, the training programme to become a family physician usually involves a four-year residency programme. At present, sexuality training (i.e. in a formal residency programme or postgraduate course) is not a prerequisite for becoming a primary care physician, and relatively few physicians working in this country undergo such training (Tandeter, 2007).

Physicians are the gatekeepers in treating sexual problems. In view of the limited empirical knowledge regarding communication, diagnosis and treatment of sexual health among older adults, the objective of this qualitative study was to examine the perspectives

of primary care physicians regarding discussing sexuality with their older patients.

1.2 | Study objective

The objective of this study was to examine the perspectives of primary care physicians with and without training in human sexuality with respect to discussing sexuality with their older patients.

2 | METHODS

Qualitative phenomenological research seeks to identify phenomena based on how they are perceived by the actors in a particular situation. In this study, the descriptive power of this approach enabled us to achieve an in-depth understanding of the physicians' perspectives on sexuality in older adults (Creswell & Poth, 2018).

2.1 | Research population

The sample included 38 practicing physicians in Israel, 22 men and 16 women. The study was funded by the Israel National Institute for Health Policy Research. The criterion for inclusion was an MD degree plus a specialisation in general practice (GP), gynaecology, urology, rehabilitation or psychiatry. Table 1 shows the distribution of specialisation areas and the demographic characteristics of the sample. Of the 38 physicians, 17 were not trained in human sexuality. In addition to their main area of specialisation, the other 21 physicians were certified as sex therapists by the Israel Society for Sex Therapy (ISST), the European Society of Sexual Medicine (ESSM) or the American Association of Sex Educators, Counsellors and Therapists (AASECT). Based on the purposeful sample approach, we sought out participants who best represented the population's heterogeneity in terms of age, religion and socioeconomic status (Patton, 2002). We attempted to include an equal number of male and female physicians as well as to ensure appropriate representation of physicians from different population groups.

The 17 physicians (eight women and nine men) who did not have any training in human sexuality ranged in age from 36 to 64 years old and their medical practice experience ranged from 7 to 38 years. The 21 physicians who were certified as sex therapists (14 men and 7 women ranged in age from 45 to 67 years old and their medical practice experience ranged from 15 to 45 years. Both groups included participants from across Israel.

2.2 | Research procedure

After gaining ethical approval for the study, the researchers sought out relevant participants, who were contacted by email or phone to be interviewed for the study. Physicians certified in sex therapy were found through lists of therapists published by the Israel Society for Sex Therapy (2016) and with the assistance of the Association of General Practitioners and Family Doctors. The participants were given a comprehensive explanation of the study and then signed informed consent forms. Confidentiality and anonymity regarding the names of participants and their practices were assured. The interviewees received no compensation for participating in the study.

The interviews were conducted in Hebrew, recorded and then translated into English. Each translation was verified by two native speakers, one of whom is a certified translator. Data collection commenced in May 2017 and was completed by June 2018, when theoretical saturation was reached (i.e. additional interviews yielded no new material for analysis). The interviewers (IL

TABLE 1 Demographic characteristics of participants ($N = 38$)

Characteristics	Not trained in human sexuality ($N = 17$)	Trained in human sexuality ($N = 21$)
Age, years (mean), range	$M = 46.81$, $SD = 7.85$, 36–64	$M = 57$, $SD = 10.25$, 45–67
Seniority, years (mean), range	$M = 16.75$, $SD = 7.46$, 7–38	$M = 20.37$, $SD = 10.20$
Country of origin		
Israel	15 (88%)	17 (80.95%)
Other (USA, Africa, Europe)	2 (12%)	4 (19.05%)
Men	9 (53%)	14 (66.7%)
Women	8 (47%)	7 (33.4%)
Medical specialty		
Family medicine	17 (100%)	
Urology		6 (29%)
Gynaecology		1 (152%)
Rehabilitation		1 (5%)
Psychiatry		3 (14%)

and AGM) were both female. One is a social worker (PhD) and the other a gerontologist (PhD), and both are experienced in qualitative research.

A total of 47 physicians were invited to participate in the study. The response rate was 78%. Reasons for refusal to participate included workload, problems in scheduling the interview and lack of interest in the topic. Participants were interviewed in their homes or in primary care clinics, according to their choice (most chose the clinics). The interviews lasted less than an hour. Participants were informed they could withdraw from the study at any time and could refuse to answer any question. None of the participants dropped out.

2.3 | Research tool

The qualitative data in this study were collected by in-depth semi-structured face-to-face interviews, which allowed for learning about and understanding the experiences of the research participants. An interview guide was developed based on the literature, and each interview was conducted based on this guide. The interview guide deliberately covered broad topics because the authors sought to promote open and uninhibited discussion to obtain authentic input from the physician.

The interview guide included significant key areas, among them attitudes and barriers toward sexuality in old age and participants' training in the field of sexuality. The guide was flexible and facilitated meaningful dialogue between interviewer and interviewee (Brinkman & Kvale, 2015). See Appendix 1 for the interview guide.

2.4 | Data analysis

Thematic content analysis of the data consisted of several phases. Each research group was analysed separately by one of the researchers. IL analysed the group of physicians without training in human sexuality, while AGM and LA analysed the group of physicians who were trained in human sexuality. The research team first read and analysed the transcripts. After reading all the interviews several times to achieve immersion and obtain a sense of the text as a whole, the team broke them down into smaller parts or units of meaning. The researchers read each interview transcript line by line, jotting down notes to capture and identify initial units of meaning emerging from the data and to allow the subthemes and their names to flow from the data. After the researchers considered variations of similar subthemes, the parts were then gathered into clusters and the meaning units were converted into abstractions using more scientific language. The researchers then reviewed and discussed the larger themes. Next, the researchers grouped the statements into units of meaning or themes represented by quotes that exemplified the participants' experiences and perceptions.

During the analysis, the researchers compared the results from the two groups and sought agreement on their interpretation of the lived experience. The core themes that emerged from the data were reordered conceptually and placed back into context, facilitating analysis and integration of large amounts of data and generation of abstractions and interpretations, while maintaining the unique nature of each group. The researchers then examined these themes, looking for similarities, differences and connections between the groups (Creswell & Poth, 2018).

2.5 | Ethics

The study was approved by the Helsinki Committee of Meir Medical Center and the Ethics Committee of Bar-Ilan University. A detailed description of the study was provided to respondents, who were encouraged to ask questions and express their concerns regarding the study. All respondents signed a consent form prior to participating in the study. Respondents were informed they could stop the interview at any time or refrain from responding to certain questions that made them uncomfortable.

Prior to conducting the interviews, the interviewers underwent a process of reflection (Finlay & Gough, 2008) that included reflecting on the identities, social locations, assumptions and life experiences they brought to the research endeavour, along with their interactions with the interviewees.

3 | RESEARCH FINDINGS

The qualitative analysis of the interviews yielded three main themes:

Theme 1 Discourse between physicians and older adults regarding sexuality.

Family physicians who were not trained in sex therapy indicated that they did not regularly ask their older patients about sexual functioning and/or problems with sex. Many of the physicians in this group stated that the focus of their meetings with patients was medical, with other topics given lower priority. They mentioned the barriers that prevented them from asking about sexual functioning: workload, time constraints and fear of offending their patients. They noted the healthcare system's demanding requirements and the particularly limited resources at their disposal. They expressed anger, frustration and even despair regarding the limited time allocated to the physician-patient encounter. They also speculated as to whether questions on sexual functioning would serve to distance patients from physicians considering the short time allocated to visits and their feeling of being unable to generate intimacy and closeness in discussing such personal topics.

> If the patient does not bring this up, neither do I. There's no time. If only I had enough time to do other things I'd like to do. And, really, we also feel somewhat embarrassed—this is a topic that's not

> easy to bring up. The patients also don't always want to talk about this. Perhaps it seems strange to them: 'Why is my physician asking me about this when I didn't bring it up myself? It seems somewhat like prying.' But I think it's a matter of our embarrassment as well. Some physicians may feel they lack appropriate knowledge. I don't know. I'm at a point where I should know—I'm okay with it. But, really, it's embarrassing to have such a discussion—what will the patient think and how will I respond? This is a topic that's not easy for me to talk about (Family Physician).

Physicians who were not trained in sex therapy noted that during most of their encounters with older patients, the discussion focused on illnesses, medications and tests, and the topic of sex was put aside. Although some of the family physicians underscored the importance of this topic, they noted that in the case of older patients they were required to give priority to a wide variety of more pressing medical issues. Most of the family physicians indicated that if they did discuss sexual functioning with their older patients, it was usually with patients who had chronic illnesses. As such, the catalyst for such discussions was the patient's health status, the illnesses that brought the patient to the physician's office, and the medications the patient was taking or supposed to be taking.

> What this brings to mind are the side effects of different medications… the case of someone who does not take a prescribed medication. Because everything is recorded in the computer, we can tell if someone is not taking a medication. When I see that a patient is not taking a certain high blood pressure medication, I ask if there's any particular reason for not taking it. At first the patient evades the question and says the medicine isn't necessary: 'I don't feel good when I take it'… and this can lead to a discussion on sexual function (Family Physician).

In contrast, primary care physicians who were trained in sex therapy felt very comfortable discussing sexual issues with older patients. Moreover they emphasised the importance of discussing sexual matters as they perceived sexuality to be an integral part of adult life.

> It is important for physicians from all specialties to view their (older) patients' sexuality as an important part of their lives (Gynecologist, Certified Sex Therapist)

Physicians who were certified sex therapists believed that although such topics may cause discomfort to both physicians and older patients, it was the physicians' responsibility to initiate and prioritise such discussions and to integrate them into healthcare encounters.

> It is the physician's responsibility to ask about sexual functioning! When you ask physicians why they don't 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 functioning. You don't want to embarrass them? But you do ask about their urine and excrement… (Sexologist).

Physicians who were certified sex therapists discussed the need to develop a comfortable relationship between physicians and older patients – one which would facilitate open discussion about sexual matters within medical consultations. They discussed creating a 'zone of openness' in the physician's office where sexual matters could be raised without hesitation.

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

Physicians advocated a sensitive approach that they believed would be more conducive to discussion.

> You can gently ask 'How is your husband doing?' or 'How are things at home?' Of course, not 'How is your sex life?' No! You can ask very delicately, 'How is your relationship? You intimate relations?' 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… (Sexologist).

Theme 2 Diagnosing sexual dysfunction among older patients.

Family physicians with no training in human sexuality indicated that most patients who complained about sexual issues were men and that their main complaint was impotence. They described a variety of questions (for the purpose of diagnosing this condition) that focused on the physiology of the penis. These visits included physical exams. Very few women visited their family physician for sexual issues. Some came to ask for medications for their husbands, whereas others described gynaecological problems that led to a discussion of sexual function. The major complaint among women was diminished libido. The physicians reported asking their male patients about their symptoms, how long they had been experiencing these symptoms, whether their problem was with libido or with erections, whether they had an erection in the

morning, what medications they were currently taking, what illnesses they currently had, and what their risk factors were. The physicians appeared comfortable diagnosing the patient through a series of questions, just as they would diagnose any other illness.

> First we discuss the matter of desire in general. It's very important for me to understand whether the problem is organic or functional, so I ask questions. Does the patient have a problem with morning erections? Does the patient have a problem with desire? Where is the problem, in his opinion? Is there a problem with erections? That is, does the problem go beyond an organic problem? I also check the patient's level of testosterone. But often it is really a matter of desire on the part of the partner, of showing more affection, of taking another step to enhance lust and desire. Not just the act itself (Family Physician).

> In most cases, the ones who mention sexual dysfunction are men, and they usually ask for medication. It's rare, but women sometimes also come in for this reason and I must say that it's not so much because it bothers them, but rather that they think it bothers their husband; they think that's the reason he's irritable and so on (Family Physician).

Although most of the family physicians tended to discuss the physiological aspects of the problem, a few of them described a diagnosis that took into consideration issues of intimacy and the patient's relations with his/her spouse. They examined whether the patient was in a couple relationship, whether he/she engaged in sexual relations, whether these relations (if in the context of a long-term relationship or marriage) had changed over time, and which member of the couple complained of difficulties. These physicians considered the problem in a comprehensive and in-depth manner. Some described a number of meetings in which they used the diagnostic process to gain a more complete picture of the patient and sometimes even met with both members of the couple to broaden the picture and find the root of the problem. Physicians trained as sex therapists held a relatively broader view of sexuality (e.g. discussing personal and interpersonal aspects that might be involved in sexual problems). They described the social, dyadic and psychological aspects related to sexual function. Nevertheless, even physicians trained as sex therapists tended to diagnose any sexual problem among older people as organic.

> With older adults I assume the sexual dysfunctions are more mechanical in nature and not performance anxiety or other psychological disturbances… (Sexologist)

Physicians trained as sex therapists exhibited more knowledge than those without training regarding various sex-related problems in older age and discussed different medical conditions that could impact sexual function among older adults, such as vaginal dryness and hormonal changes. Also, when physicians trained as sex therapists (as opposed to those without training) examined older patients, they acknowledged the psychological and emotional aspects of sexuality in addition to the organic sources of the dysfunction.

Theme 3 Treating sexual dysfunction among older adults

Among most of the family physicians who did not have any training in human sexuality, treatment of sexual dysfunction among older patients took the form of prescribing medication for erectile dysfunction in men. In some cases, they described visits in which the patient took the initiative and asked for medication; in other cases, after the patient described problems in sexual function, the physician was the one to offer this option. These physicians saw their role as one of explaining the medication's benefits and risks and adjusting dosages in those cases where patients were taking other medications as well.

> Several medications can be offered, among them Viagra and Cialis. For example, Viagra is not appropriate for ongoing treatment. You can take it whenever you want, but you need to know that you're about to engage in sexual relations because you need to take it beforehand. You have to plan. And also a man who has sexual urges will have an erection. And when you take Viagra you need to refrain from taking some other medications at the same time, especially people with heart conditions (Family Physician).

The family physicians without sexuality training indicated that women visited physicians significantly less frequently than did men for the treatment of age-related sexual function problems. Treatment for women also focused on physiological treatments, including medication and local creams:

> After menopause women often experience vaginal dryness. After all the hormonal changes they go through, they sometimes have pain as well. Sometimes they get recurring urinary tract infections. Sometimes they experience pain upon engaging in sexual intercourse due to vaginal dryness. All these problems can be treated with local treatments. There are creams. Sometimes there are pills. If they have infections, they need pills. Also, you can advise them to take preventative measures. If they have recurring urinary tract infections due to dryness and changes in the vagina, you can instruct them to be proactive to avoid problems. Some women have urinary leakage and that's not pleasant. Or uterine prolapse. That's also not pleasant (Family Physician).

A minority of the family physicians without sexuality training indicated that they treated sexual dysfunction by meeting with both members of the couple and suggesting the following: foreplay, being open to the needs of the other, reducing tension with respect to complete penetration and enhancing intimacy. Some of these physicians described having difficulty with such discussions, stated that they were not psychologists and mentioned the limited amount of time allocated to each patient visit and the need to attend to patients' major needs.

Physicians trained as sex therapists offered their older patients a greater variety of medication-oriented interventions (e.g. oral medications, local creams or hormones, intracavernous self-injection therapy, penile implants). This biomedical approach seemed to intersect with and build upon the assumption that older adults want penetrative sex, and these physicians believed they needed to provide treatment that would enable such sex. Therefore, older men were offered PDE5 inhibitors to enable them to achieve an erection, while women were offered lubricants or estrogenic creams to avoid pain during intercourse.

> When a patient comes and says he has a problem, I always do a hormonal profile, prescribe testosterone or oral medication. If that doesn't help pretty fast, we move toward injections, and in fewer cases also implants… With older adults, I start much faster with injections, because I don't trust the efficacy of testosterone, Viagra, Cialis, etc. (Sexologist).

Yet unlike physicians with no prior training in sex therapy, physicians trained as sex therapists spent more time on the issue of reciprocity when addressing sex-related matters with older adults. They emphasised the importance of normalising the patient's situation and reassuring him/her as part of the intervention. According to these physicians, if they were to rush to offer medication, they would be validating the idea that something was wrong with their patient's sex life that needed to be fixed.

> Even if a woman experiences decreased libido or a man has decreased erectile function, they can still have wonderful sex if we help define sex differently and understand what the meaning of having sex is for each and every one of them. Mutual pleasure can be obtained in many ways (Sexologist).

4 | DISCUSSION

The objective of this study was to examine the perspectives of primary care physicians with and without training in human sexuality with respect to discussing sexuality with their older patients. The goal was to broaden our understanding of the attitudes of these two groups of physicians regarding sexuality among older adults. The study found that physicians who were not trained in human sexuality tended not to initiate discourse on the subject and to discuss sexuality from a medical perspective only. They implied that they did not initiate conversation on these issues due to work overload and lack of time. In contrast, physicians who had been trained in sex therapy and who perceived sexuality in old age in a more holistic way communicated openly with their patients about this topic. When a sex-related problem came up, most physicians who were not trained in human sexuality tended to focus on its physiological aspects by discussing symptoms, prevalence of the disorder, medication, and how this problem may be intertwined with other illnesses. In contrast, physicians trained in human sexuality tended to view intimacy and marital relations as an integral part of whatever diagnosis they made. Physicians without previous training in human sexuality tended to view treatment of sexual dysfunction in older adults as consisting solely of pharmacological treatments administered to men suffering from impotence. Physicians trained as sex therapists, in contrast, offered older patients a greater variety of medication-oriented interventions. Furthermore, physicians without training in human sexuality indicated that most patients who sought help with sexual functioning were men complaining of erectile dysfunction.

As noted, physicians without previous training in human sexuality tended not to initiate discussions with their older patients about sexual matters. These physicians cited a number of barriers to such discussions, among them lack of time, heavy workload, a sense that such matters were outside their area of expertise and a feeling that these were intimate matters that should not be discussed (Fileborn et al., 2017; Gott, Hinchliff, & Galena, 2004; Haesler et al., 2016; Levkovich, Gewirtz-Meydan, Karkabi, & Ayalon, 2018, 2019). These findings are in line with those of previous studies indicating that medical personnel lack self-confidence in this area and feel uncomfortable discussing these topics and that family physicians feel more confident about providing diagnoses and treatment in their own areas of expertise (Campbell, Stein&, 2014; Gandaglia et al., 2014; Gilmer, Meyer, Davidson, & Koziol-McLain, 2010; Hughes & Lewison, 2015).

In contrast, physicians trained in human sexuality exhibited more knowledge on the topic of sexuality in old age, including both physiological and emotional aspects, and tended to be more willing to discuss this topic. Physicians with previous training in human sexuality even recommended creating a welcoming atmosphere during clinical meetings to help older patients feel that their sexual needs are legitimate and can be discussed openly (Wallace, 2008), as they tend to see the patient holistically and to realise that a patient's well-being depends on many interconnected components.

With respect to diagnosis, the participating physicians stated that male impotence was the most common complaint raised. Research shows that the rate of impotence ranges from 2% among men under 40 to 71% among men over 70 (Prins, Blanker, Bohnen, Thomas, & Bosch, 2002; Rosen et al., 2004). The physicians with no previous training in human sexuality focused their diagnoses on physiological issues. They evaluated the patient's symptoms, frequency of dysfunction, background illnesses and medications, and occasionally performed a physical examination as well. Yet, they did not seem to take into account the fact that their patients' sexual problems may be caused by issues that are not physiological in nature. For example, psychological issues such as depression and the medication

prescribed for depression are tied to sexual dysfunction in old age (Taylor & Gosner, 2011). In contrast, the physicians with previous training in human sexuality tended to view physical symptoms of sexual dysfunction in terms of biological, psychological and social factors.

The study participants also differed in how they perceived male and female sexuality among older adults. Physicians without previous training in human sexuality claimed that men engaged in sex for the physical pleasure of penetration and that women mainly engaged in sex for closeness and intimacy and were tolerant of their own decreased libido (Levkovich et al., 2019). These physicians also claimed that most patients who consulted their physicians about sexual function were men complaining of impotence (Levkovich et al., 2018). These physicians described PDE5 type drugs such as Viagra™, Levitra™ or Cialis™ and considered these to be safe and very effective for treating sexual dysfunction among older men (Buvat et al., 2011). Indeed, family physicians without previous training in human sexuality saw men's problems with sexual functioning as common and able to be solved effectively by means of medication, whereas women's problems were viewed as being more complex and requiring a comprehensive solution involving both medical and emotional treatment (Levkovich et al., 2018, 2019).

Physicians with previous training in human sexuality adopted an approach similar to that of those without previous training in terms of diagnosing and aiming to resolve the sexual issues of their female patients. Research indicates that between 25% and 63% of older women experience problems with sexual function, with lack of oestrogen identified as the primary cause (Addis et al., 2006; Ambler, Bieber, & Diamond, 2012). Moreover physicians who treat women with gynaecological problems are aware that older women have difficulties with sexual function; nevertheless, very few physicians discuss this issue with their female patients (Stead, Brown, Fallowfield, & Selby, 2003). These findings underscore that although medical issues often underlie women's sexual dysfunction, these problems are less frequently addressed.

Training in human sexuality may make physicians feel more comfortable asking their patients about the psychosocial aspects of their problems and not just the physiological ones. For patients to feel more comfortable talking about sexual functioning, they must feel that their physician is giving them the time and opportunity to discuss these matters in complete privacy (Sarkadi & Rosenqvist, 2001). At the beginning of the discussion, the physician should ask for the patient's permission to talk about such personal topics, for example by asking, 'Are you experiencing difficulties with sexual functioning?' or 'People who take these medications sometimes experience difficulties with sexual functioning; is this something you've experienced?' (Taylor & Gosner, 2011). In addition, older people often come to doctor appointments accompanied by a family member. Physicians must therefore show sensitivity by determining whether the patient feels comfortable discussing such matters in the presence of the family member (Taylor & Gosner, 2011). Training in human sexuality can help physicians cope with these barriers, acquire a deeper understanding of the topic and discuss it with more self-confidence.

Moreover understanding the cultural context of this study is important. Israeli society is shifting from traditional family values to more modern and individual values, and the norms of older adults are likely to be more conservative (Ayalon, Gewirtz-Meydan, & Levkovich, 2019). They may see masturbation as a sin or something negative and may consider many sexual acts such as cuddling or hugging to be irrelevant or illegitimate. Most older Israelis were not part of the US sexual revolution that reached Israel only decades later (Ayalon, Levkovich, Gewirtz-Meydan, & Karkabi, 2019).

4.1 | Limitations

This study has several limitations that should be considered. Qualitative phenomenological research facilitates delving deeply into a particular phenomenon but at the same time it precludes the inclusion of broad population groups. Hence, caution must be exercised in making generalisations from this study's findings. In addition, the research was conducted among a relatively small number of participants, and neither cultural issues nor sexual orientation was directly examined in the present study. Moreover, because the research was conducted in Israel among Israeli physicians, it may not reflect the opinions of physicians from other countries. Thus, generalisations to other ethnic groups (e.g. Asian or Latino cultures) should be made with caution, and potential biases must be acknowledged.

The differences between the two research groups constitute another limitation. The physicians in the sex therapist were older and had more years of professional training than those in the group not trained in human sexuality. Moreover in Israel a specialisation in family medicine requires four years of study, compared to other specialisations such as sexology and urology, which are six years.

In addition, the current study did not examine gender and age differences between the interviewers and the interviewees. For example, mismatches of this nature may have generated greater discomfort by intensifying the power imbalance between a young female interviewer and an older male interviewee. Such mismatches may also have generated distance, making the interview more tolerable and less emotionally stressful for some respondents. In many societies and particularly in conservative societies such as Israel, the gender of the doctors and of their patients can be significant. Finally, this was a retrospective study in that study participants were asked to reflect upon their experiences and their treatment of patients rather than describing them in real time. The retrospective nature of the study should also be taken into consideration. We recommend that future research in this field examine all these topics and issues in depth.

5 | CONCLUSIONS

The aim of this study was to examine the perspectives of primary care physicians with and without training in human sexuality with respect to discussing sexuality with their older patients. The objective was to broaden our understanding of physicians' attitudes

regarding sexuality among older adults. Differences were indeed found between the two groups of physicians across the three domains examined: initiating conversations about sexuality, diagnosis of sex-related problems and treatment.

Physicians who were not trained in human sexuality tended not to initiate discourse on the topic due to workload, time constraints and fear of offending their patients. They tended to focus on the physiological aspects and to view treatment of sexual dysfunction in older adults as consisting solely of pharmacological treatments administered to men. In contrast, physicians with training in human sexuality tended to view their older patients as complete individuals and to communicate with them openly. They tended to see intimacy and marital relations as an integral part of whatever diagnosis they made and offered older patients a greater variety of medication-oriented interventions than did physicians without previous training in human sexuality.

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SUPPORTING INFORMATION

Additional supporting information may be found online in the Supporting Information section.

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