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Barriers to seeking treatment for sexual problems in primary care: a qualitative study with older people

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Background. Although it is known that only a small minority of people experiencing sexual problems seek treatment for these, barriers to treatment seeking remain relatively unexplored. This is particularly true for older people, whose perceived 'asexuality' has led to them being excluded from sexual health research.

Objective. The aim of the present study was to identify barriers experienced by older people in seeking treatment for sexual problems.

Methods. Semi-structured interviews were conducted with 22 women and 23 men aged 50–92 years recruited from the age/sex register of a Sheffield general practice. A central component of the interviews involved exploring participants' attitudes towards, and experiences of, seeking help for sexual problems. Interviews were analyzed using the 'framework' approach.

Results. The GP was seen as the main source of professional help if sexual problems were experienced. However, several barriers were identified as inhibiting help being sought. These included the demographic characteristics of the GP, GP attitudes towards later life sexuality, the attribution of sexual problems to 'normal ageing', shame/embarrassment and fear, perceiving sexual problems as 'not serious' and lack of knowledge about appropriate services. Twenty-five participants had experienced recent sexual problems which informed their responses.

Conclusion. These findings indicate that many older people have sexual problems that they would like to discuss with their GP, but they feel unable to do so. GPs may need to be more proactive in raising sexual health issues in consultations if these needs are to be met.

Keywords. Older people, primary care, sexual health, sexuality, treatment seeking.

Introduction

The recently published UK National Sexual Health Strategy identifies 'protecting, supporting and restoring' sexual health as a key role for primary care.[1] However, in order for this role to be fulfilled, patients have to be willing to discuss their sexual concerns within consultations, which currently does not appear to be the case. Indeed, a survey of the prevalence of sexual problems among 1768 adults reported that 49% ($n = 281$) of male respondents and 39% ($n = 293$) of female respondents would like to seek help for sexual problems, but only 4–6% of these participants had actually done so.[2]

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Patient barriers to discussing sexual problems within medical consultations remain relatively unexplored, although a study undertaken with women aged 40–80 with type II diabetes[3] identified that participants felt uncomfortable raising these problems with their GP, and only one participant had raised sexual issues raised with her by her GP. The following barriers to initiating discussions about sexual issues were identified: age and gender of the GP, sexual issues being a specialist rather than a generalist area, and a lack of time and privacy in consultations.

However, overall, little is known of the attitudes and experiences of older people who experience sexual problems because research in this area has typically been youth focused. This is likely to reflect the perceived asexual status of later life which is also known to influence policy decisions,[4] clinical practice[5] and popular portrayals[6] of older people. Such stereotyping may also be internalized by older people and, as such, impact upon attitudes towards their own sexuality and potentially influence treatment-seeking behaviours.

Older people who suspect they have a sexually transmitted infection (STI), for example, delay longer between symptom recognition and clinical presentation than younger people.[7] However, whether they experience similar barriers to seeking treatment for sexual problems within primary care remains unclear.

This study reports findings from a qualitative, interview-based study with 45 people aged 50–92 which explored key issues relating to sexuality and ageing, including attitudes towards, and experience of seeking treatment for sexual problems.

Methods

In-depth, semi-structured interviews were conducted with 22 women and 23 men aged 50–92 years (Table 1). This relatively wide conception of 'older' was adopted because the term has taken on a particular meaning within sexual health research, with 'older people' typically defined as those over 50.[8–10] All participants were recruited from the patient lists of one general practice surgery in Sheffield in the North of England. The surgery is located in an area of 'medium deprivation' (as measured by the Townsend Deprivation Index) with only 0.4% of patients from ethnic minority groups. Purposive sampling was used to maximize sample diversity, with the aim of recruiting ~10 men and 10 women from three age groups: 30–49, 50–69 and >70 years. Within these age groups, patients listed on the practice register were selected at random. This list of potential participants was then screened by a GP within the practice to ensure that letters of invitation were not sent to people who were known to have been recently bereaved or to be cognitively impaired. Attempts were made to include single individuals and those with partners, including people who were living as married, married, widowed and divorced. No participants identified themselves as other than heterosexual (these methods are described in detail elsewhere[11]).

Participants were contacted by letter in the first instance and invited to return a pre-paid response slip indicating whether they would be interested in participating in the study. The invitation stated that the study aimed to 'look at the importance of sexual health to people of all ages' and confirmed that all information given would be treated in strictest confidence. Approximately 25% of patients originally contacted participated in the study. Participation rates were not equal by gender and age group and, in particular, a lower than average participation rate was achieved for men aged 30–49 years (16%) and women >70 years (18%). Most interviews lasted between 45 min and 2 h and were conducted at the surgery or the participant's home between April and September 2001. The interview topic guide was developed following a systematic literature review, but was flexible and allowed participants to raise issues and concerns as appropriate. All interviews were tape-recorded with the permission of the participants and transcribed verbatim; all transcripts were anonymized. Confidentiality was assured at all stages of the research, and the study had ethical approval from the North Sheffield Ethics Committee.

Data analysis

Analysis of the qualitative data adhered to the principles of grounded theory and followed the National Centre for Social Research 'Framework' approach, involving a structured process of 'sifting, charting and sorting material' according to key issues.[12] Recurring themes and concepts were identified to make up a thematic framework, or index, which was then applied systematically to the transcripts. Both investigators undertook analysis, and reliability was enhanced by double coding a subset of transcripts and comparing inter-rater reliability. Few discrepancies emerged and, where they did, consensus was negotiated.

TABLE 1 *Participants by age group, gender and marital status*

	50–59		60–69		70–79		80+	
	Men	Women	Men	Women	Men	Women	Men	Women
Never Married	–	1	–	–	–	2	–	–
Living as Married	1	1	–	–	–	–	–	–
Married	5	5	5	1	6	3	3	1
Divorced	–	1	1	2	–	–	–	–
Widowed	–	–	–	–	–	5	2	–
All	6	8	6	3	6	10	5	1

Results

Although it was not our aim to recruit older people with a sexual problem, 25 participants reported current, or recent, experience of such a problem. Ten participants reported personal experience of erectile dysfunction (ED) (seven men and three women whose partners were experiencing, or had experienced, ED). Seven older women had experienced reduced vaginal lubrication, and one man talked about his female partner's experience of this. Reduced lubrication was reported as a 'symptom' of the menopause and as making it difficult, or impossible, to have intercourse. Four participants (two women and two men) reported direct experience of reduced libido attributed to hysterectomy, and four participants reported specific medical diagnoses as interfering directly with their personal sexual health, including cardiac problems and arthritis. Only six of these participants had sought help for their problems—two participants with ED, two regarding hysterectomy and one regarding vaginal dryness. No participant reported that their GP had initiated a discussion about sexual issues with them, even when conditions were diagnosed (and related medications prescribed) with a known impact on sexual health.

Preferred source of treatment

Participants were asked where they would seek treatment if they experienced a sexual problem. All cited the GP as their preferred source of help if in this situation, relating this to a number of factors, including having a good relationship with their GP and satisfaction with past consultations:

> Interviewer: "If you did need to go for . . . any help with sexual problems, would you know where to go?"
>
> P: "Well I think I should come straight to my family doctor me, I mean I've confidence in him to come and have a talk to him, he would advise me, in fact I've no doubt he would. I've a lot of confidence in Dr X." (Married male participant, aged 77)

However, primary care was also preferred because most participants were not aware of any other sources of help and, as explored below, those participants with experience of sexual problems found these difficult to discuss with their GP and most had not done so.

Barriers to seeking treatment

Despite the GP being seen to be the most appropriate source of help if sexual problems were experienced, significant barriers were considered to exist to seeking treatment in primary care settings. These included the demographic characteristics of the GP, GP attitudes towards later life sexuality, the attribution of sexual problems to 'normal ageing', shame/embarrassment and fear, perceiving sexual problems as 'not serious' and lack of knowledge about appropriate services.

GP characteristics. Several participants expressed preferences to consult a GP of a specific gender or age about sexual health issues. Overall, there was a preference for consultations with a GP with similar demographic characteristics to the participants:

> P: "I would see the male doctor rather than the lady doctor, I find it easier to talk to him about things . . . The doctors must get a lot of that sort of thing and the older the doctor the better, young doctors probably have difficulties I think, but if the doctor's a bit older he has been through the mill himself and he could probably help better."
>
> Interviewer: "Do you think he would have more understanding of what's going on?"
>
> P: "I think so yes. Well they would have personal knowledge really; of course they are human as well aren't they doctors? I mean [name of doctor] told me he has got five kids, its nothing to be ashamed of." (Widowed male participant, aged 80)

Preferences to consult a GP of a similar age and gender were underpinned by the desire to minimize embarrassment through discussing sexual concerns with someone they felt was likely to have had similar experiences as themselves.

Age-related factors. The perceived attitude of the GP towards an older person seeking help for a sexual problem was also cited as a barrier to treatment seeking, notably by two men currently experiencing ED. Such concerns were expressed within the context of having built up a relationship with their GP over a number of years.

> Interviewer: "Yes you have seen him [GP about ED]?"
>
> P: "No I've contemplated seeing him, but I just don't know how much importance the doctor would attach to it you know what I mean? I mean getting to our age, he says it's about time you packed up anyway [laughs]. You know what I mean, I don't want him to think I'm a sex maniac or anything like that." (Married male participant, aged 65)
>
> "I just don't know what Dr X would think about it if I came down to see him (about my ED)." (Married male participant, aged 81)

The stereotype of the 'asexual older people' was also seen as inhibiting treatment seeking in other ways. In particular, for this generation of older people, sex was discussed as something that was often considered private.

> "A lot of older people I think don't go to the doctors if they experience problems because they think it is something that should be kept quiet . . . (they) live with it instead of seeking some sort of help." (Divorced female participant, aged 62)

Moreover, age also presented a barrier to treatment seeking as sexual problems attributed to ageing were seen as 'normal' and irreversible. This led participants to feel that suitable treatments would not be available, or appropriate.

> "I think the older you get the more difficult it is to seek advice because when you're younger things should be right and if they are not then it's almost automatic to look for the remedy. I think as you get older if things aren't right then maybe it's because you're getting old." (Married female participant, aged 73)

A further set of barriers to presenting with sexual problems related to age were reported by older men experiencing ED. First, there was a common belief that younger men were more entitled to drugs such as Viagra™ than men of their age, particularly given awareness of the limited resources of the NHS to fund these medications.

> "If there were plenty around (Viagra™) to serve these people that's younger, that's the time of your life you know, I would like to take it, but I wouldn't want to join the queue before younger people." (Married male participant, aged 81)

In addition, concerns were expressed about the side effects of Viagra™, particularly given that many participants had been diagnosed with cardiac problems. Finally, for one male participant, Viagra™ was seen as 'artificial', interfering with the 'natural' progression of old age: "We accept the fact that we are what we are and it's interfering with nature." (Married man, aged 74).

'Severity' of sexual problems. The perception that sexual problems were not a 'severe' health problem also deterred treatment seeking:

> "It's something to do with life pleasure that, it's something that's not really serious, it is in a way, but it's not damaging your health." (Married male participant, aged 81)

This consideration was made within the context of concerns about GP workload and also related to participants' experiences of having to pay for medical care prior to the advent of the NHS.

Psychosocial factors. Psychosocial factors were cited by participants as presenting a barrier to treatment seeking within the context of sexual problems, including shame, embarrassment and fear. The experience of shame was related to societal attitudes towards sex, particularly amongst older people.

> "I think sex is a thing that is very much pushed under the carpet and we don't talk about it, we are ashamed to talk about it, it isn't something you go to your doctors for." (Single, divorced female participant, aged 66)

Similarly, sex was also seen to be an embarrassing topic:

> "Just the fact you can't maintain an erection I find that a little bit embarrassing . . . you're just a little bit inhibited as to what you come and see your doctor about aren't you?" (Married male participant, aged 65)

Fear of the potential underlying cause of a sexual problem was also noted as having an impact upon decisions to seek treatment. This was particularly notable within the context of ED where some participants had awareness of the association between this condition and prostate cancer.

> "I tend to be fearful in case there might be something wrong . . . I heard it on the radio, 10 000 men and I worked it out, that's 200 a week die from prostate cancer and you think is it me in that clump?' (Married male participant, aged 70)

Lack of knowledge about services/lack of appropriate services. Service-related issues were mentioned by several female participants, notably within the context of a desire to seek treatment in an anonymous setting to minimize potential embarrassment and shame as discussed above. One older woman felt strongly that Genitourinary Medicine Clinics, which she refers to as 'sex clinics', should be widely available to people of all ages:

> "I think sex clinics are a damn good idea, I think they should perhaps make people a little more aware of them . . . I think people do know of them but not much about them, I think there needs to be a lot more general knowledge about it and I think it should be made very apparent that it's for people of all ages." (Married female participant, aged 73)

However, other participants associated Genitourinary Medicine Clinics with 'VD clinics' and felt there was still a lot of stigma attached to seeking treatment within this setting.

Discussion

This qualitative study has identified that although older people see the GP as the most appropriate professional with whom to discuss sexual problems, they rarely initiate such discussions themselves. These findings confirm and extend previous research, which has

identified that a significant proportion of people who experience sexual problems do not seek treatment for these.[2] They also confirm that the personal characteristics of the GP represent a barrier to treatment seeking[3] and that most people prefer consultations about sexual issues with a health professional of the same gender and age as themselves.[3,13] That sexual problems are perceived as embarrassing and potentially shameful and inhibit treatment seeking for this reason has also been reported in relation to treatment seeking for STIs among both younger[14] and older people.[7]

However, that older age can represent a barrier to seeking treatment for sexual problems in other ways has not been reported previously. The recognition amongst older participants that sex in later life does not meet with societal expectations and therefore may be disapproved of by their GP is particularly significant and indicates that some older people at least do internalize the stereotype of the 'asexual older person'. In addition, although it is known that attributing symptoms to normal ageing can inhibit treatment seeking amongst older people for conditions such as urinary tract infections,[15] this has not been identified previously as a barrier to seeking treatment for sexual problems. Beliefs about Viagra™ amongst older men with ED have also not been explored previously. Our findings indicate that such beliefs and related decisions to request Viagra™ from the GP are complex and influenced by several factors, including attitudes towards age-based rationing and concerns about interfering with 'normal ageing'.

This study indicates that older people are not receiving information about sexual issues from their GP and have sexual concerns they want to discuss during consultations, but feel unable to initiate discussions of sexual problems themselves. One way of meeting these concerns in primary care would be for GPs to initiate discussions of sexual issues more frequently in consultations with older patients. However, the extent to which GPs would feel comfortable doing this is questionable. Research has identified significant barriers to discussing sexual problems in primary care consultations, including lack of time, limited availability to refer to secondary care, fears about 'opening a flood gate', patient embarrassment, poor knowledge, and inadequate training and skills.[3] A recent survey of the provision of sexual health among primary care physicians in Belgium concluded that "doctors have many and various barriers to discussing STIs with their patients".[16] Moreover, such barriers are likely to be compounded in consultations with older patients due to societal perceptions that sex is not important to older people and widespread concerns that talking about sex to older people will cause offence. Indeed, these suppositions are supported by research showing that sexual histories are less likely to be taken with increasing age.[5] These issues deserve further attention and are currently being explored in on-going work led by the current authors.

This study did have several limitations. First, with only one-quarter of the initial sample contacted actually participating in the study, participation bias is likely. Although this does not have significant implications for the 'logical generalizability' of our findings, it must be recognized. It is likely that participants experienced fewer barriers to discussing sexually related issues than non-participants, indicating that non-participants would be even less likely to seek treatment if sexual problems were experienced than participants. Finally, it must be acknowledged that, for some participants, discussion of barriers to treatment seeking was hypothetical as they had never been in this situation. However, a high proportion of the sample ($n = 25$) did have a current or recent sexual problem and so drew on personal experience to discuss these issues. Furthermore, recruiting older people who had received treatment for a sexual problem would have meant that people with a problem who had not sought treatment would have been excluded, and it is this group who provide the most insight into barriers to treatment seeking.

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