

General practitioner attitudes to discussing sexual health issues with older people

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Abstract

How health professionals perceive and manage later life sexual problems remains relatively unexplored and, in particular, little is known about the attitudes of GPs, who represent the first point of contact for most older people in the UK who experience sexual health concerns. This paper draws on qualitative data generated from in-depth interviews with 22 GPs working in demographically diverse primary care practices in Sheffield, UK. Analysis identified that GPs do not address sexual health proactively with older people and that, within primary care, sexual health is equated with younger people and not seen as a 'legitimate' topic for discussion with this age group. However, it was apparent that many beliefs held about the sexual attitudes and behaviours of older people were based on stereotyped views of ageing and sexuality, rather than personal experience of individual patients. The discussion considers the implications of these findings for primary care, particularly in relation to education and training.

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Keywords: Older people; Ageing; Sexuality; Sexual health; Primary care; UK

Background

Sexuality and old age are typically seen as incompatible. Dominant images of sexuality revolve around the youthful, healthy, beautiful body and represent a marked contrast with those associated with old age, invoking as they do physical decline, decrepitude and sickness. As such, later life has tended to be characterised as asexual, both within the popular imagination and in research and policy agendas. However, one of the first qualitative studies to involve older people directly in discussions about sexuality and sexual health has challenged this view of older people by identifying that sex (a term which was self-defined by participants) represents an important quality of life issue in later life (Gott & Hinchliff, 2003). Indeed, participants in this research identified that sex only assumes no importance to quality of life when barriers to remaining sexually

active are perceived to be insurmountable, for example following death of a spouse or the experience of significant health problems.

These data challenge dominant stereotypes of older people and, in particular, have significant implications for research and practice agendas in the area of sexual health. Sexual health has been defined as 'the integration of somatic, emotional, intellectual and social aspects of sexual being, in ways that are positively enriching' (World Health Organization, 1975) and represents a growing area of interest for researchers, practitioners and policy makers. Indeed, whilst medicine has historically played an important role in shaping and even defining what we mean by sexuality (Weeks, 1989), in recent years 'sexual health' has received increasing prominence, both as a reaction to the emergence of HIV/AIDS in the mid-1980s and also in response to a wider 'sexualisation' (Hawkes, 1996) of society whereby sexual desire and performance have come to be seen as serious public health concerns (Laumann, Paik, & Rosen, 1999). Although the dangers of overmedicalising sexuality at the expense of social and interpersonal

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dynamics of sexual relationships have been acknowledged (Hart & Wellings, 2002) and, in particular, the role that economic factors play in this medicalisation criticised (Tiefer, 2002) the focus on 'sexual health' is certainly a trend that is set to continue. It impacts upon how people perceive and manage their own sexuality, setting a norm against which people identify 'sexual problems' and defining the medical doctor as the most appropriate source of help if such problems are identified¹. For these reasons, how sexual health is perceived and managed in medical consultations warrants attention and this is particularly the case with regard to older people, who have largely been ignored in debates about sexual health practice and policy.

Strategies to manage the sexual health needs of the UK population have been set out in the recent *National Sexual Health Strategy* (Department of Health, 2001a). It is unsurprising that this document makes no mention of older people, but rather demonstrates a significant youth-focus by marrying together objectives of reducing the transmission of sexually transmitted infections (STIs) with those of reducing teenage conception rates. Similarly, the *National Service Framework for Older People*, published in the same year (Department of Health, 2001b) makes no reference to sexuality or sexual health, underlining the invisibility of later life sexual health issues at a policy level.

The lack of attention paid to the sexual health needs of older people within UK policy is not supported by the, albeit limited, empirical data available regarding the extent of sexual health concerns in later life. Some sexual problems are known to increase with age. For example, it has been estimated that by the age of 70, 67% of men will experience some degree of erectile dysfunction (ED) (Feldman, Goldstein, Hatzichristou, Krane, & McKinlay, 1994). The nature and extent of female sexual problems in later life remains unclear and, although it has been claimed that 'female sexual dysfunction' is 'age-related and progressive' (Berman & Bassuk, 2002, p. 111) concerns have been raised that this condition is not adequately defined (Moynihan, 2003), particularly from the perspective of women themselves (Nicholson, 2003). However, there is evidence that older women do experience sexual problems which are of concern to them, including vaginal dryness, loss of libido and concerns relating to body image (Gelfand, 2000).

It is perhaps unrealistic to expect these types of problems to be acknowledged within UK sexual health policy given that this has focused upon the prevention and management of STIs and HIV. However, even within this context where it is known that the incidence of STIs peaks among people in their 20s (Public Health

Laboratory Service, 2000), a policy focusing *only* upon this age group obscures the existence of infections in middle aged and older age groups leading to the erroneous conclusion that sexual risk-taking occurs solely amongst younger people². This age-bounded focus is not borne out by available data. It has been estimated, for example, that approximately 16,000 individuals over the age of 50³ attend Genitourinary Medicine (GUM) Clinics in England and Wales annually (Gott et al., 1998a) and that approximately 75% of such attendances are motivated by concerns relating to STIs (Gott, Rogstad, Riley, & Ahmed-Jusuf, 1998b). Moreover, by the end of December 2002, 11% of cases of AIDS had been diagnosed in people over the age of 50, the majority of which were sexually acquired (Public Health Laboratory Service, 2003). Rates of STIs are also likely to rise within this age group in line with an ageing population with changing sexual attitudes and behaviours and greater expectations of sexual health than the current older generation.

The availability and use of new oral medications for ED, such as ViagraTM must also be considered as a response to, as well as catalyst for, changing perceptions of later life sexuality. Katz and Marshall (2003, p. 12), for example, claim that there has been a:

...recent cultural-scientific conviction that lifelong sexual function is a primary component of achieving successful ageing in general. The discourses of positive ageing have created the sexy ageless consumer as a personally and socially responsible citizen.

However, the extent to which these discourses can truly be termed 'ageless' is perhaps debatable and it is pertinent to highlight that these sexualised consumer lifestyle reflect an extension of middle age, rather than a sexualisation of 'old age', a life stage which remains excluded and invisible (Gilleard & Higgs, 2000) and undoubtedly asexual, or even anti-sexual. Moreover, these discourses bear little relation to the heterogeneity of later life attitudes and experiences, which do challenge emergent views of sex as a necessary component of successful ageing (Gott & Hinchliff, 2003).

Nevertheless, the implications of these new 'lifestyles' for sexual health management are clear; the numbers of older people with sexual health needs will increase and, as such, the issue of later life sexual health management becomes very pertinent. However, research suggests that discussing later life sexual health issues within medical

¹ The role of specialist psychological input into sexual health management from secondary and tertiary services must not, however, be neglected (see for example Zeiss & Zeiss, 1999).

² That this assumption is made is exemplified by the decision to only include participants aged up to 44 years in the latest National Survey of Sexual Attitudes and Lifestyles (Johnson et al., 2001), findings from which will inform UK sexual health policy in the forthcoming years (Hunt, 2001).

³ 'Older people' in sexual health research have typically been defined as aged 50 years or over.

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