Mid-to-Late-Life Women and Sexual Health: Communication With Health Care Providers
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BACKGROUND AND OBJECTIVES: Sexual health communication can be difficult for aging women as well as their health care providers. The current exploratory study was undertaken to learn more about how mid-to-late-life women approached communication about sexual health with their health care providers and what factors impacted their perceptions of their abilities to do so.

METHODS: In this descriptive qualitative study, 27 community-dwelling women, ages 50–80, were interviewed about their perceptions of their abilities to communicate with their health care providers about their sexual health. Interview data was coded for major themes.

RESULTS: All of the women in the study had self efficacy to communicate about their sexual health, especially if there was a physical problem present. For a majority of women, provider-related behaviors impacted their communication self efficacy. Provider-related behaviors that both encouraged and hindered communication were identified. Relationship quality and provider-initiated communication were among the behaviors that encourage communication about sexual health. Women in this sample valued active listening by the provider as well as a nonjudgmental stance. Perceptions of provider discomfort, lack of time or interest, as well as confidentiality concerns were identified as barriers to communication about sexual health.

CONCLUSIONS: Sexual health is important to the quality of life of aging and older women. Providers can incorporate some of the behaviors identified as enhancing of communication self efficacy so that this important health topic is covered in the clinical encounter.

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Older women identify sexual health as a lifelong need and continue to engage in sexual activity well into older age. Sexual health is associated positively with life satisfaction, greater purpose in life, emotional well-being, and psychological well-being. In a global study of older men and women, subjective sexual well-being was found to be correlated with overall happiness. However, it is often difficult for health care providers and older women to communicate about sexual health. One study found that only 19% of women ages 40–80 had discussed their sexual health problem with a provider, despite rates of sexual problems (eg, dyspareunia, anorgasmia, and lack of interest in sex) as high as 49%. This difficulty in communication may be due to a multitude of factors, including patient discomfort, provider discomfort, and negative attitudes about sexuality and aging. Interviews with providers in primary care reveal that some providers feel that discussing sexual concerns with older patients is highly problematic, likening this discussion to “opening up a can of worms.” Discussing sex or sexual health with patients who are female and older is especially challenging for providers. These discussions can be difficult for older female patients as well. Gott and Hinchliff found that older women are reluctant, in part, because of the social stereotype that sexual concerns are not acceptable as one ages. Reluctance and discomfort have to be overcome to ensure that this important aspect of older women’s health is addressed in health care encounters.

Clinician-patient communication has been found to be influential, both directly and indirectly, to patient health outcomes. A systematic review of verbal and nonverbal communication in primary care identified that provider communication behaviors contributed to positive health outcomes. For

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communication to occur, a patient (or provider) must feel able to do it.

Self efficacy—one’s belief that they can perform a particular behavior even in the face of barriers—is identified as an important predictor of behavior.17 such as communication with a provider.18 If a person feels a sense of personal agency, or self efficacy, with regard to a behavior, they are more likely to engage in that behavior.19 If a behavior is identified as challenging or difficult, such as talking about sexual health, this can affect self-efficacy.

There is little available research on patient communication self efficacy effects on health outcomes.20 Available research has not focused on communication about sexual health. This is particularly problematic because many sexual health concerns, such as anorgasmia, low desire, and some sexually transmitted diseases, do not present with physical signs, making communication especially relevant to their identification and treatment.21 Discussions of sexual health and aging are consistent with family medicine’s emphasis on comprehensive health care across the lifespan. The current exploratory study was undertaken to learn more about how mid-to-late-life women approached communication about sexual health with their health care providers and what factors impacted their perceptions of their abilities to do so. Qualitative methods were chosen to elicit rich descriptions of the phenomenon.

**Methods**

This descriptive, qualitative study was conducted in the late spring and summer of 2011. A convenience sample of 27 women was recruited from the community via posted flyers in settings frequented by mid-to-late-life adults, such as community centers, public libraries, gyms, the women’s center, and senior centers. Women were eligible to participate if they were ages 50 or over, able to complete an interview in English, and agreed to have the interview audi-taped. All interviews occurred in either the participant’s home or the principal investigator’s office. The interviews lasted between 1 and 1.5 hours, and participants received a $50 retail gift card for participation. All recorded data were identified by participant number, and all information was kept confidential. A University Institutional Review Board approved the research protocol.

The semi-structured interview guide asked a series of open-ended questions that focused on communication about sexual health with health care providers. Women were asked to indicate which of their current providers they felt most comfortable talking to about their sexual health. Questions regarding communication self efficacy are indicated in Table 1. These questions were drawn from the literature on measurement of the self-efficacy construct.22-24 In addition, year of birth, marital status, educational level, current household income, ethnicity, and race were collected. Interviews were digitally recorded, transcribed verbatim, and de-identified. Transcriptions were reviewed against the audiorecording to ensure accuracy. Qualitative data management was carried out using Atlas.ti software, version 6.2 (Atlas. ti. Version 6.2. Berlin: Scientific Software Development).

Analysis of the data followed theory-based thematic analysis, a method that is used for identifying, analyzing, and reporting patterns in the data.25,26 Transcripts were read multiple times by the principal investigator, and data were sorted into relevant codes. After completion of analysis of the eighth interview, no new codes were identified. Coded data were then examined for similar categories and further refined into data themes and subthemes.

**Results**

Twenty-seven women participated in the interviews; 13 were white women (48.1%), 13 were African American (48.1%), and one identified herself as Native American (3.7%). Mean age of the sample was 60.9 years (standard deviation [SD]=7.95) with a range of 50 to 80 years old. Almost half of the women were married (n=13, 48.1%), eight were divorced (29.6%), five were single (18.5%), and one was widowed. Those who were married tended to have higher incomes. Of the unmarried women, only two were in a relationship at the time of the interview. Education attainment was high: seven women (25.9%) had master’s degrees, nine (33.3%) had bachelor’s degrees, three had associate’s degrees (11.1%), six had some college (22.2%), and two were high school, or equivalent, graduates (7.4%). Women reported seeing several types of providers, and two thirds (n=18) reported that they felt most comfortable with their primary care provider (indicated by women as “family practitioner,” “primary care provider,” “general practitioner,” or “internist”). Six women (22.2%) reported a preference for talking about sexual health with a gynecologist, two women (7.4%) preferred talking to a non-medical provider, such as a therapist or masseuse, and one woman did not have a current provider.

Themes encompassed participant perceptions about whether they felt they could communicate, whether they would communicate, and what factors interfered with or encouraged communication. The women in this study saw themselves as able to communicate with their providers about sexual health, with little variability. However, provider-related themes related to self efficacy were identified early on in the analysis, leading to a new theme: provider-related behaviors that facilitate or hinder communication. It was clear that women’s self efficacy to communicate was influenced by these provider-related issues. Quotes are identified with the participant number in parentheses after the quote.

**Self Efficacy**

Generally, the women in this study felt they could communicate about sexual health with their providers. None of the women stated that they could not communicate with a provider about sexual health, and they
displayed a range of comfort levels with the idea, as a sampling of quotes shows. One woman said:

I think because I am open and I don’t have any reservations about talking physically, emotionally, you know, about my sexual life. Um, and that probably makes it easier for her to interact with me….I just don’t have any issues with bringing up anything: protection, emotionally, you know, uh, if I needed . . . you just go in there and talk to her about it…” (P2).

Another felt that she could communicate to the extent of getting a referral to a specialist:

So yeah, with I would say 90% of ‘em [health care providers] I would not be real . . . I would bring it up, I would be okay bringing it up but not in detail, and I’d be bringing it up like you say only to ask for a referral to somebody. (P10).

While none of the women felt they couldn’t or wouldn’t address sexual health with a provider, several women felt they would only initiate communication if they were experiencing a physical concern or problem. As an example, one woman said:

But I don’t know. I don’t see any problems that she could help me with as far as sex goes. Well, I don’t know again what sexual health means because if I had like a fungus or a sore in my genitals, that would be sexual health, and I would tell her. (P8).

Another woman said:

If I thought there was an issue physically, then I would but other than that, you know, I’m not comfortable doing that. (P19).

The women in this sample were similar to each other in that they all had positive self efficacy to communicate with providers about sexual health, but some needed the presence of a physical problem to initiate the discussion. For these women, a social or psychological concern related to sexual health may not be as appropriate for discussion with their health care provider.

Provider-Related Behaviors
Women identified provider behaviors that they perceived to be hindrances to their self efficacy to communicate about sexual health as well as behaviors that they felt enhanced their self efficacy. Provider-related hindrances to sexual health communication were reported by only seven of the women. Women discussed prior experiences that made them think that communication about sexual health would be difficult with a provider. Nonverbal behavior such as “standing over” (P3), “stiffening up” at the mention of the woman’s sexual activity (P7), and indications that the provider was rushed served as hindrances (P3, P10, P13, P14). One woman stated:

As we’re talking about her, I’m thinking ‘She’s probably in too much of a rush for just about anything, whether it’s sexual health or anything.’ (P14).

Two participants cited that concerns about confidentiality were a hindrance to their communication about sexual health with their provider. For example, one woman said:

Because the patient thinks the doctor tells everything to the state or somebody or the Social Security if they are on Social Security. (P16).

More than half of the participants (n=15) discussed provider-related behaviors that they felt enhanced their ability to communicate about sexual health. Themes that emerged from the data included type of relationship the woman had with her provider, verbal and non-verbal communication cues, and taking the time.

Relationship factors included a relationship that was established, was not forced, and where the women felt accepted:

I have a relationship with her that is . . . just so easy. Um, I think a level of trust. You know, I think she’s done a good job and, um, in building that relationship with me. (P2).

Just that idea that you’re basically approved of if I say, you know, ‘I picked up some guy last night and blah-blah-blah’ and, you know, they won’t fall off their chair and leave the room. It would just have to be somebody that would be accepting of me as a whole person. (P3).

In addition to being nonjudgmental, for three women it was important that the provider not take a

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<th>Table 1: Semi-Structured Interview Questions About Self Efficacy</th>
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<tr>
<td>• How comfortable are you bringing issues of concern to these providers and professionals?*</td>
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<td>• Of the providers you have identified, which one would you most likely discuss your sexual health with?</td>
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<td>• How difficult would it be for you to start a discussion of sexual health with your primary care provider?</td>
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<td>• What factors or circumstances would make it easy for you to discuss sexual health with your primary care provider?</td>
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* Women had been asked to identify their health care providers in the previous question.
stance as the expert in the relationship (P2, P7, P25).

Women felt that their self-efficacy for communication would be enhanced if the provider initiated communication with them about sexual health. For example, one woman said:

So yeah, probably, you know, if HE had said something as an opening line, I would have ... maybe it would have made it a little easier. It’s not really easy. (P6).

Another also endorsed this:

Maybe they could just say, you know, ask a question, once in a while, ‘How are you doing sexually? Is there something going on that I need to know about? Do you feel all of your sexual organs are operating correctly? Are you having any problems during sexual intercourse?’ (P20).

Other communication behaviors that served as facilitators included listening and being open. One woman expressed this as:

... a openness enough that and a gentleness enough that people aren’t embarrassed to bring it up. (P10).

Another expressed this as:

Because she’s just so...like nothing shocks her, she’s so laid back, and easy to talk to. (P28).

Women also endorsed educational materials in the waiting room and the inclusion of a question about sexual health on the intake paperwork as alternatives to the verbal discussion of sexual health.

Provider time was an important factor for the women in this study. Women felt that if they took the risk of discussing their sexual health, they wanted providers to take the time to listen. This can be seen in the following quote:

To make it easy with me is that if they’re going to sit down, enough time to listen to you than to rush. You know, because many times when you go in there, they’ve got so many patients and then they want to run through you and then the next thing you know, out the door. (P17).

Often women felt more at ease because in the past their providers had taken the time to get to know them. One woman stated:

She gets to know your life. I mean I think she’s spent some good time, uh, just talking about my life in general. (P2).

Another stated it this way:

And spending time. You know, um, actually these doctors that I go to, they’ll spend time...they may be writing things as they’re talking to me, which is fine. But when it comes to the time that I, I have an issue and I want to talk about it, they put down their pencil and they listen. (P6).

Provider behavior, both verbal and non-verbal, was important to how able and willing these women were to talk about sexual health. An open, receptive manner is important as well as taking the initiative for beginning the conversation. Providers encourage communication when they project interest and take the time.

**Discussion**

It is clear from these results that even among a sample of women who do not have trouble discussing sexual health, self-efficacy is enhanced if providers do certain things and avoid others. The women in this study all reported self-efficacy to communicate about sexual health. All of them, regardless of race or relationship status, felt they could talk to a provider about their sexual health, and most would, especially if there was a physical problem. Many of the behaviors that encouraged women can be replicated in the clinical encounter. Behaviors that providers already engage in, such as active listening and relationship building, are perceived by women as enhancing. Taking a nonjudgmental stance and investing time in increasing a woman’s comfort were found to be important as well. This is consistent with findings from research on another sensitive topic, domestic violence, that found women were more likely to discuss domestic violence with a provider who was responsive to psychosocial cues and asked open-ended questions. Women’s perceptions of hindrances were often based on past experiences, so a provider must be proactive in asking about sexual health so that women do not assume the provider does not have the time or interest. Women will talk about sexual health if they are asked. Opening up the conversation is likely to increase their comfort level in the future. Another important finding is that women may be holding back from talking about their sexual health because they do not perceive a physical problem. Providers need to be aware of this and include prompts in their discussions that are related to the social and psychological correlates to sexual health, as these are often the most problematic for older women.

As time is at a premium in most clinical encounters, providers can take advantage of suggestions to include a prompt about sexual health on the intake paperwork or appointment checklist. Sexual health items can also easily be incorporated into the electronic medical record. An additional strategy is to provide materials about sexual health and aging in the waiting or exam room. As the women in this study suggest, this sends a message that the topic is an acceptable one in the clinical encounter and setting.

The results of this study come from in-depth interviews of women in a particular place and time and therefore are not generalizeable to all older women. The women in this study self-selected to participate and...
were all quite comfortable discussing sexual health and aging. Most of the women were in their 50s and 60s, and thus they may not accurately reflect the experiences of women in their 70s and beyond. In spite of the limitations, the results of this study are instructive to clinical practice. Improving communication about sexual health issues for older women can improve detection and treatment of sexual problems. Detection is increasingly important as rates of sexually transmitted diseases are increasing in this population.

Understanding that provider behavior can be so impactful even in a sample of women without difficulty discussing sexual health reinforces the need for providers to be more proactive with this population. Providers can take practical steps, both verbal and nonverbal, that will increase the likelihood that sexual health communication occurs in their clinical encounters with older women.

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References


