Patient–Provider Communication About Sexual Health Among Unmarried Middle-aged and Older Women

Mary C. Politi, PhD.[1]*, Melissa A. Clark, PhD*[2]*, Gene Armstrong, BA*[2]*, Kelly A. McGarry, MD*[3]*, and Christopher N. Sciamanna, MD, MPH*[4]

[1]Centers for Behavioral and Preventive Medicine, The Miriam Hospital, Brown Medical School, Providence, RI, USA; [2]Department of Community Health and Center for Gerontology and Health Care Research, Brown University, Providence, RI, USA; [3]Division of General Internal Medicine, Brown Medical School and Rhode Island Hospital, Providence, RI, USA; [4]Division of General Internal Medicine and Public Health Sciences, Penn State College of Medicine, Hershey, PA, USA.

BACKGROUND: Although past studies have highlighted the importance of patient–provider communication about sexual health and intimate relationships (SHIR), much of the research has focused on young women's or married women's experiences when discussing SHIR with their providers.

OBJECTIVE: To describe experiences of unmarried, middle-aged and older women in communicating about SHIR with their health care providers.

DESIGN AND PARTICIPANTS: Qualitative interviews were conducted with 40 unmarried women aged 40–75 years. We compared the responses of 19 sexual minority (lesbian and bisexual) women and 21 heterosexual women.

RESULTS: Women varied in their definitions of intimate relationships. Not all women thought providers should ask about SHIR unless questions were directly related to a health problem, and most were not satisfied with questions about SHIR on medical intake forms. However, the themes women considered to be important in communication about SHIR were remarkably consistent across subgroups (e.g. previously married or never married; sexual minority or heterosexual). Sexual minority women were more hesitant to share information about SHIR because they had had prior negative experiences when disclosing their sexual orientation or perceived that clinicians were not informed about relevant issues.

CONCLUSIONS: Some women felt that providers should ask about SHIR only if questions relate to an associated health problem (e.g. sexually transmitted infection). When providers do ask questions about SHIR, they should do so in ways that can be answered by all women regardless of partnering status, and follow questions with non-judgmental discussions.

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INTRODUCTION

Patient-provider communication impacts patients' satisfaction, quality of care, and health[1–6]. Discussing sexual history with patients is an important part of a physical and emotional health assessment[7–9]. Communication about sexual history may impact patients' screening behaviors[10], willingness to disclose personal relevant health information[11], and overall relationship with their provider[s11]. However, providers frequently do not directly ask about sexual health[7,12–14] because of time constraints, their discomfort level with the topic[15,16], and perceptions of patient discomfort disclosing this information[12,17].

Communicating with providers about sexual health may be particularly difficult for older women. Although studies are limited, data indicate that older adults value sexuality and engage in sexual activity[18–20]. However, they are often perceived to be asexual, sexually inactive, or in exclusively monogamous relationships[20,21]. Providers have also reported fear of offending older women if they approach sexual health issues during the medical consult[16]. Thus many older women have reported experiencing sexual health issues that they have not discussed with a clinician[20,21]. Improving patient–provider communication about sexual health for older adults warrants further research[16,22–25].

Older unmarried women may face additional barriers to discussing sexual health with providers. Medical history forms commonly used in clinic settings often require women to define their marital status in standard categories of married, divorced, widowed, or single/never married. Using only legally defined categories limits the ability to collect information about women's broader social context. Although the purpose of these history forms is often to gather background information on patients, the forms are the first interaction patients have with new providers and may leave patients feeling ostracized and unwilling to share personal information with their providers. We previously found that regardless of partner preference, unmarried older women may feel frustrated with the inability to provide health care providers with an accurate description

of their intimate relationships and their support systems on standard medical history forms[11].

Additionally, past studies have identified significant barriers between providers and sexual minority women when discussing sexual health[14,26–28]. Some sexual minority women have reported that they did not disclose their sexual orientation to a physician because of perceived or real experiences of rejection and disrespect[29–31]. Many of these studies included only younger populations; there is limited information about middle-aged and older women.

We previously noted[11] that unmarried women 40–75 years often used the phrase "personal information" when referring to discussions with providers about sexuality, sexual history, and intimate relationships. They also reported varied definitions of "intimate relationships." The terminology used by unmarried, middle-aged and older women about sexual history and intimate relationships may provide useful information for providers in the initiation of these topics.

Although previous studies have highlighted the importance of patient–provider communication about sexual health, much of the research has focused on young women's or married women's experiences when discussing SHIR with their providers. We conducted qualitative interviews with unmarried, middle-aged and older women to explore: (1) What women considered to be "personal information" shared with providers; (2) The extent to which women thought providers should ask about sexual health; (3) The reasons women chose to disclose or not disclose information about sexual health to a provider; and (4) Perceptions of medical intake forms as a means of communicating about sexual health.

METHODS

Study Eligibility

Women were eligible to participate if they were not currently legally married, were between the ages of 40 and 75 years, received the majority of their health care in Rhode Island, and had never been diagnosed with cancer other than non-melanoma skin cancer. These eligibility criteria were based on a larger study of unmarried women's experiences with health care in general and cancer screenings in particular. In the screening protocol, women were asked their current marital status, the gender of a current partner, or gender choice of a future partner if they were not currently in a relationship. We used purposive sampling to ensure equal proportions by partner gender and marital status. Eligible women were assigned to one of four strata: (a) never married women who partner with women [WPW] or with either women or men [WPWM]; (b) previously married WPW and WPWM; (c) never married women who partner with men [WPM]; or (d) previously married WPM. WPW and WPWM were combined for all analyses because larger scale studies[32,33] have documented similarities in use of, and experiences with, health care between lesbians and bisexual women. The Brown University Institutional Review Board approved the study protocol.

Data Collection and Analysis

To facilitate recruitment, members of the research team met with key community leaders (for details about community leader participation, see Clark et al,[11]). Using information from these leaders, a recruitment coordinator met with social groups (e.g., dinner clubs, garden clubs, sports teams) and community organizations (e.g., churches, senior centers, YWCA) and attended health fairs. One-on-one interviews were conducted in the Summer and Fall of 2002 at locations designated by the participants. The interviews lasted an average of 60 to 90 minutes. Prior to the start of each interview, women were asked to complete a one-page background questionnaire. Each participant was paid $20 at the end of the interview.

We developed detailed interview guides to help structure participants' responses and facilitate analyses. An experienced interviewer conducted the interviews. All interviews were audio-taped with participants' signed consent.

The data were analyzed in a sequential process. The interviews were transcribed and two analysts reviewed and coded the data. Responses were examined for emerging themes and dominant trends across interviews. Discrepancies in respondent's answers to similar items were examined. Answers to each item were summarized. Finally, themes and trends were compared within and across each marital status and partner gender stratum.

RESULTS

Study Participants

A total of 40 women agreed to participate (19 WPW and 21 WPM). An additional five women were screened for eligibility but declined participation (due to lack of interest or scheduling conflicts). Three of the five eligible non-participants were WPW. The average age of non-participants was 47.6 years. As shown in Table 1, participants had a mean age of 55 years (range 40–75 years) and were predominately White (98%). Most were educated (73% had a college degree or postgraduate degree), employed (68%), and had health insurance (90%). WPW were more educated than WPM (90% vs. 57% had a college degree or postgraduate degree). WPM were more likely than WPW to live alone (62% vs. 42%) and have children (62% vs. 32%).

Themes

Theme 1: **Middle-aged and older unmarried women vary widely in their definitions of "personal information" and "intimate relationships."**

We specifically asked women to define what they considered "personal information." Almost half of the respondents provided answers that reflected sexuality. Other responses varied widely, but did not differ by partner gender or marital status. The range of responses is exemplified by definitions of personal information provided by the following participants:

Never married WPW: "*Medical problems that I might be experiencing that I wouldn't just share in general conversation…[or] mixed company conversation.*"

Previously married WPM: *"I think personal information is anything past my name, address, and phone number. Anything else is pretty much my choice to share or withhold."*

Never married WPW: *"…personal history, family history, sexual orientation. Probably health habits… like how much sleep do you get, and smoking, drinking…"*

Table 1. Participant Characteristics

	Total Sample (N=40)	WPW* (N=19)	WPM* (N=21)
Age in years (mean)	55.0 (SD 9.75)	54.4 (SD 7.59)	55.5 (SD 11.54)
Marital status			
Never married	16 (40.0%)	11 (57.9%)	5 (23.8%)
Previously married (widowed, divorced, legally separated)	24 (60.0%)	8 (42.1%)	16 (76.2%)
Level of formal education			
High school, some college, or technical training	11 (27.5%)	2 (10.5%)	9 (42.9%)
College degree or more	29 (72.5%)	17 (89.5%)	12 (57.1%)
Working full-time or part-time			
Yes	27 (67.5%)	14 (73.7%)	13 (61.9%)
No	13 (32.5%)	5 (26.3%)	7 (38.1%)
Insurance Status			
Insured	36 (90.0%)	18 (94.7%)	18 (85.7%)
Uninsured	4 (10.0%)	1 (5.3%)	3 (14.3%)
Living Arrangement			
Alone	19 (47.5%)	6 (31.6%)	13 (61.9%)
With a Partner	15 (37.5%)	11 (57.9%)	4 (19.0%)
Other	6 (15.0%)	2 (10.5%)	4 (19.0%)
Children Birthed			
0	21 (52.5%)	13 (68.4%)	8 (38.1%)
1 or more	19 (48.5%)	6 (31.6%)	13 (61.9%)
Race			
White, Not Hispanic	39 (97.5%)	19 (100%)	20 (95.2%)
Black, Not Hispanic	1 (2.5%)	0 (0%)	1 (4.8%)

**WPW = Women who partner with women; WPM = Women who partner with men*

Never married WPM: *"...if I am living with someone, or if I have a sexual partner."*

We also asked women for their definition of an intimate relationship. Participants provided a range of responses that did not always include sexual behaviors. For instance, participants' definitions ranged from "your primary sexual relationship," to "your primary emotional relationship," "your partner," or "the person who is important when making health decisions."

Theme 2: **Not all middle-aged and older unmarried women think primary care providers should ask about sexual history.**

Women varied in their beliefs about whether questions about sexual history are an appropriate part of a health evaluation. Responses did not differ by partner gender or marital status. Several women commented on the importance of acknowledging intimate relationships as part of an individual's overall health, as indicated by the following participants:

Never married WPW: "*They (clinicians) should ask everyone about relationships...because they have a strong influence on your physical health.*"

Previously married WPM: *"Many of the concerns are about STDs and the transfer of AIDS."*

Some of these women reported that they had never discussed sexual history with a PCP, and wished their PCP would raise the topic. A common response was represented by a Never Married WPM: *I think it [discussing sexual history] is important, but I wouldn't approach it on my own."*

In contrast, many other women did not think that sexual history should be discussed with a PCP unless they were experiencing an associated health problem (e.g., symptoms of a sexually transmitted infection). This is reflected in comments by the following participants:

Never married WPW: "*It would only be important if a problem was discovered. Things come to mind like if I had chronic urinary tract infection. Maybe psychologically if I lived alone and had any depressive symptoms.*"

Never married WPM: "*Not out of the blue, a doctor should ask you a question in that area, if he had no real reason to. If he had a reason to, if he suspects you got a STD, then that's a whole different ballgame.*"

Women who reported receiving care from a gynecologist tended to feel more comfortable discussing sexual health issues with a gynecologist rather than a PCP, as illustrated by the following participants:

Previously married WPM: *"OB/Gyn issues, if they happen to interfere with my diabetes management, I'll bring it up with my primary care physician. For the most part, I like to focus on OB/Gyn issues, gynecological issues, with my OB/Gyn."*

Previously married WPM: *"I think a gynecologist needs to know more intimate details about you."*

Theme 3: **Unmarried women are more likely to disclose information about sexual health if they perceive that the clinician does not make assumptions and appears non-judgmental.**

When asked how they decide whether to disclose information about sexual health, women described the importance of non-judgmental, non-assuming language and behaviors by clinicians. An example of a positive experience was described by a previously married WPM in a discussion about a new sexual relationship:

> "When I was about to embark on a new relationship and had not been sexually active yet, I wanted an HIV test, just wanted a clean bill of health before I embarked on this. He [physician] was wonderful, he did the test. He knew that I had a hysterectomy so he knew birth control was not a problem but he suggested I still use a condom even though I came up clean on the test. It was comfortable and not judgmental, very easy."

On the other hand, women described experiences that negatively influenced their willingness to disclose information. These experiences were more common among WPW, and are exemplified by the following participants:

Previously married WPW regarding her first discussion with a provider about sexual history: *"He gave me a little lecture and told me if I wanted information about the male genital machines and tools he'd be happy to show me...I was angry and embarrassed."*

Never married WPW: "*I've mentioned the fact that I haven't had sexual relations with men. I've mentioned that but I haven't gone into any detail other than that. I get the impression that there was an assumption of heterosexuality...It's kind of annoying and humiliating to have to explain—don't be pushing birth control on me or don't be making assumptions.*"

In addition, some WPW indicated that they were hesitant to share information because they perceived that clinicians are not informed about issues relevant to them as illustrated by the following participants:

Previously married WPW: "*When I said I was a lesbian, they put down 'No sex'. If they think I don't have sex then they probably think I'm not at risk for HIV. These are medical doctors, they should know better.*"

Never married WPW: *"They don't necessarily ask that question. But if they do, they don't necessarily know what to do with it once they ask it. I had one primary care doctor who asked, who I had told that I was a lesbian, and then he started talking about AIDS, which was a weird thing to me."*

Never married WPW: *"I've run up against a number of prejudiced physicians that didn't really want to know that I didn't live in a regular, what they would call normal, relationship...but I want them to be able to talk to the woman that I live with if there's any problem that they think she needs to know about."*

Theme 4: **Unmarried women reported feeling more comfortable talking to female providers than male providers about sexual health.**

Although we did not specifically ask about provider gender, many women commented on the gender of their physician when discussing sexual health and intimate relationships. Those who mentioned provider gender reported feeling more comfortable communicating about sexual health and intimate relationships with both female PCPs and gynecologists than with male providers:

Previously married WPM: "*The doctor never even asked me 'Do you live alone, do you live with someone else.' I think another factor is it's a male doctor[PCP] that I have and I'm a female and I guess sometimes they do shy away from topics such as sexuality because of the fear of, you know. And there's no medical assistant or nurse present...*"

Never married WPW: "I think her gender has a lot to do with it. If I went to a male gynecologist, I might not be as comfortable."

Never married WPW: "I have a male gynecologist. I have never felt comfortable being honest with him about my relationships although he has probably made assumptions over the years...Probably if I went to a woman I would feel more comfortable sharing all that."

Many WPW reported seeking female providers for most of their medical care because they feel more comfortable talking to female providers, including when discussing sexuality and sexual health:

Previously married WPW: "Eventually, I was able to say 'I'm gay' [to my PCP] and I think what made me comfortable was that she is a woman doctor. All my doctors now are women except for my dentist."

Theme 5: **Women's attitudes about medical intake forms as a means of communication about sexual health range from neutral to negative.**

Although some women did not remember specifics of recently completed forms, the majority of women interpreted the completion of a medical intake form as a means of beginning communication about sexual health. About one-third of women who remembered details about the form expressed neutral attitudes such as those of a previously married WPW, "*It seemed all right. A lot cursory, but I figured it was a good place to start.*"

Other women, particularly WPW with more negative attitudes about the form, commented on the lack of questions relevant to women who were not in a sexual relationship with a man. This is illustrated by the following participants:

Never married WPW: *"I thought it [intake form] was medically thorough but not socially thorough."*

Previously married WPW: "*It was like filling out a driver's license form. There was no intimate piece. It was more like a legal document. Maybe it was used for the doctor to cover any health insurance issues. There was no area where I could write in or mark what my relationship was or sexual history was.*"

Some women also expressed concern about providing information in writing about their intimate relationships.

Previously married WPM: *"Recently, I had my appointment with [doctor] and I thought that the questions [on the form] were rather unnecessary and a little bit prying. I mean a lot of questions that really I didn't see any reason about inquiring about these things."*

DISCUSSION

The U.S. Census Bureau reported that there were over 28 million unmarried middle-aged and older women living in the U.S. in 2007[34]. Providers may have increasing numbers of unmarried, middle-aged and older women as patients[34]. Our data illustrate important issues for these unmarried women in patient–provider communication about sexuality and sexual health, as well as perceived barriers to such communication including providers' assumptions that unmarried, older women are asexual, sexually inactive, or in exclusively heterosexual, monogamous relationships. Findings can be used to improve research and medical education about taking a sexual health history among these women[8,35], which may in turn enhance patients' willingness to discuss relevant health information.

There was heterogeneity of experiences among both WPW and WPM with patient–provider discussions about sexual health. Some women believed that providers should ask about sexual history only if they are experiencing an associated health problem. Similar to Nusbaum and colleagues[35], we found that most women felt that having the physician initiate the discussion about sexual health when relevant would make the conversations easier for them.

Many WPW and WPM reported feeling more comfortable discussing sexual health with a gynecologist than with a PCP. This hesitancy by some women in disclosing information to PCPs is consistent with the variability in women's comfort with topics considered "personal." Therefore, prior to obtaining a sexual history, primary care providers should explain the reason for asking questions about sexual health.

Women reported being more likely to disclose information about sexual health if providers did not make assumptions and appeared non-judgmental. Our data provide several examples of positive experiences women had with providers. However, other women reported negative experiences that influenced their willingness to disclose information about sexual health. These experiences were more common among WPW than WPM. For instance, consistent with previous studies[12,26,29], WPW reported experiences with providers who

assumed that they were heterosexual. This was particularly relevant for women who reported to providers that they were "not sexually active with a man," but were involved in an intimate relationship. Similar to other studies[7,10,11,35], we found that women who disclose information about sexual health want providers to acknowledge the disclosure and integrate it into their medical histories.

Women also reported feeling more comfortable discussing sexual health and intimate relationships with female providers than with male providers. Although there is some research indicating that gender concordance between patients and providers is not related to overall communication (e.g.[36]), there may be additional communication barriers between male providers and female patients when discussing sexuality and sexual health. For instance, past studies have found that male providers are less comfortable than female providers taking a sexual history and performing breast and gynecological exams with their female patients (e.g.[37,38]). Barriers to communication may be heightened when discussing sexual health and intimate relationships with sexual minority patients; WPW in our study reported a strong preference for female providers because of perceived difficulties communicating about sexuality with male physicians. Male providers should be aware of both patients' and their own potential discomfort and should remain sensitive to discussions about sexual health.

Women varied from neutral to negative in their attitudes about medical intake forms as a method of communicating about sexual health, and WPW appeared to have stronger negative reactions against the forms. Most women regardless of partner gender interpreted medical intake forms as ways to beginning communication about sexual health. Clinicians often use these forms to gather background information rather than as a substitute for communication about relevant topics. However, clinicians should consider why they are asking for particular information related to sexual health and relationships on medical intake forms given the difficulty described by women in accurately describing their sexual history and intimate relationships using these forms. If written information is deemed necessary prior to a verbal history, questions should be phrased in ways that allow inclusion of all women regardless of partner gender or partner status. Questions about sexual behaviors and physically- and emotionally-supportive relationships should be included in addition to marital status. As an example of how this could be accomplished, the phrases 'romantic, intimate, or sexual partner' have been used to assess relationship status in recent surveys of sexuality and health[39].

Although there have been several previous studies that have addressed patient–provider communication among sexual minority women, we specifically recruited both WPW and WPM to examine potential issues unique to heterosexual or sexual minority women. We found that WPW had stronger negative reactions to medical intake forms. They were also more hesitant to share information about sexual health because of prior negative experiences disclosing information to providers. In general, however, the themes that emerged were remarkably consistent across sexual orientation subgroups. Therefore, the challenges of communicating about SHIR we identified in this study are not limited to sexual minority women.

We did not find differences in participants' responses by marital status (never married or previously married). Providers' communication about sexual health and women's perceptions of their comfort with the topic may be similar among older unmarried women, regardless of marital status history. Past literature on unmarried women's experiences has focused primarily on younger, unmarried women. Future, larger studies could explore whether past marital status impacts patient–provider communication about sexual health among older, unmarried women.

There are several limitations to this study. Although we had a larger sample than often used for in-depth qualitative interviewing, it was a small, nonrandom, convenience sample. Additionally, although efforts were made to increase minority participation, only limited success was achieved in recruiting non-White women. To our knowledge, there are no studies looking specifically at patient–provider communication of sexual health among non-White women. However, there is some evidence from clinical settings to suggest that patients' race and ethnicity may impact the amount and quality of communication from providers[40]. Our results may not capture unique views of non-White women about patient–provider communication of sexual history.

Despite these limitations, our findings have important implications for medical education. Some women felt that providers should ask about SHIR only if questions relate to an associated health problem (e.g. sexually transmitted infection). When providers do ask questions about SHIR, they should explain their rationale for asking these questions, ask questions in ways that can be answered by all women regardless of partnering status, and follow questions with non-judgmental discussions. Women also varied in their definitions of "personal information" and "intimate relationships." Given this variation, providers should be mindful of how questions about SHIR are phrased since terms may not have the same meaning for all women. Questions using open-ended language may allow women to discuss SHIR using their own terminology. Providers can then use the terms women provide to guide their subsequent responses and discussions.

Medical curricula and continuing medical education programs should include competency-based skills training for taking a sexual history and responding to information about SHIR when it is disclosed. Skills training such as those suggested by Haist and colleagues[41] or FitzGerald and colleagues[42] that is inclusive of unmarried middle-aged and older women's needs may provide useful guidelines for these programs. Given women's broad definition of "personal information," providers may face similar barriers when discussing other sensitive topics such as unhealthy behaviors. Thus suggestions from Epstein and colleagues[43] such as encouraging physicians to become more aware of their internal reactions when inquiring about sensitive topics, negotiating awkward moments when information is disclosed, clarifying unclear language, and attending to the patient's fears and expectations are also applicable. Future studies can build on these findings by investigating the relationship between improved sexual history-taking skills and patients' reported comfort with their providers, satisfaction with treatment, adherence to medical guidelines, and health outcomes among both unmarried and married women.

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Corresponding Author: *Mary C. Politi, PhD; Centers for Behavioral and Preventive Medicine, The Miriam Hospital, Brown Medical School, CORO Building, Suite 500, One Hoppin St, Providence, RI 02903, USA (e-mail: Mary_Politi@Brown.edu).*

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