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Barriers and Facilitating Factors in Help-Seeking: A Qualitative Study on How Older Adults Experience Talking about Sexual Issues With Healthcare Personnel

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ABSTRACT

Objective: Barriers to help-seeking for sexual issues endanger sexual health rights of the growing population of older adults. This study set out to explore older Norwegian adults' experience of help-seeking for sexual issues. **Methods:** Thirty-two men and women aged 65–85 years were interviewed. Five themes were identified using thematic analysis: (1) Dynamics in communication, (2) Understandings of sexuality, (3) Knowledge and competence, (4) Attitudes, and (5) Structural conditions. **Results:** Results were discussed in relation to the existing research and cultural changes in attitudes, and recommendations are presented on how increased knowledge, competence in patients and health personnel can overcome barriers to help-seeking. **Conclusions:** Although the participants seemed more knowledgeable and HP less prejudiced conc. older adults' sexual health, sexuality was still experienced as mainly irrelevant in the context of health care.

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Introduction

The new generation of older adults in Western countries has more accepting attitudes toward sexuality than previous generations as a consequence of social and political changes seen in the 1960s and 1970s (Schmidt & Matthiesen, 2003; Slagsvold & Strand, 2005; Syme, 2014). In recent years, there has been an increased focus on the sexuality of the elderly and their sexual rights (Hinchliff & Barrett, 2018), and due to this focus, it can be expected that older adults will claim their right to be sexual and will require help from the healthcare system to achieve this goal. Yet research shows that there are significant barriers to seeking help for sexual difficulties in older adults (Hinchliff & Gott, 2011), which puts them at risk of not receiving the quality of professional sexual health care they are entitled to (Hinchliff & Barrett, 2018).

The growing population of older adults in the next decades will have a longer life expectancy (United Nations, Department of Economic and

Social Affairs, Population Division, 2017), and are expected to be sexually active throughout life (Kolodziejczak et al., 2018; Traeen, Hald, et al., 2017a). Given that sexual problems increase with age for both genders (DeLamater, 2012; Traeen, Hald, et al., 2017a), the need to better understand factors that improve help-seeking is necessary.

As one of the Nordic countries, Norway is often characterized as a sexually liberal culture, favoring equal rights for all individuals and groups of individuals to be sexual and to live out their sexuality (Traeen, Carvalheira, et al., 2019). Still, Norwegian healthcare personnel (HP) often find it difficult or embarrassing to initiate discussions about sexual health with older patients (Fischer & Traeen, 2016; Helland et al., 2013) due to not wanting to offend their patients (Traeen & Schaller, 2013). This resonates with earlier findings where barriers to help-seeking have been linked to HP's stereotypical views of sexuality in older people as problematic, non-existent, or irrelevant (Gott, Hinchliff, et al. 2004;

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Delamater, 2012). Such views have been attributed to HP's lack of knowledge and training (Gott, Galena, et al., 2004; Gott, Hinchliff, et al. 2004) and society's negative attitudes to older adults' sexuality (Chepngeno-Langat & Hosegood, 2012). Worries about HP's possibly dismissive reactions and personal feelings of shame and embarrassment along with a lack of understanding of sexual problems as a consequence of aging have also been associated with older patients' reluctance to seek help (Gott & Hinchliff, 2003a; Hinchliff & Gott, 2011). Also, older patients' own negative attitudes toward elderly people's sexual interest, desire, activity, and enjoyment have been found to pose a barrier (Fischer et al., 2018) where internalizing society's attitudes might elicit a self-fulfilling prophecy (Gewirtz-Meydan et al., 2018; Gott, 2005). Barriers also exist on a structural level. How clinical work is organized and performed is shaped by ageist policies within the healthcare system that may negatively influence the possibilities for discussing sexuality with older patients in an exploratory and adequate way (Hinchliff & Barrett, 2018).

Help-seeking for sexual difficulties in Western countries is still a relatively unexplored area of research, both with regard to what motivates seeking help and what experiences older adults have with HP in this respect (Hinchliff, Tetley, Lee, & Nazroo, 2018; Sinković & Towler, 2019). Framed within the Norwegian cultural context, the present in-depth interview study set out to contribute to fill the gap and gain insight into the experiences of help-seeking for sexual issues in older adults. The purpose of the paper was to produce rich descriptions of which aspects of older adults' experiences facilitate or hinder the transference of adequate sexual health care in their encounters with HP. This knowledge is of importance for HP, health administrations and educators in order to improve the sexual health care service offered to older adults and to reduce possible stigma toward sexual needs in older adults. Sexual health is often connected to other and more general health aspects in older adults, and sexual well-being is closely related to successful aging (Traeen & Villar, 2020). For these reasons, it is important to understand how sexuality is negotiated in clinical settings.

Methods

A qualitative design was used to address the research questions in this study. Semi-structured interviews were carried out with 32 individuals aged 65–85 years (15 women and 17 men). Men and women of all sexual orientations, with or without partners, were invited to participate in the study. No limit was set on the upper age, health, or living conditions, as long as the person was able to give informed consent.

Participants were recruited from senior activity centers and patient-support organizations; via newspaper articles, social media, and social networks; and through snowballing. To increase relative diversity among participants concerning sexual orientation, we also used purposive sampling (Cresswell & Plano Clark, 2018) to recruit lesbian women in our sample.

The mean age of the sample was 72 years. Of the 32 participants, three men identified as gay, two women as lesbian, and further one man and one woman as bisexual. All participants were native Norwegians. The majority belonged to the middle class and had 3 years of higher education or more, one man and one woman had started work after middle school. Two men considered themselves Protestant Christians, the rest did not present any specific religious affiliation.

Before the interview, the participants were given written information about the study and signed a consent form. The interviews, based on a narrative approach (Patton, 2015), were constructed around the following themes: (1) social background and present life situation, (2) present and previous health issues, (3) emotional climate and love in childhood, (4) sexual experiences in life, (5) sexuality and body today, and (6) expectations of future sex life and healthcare services. These themes were selected based on previous literature reviews and the recognition of areas where knowledge was lacking. Interviews were conducted either at the university campus, or participants' homes and lasted 2–4 hours. The quotes in this paper were translated from Norwegian to English. To increase readability, they were revised to obtain full and coherent sentences, but the quotes remain close to the original statements.

The analytic methods were developed within the framework of thematic analysis, as described by Braun and Clarke (2013). Initially, statements concerning experiences with HP in relation to sexuality and sexual health issues were coded. The coded statements were then categorized into coherent clusters that were in turn ordered into overarching themes that reflected the categories. The process was characterized by going back and forth between coding, categorizing, and deciding on overarching themes while reading through the material several times.

The analysis of the participants' experiences and construction of meaning must be understood as an on-going negotiation between the researchers' and the participants' social construction of reality, where the notion of an objective "truth" does not exist. These processes influenced the decisions made on all levels of data collection and analysis. Consequently, themes were constructed on the grounds of reading and categorizing the material through the subsequent interpretative filters of the researchers.

Ethical considerations

The project was approved by the Norwegian Center for Research Data. To ensure confidentiality, the interviews were anonymized after being transcribed. The participants also had the option to withdraw their participation or stop the interview at any point in the process. The interviewer's clinical experience in relation to sexual problems and psychological issues could help accommodate possible reactions during the interview. Participants were also offered counseling by an independent specialist in psychiatry and clinical sexology in case of reactions after the interview. The data material and the identifying information were kept separate and stored securely at the Oslo University.

Results and discussion

Accounts and meanings were organized into the following five main themes. (1) *Dynamics in communication*. This theme concerns how the participants experienced communications about sexual matters or issues, how talking about sexual issues

was negotiated in the clinical setting, and how such communication was initiated in these settings. (2) *Understandings of sexuality*. This theme explores how sexuality was framed and presented in a clinical conversation. (3) *Knowledge and competence*. This theme illuminated how participants explained the dynamics in communication through the negotiation of knowledge and competency about the subject of sexuality in relation to health. (4) *Attitudes*. This theme concerned the attitudes the participants perceived, held, or interpreted on the grounds of experiences or expectations they had with regard to HP or the healthcare system. (5) *Structural conditions*. This theme covered how participants thought structural conditions influenced the communication about sexuality in clinical conversations.

Dynamics in communication

Negotiating conversations about sexual matters

The most commonly narrated experience by our participants was that HP, whether general practitioners (GPs), specialists, or other HP, had never initiated the subject of sexuality or asked the informants about matters concerning sexuality during regular visits, treatments, or in connection with surgery. This man's experience was typical for most narratives in this study:

The doctor [GP] hasn't asked me how my sex-life is. He might, for instance, say, 'So, how are things?' But he doesn't ask me specifically, 'How are things with your sex-life'? He has never done that, and I don't think he ever will. (Peter, 66 years)

In this example, the doctor leaves it up to the patient to choose to bring up the topic of sexuality. By asking "how are things," he gives an open-ended invitation. This could indicate a generally permissive attitude by the doctor, but because the invitation does not give any specific instructions as to what is acceptable and relevant, or how the patient should conduct himself in relation to the sensitive subject of sexuality, it leaves the social risk of interpretation with the patient. Doctor-patient relationships are inherently asymmetric in power (Nimmon & Stenfors-Hayes, 2016), and unclear instructions may make the situation to be perceived as less safe by the patient (who has less power), in addition to the

subject of sexuality in itself demanding extra caution due to its sensitivity. When asked what he would have thought if the GP had asked, Peter said: “I think that would have been quite nice, because it would in many ways have meant that he cared about me as a whole person.” For Peter, the clinical situation was experienced as less caring, and as fragmenting the connection between sexuality and identity. According to the WHO’s definition, sexuality is an essential aspect of people’s lives—beyond the biological—and is linked to personal integrity, complex emotions, and psychosocial ramifications and thus it requires a holistic approach to sexual health by clinicians (Graugaard, 2017). Although research has indicated that many older adults find it difficult to talk about sexual issues with their GPs (Gott, Hinchliff, et al., 2004), several studies have also indicated that patients expect their GPs to initiate the subject and thereby facilitate conversations about sexual health issues (Gott & Hinchliff, 2003a; Wittenberg & Gerber, 2009).

The failure to ask older patients about their sexuality, or to inform them about how medical conditions or treatments may influence sexuality, has also been seen to compound existing barriers to seeking help, including feelings of shame about one’s own sexual needs and fear of moral rejection by HP (DeLamater & Moorman, 2007; Gott, Hinchliff, et al., 2004; Nicolosi et al., 2006).

I almost die laughing when it says in the magazines: “Talk to your doctor” ... really, Jesus Christ! My GP is a handsome 40-year-old man, and I would not dream of (laughs) talking to him about anything like that! (Karen, 79 years)

Karen’s reaction illustrates a discrepancy between her own feelings and values and how the media portrays current sexually positive and permissive attitudes. The modern imperative of both sexual confidence and taking responsibility for one’s sexual health might not quite match the pre-war sexual attitudes many older adults grew up with. Further, her reference to her doctor’s looks, age, and gender could be understood as an expression of managing feelings of embarrassment for having sexual desires. Rationalization is a common defense strategy to deal with unacceptable emotions, and one could assume

that Karen felt that initiating a conversation about her own sexual needs at her age could be seen as inappropriate by her doctor. Still, when asked how she would react if the doctor initiated the subject, Karen said: “Well, then I would have answered frankly!” HP initiating the subject of sexuality from a professional standpoint can relieve the patient from the responsibility for presenting his or her own possible sexual needs. Findings suggesting that many older patients harbor feelings of not being entitled to receive help from health care services concerning sexual issues also play into the dynamic of initiating the subject (Hinchliff & Barrett, 2018).

A possible insecurity about one’s rights did not seem to stop most of the participants, like this woman who had encountered acute vaginal pain during intercourse after she had received post-cancer treatment medication:

(The oncologist) did not talk about sexuality with me at all. When you know the treatment dries out the membrane, which is rather obvious, in my opinion ... but she (the oncologist) was completely ‘there’ when I first asked. (Silvia, 68)

Silvia expected her doctor to inform her about the possible side effect of the medication on sexual function. She said she felt her doctor not talking about this was a sign of sexuality not being considered relevant or important anymore at her age, although she actually had an active and satisfying sex life with a new partner. Even if Silvia mentioned concerns about possible negative attitudes in health care services as reasons for not being informed, she called her doctor and demanded a change of medication. She described how her doctor was both present and supportive in a non-judgmental manner, providing adequate help. Most of the other participants told of similar experiences when they initiated conversations about sexual issues with HP. Research on HP’s thoughts on how to talk to patients about sexuality has reported a preference for leaving it up to the patient to bring up the subject (Fischer & Traeen, 2016; Traeen & Schaller, 2013), not wanting to disrespect or embarrass the patient (Farrell & Belza, 2012). This preference might even be stronger when the patients are older adults, building on the assumption that older people,

who grew up in times with more restrictive attitudes to sexuality, generally find it difficult to talk about sexual issues (Gott, Hinchliff, et al. 2004). On the other hand, as exemplified in our findings, HP responding in a non-judgmental way concerning questions about sexual health may be more common in countries with generally more permissive attitudes to sexuality than countries where sexuality is more of a taboo. Finally, HP's non-judgmental responses maybe explained by cohort because contemporary HPs are mostly younger than the older patients are and grew up in a sexually more permissive time than earlier generations of HP.

Taking charge of the clinical situation concerning one's sexual health may also be an expression of personal agency, as shown by this man who took it into his own hands to secure his sexual function in light of his erection problems:

I brought it up with my GP and noticed that he might not have enough knowledge; therefore, I became a member of a private clinic with the intention of contacting a specialist, which I did, got an appointment, and had no problems explaining the whole situation to him. He said it had a lot to do with medication, of course, so I got the best medication that did not have such a negative effect on my sex life. At the same time I insisted on getting injections (Caverject), which guaranteed a hard on ... as a reserve. (Paul, 69 years)

In his account, Paul did not seem concerned about what the doctor might think about his sexual needs or wishes, his focus entirely on getting the best help to secure his ability to achieve an erection when he desired. The development of personal agency in relation to one's own sexuality depends on early emotional learning, personal experiences, gender, cultural background and acquired knowledge (Schaller et al., 2018). As Paul grew up in a family environment that was sexually permissive, where sexuality was considered normal and something one could talk and make jokes about, this might have influenced his confidence in talking about sexual issues as an older adult. A positive attitude toward sexuality is further shown to increase the likelihood of seeking help (Anderson, 2013).

The personal agency has also been associated with a sense of responsibility (Moore, 2016). The

willingness to ask their doctor was by some supported through an understanding of personal duty. As Catherine (69 years) put it: "It is just as much my responsibility, that I should ask questions about it, right, as a patient." Catherine's statement illustrates the idea of healthcare depending on a prescribed contract of shared responsibility in the communication between patient and HP, in contrast to a more traditional script where HPs are seen as having authority. Taking personal responsibility for one's health, and communicating one's personal needs, has also on a cultural level been argued to be an expression of a growing tendency in the Western world.

To understand our contemporary cultural and social context, Elias (1978) has described the development of western industrialized societies as a continuous civilization process. He noted differences not only in attitudes and behavior but also in mentalities. This observation led him to describe the civilization process of Europeans as having originated in the stage of modesty, continued through the stage of courtesy and arrived at the stage of civilization. Lyttkens (1989) further developed Elias' theories, claiming that a fourth stage in the civilization process started to develop in western industrialized countries between the First and Second World Wars. He labeled this stage the stage of social competence. As a concept, social competence may refer to two different ideas altogether. First, it may denote the fourth stage in the civilization process and, second, it may refer to a stage-specific social interaction technique. At the stage of social competence, people become increasingly self-conscious in social interactions, which may often lead to uncertainty and anxiety. The individual in the stage of social competence is a self-disciplined person who stresses the value of self-realization and considers psychological rather than moral criteria for what is appropriate in human interactions. Social competency is visible in many areas of social life definitely including the ways in which sexuality is dealt with. Sexuality has become a realm of social competence, where people strive to be acknowledged as sexually competent performers. One should have sex frequently, one should have varied sex, and one must have

knowledge of sexuality even if one does not intend to practice it oneself. Being socially and sexually competent implies taking responsibility for managing and communicating one's personal needs about one's sexual health and sexual needs (Traeen, 2008). In many ways, the development of the socially competent client, the changes in power structures between health authorities and help-seekers (Nimmon & Stenfors-Hayes, 2016), a consumerist shift in the understanding of health care (Simonet, 2014), and the structural conditions for doctors' visits leaving it to the patient to present the problems, all contribute to the diffusion of responsibility for securing a patient's sexual health rights. Still, as Haesler et al. (2016) point out, the expected responsibility in a holistic healthcare system falls on HP.

Summing up, the essence of experiences in the negotiation of the subject of sexual health issues was: "It just isn't a subject, but they (HP) answer when you ask" (Silvia, 68). Where earlier research has mostly presented older adults as reluctant to initiate talks about sexuality with HP (Hinchliff & Gott, 2011), other studies have found that older men and women are quite comfortable discussing sex with HP (Farrel & Belza, 2012). This corresponded with our second main finding, that many patients saw it as natural or unproblematic to take on the task or responsibility of pursuing help for their sexual needs. Still, studies have also found that older patients' intentions to bring up sexual issues in clinical conversations may be greater than how often they actually do bring up such topics in meetings with HP (Syme & Cohn, 2016), thus leaving it open whether or not our participants would actually ask about sexual health issues.

Understandings of sexuality

Different understandings of sexuality may shape both HP and patients in their negotiation of sexuality as a subject, specifically pertaining to its perceived relevance for older adults in the clinical situation. In our findings, if a patient had been asked or informed about sexual problems, the communication was almost exclusively related to sexual function, like erectile problems or reduced lubrication. Other aspects of sexuality like sexual

desire, satisfaction, partners' sexual health, or psychological and relational problems were not addressed.

Sexuality understood as biomedically based

Most of the men who had had sexual communication with their doctor had been offered PDE5 inhibitors, typically illustrated by this man's account of a commonly experienced situation:

He (GP) saw (on his computer) that I had gotten Cialis from the pharmacy previously. He asked: 'Do you need more?' That is the only, absolutely the only thing we have talked about when it comes to these things. (Eric, 82 years)

The GP's offer to prescribe more of what Eric already had received through another doctor represents a biologically based understanding of sexuality, where medical options are regarded as the only solution to sexual problems. Further, the lack of inquiries about his sexual health and well-being had left Eric feeling, "He doesn't seem interested." Earlier research has pointed to a lack of interest from HP in explaining a possible reluctance in patients to bring up sexual issues (Haesler et al., 2016). Several of the participants indicated that they would rather use their network to seek out competency and help, or other professionals like sexologists, psychiatrists, or psychologists, rather than their assigned GP. This may indicate that a purely biomedical approach is not experienced as satisfactory in accommodating patients' needs. At the same time, quite a few of the men in our study expected medical solutions to their sexual problems rather than psychological or relational help, which could refer to many men's reluctance to seek psychological help in general (Yousaf et al., 2015). Older adults' and HP's beliefs may still be embedded in a traditional, biological understanding of sexual function (Gott, 2006) rather than a bio-psycho-social model of sexual health, which would provide a more integrated understanding of explanations and solutions. With this in mind, older patients might not always have the needed knowledge or competency to request adequate help for their sexual issues.

For some, even talking with a specialist with competency in sexology did not guarantee a

broad approach to sexuality and sexual health. Catherine (67 years) had lost her sexual desire years ago due to lubrication problems, but also because of unresolved conflicts in her marriage. When her husband was diagnosed with terminal cancer, their lack of sexual activity became an issue:

We talked about it with the sexologist in the hospital who was rather technical. He didn't ask me if I felt any sexual desire. It was more what I could do, and what we could do, to get it on. Then he (husband) was given Viagra, but we never tried it.

The specialist in this example focused on the husband's sexual function and individual needs without enquiring about what her or their sexual challenges or needs were. The doctor thereby missed the crux of the matter, where adequate help could have been administered. Feeling disqualified and guilty, and not wishing to hurt her husband's feelings, Catherine did not further bring up her lack of desire with the specialist. Research shows that a dyadic approach to understanding sexual problems and wellbeing in older adults is often overlooked in assessments by HP (Štulhofer et al., 2019), and individualistic diagnostic systems may favor biological understandings rather than emotional or relational explanations (Bell et al., 2017). Because there are no immediate medical go-to solutions to more complex sexual problems, and because HPs tend to have little training in understanding the broader etiology of sexual problems beyond the biological, it is less likely that these aspects are addressed by HP. This may result in reduced quality of healthcare for sexual problems that require other non-medical solutions, and where men's sexuality is prioritized over women's because of treatment availability.

Existential implications of sexuality and illness can result in HP and patients avoiding a deeper probing into the subject of sexuality:

My experience is that doctors hesitate in talking about things that are a bit uncomfortable, which they don't have experience with, personal experience, especially when it concerns serious illness, death, and sexuality. (Catherine, 67)

The pain, loss, and suffering people and their partners' experience in the face of serious illness

and death, and the limited possibility to change these realities, can paralyze even experienced HP. Mourning the sexual bereavement following the loss of function or a partner is seldom thematized (Radosh & Simkin, 2016). However, even in these critical periods of a patient's or a couple's life, sexual pleasure, although not necessarily involving sexual intercourse, can still be a meaningful way to connect to one's partner, one's sense of self, and to life itself (Morrissey Stahl, et al., 2018). Lacking knowledge and experience in handling complicated patient realities can explain how HP justify not exploring the subject by defining sex as irrelevant in the situation, or outside one's professional responsibility (Haesler et al., 2016). Avoidance in HP could thus be understood as a coping strategy to handle feelings of incompetence and powerlessness (Traeen & Schaller, 2013).

Sexuality as irrelevant to health

Half of the participants reported having health conditions like cancer, myalgic encephalomyelitis/chronic fatigue syndrome (ME/CFS), diabetes, cardiovascular issues, or chronic pain, all of which are health conditions that research has shown to have a negative impact on sexual activity, function, and satisfaction (DeLamater & Moorman, 2007; DeSimone et al., 2014; Maiorino et al., 2014; Nascimento et al., 2013). In most of the participants' experiences, sexuality was not an issue in relation to checkups or treatment, although some of the men who had had prostate cancer were offered medical help as part of their follow up. Sexuality seemed even less relevant in relation to serious or more complex health issues in both men and women. Anne (72 years), had had ME/CFS from the age of 24 years, but was not diagnosed until her 50s because it was still a relatively new and controversial diagnosis. She said that it was mostly the pain related to her illness that prevented her from having sex with her husband.

There are not so many possibilities for variation. I cannot turn around in bed, I cannot lay on my side. Doing it on the floor or bathroom or kitchen bench, that was over many, many years ago. (Anne, 72 years)

Diagnostic directives in the healthcare system often do not take the patients' sexual needs or experiences into account. Treatment directives might also have been developed on grounds that do not incorporate sexual activity and satisfaction into the understanding of treatment outcomes. This suggests that treatment may improve sexual satisfaction and mobility might not even be considered by HP. However, older adults with complex health issues can still feel sexual desire and want to enjoy a sex life (DeLamater & Koepsel, 2015), and for the majority of older adults, sex remains important to their quality of life and is considered a central element of a satisfying relationship (Fischer et al., 2018; Graugaard et al., 2015; Štulhofer et al., 2018).

Understandings in healthcare services of sexuality as reproduction also exclude persons who no longer reproduce or who have disabilities hindering traditional sexual activity. Older adults seem to adhere less to narrow definitions of sexual intimacy as intercourse (Hinchliff et al., 2019). Other sexual activities, like petting, fondling and cuddling, oral sex, anal sex, masturbation, and hand-genital stimulation, are found to be common sexual activities in older adults (Freak-Poli et al., 2017; Gewirtz-Meydan et al., 2019; Hinchliff & Gott, 2004; Traeen, Štulhofer, et al., 2019). Also feeling a closeness to and warmth from another naked body are seen as common expressions of sexuality (Sandberg, 2013). Knowing common varieties of sexual practices makes it more likely that HP will offer adequate help with sexual issues in relation to specific health problems (Cruz et al., 2017).

Knowledge and competence

Limited knowledge

One of the main reasons reported by the informants as to why sexual matters in relation to health issues had not been addressed were assumptions that HP lacked knowledge and competence.

I think that most of the GPs don't have much more knowledge than just to understand Cialis. They are not world champions in everything. (Kevin, 74 years)

Kevin's perception of HP's level of knowledge underlines the medicalized approach and simple

solutions as the only offer to sexual problems. He also understood their position as generalists, suggesting that treating sexual problems required specialization or the use of other professionals.

Even specialists in the area of reproduction, like gynecologists, may have a limited understanding of sexual implications:

I think they are quite physically oriented. They are probably good at infertility and pregnancies and all that, but how good they are concerning these psychological things, of that I am not sure. (Ruth, 65 years)

Ruth did not expect to get a good answer if she had asked how the treatment would impact on her sexuality. She did not believe the gynecologists knew much about the physiological and emotional aspects of sexuality, although their work often involved sexual functioning. Health care has traditionally understood sexuality from the perspective of reproduction (Giami, 2002), and less as an embodied experience that has meaning or emotional value to people of all ages, impacting physical and emotional health and well-being (Traeen, Carneiro, et al., 2017b).

Treating sexual problems is often seen as a specialized field and not as an integrated part of general health (Gott & Hinchliff, 2003a), but for the curious HP, there is literature on sexual health available. Still, a previous study showed that although medical school students initially were motivated to address sexuality in their future clinical work, this intention seemed to diminish as the educational program progressed (Fischer & Traeen, 2016). Such findings suggest that the educational system itself may contribute to signaling the irrelevance of sexuality in the understanding of health.

Knowledge as heteronormative

Sexuality understood only as penile-vaginal intercourse may further exclude acknowledging sexual practices and their implications in other sexual orientations. Theresa (69 years), one of the lesbian participants, explained that she had visited her doctor for a cervical cancer test. She was not able to go through with the examination because the insertion of the speculum was too painful after many years of non-penetrative sex. Theresa

said she was surprised when the doctor concluded: “Ok, you’re not exactly in the risk group, you don’t have intercourse.” The doctor seemed to assume that penetrative sex does not occur among lesbians. In a survey on the quality of sexual health services for lesbian and bisexual women, 37% of the participants said they had been told that a cervical cancer screening was not necessary due to their sexual orientation (Light & Ormandy, 2011), even though HPV and other STIs can be transferred through genital fluids on the fingers or on sex toys (Anderson et al., 2014). Just as for gay and bisexual men, lesbian and bisexual women are generally at higher risk of not receiving adequate health care than heterosexual women (Barnes, 2012). The numbers might even be higher in the aging LGTB population (Cannon et al., 2017).

Knowledge as culturally dependent

Some of the participants mentioned the lack of knowledge as a consequence of cultural and historical factors. Growing up in rural Norway in the 1940s and 1950s, Samuel (80) had neither learned about sexuality at home nor in school. Sexuality was not talked about. Now, at the age of 80, he had a new partner. Struggling with erectile dysfunction and a heart condition, he had used Viagra after his surgery but had not talked with his current GP about sexual issues. When asked why not, he said:

He does not know very much about it, because he is a foreigner, and the upbringing they had, was the kind I had when I was young. (Samuel, 80 years).

Comparing his cultural history to the culture his young doctor grew up in, he assumed that his GP would not be of any help concerning his sexual challenges. Research suggests that we feel more confident following advice from people we identify with than from people whom we consider less similar to us (Gott & Hinchliff, 2003b). With the increasing population from other cultures working in healthcare services, it is important to ensure culturally sensitive and relevant knowledge and competency in communication with patients.

Competence in relation to HP’s age and gender

The lack of communication about sexual issues was for some of the participants related to age, where the doctor was considerably younger than the patient was, or that the GP’s gender in combination with age posed a barrier. Many participants said they did not think their GP had enough professional or life experience to offer adequate professional help for the problems older adults have or for the complexity of the situation. Catherine (67 years) said she generally had a good relationship with her female doctor and trusted her, but because she was only in her 30s, she said:

I would probably rather ask a good friend, who is a doctor, who is 70, because I think she has more experience, she has felt it in her body herself.

Catherine preferred help she considered more qualified on grounds of personal knowledge, from someone she knew and trusted and who could recognize her feelings and experiences. Age, gender, and experience among HP have been shown to be barriers for older women to initiate discussions about sexual health issues (Syme & Cohn, 2016). Compared to Karen’s experiences of possible embarrassment toward her doctor, Catherine’s account shows that embodied life experience may be more important in this case. Still, it might be that some of the participants in our study might have tried to handle their own feelings of insecurity by projecting their reasons for difficulties in talking about sexuality onto HP or onto their personal circumstances.

Knowledge and competence as facilitating factors

HP’s explicit communication of knowledge and competence is assumed to signal acceptance and relevance and thereby make it easier for the patient to present their sexual health concerns (Cruz et al., 2017). This was illustrated by Larry (70 years), who pointed to what he perceived as encouraging signals that made it easier for him to choose a clinic where he felt they would understand his feeling of being different as a gay man. He explained:

I have a GP who is gay. I wanted him to know who I am. There are some (medical centres) that advertise

in gay magazines, that they welcome gay people, so that it is ok to say that now I have met someone and want to try Cialis, and that is no problem.

Larry's account indicated a strategy where his chosen clinic explicitly informed patients of their knowledge, competency, and attitude concerning sexual health in relation to gay people, which made him feel confident that they would understand his sexual practices as common and therefore be non-judgmental about his possible requests or needs. Through their advertising, this clinic's approach showed a good example of "giving permission," as theorized in the PLISSIT-model (Annon, 1976), where the most basic level is communicating to the patient that it is permitted to talk about sexuality and thereby encouraging the patient to address sexual issues.

Attitudes

The tendency for sexuality to continuously being left out of the health equation in older adults indicates a lack of knowledge, but it may also be explained by negative attitudes to older people's sexuality (Hinchliff & Barrett, 2018).

Attitudes related to age and gender.

Although none of the participants' accounts indicated experiences of explicit negative attitudes from HP regarding sexual matters, some of the female participants experienced not being asked or informed about sexual matters in relation to health as an implicit expression of negative attitudes to sexuality in older women. In light of her experiences with vaginal pain after surgery, Silvia (68 years), said the following:

Do you think someone like me gets questions about their sexuality? Women at my age, who are soon 70? A sex life! Should that be a subject? She doesn't even have a partner! No, seriously!

In her statement, Silvia pointed to attitudes in society that give the impression that it would be deplorable, undignified, and frivolous to assume an active sex life at her age without a formal partner. Having casual sex, a lover, or to masturbate traditionally not considered acceptable activities for women (Baumeister & Twenge, 2002). More women in this study expressed references to ageism than the men did and seemed less sure

that they would find adequate help than the men. Although we cannot generalize, it is interesting that so many of the women pointed to perceived negative attitudes to older women being sexually active or to wanting sex. This may imply attitudes of ageism and sexism, double jeopardy for older women in society (Heidari, 2016; Jen, 2017). Men's sexuality has traditionally been less regulated and repressed than women's (Baumeister & Vohs, 2004), and this seems to continue into older age or even become stronger because female sexuality traditionally has been related to youth and beauty, where aging bodies have been constructed as unattractive and asexual. Research has also found that older female adults tended to have more negative attitudes toward sexual expressions than older male adults (Waite et al., 2009). This may be a result of internalized ageism in the female participants, although the younger cohorts were more positive than the older (Waite et al., 2009), suggesting that the grip of ageist sexism might be loosening with new generations of women growing old.

For men, not presenting oneself as a victim of ageism or sexism may also be connected to not wanting to be perceived as weak, unmanly, or socially incompetent (Yousaf et al., 2015). To illustrate this, when asked why he thought it was difficult to recruit heterosexual men for the study, Walter (68 years) said: "If you don't have a sex life, you don't want to talk about it."

Apart from the cultural bias of men still holding the higher right to their sexuality, it is also well documented that there is a reticence in men as a population to seek help for health issues in general, including sexual health issues (Parent et al., 2018). It could be that the male participants in our study perceived themselves as having fewer problems; common findings in research on masculinity, health, and aging (Tannenbaum & Frank, 2011).

Both men and women in our study presented themselves as competent, although upon a closer look, in somewhat different ways. Men's competence came out as communicating confidence in that they were not worried, were certain that they would find help if needed, and that they trusted the healthcare system. The women signaled competence by communicating the importance of

knowledge and personal agency. These findings are also supported by research on gender roles. Where women traditionally have taken on the responsibility of understanding and attending to issues concerning intimacy in the relationship (Fahs & Swank, 2016), men are more focused on retaining the impression of one's status through signaling self-confidence and are less concerned with acquiring knowledge about one's own health (Baker & Shand, 2017; Parent et al., 2018).

Attitudes related to sexual orientation

Some of the gay participants expressed concerns about possible homophobic attitudes in HP and the healthcare system. Larry (70 years), said:

I hope I don't end up in an institution. I'd rather die at home. Having to be cared for by others and all that ... I have seen so much, I know there is great fear, because many retreat back "into the closet", not to mention because of Muslims and foreigners.

Growing up in a time and country when homosexuality was a criminal offense until 1972, and diagnosis until 1977, Larry was worried about homophobic attitudes from HP in a situation where he would be helpless, or dependent on other's goodwill. Research has shown that older, gay people tend to withdraw from expressing their sexual identity when being admitted to care homes and other care facilities over the fear of rejection and discrimination (Brooks et al., 2018; DeLamater & Koepsel, 2015; Misoch, 2016). Larry also expressed worries about possible discrimination from HP with a minority cultural and religious background. Harboring stereotypical perceptions of other people's attitudes due to cultural differences can itself be perceived as a barrier to help-seeking when faced with one's own vulnerability.

In contrast, Theresa (69 years) was rather explicit in planning to be open about her sexual identity in the face of heteronormative expressions and presumptions if she were to have to enter a care facility in the future:

If I'd get to a care home, with or without my partner, I would want them to understand that I am a lesbian and how important a part of my person and my identity that is. They will be told! The so-called heteronormativity! One is bombarded by it all the time, right, also in hospitals, like: 'You miss a man',

making jokes about it ... but they are not getting away with it; it is very clear that I will say something about it as far as I have the ability to speak.

Theresa seemed less worried about negative attitudes but pointed to the automatic assumption of heteronormativity that pervades our culture, referring to the statistical majority, but also being the norm. She emphasized how important being a lesbian is for her as a whole person, not only as a sexual identity or sexual practices. The combination of assumed stigma and the lack of explicit experiences of HP addressing the subject may suggest the presence of indirect stigma at the societal level (Syme & Cohn, 2016).

Structural conditions

Several of the participants had themselves worked in the healthcare system and had thoughts about how structural conditions might form barriers or might facilitate if and how matters of sexual health are brought into clinical conversations. Laurence (74), a former doctor, criticized the healthcare system for not taking the patients' needs seriously and said:

... rules and regulations in the health system often do not help the practitioner, the rules come in first place and the actual needs of the patient come in second.

Patients' needs are in reality always assessed against structural limitations in the health care system. This means that whether sexual health needs are deemed relevant or important in each case is up to the HP to decide. Given the general lack of knowledge and training, such decisions are usually made on the grounds of personal attitudes and assumptions and therefore tend to be colored by society's attitudes and the healthcare system's general understanding that sexual matters are less relevant in relation to health, and even less so in older adults (DeLamater, 2012; Gott, Hinchliff, et al., 2004).

Some of the participants gave other, more specific indications of how the way the healthcare system is organized can create barriers for both HP and patients concerning sexual matters. As Karen (79 years) explained:

I think GPs have little time, with many patients waiting, and I have sought after him for a specific problem, and that is what the visit is about.

She also had clear thoughts about what would be required for her to feel more comfortable talking about sexuality with HP:

Well, it would require a completely different situation, a totally different time frame, a completely different atmosphere. It must be done in a very delicate and sensitive way.

In her account, Karen described an atmosphere of stress and efficiency, where problems patients present are to be solved. The description gives an impression of being a business transaction where the patient places an order and the HP provides, rather than being a caring conversation. The atmosphere did not provide a caring climate to discuss sensitive or complex matters like sexuality. With a healthcare system that due to economical and ideological changes has grown into a production system rather than a care system (Simonet, 2014), it can be difficult to find ways to accommodate the patients' needs and rights concerning sexual health in a respectful way. Still, it is also likely that better trained HPs would be able to overcome such structural limitations.

Concluding remarks

This study set out to examine how older adults experience clinical conversations in the healthcare system concerning sexual health issues and sexuality in general. Although our findings show many examples that support earlier research on older adults' experiences with HP concerning sexual health issues, our participants' thoughts and accounts also give examples of agency and confidence in relation to their own sexual health. This sense of agency in combination with knowledge and competency to negotiate the subject of sexuality and one's personal rights seems to facilitate help-seeking by contributing to overcoming experienced barriers like insecurity about assumed ageist and sexist attitudes in HP. Also, the participants' lack of experiencing explicit negative attitudes from HP, in combination with expressions of general trust in the healthcare system, may function as a facilitating factor to our participants' intentions to seek help in the future. The

above outlines a possible shift in how sexuality and sexual health issues will be negotiated in clinical settings for the coming generations of older adults, independent of gender and sexual orientation. However, HP's attitudes, feelings of insecurity, or lack of knowledge will not be overcome by leaving the responsibility to the patient to initiate such discussions.

Our study has several limitations. Firstly, although we used purposive sampling to improve sample diversity on the dimension of sexual identity, the total sample is of course not representative of the population. The absolute majority of the participants belonged to the ethnic Norwegian middle class, with at least 3 years of higher education. Interviews could have brought forth more diverse experiences on the topic, had our sample been more varied both socio-economically and culturally. Secondly, self-selected samples in qualitative research are generally vulnerable to bias associated with the risk of exaggerating some findings. For example, Bogaert (1996) found that voluntary participants in sex research were more experienced and interested in sex and that they were more self-confident than the non-volunteers were. It is likely that the participants in our study generally held a more positive attitude toward sexuality or had more positive experiences than the average older person in the population. Further, the interview situation itself could also have triggered tendencies of impression management in both the interviewer and participants as part of negotiating the subject of sexuality during the interview (Braun & Clarke, 2013). Finally, it may also be that our participants saw themselves as generally more capable, and in control of their life than the average, explained by the suggested ideal or desire of presenting oneself as socially competent (Lyttkens, 1989) and by extension, as sexually competent. As such, more research is needed to determine whether the experiences in our findings represent a cohort or cultural shift or are the consequence of the above-outlined biases.

Recommendations

To ensure equal rights and quality of health care to all groups of patients we argue that it is

central that training, for all HP, independent of cultural background, be built on scientific, sex-positive, culturally informed and LHBT-friendly attitudes, grounded in WHO's understanding of, and recommendations on sexual health rights.

Our findings suggest that older adults would want HP to inquire about their sexuality in relation to health issues and that the GP is seen as the natural first point of inquiry. HP should be prepared for a future generation of older adults, who will most likely expect them to have updated knowledge on sexuality, aging, and health. In our findings that HPs' age seemed to be less of a challenge when HP initiated the subject or showed competency on the subject. To improve confidence in HP's ability to professionally handle the topic, more qualified information suited to the older adult's sexual health needs should be developed, communicated and implemented in training and educational programs for health care personnel.

Health institutions could contribute to reducing barriers by explicitly signaling an understanding of sexual health as relevant to older adults and different sexual orientations, through information on web pages and personnel at the clinic by actively addressing the issue. This will also target ageist and sexist attitudes in the population of older adults, in HP, and in society by communicating sexuality as a natural part of health. Ultimately, in anticipation of educational programs to integrate sexual health, making older patients more knowledgeable and competent concerning sexual health and promoting sexual rights would most likely improve sexual health and help-seeking (Barrett & Hinchliff, 2018). To achieve this, different tools of information adjusted to the needs of different groups of older adults should be developed. Currently, the use of Interactive Digital Interventions in health services has for example shown promising results (Hobbs et al., 2019), and some interventions have already been developed for older peoples' sexual health (see for example <http://www.agesexandyou.com>). Accessing these tools will depend on IT competence, opportunity, and physical and cognitive ability in the aging individual, which in turn emphasizes the continuous need for more traditional educational approaches.

In conclusion, this study contributes to the limited documentation on how older adults experience help-seeking in relation to sexual issues. Both HP and older patients may lack the knowledge and may harbor attitudes that do not promote communication about sexual health issues, although an increasing number of older Norwegian adults may have more proactive attitudes and behaviors regarding their sexual needs and rights. More research is needed to balance the possible biases in our findings by for example including interviews of older adults living in Norway with other cultural backgrounds. HP can help change stereotype attitudes to older adults' sexuality and overcome barriers to help-seeking by taking an active approach to the topic in clinical conversations. Training in sexual health should include older adults' sexual health challenges in addition to minority sensitive understandings of sexual health and rights.

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