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# Sexuality, sexual health and older people: A systematic review of research on the knowledge and attitudes of health professionals☆

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ABSTRACT

*Objectives:* Sexuality remains important to older people and should be recognised as an important part of their overall care. However, this appears to be poorly understood and addressed by many healthcare professionals. This systematic review reports on knowledge and attitudes of health professionals towards sexuality and sexual health of older people, including factors that impact knowledge and perceptions.
*Review methods and data sources:* The review, conducted using Joanna Briggs Institute methods, included 23 studies of varied methodology published between January 2004 and January 2015.
*Results:* Findings indicated that healthcare professionals often consider older people's sexuality as outside their scope of practice and there is lack of knowledge and confidence in this area. Cultural norms and taboos, length of time spent working with older people, familiarity with the older person, previous training and degree of exposure to people who are not heterosexual were all identified as factors that impact knowledge and attitude.
*Conclusions:* Better role modelling and education are needed to improve knowledge and attitudes toward later life sexuality.



## 1. Introduction

Sexuality, a concept that "encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction" (World Health Organization, 2006, p. 5) is recognised as a basic human need (Maslow, 1954; World Health Organization, 2006). Its ongoing expression throughout the lifespan into older age is increasingly acknowledged in the health literature (Bauer et al., 2009; DeLamater and Moorman, 2007) and research indicates that sexuality remains important to older people's wellbeing. Many older people are sexually active and report both physical and psychological benefits from engagement in sex (Bauer et al., 2012, 2015; Colton, 2007; Frankowski and Clark, 2009; Lichtenberg, 2014). Despite this evidence, ageist stereotypes that define older people as lacking sexual appeal and desire, and the taboo nature of sexuality in older people, continue to perpetuate in Western societies (Bauer et al., 2009; Hafford-Letchfield, 2008; Weeks, 2002; Yai and Hynie, 2011). Healthcare professionals are not distanced from the popular discourse, and sexuality and sexual health in older people are often given minimal attention in healthcare settings (Bauer et al., 2009; Colton, 2007; Hafford-Letchfield, 2008).

It is common for older people to experience sexual health concerns in isolation rather than initiate communication with healthcare professionals. Embarrassment, fear of dismissal and perceptions that the professional is uninterested or does not understand, all contribute to reluctance to raise sexual issues in a consultation (Bauer et al., 2012, 2015; Colton, 2007; Farrell and Belza, 2012; Gledhill and Schweitzer, 2014; Lichtenberg, 2014; O'Brien et al., 2011). Poor communication with health professionals may lead to neglect of problems and increased risk of sexually transmitted infections (Colton, 2007; Slinkard and Kazer, 2011). Some research also indicates that even when an older person raises sexual health concerns, only minimal information may be exchanged (Colton, 2007).

As the research indicates many older people experience barriers to initiating conversations, the onus is often on health professionals to initiate discussion of sexuality as a part of holistic care delivery. However, difficulties incorporating older people's sexuality into overall care appear to be universal across healthcare professions (Balami, 2011; Dogan et al., 2008; Gott et al., 2004; Hajjar and Kamel, 2003; Maes and Louis, 2011; Saunamäki et al., 2010).

Given the strong connection between sexuality and quality of life it is important to understand factors that influence its recognition by health professionals as a component of older people's healthcare. To date no comprehensive evidence base exists around knowledge and attitudes of healthcare professionals regarding sexuality of older people in healthcare settings. While a small body of recent reviews explores older people's sexuality (Benbow and Beeston, 2012; Deasey et al., 2014; Dyer and das Nair, 2013; Mahieu et al., 2011), none address the topic systematically or consider all types of healthcare worker. The aim of this systematic review was to present the most recent evidence on knowledge and attitudes of healthcare professionals and workers in

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all healthcare settings regarding sexuality and the sexual health of older people.

## 2. Methods

Searches were conducted in MEDLINE, CINAHL, ProQuest, Google Scholar, Cochrane database, EMBASE, Web of Science, Science Direct, Ageline, CABI and J-GATE using the following search terms: sexual*, aged, ageing/aging, attitudes, knowledge, care. Studies reporting participants working with people aged over 65 years in any healthcare setting were eligible. Outcome measures were knowledge levels and attitudes of health professionals regarding sexuality/sexual health of older people. Early research in this area was extensively dated so we limited inclusion to studies published in English between January 2004 and January 2015. Quantitative and qualitative research and opinion papers offering unique commentary (i.e. information that did not emerge in research) were eligible. Reviews, news articles and conference abstracts were excluded.

Papers eligible based on title/abstract were critically appraised by two independent reviewers (EH and MB). Studies were appraised using the suite of critical appraisal tools developed by the Joanna Briggs Institute (JBI) and standardised JBI data extraction tools were used.

### 2.1. Quantitative Evidence

No eligible randomised controlled trials (RCTs) or pseudo-RCTs were identified. The JBI appraisal tool for descriptive and case series research considers randomisation, inclusion criteria, confounding factors, reliability of outcome measurement, appropriate analysis and description of withdrawals (Joanna Briggs Institute, 2014a). The JBI appraisal system considers evidence arising from descriptive observational studies to have a starting level of low quality, with quality downgraded in the case of high risk of bias, inconsistency, indirectness of evidence, imprecision or publication bias (Joanna Briggs Institute, 2014b). Quality of evidence may be upgraded in intervention trials where effectiveness is large (Joanna Briggs Institute, 2014b). The quantitative findings were not appropriate for meta-analysis due to heterogeneous populations and outcome measures and results are reported in narrative summary.

### 2.2. Qualitative Evidence

For interpretive and critical research, the appraisal considered congruity between philosophical perspective, research methodology, methods and analysis; reflexivity; representation of participant voices; ethics and conclusion logically arises from data (Joanna Briggs Institute). The JBI appraisal system considers qualitative research to provide a default level of high dependability and textual/opinion resources to provide low dependability (Joanna Briggs Institute, 2014b). Dependability of qualitative evidence may be downgraded when there is incongruity between research methodology and the research question, objectives, data collection or data analysis or when reflexivity is lacking (Joanna Briggs Institute, 2014b). No textual or opinion papers met inclusion criteria for the review.

Qualitative studies were analysed using methods described by JBI (Joanna Briggs Institute, 2014a) to identify themes, concepts and meanings within the research. Primary findings, together with illustrative direct quotes from the text were identified and assigned a level of credibility using the JBI scale of unequivocal (beyond reasonable doubt), credible (open to challenge) and unsupported (not supported by data). Findings were compiled into categories based on similarity in meaning and categories were meta-aggregated into syntheses.

## 3. Included Studies

The Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) flow diagram (Moher et al., 2009) is presented in Fig. 1. Initial searches identified 999 potentially relevant studies. After screening of title/abstract, 231 studies were flagged, and this was reduced to 148 after exclusion of papers published before 2004. Following full review of manuscripts, 125 papers that did not meet the review objective or the inclusion criteria were excluded (see Appendix 1 supporting material table). Critical appraisal was conducted on the 23 papers (15 quantitative and 8 qualitative) that met inclusion criteria.

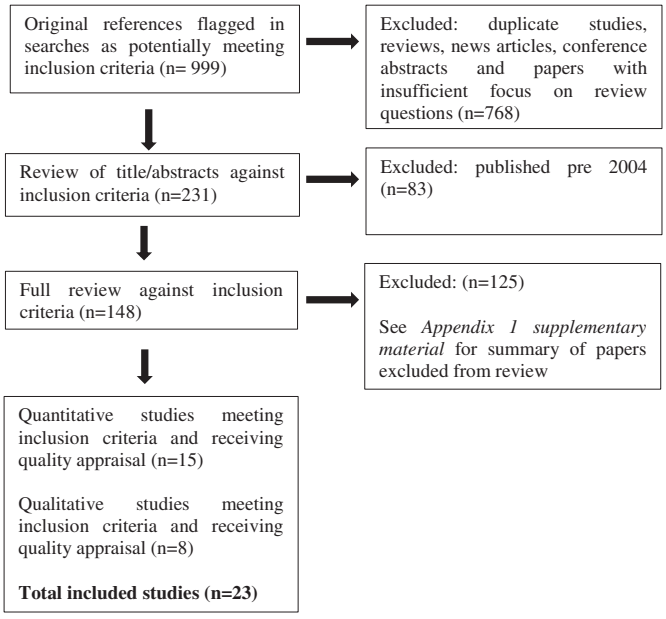


**Fig. 1.** PRISMA review flow.

## 4. Results

### 4.1. Quantitative Findings

Of the 15 quantitative studies, 14 were cross-sectional surveys and one is used as an observational pre-test/post-test design (Bauer et al., 2013). All quantitative studies provided evidence of low or very low quality due to risks of bias, including self-selected samples (often without clearly defined inclusion criteria); poor description of comparative groups; and non-validated data collection tools. Table 1 summarises included quantitative studies.

#### 4.1.1. Health Professional and Care Staff Knowledge of Sexuality and Older People

One study provided evidence supporting the notion that the healthcare professional's knowledge of sexual health influences the quality of care delivered to older people. Maes and Louis (2011) reported a moderate positive correlation between nurse practitioner ($n = 100$) knowledge of HIV/AIDs in older people and taking a sexual history ($r = 0.61$, $p = 0.00$). In the same study there was a strong correlation between knowledge, comfort in taking a sexual history and perceiving barriers to taking a sexual history ($r = 0.73$, $p = 0.00$).

Most quantitative studies (Di Napoli et al., 2013; Dogan et al., 2008; Helmes and Chapman, 2012; Langer-Most and Langer, 2010; Snyder and Zweig, 2010) used the Aging Sexual Knowledge and Attitudes Survey (ASKAS) to measure knowledge of staff with respect to sexuality of older people. This 61-item tool was designed to measure knowledge specific to sexual health, response and performance of older people, as well as general attitudes towards older people's sexual activity. The knowledge subscale consists of 35 true/false items. When scored as designed, possible scores range from 35 to 105 with lower scores indicating higher knowledge (Beere, 1990; Snyder and Zweig, 2010). The ASKAS knowledge sub-scale has been previously validated in aged