The last taboo? Exploring clinical psychologists' attitudes towards older adult sexuality

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Contents

Abstract

Aims: To explore the experiences of trainee clinical psychologists and clinical psychologists who have qualified in the last 5 years of talking to older adult about sex, sexual health and sexuality. This thesis will explore (1) The training neophyte clinical psychologists received concerning sexual health through their programme of study and through clinical practice (2) How neophyte clinical psychologists have found exploring and addressing sexual health through their clinical practice and as part of a multi-disciplinary team (3) Adaptions made to case formulation as a result of sexual health issues being raised (4) The modalities favoured by the clinician to formulate and use therapeutically (5) The impact this has on their ability to integrate sexual health issues into both formulations and their clinical practice

Background: It is unclear the level of consideration that is given to older adult sex, sexual health and sexuality by clinical psychologists and on clinical psychology doctorate courses. This may impact how often trainee and clinical psychologists consider and discuss the sex lives of older adults. Healthcare professionals have been shown to struggle to know what their role is when discussing sex with the older adult population. However, there is limited research exploring topic with newly qualified clinical psychologists and trainee clinical psychologists in the United Kingdom.

Methodology: A reflexive thematic analysis design was used to explore and analyse 15 semi-structured interviews of trainee and qualified clinical psychologists on their experiences of speaking about sex, sexual health and sexuality with older adults in a clinical setting. MDT discussions, supervision and training will also be considered.

Results: The reflexive thematic analysis identified four main themes and 23 sub themes from the interviews: (1) Who am I and who are you? (2) I am a psychologist I should

know what to do (3) How can we possibly talk about this? (4) You shouldn't be having or talking about sex.

Conclusion: The themes that have been identified in this project highlight the different barriers clinicians face when exploring sex, sexual health and sexuality with older adults. Barriers were felt to include their own and the client's background and the personal views around sex and cultural factors and how this interacts and conflicts between clinicians' personal and cultural views of sex. The service clinicians work in and the views of their supervisor can also alter the ease with which they broach the topic, as can the quality and time training clinicians received on the topic.

Chapter One: Introduction

Let's talk about sex for now

To the people at home or in the crowd

It keeps coming up anyhow

Don't be coy, avoid, or make void the topic

Cuz that ain't gonna stop it

Now we talk about sex on the radio and video shows

(Salt-N- Pepa, Lets Talk about Sex)

Chapter Overview

The World Health Organisation (WHO) defines sexual health as not just the absence of disease and dysfunction but rather a curiosity and positive outlook on sex, sexuality and relationships (2024). The topic of sexual health and wellbeing is broad ranging and can cover many areas and topics such as infection control and treatment, contraception, impotence, menopause, sexuality, sexual dysfunction and reproduction. It is also a topic that is polarising and carries with it stigma and shame. This chapter will consider the sexuality, sex lives and experiences the older adults of today have lived through and how this may impact them and their experiences of exploring the topic of sex.

This chapter will begin by discussing who will be included in the current study as ‘older adults’, whilst this term is subjective to the group using the term ‘older adult’. The historical factors that influence this group of people will also be discussed to understand where the stigma and shame surrounding older adults and sex and sexual health stems from. This chapter will also include a systematic review exploring older adults’ experiences of

talking about sex and sexual health with health care professionals to understand from the service user's perspective what barriers may be preventing older adults reaching out for support. The review will include studies from across the world, however this thesis will be exploring the difficulties health care professionals experience talking to older adults about sex in the United Kingdom (UK). The systematic review will be used to develop the thesis' research aims which will be discussed at the conclusion of this chapter.

Who are older adults?

Due to long-term increases in the average UK life expectancy, it is estimated that there are over 11 million older adults over the age of 65 years old and in ten years it is thought that there will be 13 million people in the UK over the age of 65. This would mean that 22% of the UK's population will be considered an older adult in the next ten years (Centre for Ageing Better, 2024). Yet whilst the population is ageing and older adults are dating (Laidlaw, 2013) guidance and awareness about older adult health is still under researched and underexplored (Allin et al., 2006; National Institute for Health and Care Excellence, NICE, 2020; Westwood et al., 2020). The Marmot report 10 Years On (2020) revealed that in deprived areas life expectancy has been shown to decrease. Highlighting that inequalities can impact a women's life expectancy.

It is important to begin by considering the social constructivism position that individuals learn and make sense of their surroundings through knowledge of their social environment (Willig, 2012). Therefore, the concept of an 'older adult' is a label used to discuss the older members of society but there is not a clear definition of who fits into this group and who does not. The life expectancy in the UK has increased over the last forty years and is predicted to continue to increase (Public Health England, 2018). The people in the UK in 2023 lead longer and healthier lives than they did 100 years ago (Centre for Ageing Better,

2024; Public Health England, 2018) meaning that the term ‘older adult’ applies to a different group of adults than it previously did.

To understand what they may think of an older adult then sources such as the NHS who think older adults are those over 65 (NHS, 2024) and the WHO who consider older adults to be those over 60 years old (WHO, 2019). People can retire and live happy, healthy, and active lives when once the life expectancy after retirement was short (Laidlaw, 2013). The idea of an ‘older adult’ is also influenced by the cultural context and differing factors that can impact how an individual ages (Foley, 2015; Schick et al., 2010). It has been decided that this thesis will conceptualise ‘old age’ and ‘older adults’ in social constructivism rather than chronological terms meaning that this thesis will not be defining what an ‘older adult’ is to the clinicians that take part in this study as the impact of working with older clients whom they think of as older adults is important in the richness of the data it will bring.

Sexual Health History: where it all started

Some researchers believe that views around sex and sexuality are a social construct that develop throughout history through cultural views informed by patriarchal societies and religion (Ahmadi, 2003). To ensure that the experiences of all older adults living in the UK were held in mind the political and historical shifts of the last 120 years were considered. School education impacts our views on the world and what is thought to be ‘right and wrong’ in the way people behave, in line with social norms. The aims of sex education in schools now are to inform all children regardless of gender what different bodies are like and how they are impacted by puberty. Education also includes information about the mechanics of sexual intercourse and how to stop the spread of Sexually Transmitted Infections (STI’s) (Department of Education, 2021).

It feels imperative to consider the syllabus now to understand the evolution over the

last 100 years, and therefore how naïve young people previously were. Older adults' experiences, and their parents' experiences of 'sex education' meant around puberty they received a lecture on the biology of their own body and how to maintain personal hygiene (Pilcher, 2005). A view was held that children were both too innocent to learn about sex and yet too easily corruptible. Therefore, educators were discouraged from the inclusion of a more comprehensive syllabus on sexual health. In 1914 the Board of Education highlighted the importance of parents educating their children about sex (Hall, 2004).

It should be noted that during this period the First World War was being fought which led to concerns about STI levels increasing. By the end of war in 1918 attitudes had relaxed slightly (Pilcher, 2005) and by the Second World War a survey revealed that in England half the schools provided sex education. The Board of Education felt it would be more appropriate for education around sex to be linked to biology and reproduction so that it did not draw more attention (Board of Education, 1943). Teachers were not educated on the topic which meant that they had to rely on their own experience or religious beliefs (History of Education Society, 2020). This meant that education was focussed on how animals reproduced not humans whilst failing to make the link between menstruation and pregnancy and parenthood (Pilcher, 2005). It was not until the late 1960s that the Department of Education acknowledged that young adolescents may be shocked and scared by the onset of puberty and the impact this has on their bodies (Department of Education, 1968). Pilcher (2005) stated that in the 1950s and 1960s there was an increase in the pressure put upon schools to provide sex education with the responsibility placed on head teachers, however sex education remained sparse and was often provided by medical professionals and clergymen. Clergymen promoted the view that abstinence was the best form of contraception and there should not be any sex before marriage.

Sex before marriage

In the early 20th century, there was stigma surrounding sex before marriage and sexually 'promiscuous' women. E. M Chandler (2022) explained how in the 1970s she was struck by the change in the cultural view amongst teenage girls compared with her own experience as a teenager 'everyone knew that sex outside marriage was wicked', and young people now had 'the freedom to move lightly into intense sexual experience'. The stigma that had been seen in the UK surrounding sex outside of marriage suggested that women would be judged and viewed by society as not 'respectable' (Charnock, 2020). In the early half of the 20th century sex was viewed to be very private between a husband and wife with little discussion or information shared (Charnock, 2020). Views on sexuality, and often women's sexuality being judged stems from patriarchal origins that sex is embarrassing a shameful act that should not be acknowledged (Kasif & Band-Winterstein, 2017).

The strength of the belief that sex before or outside of marriage is 'bad' and should be feared is somewhat shaped by cultural influences. The cultural context that individuals grow up in and continue to live in can influence and alter their actions, or the shame they feel if they do not adhere to how they believe they should be acting to fit in with the cultural beliefs of those around them (Adamczyk & Hayes, 2012). The cultural beliefs surrounding sex have left many people believing that they should not be having sex before they are married or outside of marriage, even if they have previously been married and are now widowed or divorced. This belief can lead to sex being thought of as sinful and something that should not be discussed with other people.

The stigma around sex can be linked but is not exclusive to concerns surrounding falling pregnant outside of marriage and being labelled an 'unmarried mother'. During the

period of 1920-1970s some women were admitted to unmarried mothers' homes or 'Mother and baby' homes which were run by nuns.

Mother and baby homes

In the last 20 years mother and baby homes have been publicised through the news, with retrospective apologies being made to families and the damage they caused (Fronek & Cuthbert, 2013). Mother and baby homes or Magdalene laundries were first opened in 1767 and are infamous for being the place, particularly in Ireland, where young women who were viewed as 'promiscuous', pregnant outside of marriage or involved in prostitution were sent (Clarke, 2021).

In the mother and baby home there was a high mortality rate for mothers and infants with some individuals spending years living in terrible conditions, receiving limited medical care during pregnancy and birth (Garrett, 2017). In the mid-1900s homes were founded to house unmarried pregnant women; women who arrived at these homes were at times sent there due to the shame their families felt about them becoming pregnant, while others were sent there due to being cut off financially by their families and having no other organisations or support systems to turn to (as these homes were run by the state and religious organisations). There were many 'Homes' in Ireland that were funded by both the church and Irish government (Specia, 2021). The influence the state and church had on mother and baby homes may impact the views older adults hold today regarding organisations with perceived authority.

A 2015 investigation run by the Mother and Baby Homes Commission of Investigation revealed that around 35,000 women gave birth in one of these 'homes' in Ireland (Clarke, 2021). One of these 'homes' – Tuam Mother and Baby Home, which ran between 1925 and 1961 – is known for particularly dreadful conditions that lead to high

mortality rates of babies and mothers. An investigation in 2014 by historian Catherine Corless discovered 800 remains of babies in a septic tank at the site of the home (Garrett, 2017). Further investigations revealed 798 babies' death certificates; sadly, two babies birth records could not be located and therefore their names could not be found. Catherine Corless' findings caused national and international scandal and horror at the needless deaths of so many innocent babies, but mother and baby homes were not operating in the shadows in secret: they were a known commodity supported by the church where families sent their daughters to protect themselves from shame (Buckley & Grimes, 2021; Clarke, 2021; Garrett, 2017).

The findings at Tuam instigated an inquiry into 18 institutions in Ireland, revealing that 15% of all infants who lived in one of the Mother and Baby homes investigated died, meaning around 9,000 children died between 1922 and 1998 (BBC, 2021). Many families involved in Irish Mother and Baby homes are eligible for compensation for their treatment in these 'cruel' organisations (Guardian, 2021), with the Irish government issuing an apology for the harm caused to numerous families, parents and children that were harmed in and because of these homes (House of Commons and the House of Lords, 2022).

Mother and baby homes are often linked to Ireland, but homes existed in mainland Britain run by the church. Half a million women are thought to have lived in mother and baby homes in England in the 1900s. Many of these women's infants were adopted due to the lack of resources and support that was available to them (Paton, 2012).

Mother and baby homes were symptomatic of the views and stigma that surrounded women being sexually active, and at times becoming pregnant outside of marriage. The stigma of women being sexual beings in a patriarchal society led to questions of their morality and shame being placed on them and their families.

The 1960s pill

The 1960s or the ‘Swinging 60s’ in UK is a notable period where some of the views changed and attitudes to sex outside of marriage and for pleasure relaxed. It is also this period that saw the introduction of the contraceptive pill for married women on the NHS (Pilcher, 2005). Whilst there have previously been other methods of contraception the pill was the first time that married women were in control of whether or not they became pregnant, offering more choice about whether and when to have children (Cook, 2005). Whilst there were other methods of contraception that women could use such as douching, syringing, and using a diaphragm these methods were either unreliable or challenging to use as it was felt that women should not be the one to initiate sex and therefore could not insert the cap prior to sex (Cook, 2005).

The power dynamic in marriages in the 60s where often not evenly matched. With women often financially powerless due to being home makers and often thought to be the passive members in the marriage (Cook, 2005), the introduction of the pill provided women with subtle power with the women having control for the first time over how many children they had. This meant that they no longer had to follow in their mothers’, and grandmothers’ footsteps and could prioritise a career (Hana, 2021), challenging old-fashioned views and what a women’s ‘role’ was within society, and with a family. Women were required to have a GP appointment to get the pill, yet many doctors at this time were not in agreement of their role in prescribing the pill. Explanations for this were concerns about safety, reluctance to be involved in sexual medicine and an acceptance that women were supposed to reproduce and medicine should not be used to prevent this (Cook, 2005).

Historically there has been a higher number of male doctors than female doctors it was not until 1865 the first women qualified as doctors, however the rules were changed

meaning that no other women could sit their exams to become a doctor. In 1876 the Medical Act was amended so all applicants who qualified could become licensed doctors regardless of their gender (Thackray Museum of Medicine, 2024).

There has long been stigma over women attending any university, let alone a course and career as demanding as medicine. Whilst the number of female doctors entering medical training has increased, with 62% of students starting medical studies in 2022/2023 being female (General Medical Council, 2023). In 2023 the GMC workforce report stated that the percentage of female licensed doctors is 49% in the UK. Suggesting a movement towards equal opportunity for females.

The impact of older women having to attend medical appointments, often about their gynaecological health with male doctors could have a negative impact. The possible effect being that women may still feel uncomfortable having intimate examinations or talking about intimate gynaecological issues with a male doctor. This may have resulted in older women avoiding talking to the GPs around their concerns around their sexual health due to embarrassment and shame (Schaller et al., 2020) this deterrent for women seeking medical support could result in negative health outcomes due to women avoiding appointments.

It is important to also consider the cultural implication of female patients being seen by male doctors: a study complete in the United Arab Emirates (Rizk et al., 2005) stated that 86.4% of participants preferred to see a female clinician, with 12% having no preference and only 1.6% wanting to see a male clinician. The results from the study demonstrated that 74.3% of participants stated the reason behind this decision was religious. While this study was not exploring the views of older adults it is important to hold in mind religious and cultural views and how they may impact an individual's health care preferences.

Research has shown that stigma remains that it is the women's 'job' to consider contraception in an effort to avoid pregnancy, with young women sharing that men believe contraception is 'not their job' (Brown, 2015).

Women's independence and divorce

The rates of divorce have increased in the last 100 years; it has moved from an uncommon occurrence in 1914 to 50,000 divorces in 1971, which increased again to 150,000 in 1981 (UK Parliament, 2024). In 2024 it is thought that 42% of marriages will end in divorce (Wayman & Long, 2024): between January and March 2024 there were reported to be 27,908 applications for divorce (Ministry of Justice, 2024). This has meant that more individuals are entering new relationships and navigating sex with new people. Sex with multiple partners has shifted contraception considerations from preventing pregnancies to the prevention of STIs.

Laidlaw (2003) stated that the differing life expectancies between women and men may result in many more women being widowed and having to consider the type of relationship they would like after the loss of their husband. The traditional sex-power imbalance in relationships has evolved; now in 2023, women have greater independence and voice their views in relationships. For older women dating for the first time this is a new conversation for them to navigate, with discussions around contraception, monogamy, and beliefs about the role of women (Fileborn et al., 2015; Morison & Cook, 2015; Morrissey Stahl et al., 2018; Yun et al., 2014). The level of guilt women and men feel moving on from a deceased spouse should not be ignored; this level of guilt from 'forgetting' about one's partner compounded with the guilt and shame of exploring their sexuality outside of marriage and risking compromising their relationship with their children is thought to impact wellbeing and sense of self (Bildtgård & Öberg, 2017).

Intersectionality

To fully understand the different experiences of older adults an important consideration is intersectionality. Intersectionality is the understanding that a person, and their experience of the world is not solely down to one of their demographics such as gender.

People are multidimensional; a person's experience is shaped by their gender, age, race/ethnicity, religion, disability and socioeconomic factors. Each of these factors are connected and can involve discrimination in relation to structures of power such as religion, government and historical patriarchal views. Over time the discrimination experienced can change, as can the impact of different demographics in different geographical locations (Hankivsky, 2022).

Culture

Religion and culture are thought to play a part in the stigma and shame surrounding sex, as seen in the media when religious figures such as the Pope comment on reproductive health. In conjunction with historical conservative Catholic views on sexuality and marriage (Laplante et al., 2021). Societal views impact how people behave and often motivate them to act in ways in keeping with the 'norm'; this is true of how individuals act in relation to sexuality (Folley, 2015; Yelland & Hosier, 2017), and the 'norm' is often influenced by who surrounds us and who people are socialised around (Ahmadi, 2003). This is known as sexual cultural scripting (Wiederman, 2015). However, it feels essential when exploring the older adult population of today to understand the change in religious and cultural views in UK over the last 100 years. UK, especially London in 2024, is thought to be a 'melting pot' of multiple cultures and religious beliefs with many people across the world migrating to the UK. After WWII UK needed restoration, this led to the Windrush generation moving to the UK to

support with new jobs in production and in the NHS which started in 1948 (NHS England, 2024).

The Windrush generation saw 1,029 individuals arrive in the UK from 1948 onwards (The Greenwich Museum, 2023) from countries in the Caribbean. They were later followed by thousands from India, Pakistan and Africa, totalling 510,000 individuals arriving in the UK (BBC, 2020). The political revolution spread across Europe, both as the end of WWII and the later Cold War led to many refugees (BBC, 2020). The influx of cultures into the UK over the last 100 years may have impacted society's views on sexuality however there is little research in this area (Ahmadi, 2003).

Religious Views

It has been well documented in previous research that religion has dictated views on sexuality in society with words such as 'sin' and morality being used to discourage what is thought to be promiscuous behaviour (Leavitt et al., 2021; Parker, 2009). Research has also demonstrated that the interpretation of religious teachings can be more influential on a person's views on sex and religion than their religious denomination (Leavitt et al., 2021). Adolescents growing up absorb, and at times learn their views on sexuality and premarital sex from those around them, which is often their parents and close family members (Regnerus, 2005).

Regnerus (2005) reported how Social Learning Theory is thought to influence how individuals' sexuality socialisation occurs through modelling. Meaning individuals often witness the behaviour they think they should be following in their religious community. This is one way the community's views are passed on their attitudes, this can also be impacted by parental religion. Religion can influence the parents' knowledge of, and value placed on sex,

including the morality or immorality of it, which in turn can affect how they communicate with their children about contraception, abstinence, and advice they give.

The level of education the mother has received, and the gender of the child can also impact the way in which this information is communicated. Patriarchal religious views are thought to influence how women and sex are understood by religion. Jung and Hunt (2009) described how the emphasis placed on childbearing as a "compulsory trap" placed on women by religion can mean that women's sexual pleasure can be lost, with access to contraception restricted or frowned upon by some religions.

A secondary consideration is that a large amount of research and teaching on religion and sex has taken place without input from women and girls (Jung & Hunt, 2009). Consideration and space is needed to learn about women's sexual scripts and the link to their religion and how this has impacted their sexual experience and wellbeing. In recent times science has been thought to have a greater influence in determining viewpoints in society, and with the development of understanding of sexuality (Parker, 2009). As scientific evidence grows in society there is still a significant role of religion and the differing views that now exist in society, and even within families.

Gender

Masculinity and virility

Patriarchal views in society impact men and their wellbeing. A common myth is that men continue to have sex with little difficulty until death. Whilst not commonly spoken about, many men struggle with impotency, erectile dysfunction and require medication to be sexually active (Albersen, et al., 2009; Davis et al., 1985). A study in the USA stated that 38% of men over the age of 50 years old have discussed sexual dysfunction with a health professional (Lindau et al., 2007). Whilst it is possible that these men have felt able to discuss

the topic with a health professional it also raises the question why this number is so low, and the psychological impact if these men do not feel able to share concerns. Sexual dysfunction can also be a warning sign that someone is suffering from an underlying health condition such as cancer or diabetes (Gendrano et al., 2005; Laumann et al., 2005). This confirms the importance of understanding male older adult sexuality due to the sex being an important part of older adults' lives (Gott & Hinchliff, 2003).

Femininity and promiscuity

The asexual grandparent or older adult is a common assumption, yet older adult women have shared that when they have a partner they do place high importance of sexual activity, in whatever form this takes (Gott & Hinchliff, 2003). Gott and Hinchliff (2003) showed that, while some women felt that sex was not high on their agenda, others shared its importance and their frustration as their husbands or partners suffered from erectile dysfunction with some voicing that they wanted to get a vibrator to support them in their sex life. Women have been shown to live longer than men, which means that in today's society there is a large number of widows who are considering dating or entering sexual relations (Laidlaw et al., 2009). Women are also more likely than men to suffer negative opinions of others in relation to their sex life (Gale et al., 2018; Morrissey Stahl et al., 2018; Yelland & Hosier, 2017).

The theory of Benevolent Sexism (Glick & Fiske, 1996) relates to a conception of women as purely loving innocent beings. Patriarchal norms in society reduce 'good' women almost to one-dimensional status, while viewing women who do not conform in a hostile way (Glick & Fiske, 1996). In conjunction is the concept of the 'invisible' elder women (Fileborn et al., 2015), where women are viewed as silent in their older age and often grief. Conversely, previous studies have suggested that negative views about elder women being sexually active

and dating is a result of ageism rather than sexist views around women's sexuality, with little difference found between the genders (Yelland & Hosier, 2017).

LGBTQ+

In the last 100 years the world and societies views have changed in regard to LGBTQ+ rights, with same sex marriages being legalised in the UK and some states in America, historically religions such as Catholicism have reportedly been against same-sex marriages. Across the world it has also been documented that men who have sex with other men have experienced discrimination.

In the UK in the past men could be charged with "gross indecency" under Section 11 of the Criminal Law Amendment Act (1885) if they were discovered having sex with another man. Some of these men were forced to be 'treated' with chemical castration with anaphrodisiac drugs, with side-effects including reduction in libido, breast growth and increased risk of cardiovascular disease. Understandable this could impact men's psychological wellbeing, as highlighted when Alan Turing, who was charged and subjected to chemical castration, ended his life (Hofstadter, 2013). Professor Turing was a well-known mathematician who greatly aided the war effort in WW2 by breaking the German's enigma code and saving many lives. Yet, in 1952 when he was arrested and charged, he lost the support of the government. The UK government later issued an apology to Turing and men who experienced a similar fate, but the impact of how gay men were treated in the UK, and still around the world today still has an impact on wellbeing of the LGBTQ+ community especially those who lived through those times.

There has never been a law regarding lesbian relationships, although in 1921 amendments to the 1885 Criminal Law Amendment Act to include female relationships were considered (Huzar, 2019). Yet this does not mean that lesbian relationships have not suffered

from shame and stigma (Gates, & Viggiani, 2014). Historically women have at times lived together as ‘friends’ and ‘companions’ as their romantic relationships were not accepted by society. In the UK women were not allowed to marry another woman and The Marriage (Same Sex Couples) Act 2013 was passed in July of 2013. The first same sex couple marriage took place in March 2014 (Government Equalities Office, 2014).

Women were not allowed to adopt a child together until The Adoption and Children Act 2002 was passed which legally came into force in 2005. This law game same sex couples the same legal rights when adopting as heterosexual couples (Legislation Gov UK, 2024). In every African nation apart from South Africa two women are still not allowed to be married (BBC, 2023). The stigma women have experienced across the world which can be amplified in different cultures. This can impact the wellbeing of an individual as much as the men who identify as gay.

Across the world women and men can suffer from the stigma of being in a same sex relationship, in 64 UN countries it is illegal to identify as LGBTQ+, in some of these countries same sex sexual acts can be punished with the death penalty. In countries such as Brunei, Mauritania, Saudi Arabia, Yemen, Iran and in some parts of Nigeria the death penalty for same sex sexual acts still applies. In a further five countries there is yet to be a clear decision on whether the death penalty could be applied if individuals are seen to be engaged in same sex sexual activities. These countries are Afghanistan, Pakistan, Qatar, Somalia, and the United Arab Emirates (BBC, 2023). In the UK historic punishment for same sex sexual acts only applied to men, whereas several of the countries who punish homosexual relationships have also punished women.

Previous research has suggested that religion can impact attitudes to same sex relationships (Olson et al., 2006). It is important to acknowledge that many older adults in

2023 grew up in a time when homosexual relationships between men were illegal. In 1967 sex in private between men was decriminalised (BBC, 2017). However, in 1988, there was a setback when Section 28 of the Local Government Act was introduced that stated that local government department would not intentionally encourage homosexuality as a family relationship (BBC, 2023). Between 2000-2007 legal rights in the UK for the LGBTQ+ population changed, with the age of consent changed to 16, new rules meaning that the LGBTQ+ population could serve in the Armed Forces and abolition of Section 28 (BBC, 2023). This can lead to individuals experiencing a sense of shame and stress about who they are attracted to, in a society that privileges heterosexual relationships and marriages (Rostosky & Riggle, 2017). The impact on individuals identifying as homosexual, bisexual, pansexual and asexual can be internalised homophobia and internalised feelings of shame (Gilbert, 2010).

The horrific case of Brianna Ghey in 2023 (Pidd, 2024) the horrific comments made by members of the UK government highlighted the difficult experiences those from the transgender and gender non- conforming community experience (Walker, 2023). Between 2016/2017- 2018/2019 there was shown to be a 32 percent increase in hate crimes against members of the transgender and gender non confirming community (Home Office, 2018). This is alongside an increase in negative media coverage in the media and a lack of education into transgender rights and needs (Willis et al., 2021). Perrson (2009) stated that the intersection of older adults and transgender community are both underserved and under researched. Considering the older members of the transgender community and the difficult and at times dangerous times they have experienced puts into context the trauma they may still be experiencing today living in a cisgender assuming society.

The AIDS Epidemic

The minority stress (Rostosky & Riggle, 2017) experienced by those that do not conform to the heterosexual norm has been further amplified by the AIDS epidemic that rocked the world in the 1980s. the previous section has detailed some of the struggles members of the LGBTQ+ community have experienced, often having to hide themselves and their relationships from family, friends, education, and their workplace. The sense of community for LGBTQ+ members was further rocked by a mysterious disease of unknown origin and unknown cure. It was initially referred to as "Grid" which stood for gay-related immune deficiency which was later renamed acquired immunodeficiency syndrome also known as 'AIDS' (The Guardian, 2021). Derek Frost (2021) shared in his memoir he and his friends were not aware of how the virus was passed and who would become ill next; this was a time of fear and deep uncertainty Frost's partner was later diagnosed with AIDS, which was deeply stigmatised by newspapers, news and even medical professionals (Guardian, 2021).

The stigma around homosexual relationships were 'causing' AIDS, even if neither member were positive for AIDS, placed blame on certain groups and allowed those placing the blame to feel 'safe' from becoming ill (Joffe, 1995). The illusion of the 'other' and the stigma this created caused sex to seem forbidden and dangerous which was supported by the adverts used to demonise AIDS and gay sex (Joffe, 1995). The danger associated with sex linked to AIDS still impacts older adults today, due to the stigma and shame they experienced alongside the loss of friends and partners to this disease.

Increasing STI rates/sexual risk-taking

For the gay community, the language and discussion around STI rates has been common; however, for many heterosexual people concerns around STIs are a new concern. NICE's (2020) publication reported that STI rates in the older adult population have

increased, making anxiety for older adults navigating the use of contraception a new concern for many with a lack of insight into how to instigate this conversation (Morison & Cook, 2015; O'Mullan et al., 2019). Older adults have conflicting thoughts from having vivid recollections of the AIDS adverts (Morison & Cook, 2015; O'Mullan et al., 2019) to knowing that pregnancy is no longer a fear. Yet there has been little consideration or investment into sexual health education with older adults. For instance, NICE guidelines in 2019 did not even mention older adults.

Today - The Asexual Grandparent

Talking about sex and the sexuality of older adults is an evocative topic for many individuals. An ageist view is held by many that old adults no longer have sex or even think about sex. The theory of Benevolent Sexism (Glick & Fiske, 1996) explores the concept that older women are thought to be pure beings who are solely thought of as kind innocents who are "invisible" (Fileborn et al., 2015). This links to patriarchal views that women can be viewed as "good" or are villainised or judged due to their sexual decisions (Morrissey Stahl et al., 2018; Gale et al., 2018; Yelland & Hosier, 2017). Society views older women as careful and pure people who would not be likely to engage in sexual activity (Inversen et al., 2009; Glick & Fiske, 1996) or even consider their own pleasure and needs. Folley et al. (2015) described the power that cultural views have on older adults to feel that they cannot express their sexuality. It is possible that ageist views have filtered through to professionals who feel ill-equipped to discuss sex and sexual health with older adults, Laidlaw (2003) discussed assessment, formulation and intervention concepts but failed to mention the sexual needs of older adults.

The attitudes held by society regarding older adults can impact wellbeing and therefore overall quality of life. Research has demonstrated sexual difficulties such as erectile

dysfunction and capability to become sexually aroused was correlated with lower life satisfaction and higher rates of depressive symptoms (Jackson et al., 2019). Older adults have been shown to value their sexuality although they reported disappointment with sexual health resources and support from professionals (Portellos, et al., 2023). Older adults may need support to stay sexually active and remain happy with their sex life which highlights the importance of being able to seek support, with older adults who experienced difficulties in relation to sex shown to have poorer overall sexual wellbeing (Jackson et al., 2019).

Attachment

The relationship patients or clients have to their health care professionals can be considered using an attachment lens (Ainsworth, 1978; Silver, 2013). Attachment style can impact how an individual relates to others. The style can also impact how quickly, or how complex building a trusting relationship with a professional can be due to their own personal experiences. Previous research has suggested that the attachment style of a patient could impact their interactions and communication with healthcare professionals, and in some cases their adherence to medication (Ciechanowski et al., 2001; Holwerda et al., 2013).

Considering the other half of the client- clinician dyad, as clinicians own personal views and experiences also impact the interaction and the level of comfort that is experienced in the dyad (Mimura & Norman, 2018; Silver, 2013). In the NHS patients often don't see the same GP which means that they struggle to create a positive relationship with them and therefore struggle to trust and share some of their concerns with a GP they don't know (Frederiksen et al., 2010). The clinician's own attachment style can alter their experience of their own team dynamics and interactions with patients which in some cases may impact health outcomes (Mimura & Norman, 2018).

Literature Review - Meta-Ethnography

After considering the stigma associated with discussing not only sex but discussing it with older adults there is limited research exploring clinical psychologists' experiences of talking to older adults about sex and sexuality in the UK. Therefore, this review will consider the voices of health professionals experiences of talking to older adults about sex, sexual health and sexuality.

Research Aims

The aim of this meta-ethnography is to explore and clarify health care professionals' experiences of talking to older adults in a health care setting about sex and sexual health in the hope this will provide some understanding of themes, with a view to informing this thesis and guiding future research.

Methods

Design

The current review will utilise a meta-ethnography design developed by Noblit and Hare (1988). A meta-ethnography design was selected for synthesis to provide third order interpretations to provide a deeper understanding on concepts linked to sex and sexuality of older adults (Britten et al., 2002). A secondary reason behind the choice to use a meta-ethnography design is to inform doctorate thesis questions (Atkins et al., 2008).

The analysis utilises seven steps which have been described by Noblit and Hare (1988, this current analysis followed these steps and further recommendations made by Britten et al (2002) and Sattar et al., (2021). (1) Starting the analysis, (2) outlining what is relevant, (3) reading the research numerous times, (4) linking studies, (5) interpreting the research into one another, (6) synthesizing interpretations, (7) describing the synthesis.

Inclusion and exclusion criteria

Prior to the start of the search, it was decided to include only published and peer reviewed research articles that explored health professionals' experiences of talking to older adults about sex and sexual health. Whilst this thesis is being conducted in the UK with professionals working in the UK, studies were not excluded from this analysis if they were conducted outside of the UK. What is thought of as an older adult differs in different cultures (Foley, 2015; Schick et al., 2010) so the exclusion criteria were set at under 40 years old, with no upper limit. All qualitative methodology was included in line with the meta-ethnography design (Sattar at al., 2021).

Search strategy

An electronic search was conducted to find articles through the following databases: APA PsycArticles, CINAHL Complete, APA Psychinfo and MEDLINE with Full Text. All databases were searched in May 2023. The below terms were used:

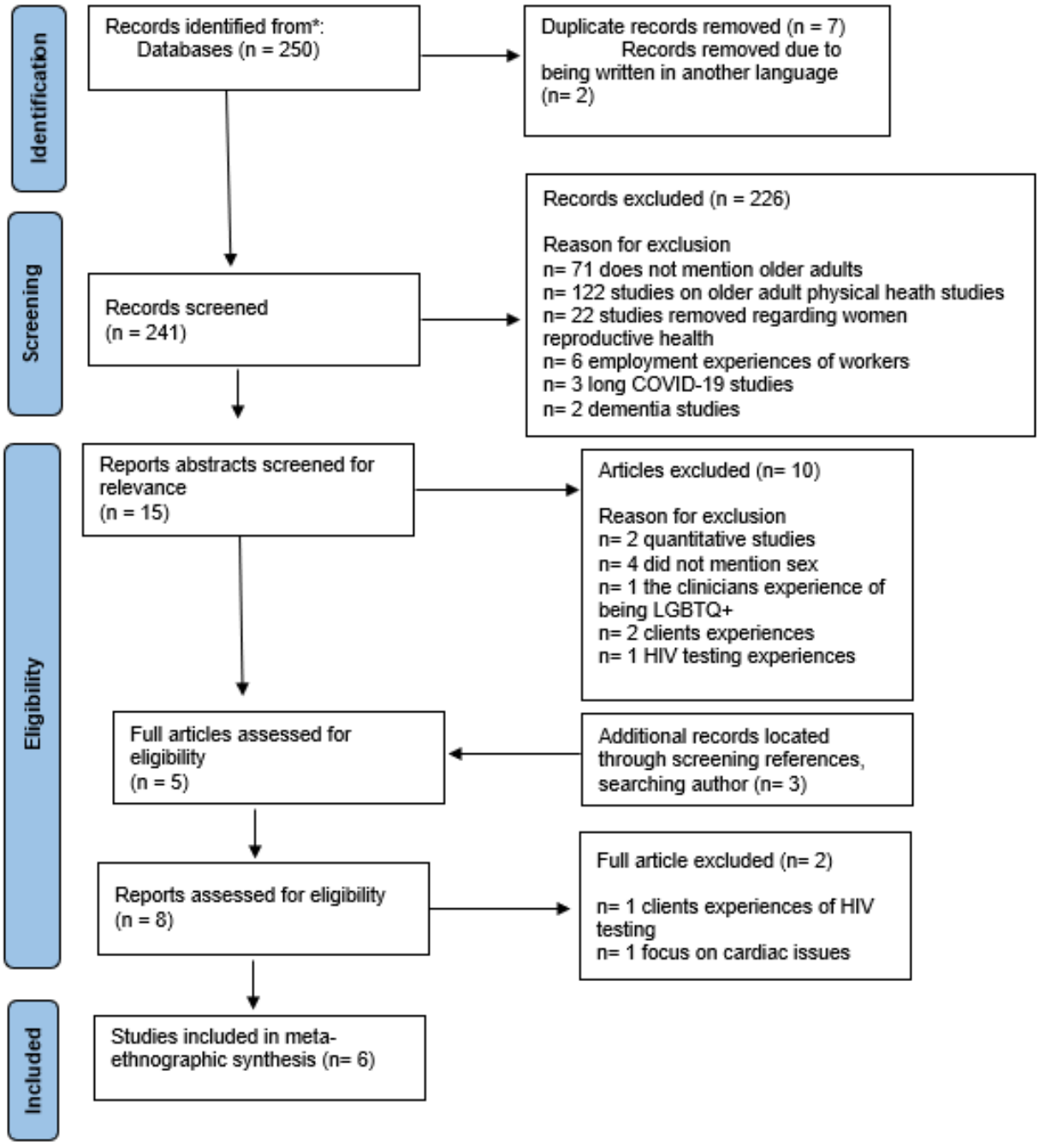
1. Older adults or elders or elderly or geriatric or geriatrics or aging or ageing or senior or seniors or older people
2. Sex* or "sexual health" or sexuality or "sexual wellbeing" or "sexual behaviour"
3. Qualitative research or qualitative study or qualitative methods or thematic analysis
4. Clinicians or NHS or doctors or nurses or health professionals
5. 1 AND 2 AND 3 AND 4

The current search reviewed published journals and peer-reviewed articles that were written in English. The database search provided results, with 250 results. Duplicates and

articles not in English were removed which left 241 results. Screening of the titles of 241 journals was completed utilising the inclusion/exclusion criteria after which 226 titles were removed as detailed in Figure 1. After which 15 abstracts were screened and 10 studies were removed. A hand search of the reference list of included studies and grey literature were reviewed which yielded a further three studies. The eight full articles were reviewed, with six articles determined consistent with inclusion and exclusion criteria. The selection process can be seen in the Prisma flow chart in Figure 1.

Figure 1

Prisma Flow Diagram



Quality Assessment

Qualitative research is known for the potential to be varied in methodology and

quality. Therefore, it is important to evaluate the study (Long et al., 2020), to understand and evaluate the strengths and weaknesses before further analysis takes place (Malterud, 2019). The tool used for assessment in the current study was the Critical Skills Appraisal Programme checklist for qualitative research (CASP; Critical Appraisal Skills Programme, 2018). The CASP tool was selected as it is an appropriate tool for novice researchers (Long et al., 2020) whilst facilitating a deeper understanding of the research by analysing the method, sampling and analysis critically (Barnard et al., 2018). This information and the developed CASP score can be seen in Table 2. The CASP tool uses 10 questions, with the overall maximum score being 10 and the minimum score being 0. The higher score the better the quality of the study. The CASP questions can be found in Appendix 6.

Data extraction & synthesis

The data extraction and synthesis process utilised in this analysis is detailed in the below steps, which were taken from Sattar et al. (2021), Atkins et al. (2008) and Britten et al. (2002).

Step 1- Reading research on older adults' sexuality and stigma

Step 2- Creating the aim and deciding on exclusion/inclusion criteria.

Step 3- Research was screened, and read several times to absorb the meaning and themes. Sattar et al. (2021) reported that it is essential to understand the stated that it is vital to understand the background of the research to interpret the results. This data can be found in Table 2.

Step 4- To discover the concepts that are found in multiple studies and the relationship between them. An example of these concepts a study used in this analysis can be found in Table 1.

Step 5- Concepts from each of the studies are retrieved from each study and are then compared and translated into each other considering primary and secondary order themes. To facilitate this each study was entered into Table 1. The concepts that are developed were not taken word for word from the studies but developed to be overarching and incorporate ideas from multiple studies (Atkins et al., 2008).

Step 6- First and second order constructs were considered to inform the third order constructs developed by the current author, which are in Figure 2. This also led to the line of argument synthesis shown in Figure 4. The findings are discussed in the Results section of this review.

Step 7- Report the findings, including the strengths and weaknesses of the analysis, and future recommendations. These areas are detailed in the discussion, limitations and conclusion section of this review.

Table 1

Extracted Data: Example of how data was extracted

Extracted data	Malta, et al., (2018)
Purpose	To explore clinicians' knowledge and attitudes towards management of sexual health with older adults
Setting	Victoria (Australia)
Sample	15 GPs and 6 practice nurses
Data collection	Semi- structured interviews
Key concepts	
Sexuality is important for older adults	Ageist views around older adult sexuality
Initiating sexual health discussions in general practice	Avoidance of starting conversations, even without negative experiences
Barriers to sexual health discussions with older patients	Time and relationship quality influencing the ability to have a conversation
Facilitators to sexual health discussion with older patients	Gender similarities and relationship quality supporting women to have these conversations
Explanation/ second-order interpretation	*Perception about older adult sexuality,*

Note. Based on Britten et al., (2002)

Table 2

Key characteristics of the selected studies

Reference	Sample size	Demographics	Purpose	Study location	Data collection method	Analysis method	CASP score
Gott, et al., (2004a)	22 GPs	13 men: 9 women Aged 34-57;	GPS experience of exploring sexual health with older adults	Sheffield (UK)	Interviews	Grounded theory	8
Gott, et al., (2004b)	22 GPs, 35 nurses	GPs: 13 male: 9 women Aged 34-57 Nurses- 35 women Aged 32-60	Identify barriers that inhibit the discussion of sexual health (mention older adults in abstract)	Sheffield (UK)	Semi-structured interviews	Analytic process supported by QSR NUD*IST (grounded theory)	7
Levkovich, et al., (2019)	16 GPs (family physicians)	13 men: 13 women Aged 36-64	To explore physicians perception and attitudes regarding older adult male and female clients and sexual function	Israel	Semi-structured interviews	Content analysis	6
Malta, et al., (2018)	15 GPs and 6 practice nurses	GPs- 8 men, 7 women Practice nurses- women The oldest participant was under 30 and the oldest over 60 years old	To explore clinicians knowledge and attitudes towards management of sexual health with older adults	Victoria (Australia)	Semi-structured interviews	Thematic analysis	8
Levkovich, et al., (2021)	17 physicians with not training sexuality 16 physicians who were certified sex therapist	Training received- 9 men: 8 women Aged 36- 64 No training 14 men; 7 women Aged 45- 67	Explore perspectives of two groups of clinicians towards discussing sexuality with older adults	Israel	Semi-structured interviews	Thematic content analysis	6
McGrath & Lynch (2014)	22 Occupational therapists	4 men; 18 women Aged 27-52	To investigate clinician's perspectives on exploring sexuality with older adults	Ireland	Focus groups	Content analysis	7

Note. Taken from Sattar et al (2021)

Results

CASP Appraisal

Levkovich et al. (2019) stated that purposeful recruitment took place, but failed to explain how this recruitment took place or how the researchers determine the inclusion and exclusion criteria of the participants. This may have resulted in there not being a wide range of participant with different experiences of supporting older adults. Gott et al. (2004a) discussed recruitment in more depth than other studies, sharing that GPs were recruited from more diverse GP practices. Whilst the study did not share how these practices were identified it may have provided valuable data, from GPs experiences in the UK working in more diverse practices supporting older adults from different religious and cultural backgrounds. Gott et al. (2004a) explored in more depth how and where the interviews took place. The gender, age and profession of the researchers was also considered: this is an important consideration when discussing clinicians' personal experiences and attitudes to discussing sex with different genders.

The relationship between the participant and researcher is thought of as an important factor in gaining qualitative information, particularly to what degree participants feel able to share information with the interviewer. Levkovich et al. (2019) did not mention the relationship between the participant and researcher but did state that the researcher completed a period of reflection before interviews. This is valuable information, but it would have been beneficial to know more about this period, how researchers experienced this and what areas they were considering prior to the interview that could have in turn impacted the interview and analysis of the dataset. It is not clear if this period of reflection was supported by a supervisor or if it was done alone. If participants were supported to reflect by another then the personal experience of the supervisor could also have impacted the interview and what was

deemed important. Gott et al. (2004a) stated that all interviews were completed by female researchers and Gott et al., (2004b) stated that all interviews were completed by female researchers between the ages of 24 and 32. This is important information to consider as this may have impacted the level of comfort participants felt discussing the topic with women of a certain age. However, the study did not reflect on this bias or influence the identity of the interviews and participants may have had on the information shared.

A number of different analysis methods were used in the selected study; two studies used content analysis (Levkovich, et al., 2019; McGrath & Lynch 2014), Malta, et al. (2018) used thematic analysis and Levkovich, et al. (2021) stated that they used thematic content analysis. Gott et al. (2004a) used grounded theory and Gott et al. (2004b) stated that they used Analytic process supported by QSR NUD*IST. Gott et al. (2004b) used a reference for grounded theory, but they did not state in the study that they used grounded theory.

McGrath and Lynch (2014) provided more detail on ethical considerations such as considering the context of the country that the study took part in. This adds an additional layer of understanding to the dynamic occurring between the researcher, clinician and client, however, this was not explicitly reflected upon in the study.

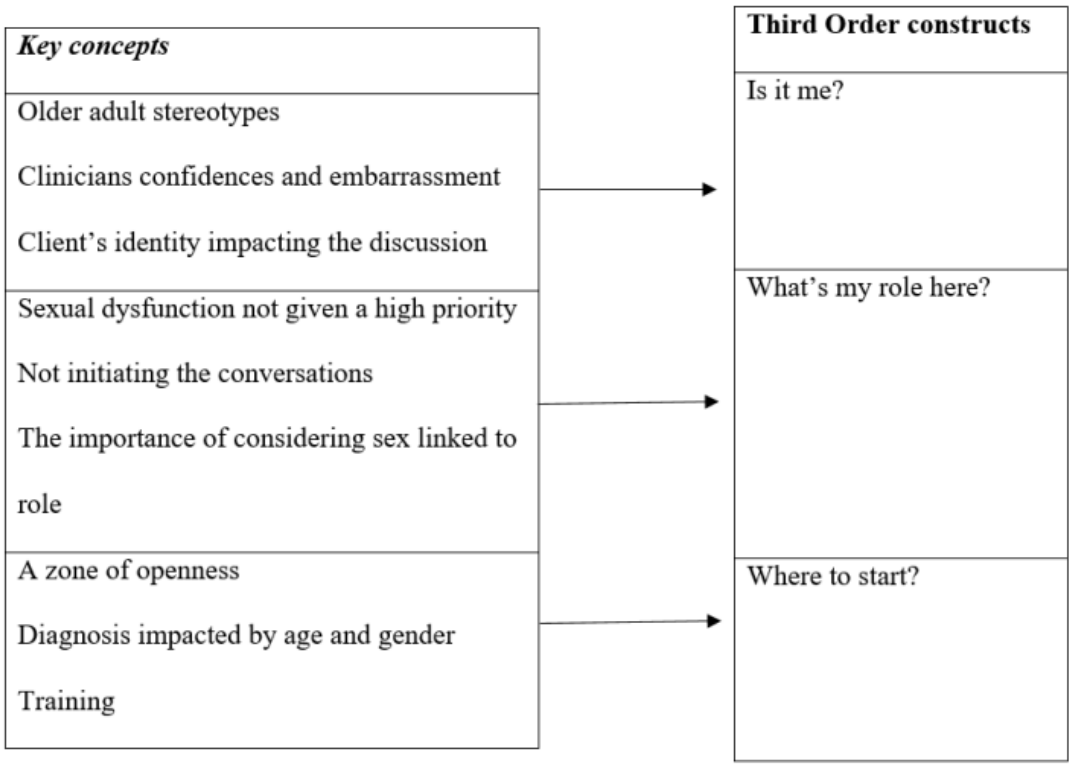
One of the main concerns regarding the studies selected for this analysis is that two of the study's, Gott et al., 2004a and Gott et al., 2004b used a similar sample. The 22 GPs who took part in both of studies may have been the same participants. It is possible that the same interviews and analysis were used to produce the themes in both studies. This therefore may impact the themes and subthemes produced in this review as the information provided by the 22 GPs selected for both Gott et al. (2004a) and Gott et al. (2004b) were considered twice in the current review.

In the studies selected the questions participants were asked by the interviewers were not provided. This raises the question whether some important areas regarding older adults sexuality may not have been considered due to the bias of the researchers. This means that the themes and subthemes that have been produced in the current study may not fully encompasses all areas of older adult sexuality and sexual health considered by the health professionals interviewed.

Levkovich et al. (2021) and Levkovich, et al. (2019) shared the country of the participants and their gender, this may have provided important information about the background of participants and that may have impacted how they viewed sex and interacted with different genders. McGrath and Lynch (2014) acknowledged that the occupational therapists' views of sex may have been influenced by working in Ireland. Malta, et al. (2018) did not discuss the cultural or ethical background of participants but did share whether participants were in urban or rural areas. The other studies included in this review did not comment on the cultural or ethical background of the participants included in their studies (Gott et al., 2004a; Gott et al., 2004b).

Figure 2

Overview of Key Concepts and Third Order Constructs



Note: Taken and adapted from Priestley and McPherson (2016)

Is it me?

Older adult stereotypes

The power of the older adult stereotype in relation to sexuality was discussed in a number of studies (Gott et al., 2004a; Malta et al., 2018). It was shared that sexual health did not appear to include older adults. Gott et al., (2004a) shared that it is in some respects a positive thing that sexual health does not include older adults, an example provided was that a General Practitioner (GP) that they felt that older adults could be 'neurotic' and that bringing up the topic of sexual health could cause unnecessary anxiety and stress within this

population. One of the factors impacting clinicians experience of discomfort of talking to older adults were linked to thoughts of talking to parents about sex (Gott et al., 2004a). Gott et al. (2004a) and Gott et al. (2004b) shared that there were concerns that talking to patients from ethnic minority backgrounds about sex may cause offense. However, an alternative perspective was that the concept of treatment was more complex and includes not only consideration of sexual health considerations and treatments from a medical lens but also a holistic view on the psychological impact on sexual activity in later life. Such as difficult relationship dynamics and the motivation to be sexually active (Gott et al., 2004b).

Clinicians confidences and embarrassment

The influence of clinicians' views of sex and their own personal embarrassment and confidence was shown to influence their ability to discuss the topic of sex (Gott et al., 2004a; Gott et al., 2004b; Levkovich, et al., 2021; McGrath & Lynch, 2014). Gott et al., (2004b) reported that language felt a huge part of the discussions that clinicians had with clients, with clinicians sharing that they were unsure about the language that they were able to use in consultations without causing offence to older adult clients. Yet, whilst participants shared their reservations about discussing the topic due to fears of causing a rupture or offence, they couldn't not think of a time when they had offended a client by discussing sex or sexuality. Worries over offending clients (Gott et al., 2004a) were linked to both initiating the topic but also concerns that they were not as knowledgeable on the topic of older adult sex as they could be, and should be as a clinician Levkovich, et al. (2021). Occupational therapists shared that they felt like it would be opening up a 'can of worms' that they would not be able to understand or contain for the client (McGrath & Lynch, 2014).

Client's identity impacting the discussion

In Gott et al.'s (2004b) paper, clinicians shared that they felt more uncomfortable discussing sexual health with older adults who were not in heterosexual relationships. The impact of stigma, and the heteronormative lens that exists in services meant that one clinician questioned whether or not it was ethical to be prescribing Viagra to older men who were not in a stable relationship. This finding demonstrated the impact homophobia has on clinicians, in their treatment of and understanding of clients, therefore influencing the care gay and bisexual men receive, which could make it less likely for gay or bisexual men to reach out for support from medical professionals.

Malta et al. (2018) shared an alternative view from GPs that their experiences of growing up in the 'hippy' 60s meant that they had a more accepting view of sex which allowed them to hold a more curious view of sex and gender whilst supporting clients to have these conversations. McGrath and Lynch's 2014 study took place in Ireland, and one of their findings was the power the church had on society creating a culture where sex was not discussed. The trauma of the negative experiences non-heterosexual older adults was still felt in their clinics.

The perceived gender differences in how clinicians held conversations and what they assumed clients wanted from consultations were noted. With it being expected that men would place higher importance on penetrative sex compared with women who were thought to want to get sex over with or being motivated by their husband's needs (Levkovich et al., (2019).

What's my role here?

Sexual dysfunction not given a high priority

GPs spoke about the time pressures that had been placed on them, meaning that their consultation time had been reduced. They felt that they needed to priorities the time they had with client, this meant that they felt in the hierarchy of clients' needs sexual health and dysfunction were not priorities (Gott et al 2004a; Gott, et al., 2004b; Levkovich, et al., 2021; Malta, et al., 2018). Ageist attitudes towards sexuality were shown to be supported by guidance stating that the priority in sexual health was the increase and management of STI rates in teenagers (Gott et al, 2004a & Gott et al., 2004b).

Some older adult women were labelled as neurotic by clinicians, who felt that bringing up sexual health would only cause them additional anxiety and not benefit their wellbeing (Gott et al., 2004a), while some clinicians felt that sexual health is not as relevant in older adult relationships (Malta et al., 2018). The impact of physical health difficulties on sexual dysfunction was thought to be less relevant to older adults who were currently in hospital and therefore not able to engage in sexual activity with their partners (McGrath & Lynch, 2014).

Not initiating the conversations

The difficulty clinicians felt in broaching the topic of sex and sexual health was reflected in a theme of clinicians sharing that they were happy to have conversations about sex with older adults especially if it was the older adults who brought up the topics (Gott et al, 2004a; Levkovich, et al., 2019). Levkovich, et al. (2019) stated that all GPs had found that male clients were more likely to initiate conversations around sex compared with the female clients they saw. The desire for clients to initiate the conversations appeared to link to clinicians' own feelings of shame and embarrassment and does not minimise the importance

of clinicians leading and feeling able to start these conversations. Clinicians trained in sex therapy shared the importance of these conversations being started by clinicians so that all clients could have the opportunity to take part in these conversations if they wanted to and not being held back by their own embarrassment (Levkovich, et al., 2021). A large number of older adults experience chronic health conditions which can have an impact on their ability to be sexually active. This was used as a gateway for clinicians to tentatively explore the impact on their ability to be sexually active and how this may impact their wellbeing and relationships (Levkovich, et al., 2019; Levkovich, et al., 2021; Malta, et al., 2018).

The importance of considering sex linked to role

Studies suggested that there was a perceived difference in the different roles of clinicians and their capacity to facilitate conversations on sex (Gott et al 2004a; Gott, et al., 2004b; Malta, et al., 2018; McGrath & Lynch, 2014). Practice nurses working in GP practices were reported to think about clients' needs more holistically, whilst also having more time in consultations to consider the multifaceted needs of older adults (Gott et al., 2004b). Female older adult patients were shown to seek out Practice Nurses, at times not even in professional consultations to discuss sexual health concerns (Malta, et al., 2018). Occupational therapists mentioned that whilst they were happy to discuss sex and the needs of the clients they were seeing they felt to fully meet the needs of the clients they required a Multi-Disciplinary Team (MDT) discussion and response as the need may not be appropriate or fit within their professional remit (McGrath & Lynch, 2014).

However, a drawback of practices placing the responsibility of older adult sexuality on the practice nurses was that they were unable to refer on older adults for further consultations with other professionals, and frustrations that GPs would not follow up concerns that they raised (Malta et al., 2018).

Where to start?

A zone of openness

The quality of the relationship between the clinician and client was shown to be instrumental in allowing open conversations about sex, sexuality and sexual health (Gott, et al., 2004a; Gott et al., 2004b, Levkovich, et al., 2019; Levkovich, et al., 2021; Malta, et al., 2018). Extended consultation times with clients allowed a positive relationship to be formed with clients with a more organic transition into discussing sex (Malta et al., 2018) with clinicians giving clients 'permission' to discuss sex and other more intimate topics (Gott et al., 2004a). This was described as creating a zone of openness with clients, in that they were able to bring up any topic in this 'zone' (or appointment).

Diagnosis impacted by age and gender

Studies discussed the gender differences in how sexual dysfunction was labelled, with erectile dysfunction labelled as organic compared with women whose difficulties were thought to be linked to anxiety (Gott, et al., 2004; Levkovich, et al., 2019; Levkovich, et al., 2021;).

The importance of being able to have penetrative sex was shown to be very important to older men, with GPs sharing that men would delay medical intervention if they thought that it would reduce their ability to have sex (Levkovich, et al., 2019). GPs explained that some medication for chronic conditions such as diabetes may impact men's ability to get erections and increase likelihood of erectile dysfunction, yet they would be more likely to share these side effects with men in their 40s than a man in their 70s (Gott et al., 2004a). This demonstrates the impact age has on the quality of medical input received. The concern around STIs in older adults was also reflected on by GPs, with there being a higher likelihood of them discussing safe sex with younger females taking the contraceptive pill compared with

older females as they assumed they were likely to be in a monogamous heterosexual relationship (Gott et al., 2004a).

Training

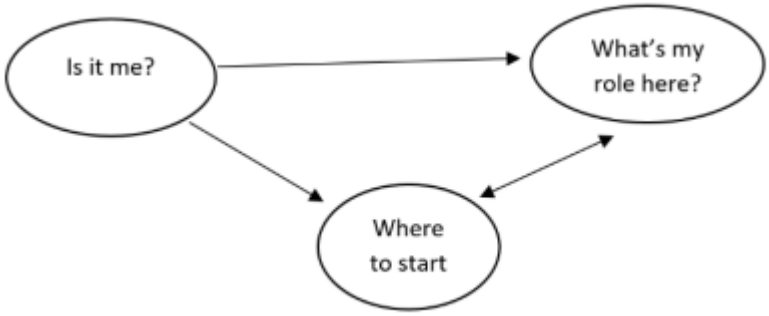
A lack of training on older adult sexuality was felt to be detrimental to the clinicians ability to explore sexuality (Gott et al 2004a Gott, et al., 2004b; McGrath & Lynch, 2014). A barrier to clinicians developing their knowledge was the pressure their services were under and the lack of time they could take off to attend training, with some GPs sharing training in older adult sexuality was not a priority (Gott et al., 2004b). Gott et al., (2004a) shared that older adult sexuality was introduced in GP or medical training that doctors receive, which is another example of the ageist stigma that surrounds older adult sexuality.

Line of argument of synthesis

The line of argument of the third order constructs developed are presented in Figure 3. The diagram demonstrates how the three constructs are linked and interact regarding clinicians' experiences of talking to older adults about sex and sexuality. It is thought that that clinicians' experiences of talking to older adults about sex is influenced by both the clinicians' identity and the client's identity. This informs the 'Is it me?' construct, which influences the construct 'Where to start?'. 'Where to start?' is centred on clinicians' experiences of confusion and discomfort in having this conversation. 'Where to start?' is thought to have a two-way relationship with the third construct 'What's my role?'. Clinicians' views on their role in discussing sex informs how they experience these conversations and in turn is influenced by who they are, and their own personal identity. 'What's my role?' has a two-way relationship with 'Is it me?', as identity influences clinicians' views on where it is their job to discuss sex.

Figure 3

Line of Argument Synthesis



Discussion

The aim of this review was to explore health professionals' experiences of talking to older adults about sex and sexual health in a professional setting. The review found three third order constructs, which seemed to underpin clinicians' experiences, barriers and what facilitates discussions around sex with older adults.

Prioritising

GPs spoke about the need to prioritise the time they had with clients due to the time pressure they are under during consultations. Yet previous research has shown that sexual difficulties and dysfunction can be a warning sign or a symptom of serious health conditions (Basson et al., 2010; Colson, 2016) and mental health difficulties (Zemishlany & Weizman, 2008). National guidance also influences the priority placed on topics GPs discussed in consultations, with Gott et al (2004a) stating that the importance placed on STIs rates in teenagers as the guidance had highlighted that this was a current concern meaning this topic was commonly considered in consultations. Yet there has since been an increase in the prevalence of STIs in older adults which may have possibly impacted the priority placed on this topic.

Prioritising in health appointments could result in serious health complaints being missed, arguably the pressure placed on GPs and the NHS is now greater than it was at the time the studies included in this review were completed (BMJ, 2023). This raises the question of whether the reduced time GPs and other health professionals have with clients means that more conditions will be missed, and that the holistic stance GPs once had no longer exists in 2024.

The stigma and shame that surrounds sex can make it difficult for clients to share their concerns with health professionals, yet women and men were brave enough to share their concerns with professionals. Older women were shown to feel more comfortable sharing their concerns with female nurses, possibly due to the more holistic approach (Gott et al., 2004b), or this could be influenced by the gender of the clinician. Traditional views around sex mean that older adults can feel increased levels of embarrassment discussing sex with someone of the opposite gender who is not their partner. It is possible that clinicians feel more hesitant in broaching the topic with someone of another gender due to fear of causing offence.

Non- heterosexual patients

In Gott et al.'s (2004b) paper, clinicians shared that they felt more uncomfortable discussing sexual health with older adults who were not in heterosexual relationships. The impact of stigma here meant that one clinician questioned whether or not it was ethical to be prescribing Viagra to older men who were not in a stable relationship. This finding demonstrated the health vulnerability experienced by members of the LGBTQ+ community as a result of historical prejudice, stigma and moral judgement (Albuquerque et al., 2016). This is also evident in evidence that women who identify as lesbians have reduced access to preventative health care such as mammograms and pap tests (Kerker et al., 2006).

The impact homophobia has on how clinicians act and therefore influences the care gay, lesbian and bisexual individuals receive, could make it less likely for gay or bisexual men to reach out for support from medical professionals. In some cases, those who do reach out for support could receive unsatisfactory health care. This can be conceptualised as cross-cultural theory, as the stigma members of the LGBTQ+ community may experience can amplified by cultural views (Albuquerque et al., 2016). Albuquerque et al. (2016) stated that some health care professionals may find it difficult to amalgamate their personal, religious and cultural views with their professional beliefs. This highlights the importance of the education and training health professionals to understand the possible prejudice that they may hold and how to support all clients to receive the health care they need free from discrimination or judgement.

Limitations

This meta-ethnographic review included research from across the world, with studies from the UK, Israel, Ireland and Australia. This means that the studies health care systems are very different structurally, culturally and financially. Whilst this meant that understanding could be gained of clinicians' experiences across the world, and showed some similar experiences, the results have limited applicability for understanding the experiences of health professionals' experiences in the NHS.

Another limitation is that two of the studies were published in 2004 (Gott et al., 2004a; Gott et al., 2004b), meaning that the findings and experiences may have been dated. The views by clinicians may have been a sign of the social norms at the time which may not be replicated if the research was to be repeated today. Moreover, the studies also stated that clinicians felt unprepared for conversations around sex due to a lack of training yet due to the studies taking place 20 years ago the training that clinicians receive may have improved.

All qualitative research that takes place can be subject to bias of the researchers own personal views and experiences which influences the way in which the literature is analysed (Malterud, 2019). It should be noted that the current review was conducted by a young, white, heterosexual woman who is currently employed by the NHS as a trainee clinical psychologist. Societal views surrounding sex (Nagoski, 2015) and the pressures of working in the NHS (BMJ, 2023) may have impacted the views of the researcher, and therefore the interpretation of second-order concepts, and the development of the three third order concepts.

Conclusions

The current meta-ethnographic synthesis provides insight into the experiences of health care professionals exploring older adult sex and sexuality with their clients. The review highlights the barriers clinicians experience such as lack of training, ageist views, and concerns around offending clients. The issues discussed in this review indicate a number of directions research into older adult sexuality could take. One area of further research is trainee and qualified clinical psychologists' experiences of talking to older adults about sex, sexual health and sexuality.

Research aims and questions

The meta-ethnographic synthesis found that health care professionals struggled to talk to older adults about sex and sexual health due to barriers such as identity, sexuality, training and thoughts around which discipline was best suited to having this discussion with older adults. This thesis will therefore explore trainee clinical psychologists and clinical

psychologists' experiences of talking to older adults about sex and sexuality, what supported these conversations and what made them more difficult. Doing so will address gaps in the literature, with one gap being the limited amount of research exploring the topic of older adult sexuality, and a second gap being the question of clinical psychologists' experiences of talking about sex to older adults. This thesis will therefore aim to develop some understanding of clinical psychologists' and trainee clinical psychologists' experiences of doctoral training, their experiences clinically and how this has supported their development as therapists.

Aims

One of the aims of this study is to explore how sexual health and sexuality translates into the professional training of clinical psychologist trainees in the United Kingdom. The majority of trainees in the UK are funded by the NHS and receive Band 6 salaries. They have placements in NHS services, with many having worked in the NHS before training as assistant psychologists or other complementary roles. There is a limited amount of research exploring trainee clinical psychology training courses across the UK approach the teaching of sexual health, or how trainees or newly qualified psychologists feel approaching these topics with clients and, in particular older adult clients.

This thesis will explore:

(1) The training neophyte clinical psychologists received concerning sexual health through their programme of study and through clinical practice

(2) How neophyte clinical psychologists have found exploring and addressing sexual health through their clinical practice and as part of a multi-disciplinary team

(3) Adaptions made to case formulation as a result of sexual health issues being

raised

(4) The modalities favoured by the clinician to formulate and use therapeutically

(5) The impact this has on their ability to integrate sexual health issues into both formulations and their clinical practice

Chapter Two: Methodology

"Sex is an attachment behaviour, reinforcing the social bond between adults. Sometimes it take the form of passionate, joyful sex between people who are falling in love with each other." Emily Nagoski,

As detailed in the quote above sex takes many forms and means different things for different people. This study will explore clinicians' views on discussing sex and sexual health with older adults and discussing this topic with other professionals in MDT meetings and in supervision. To fully explore and understand clinicians' views and experiences, reflexive thematic analysis will be used. The reasons behind this selection and further details on thematic analysis will be detailed in this chapter.

Position and Orientation

Some believe that it is important in qualitative research for the researcher to detail their philosophical stance. This is thought to be important for the reader so they can understand how the researcher's views may have influenced the analysis and interpretation of the results. Social constructivism epistemology was used to inform the reflexive thematic analysis design selected for this study.

Epistemology

The epistemological position held by the researcher of the current study was considered with the support of Willig's (2012) paper where the different orientations are explored. Willig (2012) shares that qualitative research explores meaning which is influenced by an individual's subjective experience as this impacts how a researcher makes sense of and analyses participants' interviews. The researcher's own opinions and beliefs facilitate and limit the information that can be gained from qualitative information. For example, the

researcher's experience of the subject under investigation should be considered as it may frame and alter the analysis of participant's interviews.

The researcher's life experiences in the current study need to be considered as they influence the meaning that is given to the data in the current study. The researcher is a white, middle class, cis-gendered women in her late twenties. They were also raised in a family of medics, predominately doctors and nurses, where a medical lens was heavily present in family conversation, to some extent removing the shame of normally taboo subjects. An underlying assumption in the family discourse is that open discussions around potentially embarrassing topics can ensure that people feel able to seek support for possible health problems in order to guarantee that sinister health complications are not missed. This may have resulted in the researcher being more open to discussing personal and potentially embarrassing topics, such as sex. For example, I feel passionate about the topic older adult sexuality, which is a doubly tabooed topic, and wanting to open up the conversation with other clinicians to support the holistic wellbeing of the clients' clinicians support in the NHS.

Willig (2008) shared three questions that researchers are able to use to explore their own bias and assumptions. The questions explore areas such as: the knowledge they hope to develop, what is the relationship between the researcher and the knowledge that is developed, what assumptions they hold in areas such as psychology and societally. These questions were used in the current study which provided the following answers. That the researcher is thought of as an 'architect' who aims to 'deconstruct' due to their belief that the social and psychological world is socially constructed (Willig, 2012).

Social Constructivism Theory

Qualitative research commonly assumes that the knowledge that researchers want to develop is not solely knowledge about the topic or experiences but also how participants and therefore society in general construct this knowledge (Willig, 2012). Social constructivism

theory states that our knowledge about the world is developed through interactions between people socially, the internet and the media. This impacts our views, values and creates a shared view in society (Segre, 2016). This could be between a small group of individuals that create their own cultural views, or could be on a large scale, such as a societal view. This is explained by Segre, who wrote that "Everyday life is made possible by a common, shared stock of knowledge which provides instruction on the appropriate conduct in a variety of circumstances" (2016, p94). This concept can be further understood by Berger and Luckman's description of how people understand the world around them ''differentiates reality by degree of familiarity'' (1966, p 57). Social constructivism can be used to explain cultural views of sex and sexual health (Folley et al., 2015).

As discussed in the introduction section of this project, a person is influenced by the environment they have grown up in, for example an older adult who grew up as a catholic may be more likely to have been taught by their families and the church that sex outside of marriage is a bad thing, at times leading to negative results such as Mother and Baby homes (Clarke, 2021). Once married it was believed that sex between married couples should not be discussed (Kasif & Band-Winterstein, 2017). An individual who grew up in this kind of environment may hold views very different to the views of someone who grew up in a family where sex was not a taboo subject and who received sex education lessons in school.

When considering the impact social constructivism has on the view an individual holds about sex, there are a number of factors that could be considered: religion, age, gender, culture, sexuality and own sexual history. Social constructivism and intersectionality could be a possible explanation why some people find it more difficult to discuss sex and sexual health, this could be a result of their views or concerns around the views of the client. As the differing, or possible different views held by the client and clinician may result in both members of the dyad feeling more hesitant when broaching the topic of sex, sexual health or

sexuality due to fear of causing offence or embarrassment. It is possible that differing cultural views may be revealed through the- reflexive thematic analysis of this study (Ussher et al., 2017), or be discussed explicitly by participants.

Feminist Theory

Willig (2012) states that qualitative research is somewhat political in nature, with researchers being drawn to give a voice to those in society who are underrepresented in society or social groups that are at a disadvantage. This is true of the current project where older adults are being considered; previous research has stated that older adults can be at a disadvantage with some receiving suboptimal health care (Rogers et al., 2015). In conjunction, is that the voice of psychologists discussing older adult sexuality has not previously been discussed in the UK. Feminist researchers have been critical in supporting the development of qualitative methodology in psychological research (Willig, 2012).

There is thought to be gendered discrimination in academia with fewer women working in academia, publishing articles and articles published have fewer citations demonstrating the importance of considering intersectionality in research (Kucirkova & Fahad, 2023). A feminist position has been developed from intersectional feminism, which determines that different forms of inequality interact with each other (class, gender, race, education) and impact an individual's experience of discrimination in society and helplessness (Crenshaw, 1989; Harding, 2004).

Feminist theory seeks to remove the power imbalance in research, it is therefore important to consider this in the current project due to social inequality older adults experience in society and more specifically in health care. The clinicians supporting older adults have to consider the ageism that clients may experience; which is further influenced by their gender, class, race and sexuality. In order to consider the power imbalance of older adults and clinicians in services a feminist lens will be utilised. The experiences of

discrimination and difference will be considered in the interviews with clinicians to support the consideration of the clinicians- client dyad. The understanding of this dyad will be used to inform recommendations for clinical psychology doctoral teaching, supervisor training and therapeutic interventions. Recommendations will be provided in the discussion section of this study.

Summary

This section states that the main epistemological position in this project is social constructivism theory. This is due to the belief that the qualitative data from the interviews will support the development of an understanding of clinicians' views of older adult sexuality, the construction of this belief, how this belief impact therapeutic and indirect clinical work as a clinical psychologist in the NHS. The development of this understanding may be impacted by the constraints caused by semi-structured interviews and the possible dynamic of being interviewed by a trainee clinical psychologist whose belief is that older adult sexuality is an import topic for health professionals to consider in services. The development of the themes in the results section of this study will also be informed and to some extent limited by the researcher's own beliefs, values and life experiences.

Reflexivity

Willig (2012) discusses the importance of researcher reflexivity in qualitative research as the researcher orientation and experiences gives meaning to the data. Previous research has detailed the importance of ensuring high levels of reliability and validity in qualitative methodology (Long et al., 2020; Malterud, 2019). From September 2022 until the completion of the analysis, a reflective journal was kept by the researcher. The journal was used to record all thoughts that arose around the project; this included more formal theoretical considerations whilst also capturing new undeveloped ideas (Bazeley, 2013). This included

personal reflections of the interviews and data, but also took a self-critical stance. This ensured that the researcher's preconceived views or opinions did not influence the themes that were created any more than would be expected. The journal was also reviewed to support and justify the development of themes, analysis and the write up of the study (Bazeley, 2013; Hammersley & Atkinson, 2007).

Design

The inclusion criteria of the meta-ethnographic synthesis used to inform this project was a qualitative methodology. Although the methodology did differ between studies, all of the included studies provided rich insight into the dilemmas and complexities facing health professionals when considering older adult sexuality. The nuances considered in the studies would not have been captured by a quantitative methodology. Therefore, it was proposed that, due to the exploratory aims of this study, a quantitative methodology would not be able to fully explore participant's experiences in detail, or with the "greater depth of understanding we can derive form qualitative procedures" (Kaplan, 1964, p.2060).

A qualitative research design implementing a Reflexive Thematic Analysis design as detailed by Braun and Clark (2006) and further developed by Braun and Clark (2022) was selected. After consideration it was felt that this design would be the best fix to explore this topic for a number of reasons: (1) it employs individual interviews which would allow participants to explore the topic in-depth without feeling self-conscious and (2) analysis would provide themes that could go on to inform further research in this area which is critical to increase the understanding of trainee and clinical psychologists experiences of talking about older adult sex, sexuality and sexual health in the UK.

Participants

A purposive sampling was used in this study as a sample of trainee clinical psychologists and qualified clinical psychologist who have qualified in the last five years were required. After consideration it was decided that only trainee clinical psychologists and clinical psychologists who had qualified in the last five years would be included. This was to increase the likelihood that participants would be able to reflect on their experience of training, and (recent) teaching on older adult sexuality.

The decision to interview clinical psychologists and trainees and not general health professionals was due to the lack of literature in this area, with experiences of psychologists not having been previously explored. After reflection it was decided that it was important to explore one group of clinicians first, and it was also noted that clinical psychologists often provide supervision or are in leadership roles within teams. It was therefore felt that psychologists' views may be impacting how different teams' function. It is an area that sees the stigma of both older adult's ageist views and the taboo that still exists around sex. One of the aims of this research is to explore the teaching provided on older adults and sex it was felt important that participants were able to consider the teaching they received whilst undertaking their clinical psychology doctorate training, and how if at all this impacts their practice.

After reviewing the literature around thematic analysis, it was decided that 12-16 participants would be an adequate sample for the qualitative interviews. Guest et al. (2006) found that the number of codes found after 12 interviews decreased and were not of the same quality. Therefore, it was agreed that 12 participants would be sufficient, but the target would be 15 participants.

The sample is made up of 15 participants, with 11 trainee clinical psychologists and 4 qualified clinical psychologists. Due to the smaller number of qualified clinical psychologist participants and the small number of trainee clinical psychologists from different universities it may be that the findings are not generalisable, to all trainee clinical psychologists or newly qualified clinical psychologists in working in the UK (Braun & Clarke, 2022). However, the experiences of the participants provide insight and could be transferable to other trainee and clinical psychologists experiences (Braun & Clarke, 2022).

All the participants were able to choose their own pseudonym; they were assigned this in alphabetical order corresponding with the order of their interviews, so Alvin was first with Bonnie second and so on. Participants in this study self- selected their own pseudonym allowing participants to select a name that they felt matched their culture, religion, gender and personal preference. Information on how the participants in this study were recruited is detailed in the Recruitment section.

It was not an inclusion criterion for participants to currently work in older adult's services. Several of the doctorate programmes require students to attend a six-month placement in older adult's services, or many may have worked in these services before training, as support workers or as assistant psychologists. It should also be considered that placements in neuropsychology, stroke services and clinical health services may provide trainees with experience of working with older adults. The different pathways and experiences of participants were all felt to be valuable.

To be included in the current study participants were required to have attended, or to currently attend a clinical psychology doctoral course in the UK, although they were not required to be currently working in the UK or the NHS. It was felt that participants had to

have attended a doctoral course in the UK so that they could consider and reflect on their experiences of training, allowing themes and recommendations to be developed in regard to the clinical psychology doctoral training that is being funded by the NHS.

In the current study it was decided that participant demographics would not be shared in a table in order to protect participants' identity as in their interviews' participants shared personal information such as their gender and sexuality, experiences of their training and workplace. In this study four participants identified as male, one person identified as non-binary and ten participants identified as women. There were a larger number of female participants, and whilst this may be a potential limitation of the sample it is reflective of the clinical psychology population, as the larger proportion of trainee clinical psychologists getting onto training are female (McCormack et al., 2022). The strengths and limitations will fully be discussed in the discussion section of this thesis.

The university that the participants attended for their doctorate was also included in the survey participants completed before they took part in the interview. However, to ensure anonymity this is not included in a participant demographic table. Participants who took part in this study were currently training at or had attended the following universities: Essex, South Wales, Sheffield, Teesside, Lincolnshire, Leicester, Southampton and Plymouth.

It was felt that this information is important due to the fact that some of the interviews reflected on the training they received on sex, sexual health, sexuality and older adults. It is understood that the structure and model favoured by different universities may alter how much consideration is given to these topics. This is not to say that one university is better than another, only that on this topic some students may be better prepared for these discussions.

Recruitment

Recruitment for this thesis was conducted through different channels. One way in

which participants were recruited was through clinical psychology doctorate courses. The researcher spoke with a number of clinical psychology doctorate courses in the UK via email, and the courses then distributed the information flyer (Appendix 3) throughout their three cohorts by email. Participants who had already taken part in the study also shared the information flyer with trainee clinical psychologists and qualified clinical psychologists that they felt may be interested. Another form of recruitment was through social media where the flyer was shared with clinical psychology trainees and newly qualified clinical psychologists. This was also supported through word of mouth with participants sharing the research with their friends, cohort and colleagues. The final way in which participants were sought was through The British Psychological Society (BPS) and its Division of Clinical Psychology and the Pre-Qualification Group (PQG), and the BPS Division of Clinical Psychology and Older Adult Faculty also shared the recruitment poster. The researcher also presented their project at a conference day in 2023 at the University of Essex for the three cohorts completing clinical psychology doctoral training, where students were encouraged to contact the recruiter if they would like to take part in the study.

Materials

All interviews conducted for this thesis took place over Zoom, participants gave consent for the interviews to be recorded and saved. The consent was given in writing over email and verbally before the interview started. It was ensured that participants were aware that they could withdraw from the study at any time. The recordings were saved on the main researcher's account with a password required to access the recording. As the recordings took place online it meant that participants across the UK, the clinical psychology training across the UK and remove the location of training or NHS trust initiatives.

A semi-structured interview plan was devised (see Appendix 4). This was designed based on the aims discussed in this chapter, over time the structure evolved with the support of a qualified psychologist working in an older adults' inpatient services. However, it should be stated that the plan was used to support the interviews with participants and not as a formal structure. In each interview all four aims were discussed but the research was led by the participants on certain areas that felt critical to their personal experiences. Consistent prompts were utilised throughout the interviews to support clinicians to answer, with the Gibbs (1988) model of reflection and the University of Edinburgh's Reflective Toolbox (sourced, 2022) used.

Data Collection

All data was collected between October 2023 and November 2023. Participants were sent a survey that they completed before they took part in the semi-structured interview. The survey explored but was not exclusive to: the gender the participant identifies as, year of study or year since qualification and their experience of supporting older adults professionally. The semi-structured interview explored key topics, but the order that the topics were discussed was not regimented and further exploration occurred in some of the interviews. Some of the key topics discussed were:

(1) The training neophyte clinical psychologists received concerning sexual health through their programme of study and through clinical practice

(2) How neophyte clinical psychologists have found exploring and addressing sexual health through their clinical practice and as part of a multi-disciplinary team

(3) Adaptions made to case formulation as a result of sexual health issues being raised

(4) The modalities favoured by the clinician to formulate and use therapeutically

(5) The impact this has on their ability to integrate sexual health issues into both formulations and their clinical practice

Procedure

After recruitment participants then contacted the researcher via email, which was documented on the study information sheets. The participants were allowed time to discuss any questions they may have, via email or over the phone before they consented to take part in the study. They were then sent a consent form (Appendix 1), which they reviewed and signed prior to an interview taking place. Once the consent form was received a time for the interview was arranged, as detailed on the information sheet and the consent form the interviews took place over Zoom. Prior to the interview participants completed a survey of demographic information, this was used to inform how the questions were asked in the interview, this information can be seen in Appendix 5. Upon meeting over Zoom time was taken for introductions, if there were further questions regarding the information they had included on their survey sheet then this was a chance for the participant to elaborate on their answers, with the researcher documenting this information. Participants were reminded of the information detailed on the information sheet, participant sheet and the consent form. The interviews lasted between 42 minutes and one hour and 15 minutes.

Time was taken at the end of the interviews to debrief with the participants, if they wanted this space. All participants were given detailed of charities that could provide them with further support if needed. None of the interviews occurred straight after each other, this allowed the researcher time to reflect on the interview and detail any thoughts in their reflective journal.

The interviews were transcribed by the lead researcher; this was an in-depth transcription including pauses and all utterances the participants made. When applying for ethics the researcher stated that an outside organisation may be used to transcribe the interviews. This information was also included in the consent form, so the interviewees were aware an outside organisation may view the recordings of their interviews. However, after the interviews were complete it was decided that if the researcher transcribed the interviews this would add an additional layer of understanding to the data and participants' experiences. The researcher then read through these transcriptions and listened to the recordings numerous times to fully get a feel for the information before analysis took place. Notes were made on the transcription by the researcher for information such as tone and any other information that was felt to be valuable. Further thoughts and reflections were also detailed in the researcher's reflective journal and shared with the researcher's supervisor.

Analysis

The transcripts were analysed using reflexive thematic analysis detailed by (Braun & Clarke, 2006; Braun & Clarke, 2022). Reflexive thematic analysis was selected to analyse this data for a number of reasons, one of which is that there is a limited amount of research in this area so therefore this is a somewhat exploratory study. To understand better clinicians' feelings and emotions about discussions and supporting older adults with their sex lives and sexual health. As Braun and Clarke state "thematic analysis is a method for identifying, analysing and reporting patterns (themes) within data" (2006, p 76). Reflexive thematic analysis is made up of 6 steps (Braun and Clarke, 2022), each of these steps are detailed below in Table 3.

Table 3

Detailing the steps involved in reflexive thematic analysis taken from Braun and Clarke (2022)

Step	What this involves
Step 1- Familiarisation with the data	This includes rewatching the video interviews to gain a deeper understanding of the interviews. The interviews were then rewatched a second time to transcribe the interviews. The transcripts were then reread, this was done alongside reviewing notes taken after the interview and after rewatching the interview. This included initial thoughts generated, including tone and non-verbal cues. The reflective journal was also reviewed at this stage.
Step 2- Generating initial codes	Step 2 included reviewing all transcripts and noting sections that were of interest, linked to the aims of the study and significant descriptions. Time was spent coding all transcripts. Each transcript was reviewed and coded before the different code labels were gathered.
Step 3- Generating initial themes	This step included reviewing all initial codes. This was to help identify patterns such as shared or clusters of codes or underlying concepts in the different transcripts. This may have been similar codes or similar underlying concepts in the codes. This is how the initial themes were created, this is an active process and these themes continued to develop influenced by the data, aims and the researchers' knowledge. In this step the initial themes were reviewed to insure the themes 'fit.
Step 4- Developing and reviewing themes	The initial transcripts were also reviewed to ensure that the themes developed were correct and information was not lost during the previous steps. Themes were also individually reviewed to check the codes and themes created shared a clear meaning. Themes were collapsed together if when reviewed they had a shared concept or separated if the theme related to two different concepts. This step also includes the development of what is known as a thematic map which details how the themes interact with each other and the research field.

Step 5- Refining, defining and naming themes	After themes were collapsed and separated each theme was reviewed again to check that the theme had a clear concept and how this fit into the overall dataset. During this step notes were written which were reviewed until a finalised this name was created to describe the theme.
Step 6- Producing the report	The final stage is the write up of the current study which involved detail the themes and subthemes created. The themes generated from the dataset are discussed in relation to the current literature, research questions created and recommendations for future research and clinical application. This is presented in an introduction, method, results and discussion.

The thematic map will be included in the results section of this report, as will the theme name headings and information on each of the themes and what they include. After consideration it was decided a 'bottom up' approach would be appropriate for the current study. One way in which this was ensured was by collecting and reviewing the data at the same time, so Step 1 was occurring as further data was collected (Jovicic & McPherson, 2019). This allowed the interview schedule to be developed to include new areas of exploration.

To ensure trustworthiness in line with Braun & Clarke (2006) the supervisor of the researcher reviewed and critiqued the themes; time was also given for the researcher to justify the themes to their supervisor.

Ethical considerations

All participants who took part in the current study provided informed written and verbal consent prior to taking part in interviews. Prior to participants providing consent for the study, they were given information on how their details would be stored. The researcher and the transcriptionist were the only people who had access to the recordings of the

interviews. The recordings were saved under the pseudonym in a password-protected document. Once the thesis and viva corrections have been completed the recordings the researcher has saved will be deleted. The transcripts were also saved under their pseudonyms and will also be deleted upon completion of the thesis.

A potential concern is that some of the participants may have left the NHS or clinical training and therefore feel that they are able to be more open about their experiences and any difficulties that arose. For participants that are still part of the way through their training or employed by the NHS as a qualified member of staff they may feel concerned about disclosing some information regarding the services they work in. It is also possible that reflecting on the university course they attend may leave them with feelings of annoyance towards the course due to feeling unprepared in certain clinical settings.

It should also be noted that the topics discussed in the interview could make some individuals uncomfortable and possibly embarrassed. It could cause them to reflect on their own practice or on their own family members unconsciously (Simpson et al., 2017). This could have an impact on participants after the interview. Due to the nature of the topic, it is possible that these discussions could have triggered difficult memories participants have around sex, sexual health or receiving support around these topics. Participants were provided with information on services that provide support before they started the interview and were reminded of these services at the end of the interview.

Before participants for the study were recruited, ethical approval was applied for and obtained from the University of Essex. Due to participants being recruited through university courses, word of mouth and social media, NHS ethics approval were not required.

As detailed in the interview schedule section, participants provided informed consent before they completed their interviews. Prior to the interviews commencing, confidentiality was explained; this included that if the research was concerned for their safety or the safety of

someone else the researcher would have to disclose information, including possibly sharing this information with the research team. After consultation with the research supervisor, authorities and emergency service could be informed. Participants were provided with a participants information sheet which detailed information of charities they could receive support from.

Disclosures

At the start of the interviews, confidentiality was discussed, ensuring that participants understood that if they said anything what was deemed to raise concern about their, or someone else's safety then confidentiality and their anonymity would have to be broken. I explained that if this event occurred then I would first discuss it with them and I would share my concerns with my supervisors, and if it felt appropriate then I would contact emergency services or other relevant organisations. No concerns were raised in any of the interviews.

Planned Dissemination

This study was part of the researchers Clinical Psychology Doctorate at the University of Essex. The research team discussed and agreed on a number of peer-reviewed journals that the study would be submitted to. Participants were given the option when they completed the interviews to be notified of when the study would be completed so they could be given a summary of the findings. If participants did want to be notified, they were provided with a final summary over email once the study was completed.

Conclusion

This chapter provided details of the methodology selected, the philosophical views of the researcher and analysis selected. The chapter also includes the reasoning behind the selection of reflexive thematic analysis as well as how participants were recruited, the interview schedule and how the data was analysed.

Chapter Three: Results

Chapter overview

This chapter presents the results of 15 semi-structured interviews conducted with 11 trainee clinical psychologists and 4 qualified clinical psychologists. The analysis has been completed using a reflexive thematic analysis methodology. This chapter will present the demographic information of participants who self-selected for the study. The themes and subthemes will then be presented utilising participants' own quotes from the interviews.

Demographic information

Of the 15 clinicians who volunteered to take part in the study, four participants identified as male, one person identified as non-binary and ten participants identified as women. The experience of participants who took part ranged from first year clinical psychology trainees to psychologists who had been qualified for four years. The number of participants that were currently attending or had attended; six from the Universities of Essex, one from South Wales, three from Sheffield, one from Teesside, one from Lincolnshire, one from Leicester, one from Southampton and one from Plymouth. Trainee clinical psychologist participants were made up of; one participant who was on the first year of the doctorate course, three were in their second year and seven in their third year. Of the qualified participants two were in their first year qualified, one in their second and one in their third post qualification.

Participants selected their own pseudonym that they felt captured how they identified using the letter corresponding to their order of participation, meaning the first participant was A and the final participant O. If participants chose to not pick a name one was given to them. A number of participants were conscious of being identified due to the demographic information provided, and therefore it was agreed that participant demographic information

would not be cross referenced resulting in them being identifiable. Ethical approval was not sought to gain detailed demographic information from participants to present in the current study. Participants shared their concern of being identified due to the limited number of trainees at the universities they had or did attend. They did not want to be identified due to the possible criticism of the course or placements.

Table 4

List of Participants

Order of Participation	Self- Selected Name
1	Alvin
2	Bonnie
3	Chris
4	Defne
5	Elsie
6	Freddie
7	Gabby
8	Hannah
9	Ivan
10	Jade
11	Ken
12	Lyla
13	Mike
14	Naomi
15	Olive

Overview of findings

From the interviews 4 themes and 23 sub-themes were generated. Each theme will be described individually followed by the subthemes. Quotes from participants are also included to bring the themes and sub-themes to life, the quotes range from phrases to paragraphs. A

thematic map (Braun & Clarke, 2022) was generated to illustrate the relationship between the themes. The datasets from the trainee clinical psychologists and the newly qualified clinical psychologists were not reviewed and analysed separately as trainees and newly qualified may have similar experiences of supervision with new supervisors, new teams and trainee. Newy qualified members of staff may also have limited experience of talking about older adult sex, sexuality and sexual health. To ensure that information was not lost, and participants experiences were all valued all datasets were reviewed and analysed together to create the themes and subthemes seen in Table 5.

Table 5

Themes and subthemes

Theme	Subtheme
1. Who am I and who are you?	o The impact of the church o It's a very different world o I will automatically associate them with my grandparents o Maybe I'm a little bit judgmental o Gender
2. I am a psychologist I should know what to do	o I don't think it ever got relayed back to [the] MDT o I have permission in supervision to be thinking about that o I feel quite like excited for the future o It's always been with a risk focus in mind o The permission the teaching gave o That's relevant to a formulation
3. How can we possibly talk about this?	o I just I felt embarrassed. I felt like, Oh, my gosh! o This whole narrative about older people not really having sexual needs o Kind of just generally find that area interesting o A strong enough therapeutic relationship o Talking about having sex with like a husband or a partner o What is the script?
4. You shouldn't be having or talking about sex	o Taboo o They shut it down and they wouldn't want to talk about it o What does that make them think of me? o Their children I think they would find it strange o Sex was tinged with, with sadness o Learning Disability

Table 6

Cross- comparison of participants by subtheme

Participants	Subthemes																						
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23
Alvin	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*		*	*	*	*	
Bonnie	*	*			*	*	*	*	*	*	*	*	*	*	*	*	*	*		*		*	*
Chris	*	*	*			*	*	*	*	*	*	*	*			*	*	*				*	
Defne	*	*	*	*	*		*	*		*	*	*	*	*			*	*					
Elsie	*	*		*	*	*	*			*	*	*	*	*			*					*	
Freddie	*	*	*	*	*	*	*	*		*	*		*		*	*	*	*					*
Gabby	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*		*	*				*	
Hannah			*	*		*	*	*	*	*	*	*					*				*		
Ivan	*	*			*	*	*			*	*	*	*	*			*	*		*		*	*
Jade		*			*	*	*	*	*	*		*	*	*		*	*	*	*	*		*	*
Ken	*	*	*	*	*	*	*	*	*	*	*	*	*				*	*	*	*	*	*	
Lyla		*		*	*	*	*	*	*	*	*	*	*				*		*	*	*	*	
Mike	*	*	*	*	*	*	*	*	*	*	*			*	*	*	*	*		*			
Naomi	*	*		*	*	*	*	*	*	*	*	*	*		*	*	*	*				*	*
Olive			*		*	*	*		*	*	*	*	*		*	*		*					

Theme 1: How does my identity and the client's identity influence therapy?

All of the participants were invited to think about their experiences of clinical practice before training, during clinical psychology training and those who had qualified were able to also reflect on their qualified role. Participants described how their own identity, whether this was their religious or cultural background, influenced their own views of sex and sexuality which they reflected influenced how they felt talking about sex, sexual health or sexual wellbeing in therapy with older adults. Participants shared that they often felt shame talking about sex due to the stigma surrounding the topic. They shared their experiences of having these conversations, but also the times they had avoided the topic due to concerns they may offend clients and cause a rupture in the therapeutic relationship. They described how this was further compounded by client's identity and previous experience, such as the time period they grew up in and how this played a role in how their views on sex were formed. This theme is made up of five subthemes: The Impact of the Church, It's a very different world, I

will automatically associate them with my grandparents, Maybe I'm a little bit judgemental and Gender.

The impact of the church

Participants shared how they felt their religion and culture had shaped their views of sex, such as growing up outside of the United Kingdom and experiencing multiple different religions.

> *"I think there was probably a religious element to it… And a lot of there was kind of like a lot of arranged marriages and things like that which I think then also was there was like some dysfunction stuff. But again, it wasn't talked about, and things like that. There was things like conversion therapy still kind of active and talked about and, etc."* (**Mike**)

They also described how they had been surprised by the views clients they worked with held about sex due to their religious background:

> *"…Was gonna go to hell for what had happened, and which was again really interesting for me, 'cause it wasn't necessarily something I was expecting, and it was lots of layers I felt when I was talking to her".* (**Bonnie**)

Participants shared their experiences that the influence of religion was even more powerful in older adult services compared with other services they had worked in:

> *"The impact of the church, like the churches, used to be a much stronger institution. The way that adults might have been older adults might have experienced sex before marriage is taboo".* (**Chris**)

They also shared the power their culture, or their families culture had on them and their views of sex which impacted them feeling confident in being able to think about sex would not be appropriate, to the extent that they did not even know the words to describe sex.

> *"But in Turkish I almost couldn't find the language. So I know, I said. I'm bilingual, but I've grown up in England so language that I have in Turkish pretty basic level… And I just couldn't find the language that would be appropriate. But I also think it brought something up in me where, like in English, I can be open about sex, but in Turkish it felt shameful." (**Defne**)*

Other participants shared that moving back to the United Kingdom they have been surprised by the level of stigma sex still holds in society:

> *"Because I've moved around a lot to lots of different countries, I think it's even harder to talk about sex here [UK]. I think I lived in Denmark, and it's a country where and in terms of sex and body image is very liberal"* (**Freddie**)

There was a feeling shared by other participants that felt it went against British culture to find it easy to talk about sex positive cultures…

> *"It probably says something about yeah my own… Oh, my gosh! My own Britishness, my own embarrassment."* (**Alvin**)

> *"I went to Catholic school. We didn't talk about sex, you know, and so I feel like I've got a lot of catching up to do compared to… the other trainees like on my cohort."* (**Naomi**)

The families, schools and countries participants had grown up in appeared to impact not only their views and language around sex but there was also a subtle impact on their

identity and what it meant for them as ‘Turkish’, ‘British’ or an ‘expat’ to be explore sex later in life and understand the feelings of shame associated with even the using the word ‘sex’.

It’s a very different world

Participants spoke about feeling very aware of the perceived generational differences between themselves and their older adult clients. They shared that older adult clients seemed very different to other client groups:

> *“I love working with the older adults and the older people because they are such a respectful generation. But you're right, like… that's a taboo to talk about sex, you know you don't talk about it”.* (**Alvin**)

Participants shared that they felt hyper-aware of the stigma older adults may have grown up with such as view around sex before marriage, LGBTQ+ rights and even the level of sex education they had received:

> *“This country alone has changed so much, you know, with AIDS epidemic and you know, laws around divorce…for older adults I think for that generation it was more you spoke to the person you're having sex with about sex and no one else, and that saved for the relationship.”* (**Freddie**)

This hyper-awareness influenced the level of importance that was placed on sex in the sessions and their perceived ability to bring it up. Bonnie shared that she was shocked by the practices that were still occurring in her local area in the last 100 years.

> *“She got pregnant with a boyfriend when she was about 18, and they weren't married, and then, in those days like that was really frowned upon, and to the point where her parents shipped her off to a Mum and Baby Institute.”* (**Bonnie**)

Ken described how he was aware that the older adult population is constituted of different generations of older adults whose experiences in their lifetime have been very different:

> *"This might sound like a bit of a sweeping generalisation for a lot of people who are older you know not necessarily well, and 65 is not that old I don't think, but like people who are much like sort of 80's and plus, I would say that upbringing and life has been very different and it's a very different world. To what we have now in terms of openness about that kind of thing".* (**Ken**)

Participants shared that the differences they felt, and hoped that the younger people they saw in children and young people services had experienced, Elsie shared:

> *"I think people who and particularly people who aren't heterosexual in particular kind of haven't had those opportunities to maybe feel safe before, obviously illegal in a lot of countries still, there's a lot of stigma and prejudice. I think it doesn't always feel safe. I hope people who are in a younger generation have been exposed to more opportunities to have safe conversations."* (**Elsie**)

I will automatically associate them with my grandparents

Some of the participants shared that part of their difficulty talking about sex concerned their embarrassment of feeling like they were talking about sex with their grandparents.

> *"I think I'd feel so uncomfortable talking about that kind of thing with my grandparents. Yeah, so I think it's that kind of association that that makes it difficult."* (**Olive**)

Mike echoed this sharing some of the difficulties he has experienced talking about sex with his grandparents and the difference in generations in terms of understanding LGBTQ+:

"Some of it's just to think about talking to my grandma. She's like, what bloody hell is bisexual" (**Mike**)

Freddie and Hannah discussed how they would feel talking about sex with their parents and how, for Freddie, that feels somewhat comfortable but conversations with older adults appear to hold an additional layer of complexity.

"My mum is much more open and I wouldn't necessarily talk to her about sex, but I have the option if I needed to, I think. Whereas, I would not even dream of talking to my dad about sex would just be such a no go. So, I think yeah, though same generation that the gender roles don't matter. I think generations going up it feels so awkward" (**Freddie**)

Whereas for Hannah her own age and experiences appears to make this conversation easier.

"I kind of see people I guess, like my parents being older and my mom just having a new partner. And so I kind of see that that is part of older adults life. And I don't know if that makes a difference. Yeah, I suppose if I was younger I don't know, I might find it more difficult" (**Hannah**)

Gabby reported that she has previously experienced older adults also putting her in the grandchild role and therefore she feels that it is an important to acknowledge to build a good therapeutic alliance:

"Age was always something I've brought into the room a little bit, because I think I get treated a bit like a grandchild sometimes, but with her I never did. She saw me very much felt like I was an equal, and she respected my position regardless of my own age." (**Gabby**)

Maybe I'm a little bit judgmental

Additionally participants were at times confused that their own personal views of sex differed from their professional views of sex.

> *"It's made me think a lot that I am someone that within my friend group talks very, very freely about sex, and but I do definitely find it trickier to bring it into the room with clients, and I think it's a very, very important part of people's lives. So I think your thesis or your research is causing me to question some of those like those barriers. Why they're there."* (**Freddie**)

> *"I'd think in my personal life I don't have any problems talking about people's sexuality, or, you know, people's sex lives or whatever I don't have a problem with those. I feel comfortable having those sorts of conversations."* (**Lyla**)

Other participants acknowledged that they felt that they were less confident talking about sex than others around them appeared to be:

> *"I'm not always the most comfortable talking about sex. And so, I think I'm probably okay with that. I'm like, that's fine, like, yeah, I need to know all the information, whereas potentially somebody else might be like, no, I'd like to know more about what that intimacy was like and what it meant to you to be able to understand your experience."* (**Naomi**)

Olive shared that she felt that her own views around sex could sometimes impact how she viewed a situation that was shared with her:

> *"Maybe I'm a little bit judgmental, judgmental probably a bit strong…I think maybe I like project my own feelings about what I need, like my own sort of needs and expect that other people's will be the same and without realizing I'm doing that"* (**Olive**)

Conversely, Hannah shared that she was aware that she struggled to and didn't want to talk about sex in her personal life and at times questioned this. Yet she was able to talk about sex in a clinical setting:

> *"I wouldn't say that I sort of always talk about sex in my own friendships. And I suppose, yeah, I thought, does that matter so that, you know, is that okay? If I don't talk about it a lot and I've come to the conclusion it doesn't really matter, but it's kind of important to allow it to be spoken about in therapy, if that's what somebody needs"* (**Hannah**)

Gender

Gender is a complex concept and a definition of gender was not provided to participants when asking about their experience of gender differences in therapy. Olive reflected that she thinks she is more critical of men compared with women:

> *"I wonder if I would have felt some anger towards [client] if she was a man I would have felt some anger towards her"* (**Olive**)

Participants hypothesised that they felt that if older adults perceived them to have the same gender then they would be more comfortable sharing information about their sexual wellbeing:

> *"I think, the sense that I got from the men is that they felt kind of quite comfortable talking to me about that, and it was something that came up quite quickly, whereas for her, it's not something that she was going to offer up offer as a potential, potential hypothesis."* (**Ken**)

Other participants shared that they felt that they themselves felt more comfortable talking to an older adult about sex if they shared the same gender as they felt they were able to understand their experiences better:

> *"I think it would feel more comfortable talking to a woman just because I feel that sense of like shared identity, I guess."* (**Elsie**)

> *"My own… Oh, my gosh! My own Britishness, my own embarrassment. You know that that. Maybe there's something about gender, that when it's your own gender it's all easy to talk about"* (**Alvin**)

Two participants Gabby and Defne shared that they felt that there was a lot of stigma still surrounding women and sex compared to men. Gabby provided an example of this in the media:

> *"You see like adverts, like you know the Blue Pill.. used like a bit of a joke by the media that actually, you know erectile dysfunction is common in older adults. Yeah, because of physical health or whatever. But vaginal dryness is never spoken about, and which is the equivalent in my eyes. An I think that is something you don't necessarily see those in films all kind of being like, masturbation is associated with males, not females regardless of age. So sex isn't normed for females. Sex is being used is a term for men, and it's been adapted for females is my perspective."* (**Gabby**)

Defne shared that she felt that the patriarchal views of sex still held in society today continue to impact women:

> *"As a feminist I think it is a way of silencing women and controlling women's behaviour, especially if I think of Turkish culture, because it's just simply not the same for men."* (**Defne**)

Theme 2: I am a psychologist I should know what to do

The clinicians often spoke about the confusion they had about what their role of a psychologist was within a team, especially around a topic that is divisive as sex. They spoke about the barriers and facilitators that allow psychologists to feel confident in supporting teams to implement a psychological perspective around sex. They also shared some of the barriers they had encountered, or felt fearful of encountering. It is also important to hold in mind that the participants in this study were either still in training or in the first five years of being qualified so they had experience of multiple teams on placement and some had the experience of being the newly qualified psychologist in a team but none of them had been in the same team for an extended period of times as a qualified member of staff. This theme is made up of six subthemes; I don't think it ever got relayed back to [the] MDT, I have permission in supervision to be thinking about that, I feel quite like excited for the future, It's always been with a risk focus in mind, The permission the teaching gave, the confidence to teaching gave and That's relevant to a formulation.

I don't think it ever got relayed back to [the] MDT

Participants shared some of the barriers that left them feeling silenced in MDT conversations. They recognised that this silencing could be attributed to their newness to a team and or that the culture of the particular team was such that certain topics would not be discussed.

> *"Think that, doesn't help having those sorts of conversations when you don't really know everyone is, you don't really know."* (**Lyla**)

Ken shared that circumstances were further complicated in teams where there was a predominant medical model, especially if psychology was not held in high esteem.

"Because it felt, you know, I guess it's not something that's as you know, chatted about that much. Generally, it's not something that was has really come up in any of the team meetings and I don't know if that's because it's a psychiatry service and is very medicalized and they really talk about life factors that might be impacting someone's distress" (**Ken**)

When a psychological perspective is not heard in teams this can leave psychological staff feeling that their voice is not heard or respected:

"I think psychological. Well, psychologist's voices are actually often not really. I think they're not often privileged in the way that maybe other voices are. I think it could sometimes be hard to actually get other people to receive different ideas that are perhaps a contrast with that nursing or medical approach, particularly to get them heard in a meaningful way. I think, like tokenistically, they can be heard, you know, but actually getting people to act on them, can be really difficult" (**Alvin**)

Participants shared reflections about how they felt being the person who has to talk in an MDT session.

"To be honest, I'm not amazingly good in MDT situations. I really enjoy watching MDTs. I'm weirdly fascinated in how they work... It's fascinating to see how they're all completely different. Some of them are really calm, some of them really diagnostic. Some of them are really just chaotic messes… But I'm not very good at piping up, and that's something I know I need to work on going into qualified life as a psychologist. That's one of your roles is to advocate to make sure that the client stays the centre of the conversation" (**Naomi**)

I have permission in supervision to be thinking about that

The relationships psychologists have with their supervisors can be essential in supporting reflective and reflexive practice. It is also a space that clinicians can challenge their views and consider the assumptions others might have about them. Elsie shared her experience of her older adult placement supervisor:

> *"He was a really good supervisor we should name drop him because he was very lovely. That really helped me to feel like I have permission in supervision to be thinking about that and how important it was take a pause to reflect on like what I'm bringing to the room just by, you know, just by being like a woman in the room just by, you know, openly talking about having a husband, what that would kind of signal to the people, and how that might interact with other people's difficulties."* (**Elsie**)

The length of time and how comfortable participants felt with their supervisor appeared to be vital for some clinicians to feel safe enough to have new conversations around sex.

> *"I think I think having already been so as a 12 month placement, or having already been there for 6 months, probably made the biggest difference in terms of feeling comfortable to speak quite openly about stuff. And yeah, I wonder if it would have been different earlier on."* (**Ken**)

Chris and Defne shared that their supervisors were surprised by the discussion about sex or did not appear to consider it to be an important fact in understanding a client.

> *"Maybe they'd have been a bit more up on like sex positivity kind of stuff. I'm not saying my supervisor was a prude, but I don't think she was like you know. I don't think it was on her radar"* (**Chris**)

However, Defne's recent teaching on sex and sexuality meant that she felt confident being the one who brought the topic to supervision:

> "*I remember, that period of time straight after that teaching where I had asked all my clients about sex, and I just vividly remember my supervisor looking a little bit confused. I think maybe she didn't feel this and it could have been the way I interpreted it but she just looked a bit confused about why are you asking about sex all of a sudden."* (**Defne**)

Ivan shared a difficult relationship he had with one of his supervisors that meant that he did not feel comfortable sharing parts of himself in that relationship which could have impacted his work with clients:

> *"I never, never told her that I was gay or I never acknowledged that part of [myself]. But I just didn't ever have those types of conversations with her…. as well like thinking about safety around sex and sexuality affects us all, doesn't it? It's part of our, we've all got a sex, we've all got kind of sexuality of, you know, in various forms, and if we don't feel comfortable talking about that, you know relations ourselves in the Supervisor then we might avoid talking about it for our clients as well."* (**Ivan**)

I feel quite like excited for the future

A subtheme that came from the interviews was that participants were questioning their views on the importance they placed on questions around sex, sexuality and sexual wellbeing. This conversation led onto conversation where they described their hopes for what they could achieve in their roles. Chris shared that they had started to make changes to the narrative on older adult wards around LGBTQ+ rights, it was shared that whilst on CAMHS and adult mental health inpatient wards there is information about LGBTQ+ rights and needs and often rainbow decorations on older adults wards this is often forgotten.

"I'm in a staff network group, which is for like LGBT people, and I discussed it there because I wanted to change the ward" (**Chris**)

Hannah shared her views on the importance of these discussions and how sex is something that is part of many people's lives just like other complex factors that makes up a person:

"It's kind of a part of life and just as death is all you know, subjects, faith, spirituality, all of that. It's kind of just being able to talk about it. And it's fine." (**Hannah**)

Jade spoke about how her role on placement naturally becoming one to start new conversations with staff and how this did have an impact during her time there.

"I think we used to add a lot of humour in there to make the person who didn't kind of talk about it very often to help her feel more comfortable. And she used to join in with kind of the humour. And it got to a point where occasionally she would start the conversations. Yeah, we spoke about sex a lot in the office to the point. It was written in my goodbye card." (**Jade**)

Gabby shared the importance sex can have in understanding a person and what motivates them:

"That kind of give us insight into what sex may serve as a functional, what that may look like people. But also, I guess it's also understanding whether older adults want to think it's important and want to talk about it." (**Gabby**)

Bonnie spoke about her hopes for the future as a psychologist and how she could be on the "brave" clinicians to bring difficult conversations to services and how important this is:

"I feel quite like excited for the future that we can start to have those conversations and so kind of draw attention to sex and sexuality and sexual health like. I feel like we have a real opportunity as psychologists to make them, to help other people think and to make a difference, maybe, which feels nice. Actually, you just need some brave people to start the conversation." (**Bonnie**)

It's always been with a risk focus in mind

Participants shared that when they had worked in teams supporting older adults when sex, or sexual behaviour was mentioned the conversation often would only consider the risk factors such as a diagnosis of dementia and vulnerability:

"Like 90% of the patients on the pathway, if not more all had diagnosis of dementia, and so it would be in context of that, or like sexually disinhibited behaviour" (**Lyla**)

"We literally, we collected behavioural data on aggressive behaviour and then we had a whole chart for sexually disinhibited behaviour". (**Alvin**)

Mike shared that in forensic settings he was aware that when men got older there was often the assumption that they would be less likely to commit a sex-based offense:

"So I think there's still that lingering thing like, yeah but at 70 they're not yeah, not gonna commit another sexual offense. Well, actually, if we look at the context, it's very plausible, especially with the online world." (**Mike**)

Conversely, Gabby shared her experience of older adults who might have experienced sexual abuse when they were younger were more hesitant to discuss sex as they associated it with risk:

"I've noticed that… older adults don't necessarily disclose sexual abuse as more, as openly as I think they do in the end but it's kind of the narrative around it is a little bit

more distant. And what I mean by that is it happened when they were younger, so they don't want to open Pandora's Box, or etc., etc. So when sex kind of comes into that, I think as a current activity of sex that is in the back of my mind to be like I don't know whether they're fearing that sex links to sexual abuse?" (**Gabby**)

Bonnie shared her experiences of conversations centring on risk and how this has meant that curiosity around sex has been lost and therefore a part of a person's identity has been lost.

"I think it's when in the past, when people have spoken about sex or sexual health, it's always been with a risk focus in mind… like in the past it so it's been seen as a problem rather than part of human life that everybody is entitled to be a part of yeah, I think it's it's really interesting, because I think I think that's what it is. It's always when it's discussed is because of risk rather than thinking about somebody's wellbeing and part of somebody's wellbeing which is quite, that makes me feel quite sad" (**Bonnie**)

The permission the teaching gave

Participants reflected on the teaching received on their clinical psychology doctorate course and whether this support the facilitation of conversations in the clinical role. Some shared that they felt the timing of when they received teaching on older adults and sex was too late as it was after they had finished placement, meaning that whilst on placement some felt that they were lacking in skills:

"I think because it came after the placement. I guess that was. It's hard to know. It was helpful in some ways, because you could reflect on what you'd done, but also a little bit tricky, because we didn't have those kind of skills" (**Elsie**)

Mike shared that he felt the culture within his cohort supported their teaching and allowed the cohort to discuss difficult and complex topics:

> *"Our course cohort its very social, constructivist kind of led, and like breaking down those barriers. Kind of things, and I think that's led by a couple of people in those things, and it kind of catches on, doesn't it?"* (**Mike**)

Jade and Defne shared that they found that the teaching gave them permission to bring the topic to placement and gave them the confidence to bring the topic up in therapy:

> *"And I don't think I would have acknowledged actually that it was what gave me permission to do it, or so like the things I was just saying to you about noticing. When they felt more relaxed, I was more able."* (**Jade**)

> *"And I wonder if that was because of the teaching, of just the permission the teaching gave, the confidence to teaching gave."* (**Defne**)

Ivan shared that his experience of course staff shying away from thesis topics around the topic of sex and sexuality:

> *"But and no one in the team supervised my (thesis) Oh, that's not, that's not true, [redacted] that's the second supervisor and the last 18 months or so, but it was externally supervised.* (**Ivan**)

Ivan also shared his views regarding the training clinical psychologists and how important he felt it was for psychologists to finish training competent in speaking about sex due to the significance it can have in client's lives.

> *"I think that as psychologists, we. I think, sex and sexuality, such a core condition of being a human being is such an like such a big part of the human experience. I think that clinical psychologist should leave training and be competent to understand that*

from a theoretical point of view, as well to actually understand… and the history of human sexuality and perspectives on human sexuality and also be confident to have discussions to explore sexual function and explore because also is what such a big thing about put, you know, everyone bangs on about quality of life, you know, like what is like, but to not ask about sex like. And you're asking about someone's quality of life like" (**Ivan**)

That's relevant to a formulation

Participants shared their experiences different modalities and how they supported formulations, Chris shared their experience of working with an older women who had 'come out' and how she considered her sexuality when formulating:

"Possibly that's relevant to a formulation depending on how she experienced coming out. And, you know, kind of internalized feelings around that and all her experiences of perhaps like discrimination, and difference, because I guess it's like a sexual minority whether or not you would experience difference." (**Chris**)

Freddie shared her experiences of working in IAPT and how sex was spoken about often to understand a person's difficulties:

"So I think that can, and also in even in IAPT, I spoke about sex quite often it came up in the like, either in physical changes or what they're doing differently. So they'd be like, Oh, my libidos dropped, or I'm not having sex as much." (**Freddie**)

Gabby shared how her understanding of sexual needs changed through a Compassion Focused Therapy case highlighting the different needs sex can serve for a person.

"It was kind of seen as more of a self soothe action. But also seems a bit of a drive as a bit of kind of they kind of thought they were good at it… You kind of query what you

do to kind of soothe yourself 'when I'm stressed I kind of masturbate' you like, okay, that could be like a self-soothing action. Actually having sex with men, random men that she doesn't know that was a drive, because it almost kind of kept her distracted from everything else, but also kind of gave her confidence." (**Gabby**)

Conversely, Ken shared that in his experience, it is the therapeutic alliance that makes the discussion around sex possible and meaningful for an understanding of a person and their difficulties:

"I think to be honest, regardless of what the model you use is, I think, probably and this is based off of this isn't based off any literature or anything it is just based off of a gut feeling it's probably more in the relationship that how you get to that. I think if you can safe enough or a space where someone feels able to sort of talk about that kind of thing I think, regardless of what you kind of do with that" (**Ken**)

Ivan shared his thoughts around the use of systemic, psychodynamic and CFT theories to understand sex and a person. However, he highlights the importance of sex not being demonised and labelled as a 'bad' thing.

"I think all of them lend something different, you know, like systemic ideas and theories are brilliant at thinking about kind of wider, societal and cultural kind of impact on how these conversations happen, or how we think or feel, or how we behave sexually and also thinking about the relationship between a sexual problem, and it being perhaps located in one person in terms of that person's penis, might not get hard, but actually being able to kind of think about rather than kind of kind of intra personal aspects more into kind of, and our interpersonal aspects as well. Then you've got things like psychodynamic… which talks a lot a lot about sex. But very pathological ways. And and yeah, quite quite scary kind of ways of talking about sex

or making sense of it. And and you know, you've got things like compassion focus therapy where you you know, you're from that evolutionary perspective, and I suppose some of that is, we talk about and post. Sexual impulse has been quite important, and a way to regulate and a way to kind of self soothe. You know this, I think they all link something unique." (**Ivan**)

Theme 3: How can we possibly talk about this?

Participants described their uncertainty about how they could introduce the topic of sex due to feelings of discomfort or shame. They often did not have the language to describe or ask about sex and sexual relationships in a clinician setting. Some participants shared that their curiosity of the topic supported their exploration but the more crucial factor appeared to be the strength of the therapeutic relationship. The six subthemes within theme three were; I just I felt embarrassed. I felt like, oh my gosh!, This whole narrative about older people not really having sexual needs, Kind of just generally find that area interesting, A strong enough therapeutic relationship, Talking about having sex with like a husband or a partner and What is the script?

I just I felt embarrassed. I felt like, Oh, my gosh!

Participants shared that there fear of being part of discussions around sex were often linked to feelings of embarrassment and awkwardness:

"I wonder if, if my lack of having these discussions with these couples was more centred around my confidence, is it confidence, embarrassment? I don't know." (**Defne**)

Gabby shared that she was shocked by her reaction to being involved in these conversations:

"And actually, that for me completely shocked me. Someone who, I feel is fairly open to thinking about the actual reality of kind of old adults with sex that that shocked me." (**Gabby**)

Lyla shared her hypothesis that the embarrassment was increased because the conversations were centred on older adults:

"Cause people felt uncomfortable, probably talking about sex at work anyway, but, like even the context of older people. I think maybe they even felt bit more uncomfortable" (**Lyla**)

Olive shared an example of a time she's felt embarrassed by the topic of conversation which she wanted to distance herself from:

"I almost like, like that, like sort of took a step, that like physically sort of move back a bit. I mean, I was on the phone. But yeah, kind of almost like froze like, Oh my God, what do I do with this? So yeah, there's definitely like tension there probably like some elevated heart rate. And yeah, general kind of like anxiety symptoms." (**Olive**)

The culture of the setting these conversations happened in also appeared to impact clinician in how comfortable they felt discussing these topics, even whether that was the type of conversation they were allowed to have:

"There was a lot of like timidity on the ward, I think, even with me to in their interactions round that patient about how to discuss sex with them or sexuality with them. And whether or not that was like an appropriate thing." (**Chris**)

Jade shared that this feeling of discomfort was also seen in the teaching on the Clinical Psychology Training:

"And I think other people in the cohort feeling really awkward with the topic as well. I remember that. And it is a shame, because, yeah, that teaching was good, and I remember taking it back to placement" (**Jade**)

This whole narrative about older people not really having sexual needs

Participants shared their experiences of ageist assumption that older adults did not have sex, or would not be physically able to have sex.

"I think because of this whole narrative about older people not really having sexual needs." (**Lyla**)

"If I'm honest, one of the questions that came through my head was. 'How is she doing that with her back pain like and her neck pain'? Like and that's one of the questions that in my head is almost kind of weirdly" (**Gabby**)

Freddie and Gabby reflected on how this assumption meant they may be less likely to show curiosity about sex and sexuality when speaking to older adults:

"It was something weighing on her, whereas unless someone of a younger generation has explicitly said they couldn't, they weren't having sex. I think I think my assumption would be that, that's a bigger deal for a younger person than it would be an older person." (**Freddie**)

"That's the same with anybody, really, now that I think about it, you know you should be doing that... I don't know. It feels a little bit more intimidating." (**Naomi**)

When working in Learning disabilities services Jade was made aware of this ageist view:

"We got a sex education program approved in that team, but only our younger adults could attend. So older adults, it wasn't considered appropriate for them to attend." (**Jade**)

Elsie shared her hypothesis that clinicians found it hard to understand older adult sexuality as very few older adults are still working:

"It's just I just think it's because, as clinicians, I'd rarely think any of us are older adults. So I mean, it could be the occasional person who's, you know, working over 65. But you know, if we're lucky, we're are not. So there's no clinicians active really, that are kind of in that can relate to that, because nobody is an older adult." (**Elsie**)

Kind of just generally find that area interesting

Curiosity around older adult sexuality appeared to support clinicians to be brave and start conversations in supervision and in therapy with older adults.

"No, it's never not gone well, but there's been times, I guess, when I brought it up and they just went 'No, that's not important. Okay I wonder why it's not important, and we explore to a bit. And they're like, no, it's just like if it's not something that I'm worried about. And then that's it." (**Elsie**)

During awkward conversations Defne shared an experience of how she persevered with the conversation which allowed the topic to be explored:

"So it was just this real awkward where she felt awkward. I felt awkward, and she was really I would say she was really brave because she persevered, and she really tried to talk about the difficulties with me. And I think I did, too I really wanted to hear what was going on for her." (**Defne**)

Ivan shared that earlier on in his clinical psychology doctorate training he was not as curious around this topic as he normally would be:

> *"That was my first ever placement on the programme and training, so I was quite maybe may maybe in terms of autonomy, you know, in terms of being brave and kind of thinking about the things that I would think about would be important. I suppose I was less relying on kind of my curiosity. Which naturally would have kind of encompassed sexuality in sex."* (**Ivan**)

Mike spoke about their experiences in forensic settings which alongside their interest in the topic allowed their confidence in exploring this topic to grow:

> *"I think the thing is because I was interested in forensic psychology, and therefore kind of my undergraduate was based around that, as was my master's. And then, in practice and kind of like, my research area has been around primarily sexual offending. So I think I was probably predisposed to be okay to talk about sex and things like that. Anyway, and kind of just generally find that area interesting. And you know whether that be offending or kind of dysfunction"* (**Mike**)

Gabby shared that after working in forensic settings she was aware that her confidence in this setting, regardless of age, differed:

> *"I think I'll still be curious. I probably wouldn't tiptoe as much if that makes sense and kind of be a bit vague. I think I definitely in forensics, depends on the offence and depends on the relationship that you have or see in any setting but I often notice that it's brought into the room a little bit more freely by the individual than in older adults. I think that then I'm attuned to that which then kind of gives me a little bit of a doorway to kind of step that step into that conversation without as much hesitation I guess"* (**Gabby**)

A strong enough therapeutic relationship

A *good enough*, therapeutic relationship appeared to be crucial when broaching the topic of sex and sexuality with older adults.

> *"You know we developed a strong enough therapeutic relationship where she felt she could tell me about those things that's like, oh, that's really good. That shows something that she feels safe enough to talk about. It's quite a really honouring thing for someone to bring that they feel safe enough to talk about, about it."* (**Naomi**)

> *"Yeah, but she actually responded, really well. And I think there was definitely something in our relationship that meant I felt comfortable enough to, to go there."* (**Bonnie**)

Participants shared that a good relationship felt important so that if bring up the topic caused a therapeutic rapport then this could be repaired.

> *"Like I didn't think that she would feel embarrassed or put on the spot, and it was quite a few sessions in, so we had a really good rapport by that point."* (**Freddie**)

Mike shared that in a group setting for family and friends of offenders in a forensic service it took time for group attenders to feel comfortable enough to tackle complex topics like sex and sexuality:

> *"The groups that I was running, for the women were like 5 week courses. So I think you probably did. We did probably get those conversations until like week 3 week 4. Once the group was kind of quite well established.* (**Mike**)

Talking about having sex with like a husband or a partner

A subtheme that was developed from the interviews was that some clinicians felt differently exploring sex with older adults dependent on their current relationship status.

Chris shared how dependent on relationship the idea of sex could often be forgotten in services:

> *"There's also something about forgetting that people who are single or who are widowed have sexual needs as well. You know that that that doesn't to go away."* (**Chris**)

Olive shared her hesitations around the perceived 'promiscuous' aspect of sex outside of a relationship and how this could may have impacted her emotional interpretation of the situation:

> *"It was something around the I guess, kind of more promiscuous aspect to it. And the fact it wasn't like, I don't think I still would have found it uncomfortable, but not as uncomfortable if it was talking about having sex with like a husband or a partner."* (**Olive**)

Freddie shared that she was more tentative when exploring relationships of a client who was married, and who appeared to have a positive marriage:

> *"If you are no longer having sex with your partner that you've had like that. This was her I think it's like a 68th wedding anniversary like they've been together such a long time. They were an amazing couple. But I think I saw you're an amazing couple, and I don't need to dig. Actually, that's a huge time span to be with someone and a huge number of years to be having sex with someone and then not. So in hindsight I think it probably was worth exploring."* (**Freddie**)

Jade shared her experiences of wives in services wanting to explore the topic when given the opportunity to share their experiences:

"Some of them whose wives stayed quite quiet during those questions got their wives involved, and it was something that they wanted to talk about, but needed permission to." (**Jade**)

Alvin shared his experience of working with an older adult exploring a new relationship but being consented about their vulnerability and how this influenced their work:

"Maybe this whole just an old bloke wants to get laid but it just happens to be someone you know who knows he's sitting on a nice pension, you know. It's a bit of an awkward thing, and where, where you how you work through that with people, is probably made more difficult by the fact that we don't want to talk about it." (**Alvin**)

What is the script?

One of the reasons/factors clinicians found it so difficult to start the conversations around sex with older adults is that they felt they did not possess the language or 'script' to have these conversations:

"I don't think they have a vocabulary around it. And I think because there's something more in terms of like scripts around sexuality." (**Ivan**)

Alvin equated this to his British culture where he feels that people avoid using the word sex:

"Being quite British, you know, we don't really talk about birds and the bees. Quite literally, we'd, we'd say birds and bees instead of actually talk same word, sex." (**Alvin**)

Freddie and Ken shared that they started the conversation tentatively considering what word would feel appropriate to use to initiate the conversation and allow the client to interpret it in their own way:

"And then how are you intimate together and just use intimacy rather than saying sex? And she seemed to kind of go with that like she was like, oh, and this is how we're intimate now, and kind of talked around sex." (**Freddie**)

"I think I use like the term 'intimacy', like physical intimacy. Rather than just saying, you know, don't know why I couldn't just say sex that probably would have been fine as well. But in my head again, being potentially too tentative at times. Just sort of yeah. Lots of I'm wondering I'm curious if you might be missing some sort of physical intimacy from your relationship?" (**Ken**)

Conversely, Bonnie shared that whilst she used similar language she was less tentative when starting the conversation which in that therapeutic relationship was receive well:

"I just I just said I'd I'm just wondering this, this is a bit of a personal question. But I'm just wondering how your experiences have impacted your relationships, having sex being intimate with other people. And yeah, I didn't really fluff it to be honest with you." (**Bonnie**)

Theme 4: You shouldn't be having or talking about sex

The final theme that emerged through the interviews was the underlying feeling that clinicians shouldn't be talking about sex. Participants linked this to the 'taboo' that still exists surrounding sex which they felt impacted them into feeling silenced and judged if they prioritised talking about sex and sexuality in a clinical setting, especially ones that had a dominant medical model. Theme 4 was made up of five subthemes; Taboo, They shut it down and they wouldn't want to talk about it, What does that make them think of me?, Their children I think they would find it strange, Sex was tinged with, with sadness and Learning Disabilities.

Taboo

Participants shared that they felt like there was a taboo surrounding sex which was amplified when talking about sex and older adults. Chris shared that in older adult services the topics were avoided:

> *"And I think also, because it's not something I know is quite taboo for older adults like in older adult services, we don't really discuss sex."* (**Chris**)

Defne shared that in Turkish culture it would be frowned upon to talk about sex especially with someone who is older than you:

> *"And as if I shouldn't be talking about it, and certainly not people that are older than me, and which at the time they were because yeah, I was young when I was in that service"* (**Defne**)

Chris shared that their experience of working in older adult services and older adult sexuality not being discussed:

> *"Certainly, it's not that there are no queer old adults or that no older adults have sex like. It's something that happens across the lifespan. So just kind of highlighting that highlighting attitudes that might be like make it harder for older adults to talk about sex and sexuality."* (**Chris**)

Gabby shared that certain topics such as sexuality and non-monogamous relationships are more of a taboo:

> *"I guess the sexuality side as well when we're thinking about it being quite sensitive topic in itself there is a societal narrative of quite stigmatizing behaviour to which there's a stigma anyway, within cultures within erm, what's the word, couple*

relationships, not open relationships. And I think people are scared of getting it wrong partly." (**Gabby**)

Freddie questioned why in therapy clinicians feel able to ask about suicide and other difficult topics but struggle to talk about sex:

"And it's also weird because it's something that's so like present in our everyday lives. Every bit of media talks about sex, Instagram, programmes they all show sex, whereas, like subjects like suicide… with a trigger warning, and we will freely ask about that in therapy. So it doesn't really make sense." (**Freddie**)

Mike shared his experiences of the topic of sex not being discussed can lead to older adults being less likely to access services in forensic services:

"We don't talk about it. We keep it to ourselves plus the shame that comes with sexual offending and the stigma. And I think those 2 things in combination then made it less likely that older adults would seek support and help." (**Mike**)

They shut it down and they wouldn't want to talk about it

Clinicians shared that the stigma surrounding sex has led to them feeling silenced in services:

"It felt easy to avoid, it felt. I wonder, if the clients wouldn't have expected to be asked about their sex life, in a memory service." (**Defne**)

Gabby shared her view of the cycle not talking about sex causes both in clinicians and clients in therapy:

"I think in terms of what might support it I definitely think about understanding the importance of recognizing that within an identity. But then I guess it's a bit of a vicious cycle, because then, actually, I hope, then, service users would then be more

open, and then that reinforces the idea of why it's important. But actually, if the counter arguments are, it doesn't get brought into the room. It kind of invalidates what you're trying to say, isn't it?" (**Gabby**)

Ken shared his experience of talking to an older adult about sex and the reaction this caused when he was brave enough to broach the subject:

"She was like and there's a bit of a pause, and she was like, "Oh, my God! Yes. yes. and no one wants to talk to me. No one wants to talk about it like I haven't got friends in my immediate circle, but I can talk to about it". The friends that she does have are all their partners is still alive so when she meets up with them, it's them and the partners. She only gets one on one conversation time that's not getting shut down about when she's talking about yeah, right? Romantic relationships, or sexual desire or anything" (**Ken**)

What does that make them think of me?

Participants shared that one of the worries they had talking about sex in a clinical setting was that it would influence how others viewed them and why they were bringing up sex:

"I think I would find it. I think I would be worried about how it would be received." (**Alvin**)

Lyla shared this concern, and that people would think that others sex life has nothing to do with her:

"I would be worried that I would ask somebody, and they'd be like, why you asked like that's got nothing to do with you. That's not what I'm here to talk about like that's got nothing to do with me." (**Lyla**)

Jade shared that she believes that the psychology team can be viewed differently compared with medical and allied health professionals which can mean that topics they share can be dismissed as less important which raises the question of MDT leadership and the hierarchy in the NHS:

> *"I think there's an element of in some teams like psychology just don't have much of a voice, or it's not listen to. Also, I find sometimes a psychologist talking about sex is often brushed off a bit, because I guess in in certain teams not every team but psychologists can be seen as like a bit Hippy. When we bring up sex, they're like, Oh, of course, that's what you're talking about. Whereas if it was to come from another profession, I think maybe a bit more accepted because it's more 'science'."* (**Jade**)

The age of the psychologist may also influence how well views are excepted within established teams. Freddie shared her awareness of her age whilst running a CPD session:

> *"But I think there is still a bit of a stigma of like being the younger person in a team and trying to bring these things in. So like, you know, almost like as if you're seen as someone that's being disruptive. Yeah trying to think I remember like there was some got some training or something, and I was like, Oh, everyone should attend this like LGBT+ training, and I also have a rainbow, Lanyard. And I was like what impression am I giving out here like."* (**Freddie**)

The role of a psychologist and how they are viewed by clients may also be influenced by age, at times there can be confusion about the different between psychiatry and psychology from clinicians and clients. The relationship between psychology and psychiatry can at times be difficult with psychiatry sometimes having a more dominant voice in MDT discussions. Ivan shared how the role of a psychologist can mean that the boundaries about what can be discussed are less clear:

"Especially when you're not an older person yourself, and you're not a physician, you know. You're not kind of shirt and tie, and you're having that conversation where all people really respect doctors, and you know, and they'll tell you things, you know, actually meeting someone as a psychologist and talking about sex and relationships. I think it's harder than if they were young. I think it's not just age as well." (**Ivan**)

Mike shared some of the reactions he has seen in teams when the psychology team shared new ideas and concepts:

"I had a few kind of like sneers, and like, oh, like with this like, they weren't so keen on it." (**Mike**)

Their children I think they would find it strange

Participants shared their concerns about how to navigate discussions around older adult sexuality when their family's members may become involved. Lyla shared how complicated these conversations are to facilitate when the family roles are changed due to diagnosis such as dementia:

"It's like families of them, obviously [they're] aware of what was going on. So it was really interesting to think that you're having this conversation with somebody's like child… but like somebody's children's getting roped into this conversation about their parents like sex life essentially." (**Lyla**)

Hannah shared her experience of working with a couple when one of them had been diagnosed with dementia and intimate discussions were held with both members of the couple:

"And so there was I remember there being discussion about kind of you know where they both slept…I know that the husband found that difficult an I mean he found the

whole thing difficult that she couldn't recognise him. But I think he found that loss of intimacy really hard." (**Hannah**)

Alvin shared his experience of supporting older adults in new relationships and the adjustment this was for their children:

"Actually, this is normal. This is just, you know, a person trying to build a relationship and some physicality with someone else and tell their children I think they would find it strange. I'm certain I spoke to someone's son who found it odd that he was in a relationship." (**Alvin**)

Children can struggle to accept that their parents may want to develop new romantic relationships in later life after the bereavement of a spouse. Ken provided an example of adult children not hearing their mother when she said that she was lonely and wanted to meet a new partner:

"When she said that whenever she mentioned romantic, I guess meeting someone in a romantic sense, that's what kind of she felt they didn't react well to that when she was like, oh, I feel lonely. They'd be like, oh well, let's get you out to like a Day centre, or like involved in some clubs or the WI or whatever it is, and she was like no that's not what that's not what I mean. And then that would be like a real barrier for any kind of helpful discussions with her with her family, who were the only people she saw really." (**Ken**)

Sex was tinged with, with sadness

A subtheme that was produced was that the topic of sex was often interwoven with feelings of loss. A loss of contact and physical touch:

"He would say, well you go home to your family, and you give them a hug, or you you go home, and you give people a hug, and you give them a kiss or whatever, and and I'm in hospital, and I don't have anybody, and my family's not here. An I've lost that and I want to like, I want to hug people. I want to touch people." **(Lyla)**

Or loss of a partner or spouse which can leave someone questioning who they are by themselves:

"Thinking about what the sexuality was like, what the sex life was out with their partner, particularly people had that loss and kind of felt like they had lost their identity as a partner or and a wife or husband, and yes, it just kind of came up about that need of kind of that that part was lost as well that they'd lost that kind of side of identity that maybe they didn't have that." **(Elsie)**

Ken described part of the grieving process being someone exploring who they were without their partner, which sometimes included exploring the idea of having a new partner.

"Yeah I think she was really able to kind of reflect on and how things have changed since her partner passed away and even the time before he passed away. And this will, I guess not only the loss of him, but the loss of a part of herself as well. Which you know she was she felt very much in touch with for a lot of her life was that kind of sexual person, you know. That was something that was really quite part of our life for such a long time, and then to sort of as her husband sort of became unwell, wasn't able to engage in those sorts of things that was part of it. And their relationship changed and then, in passing away you know, change it again." **(Ken)**

Naomi shared an example of when a sexual assault meant that sex was always linked to sadness and loss regardless of the time that had passed:

"The assault that she experienced there was kind of shock, and also just sadness as well. I think it brought up, you know, for her it was very much that sex was tinged with, with sadness was, wasn't just something to be can't just be completely enjoyed." (**Naomi**)

Gabby shared that physical pain in older age meant that some of her clients felt that they could no longer explore a part of themselves:

"Something that was a theme within session which was perceived loss. She wasn't able to carry out her identity, and it was that part of the identity that she's now on, which was the sexual intimacy side because of a chronic pain." (**Gabby**)

Bonnie shared how sessions around sex and loss could make her feel;

"Yeah, it does makes me feel sad." (**Bonnie**)

Learning disabilities

Some participants shared that an added component of navigating sex and older adults can be if the older adults have a learning disability. Bonnie shared how she feels part of her role within a learning disability team is consider sexual health in relation to their older adult clients.

"Like, some of our clients are obviously like over 60. I think it's really important, actually. And I think because the way that like learning disability teams are set up with a health focus, I think we're in a really quite a unique position where we don't just focus on mental health like it's their entire health. And so I think I'm more thoughtful about sex and sexual health now, about older adults, so I'd be more likely to think about it and then talk about it like I think I was just thinking back to a meeting we had the other day where we was talking about somebody having a UTI.

And they were an older adult with a learning disability. And I'm not sure that people necessarily think about they think about UTI's in in terms of how it impacts somebody's behaviour, but not necessarily about the sexual health as well." (**Bonnie**)

Ivan shared his experience that learning disability services were more open to talk about sex and less stigmatised:

"I'd never worked with dementia before it was all kind of very new and I suppose now I think probably my placement, my Ld placement, helped me kind of think of it. Where you've got, you know, a group of people that perhaps socially… Sometimes well find it difficult… to kind of conform social conventions a lot of the time. But there, there does seem to be… acknowledgement around sex and relationships. This kind of seems more acceptable… impulse, or a kind of sexual desire or arousal, all completely appropriate, and understandable from a human sexuality point of view… It's not pathologised as much it's maybe more of this more scaffold and around it to make it safer, or but it's less shamed." **(Ivan)**

Conversely. Jade shared that her experience was that the idea that adults with learning disabilities were sexually active was accepted but it was not acknowledged that older adults with a learning disability might be having sex, or may want:

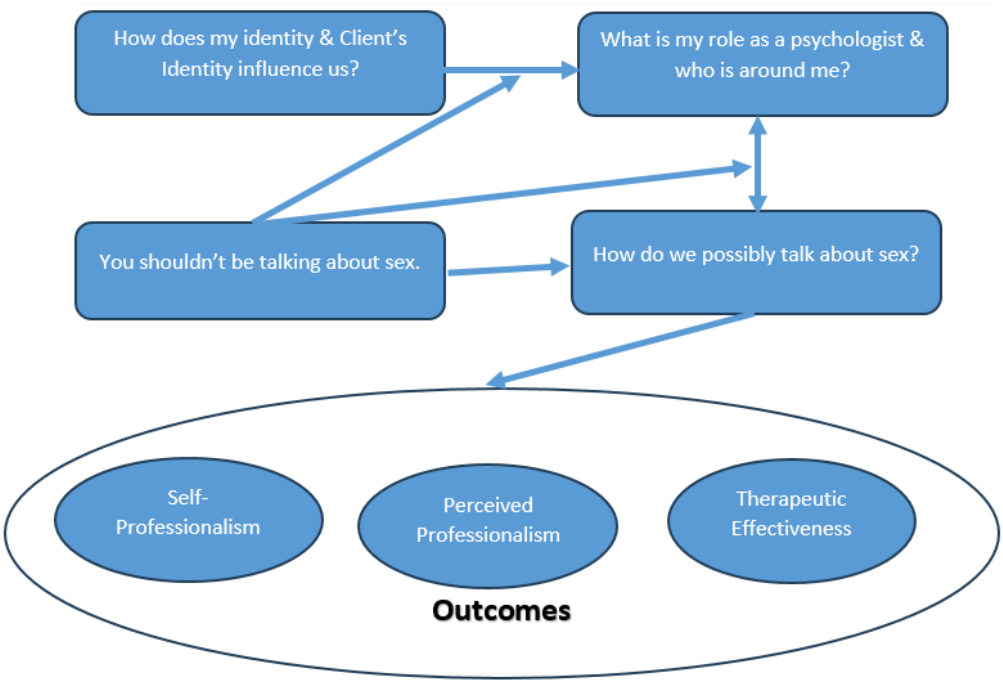
"Older adults with learning disability is like, double, no, no." (**Jade**)

Thematic Map

A thematic map has been created to illustrate how the themes are interlinked. The participants identify alongside the stigma surround sex can influence how participants view their role as a psychologist and whether this includes talking about sex professionally. In turn the concept of their role as a psychologist influences their views on how best to talk about sex and how factors impact their ability to have these conversations.

Figure 4

Thematic Map



Chapter Four: Discussion

Chapter Overview

This chapter will discuss and summarise the results of the current study, by analysing and interpreting the findings in relation to existing research and psychological theory before describing possible implications of the findings to clinical practice and the training of clinical psychologists. Finally, a reflective account of the research process will be provided to set the findings in context.

Main Findings

Research Aims

The aims of the study were to qualitatively explore trainee clinical psychologists' and newly qualified clinical psychologists' experiences of:

(1) The training neophyte clinical psychologists received concerning sexual health through their programme of study and through clinical practice

(2) How neophyte clinical psychologists have found exploring and addressing sexual health through their clinical practice and as part of a multi-disciplinary team

(3) Adaptions made to case formulation as a result of sexual health issues being raised

(4) The modalities favoured by the clinician to formulate and use therapeutically

(5) The impact this has on their ability to integrate sexual health issues into both formulations and their clinical practice

Summary of Findings

Fifteen interviews were conducted with trainee and qualified clinical psychologists. Reflexive thematic analysis revealed four themes and 23 subthemes. The four themes are listed below:

1. How does my identity and the client's identity influence our therapeutic alliance?

2. What is my role as a psychologist and who is around me?

3. How can we possibly talk about this?

4. You shouldn't be having or talking about sex

Theme one summarised how the identities of the client and therapist may influence how easy or difficult it can be to introduce and discuss sex and sexual health in a therapeutic relationship. The clinicians' personal identity could impact how they personally thought of sex and how they felt exploring the topic with a client of the same or different gender, age or cultural background. Participants shared that their knowledge of sex growing up still influenced them in their role as a trainee or qualified clinical psychologist. They described how in a therapeutic relationship they would often consider the identity of the client and judge internally whether or not it would be acceptable to the client if they even mentioned the word 'sex'. Participants shared how they would consider certain attributions when considering if the topic of sex felt appropriate or not within therapy.

The role of a psychologist, both as a trainee and qualified psychologist was an important consideration for all participants. The second theme detailed how the consideration of what is expected of a psychologist in different teams influenced how clinicians felt able or not to start conversations in therapy, supervision and within MDT discussions. The

importance of the supervision relationship and the training received throughout the doctorate programme was shared in interviews, with clinicians describing the confidence their training and trust in supervisory relationships gave them in being able to explore a 'scary' topic for the first time.

The third theme detailed clinicians' feelings of being lost and having to face the unknown. There was a sense amongst some participants that the topic was very embarrassing to even consider in a professional capacity' this was clearly evident by observing some participants' embarrassment in the interviews. The more positive the therapeutic relationship described, the more likely clinicians would be to initiate conversations around sex and sexual health with older adults. These conversations were more likely if participants felt that they had the words to describe and think about sex, such as a 'script'.

The final theme considered the power of the stigma that still surrounds sex, which sometimes meant that clinicians felt like they may even be judged or viewed differently by colleagues if they were the ones who introduced the topic of sex into services. This effectively 'silenced' clinicians, perhaps making these important conversations less likely to occur. Worries and fears for how clients' partners and families would react to the idea of sex being introduced could at times act as a barrier to clinicians feeling confident raising these issues.

Previous research has suggested that clinicians feel underprepared and under resourced for these conversations (Gott et al 2004a; Gott, et al., 2004b; McGrath & Lynch, 2014), but there is no previous exploration of clinical psychologists' experiences of having these conversations in the UK. This section will explore the findings of this study in relation to previous research and the theories that underpin psychological understanding and interventions.

Attachment and Circle of Security

In the current study, participants spoke about the importance of their supervisory relationship in being able to reflect, feel safe and share in the supervisory 'space'. This was linked to a number of subthemes; 'I don't think it ever got relayed back to [the MDT]', 'The permission the teaching gave' and 'I have permission in supervision to be thinking about that'. Participants shared how feeling safe meant that they felt comfortable to 'explore' the concept of sex in the therapeutic relationship, MDT meetings and even in CPD spaces. The idea of this safety or security allowed clinicians to feel more daring in multiple aspects of their work due to their confidence that they had the support of their supervisor if exploration of the topic did not go as planned.

Interestingly, the pattern of clinicians returning to the secure base of their supervisor is similar to that described in attachment theory (Bowlby, 1979; Ainsworth, 1978), which described how infants and children use their 'secure base' to feel safe in their exploration of the world. Children with the safe base of a caregiver, who offers them care and reassurance, feel safe to go out in the world and 'explore'. This pattern continues into adulthood and adult family, friend and partner relationships (Silver, 2013). Research has also demonstrated that it can impact the relationship between patients and healthcare professionals Ciechanowski et al., 2001; Holwerda et al., 2013). The use of a secure base appears to be similar to how trainees and psychologists have described this pattern with their supervisor. The child may get scared or hurt at which point they feel secure enough to return to their caregiver to receive reassurance and to be supported to process their difficult emotions after which the cycle restarts. This links to the subtheme of supervision where new conversations could be had in supervision where they had the space to process and develop solutions with the support of a supervisor, they felt comfortable with.

In attachment language they returned to their ‘secure base’, which offered them reassurance and then allowed them to feel confident to then go out and ‘explore’ this topic again regardless of the outcome.

Research has shown that the most important factor in the effectiveness of supervision is a good supervisory relationship, in which feedback can be shared from both parties and the trainee feels that they have some control in the relationship and the content shared in supervision (Kilminster & Jolly, 2000). Through this relationship people learn by modelling (by watching the attachment figure), as in Bandura’s Social Learning Theory (Bandura & Hall, 2018). Behaviours are learnt through observation of the attachment figure and imitating that figure. This can be a positive learning experience for neophyte clinicians and trainees when joining a team. The supervisor provides a model of how they can facilitate conversations around sexuality with clinicians and older adults in therapy. However, if the supervisor’s views on talking about sex and sexual health is influenced by stigma or judgement, the way in which they model interactions could be a barrier to these conversations. To contradict a supervisor’s pattern of behaviour can also cause stress, especially for a trainee or newly qualified clinician (Haslam et al., 2009). All trainee clinical psychologists and newly qualified clinical psychologists should be having regular supervision to support their practice and ensure safety for clinicians and services. Newly qualified clinical psychologists can also use supervision to reflect on their own role of supervising others (The British Psychological Society, 2024).

Social Identity Theory

At the time of the study all clinicians were in the midst of post-pandemic recovery, NHS changes, union strikes and national austerity. The clinicians were also in training or in their first 5 years post qualification which can be a challenging part of their career in the

middle of a system that feels uncertain and in crisis (BMJ, 2023). Themes captured the feelings of uncertainty experienced in terms of identity and status, as new psychologists but also their position within the MDT. Considering the current occupational environment of the clinicians, it is possible clinicians identify more strongly with their 'team' and want to be included and embedded in their team during times of change.

Clinicians do not want to risk becoming part of the 'outgroup' (Turner., et al., 1979), meaning that clinicians joining new teams once qualified or whilst in training on placement may conform to the team culture in terms of prototypical practice, team discussions and prioritising therapeutic elements. A subtheme regarding permission clinicians felt they were given by teaching of the clinical psychology doctorate or from supervisors allowed them to feel like this was an acceptable topic and that they could discuss older adult sex and sexuality in therapy and the MDT. This is also linked to the theme of 'what is the role of a psychologist' and clinicians exploring and understanding what this is.

Social identity theory is understood to be that an individual's 'identity' or their personal sense of self, is somewhat conditional on how they are viewed socially in a group setting in terms of group membership (in-group or out-group). So, a person's self-worth may be linked to both their view of themselves but also themselves within a group (Haslam & Van Dick, 2011; Turner., et al., 1979). Our understanding of ourselves is therefore thought to be linked to our group membership; in a clinical setting this could mean being viewed as a 'psychologist', 'trainee' or as a member of the 'MDT'. Membership to a group also causes an 'out-group' which could be 'medical staff' or other teams. These in-group out-group categories are thought to influence how a person evaluates themselves and others, such as feeling more superior or vulnerable which can influence and impact a person's self-esteem and wellbeing (Haslam et al., 2009). Participants shared their hesitancy about their role within the MDT and how to bring new topics to this discussion. They further described how

raising topics concerning sexual health and wellbeing created hesitancy as they felt other professional might view or judge them differently.

The second theme of ‘I am a psychologist I should know what to do’ and the third of ‘How can we possibly talk about this?’ were made up of subthemes that demonstrated the worry and vulnerability clinicians felt regarding their own practice and what they had permission to do. This was amplified by feeling that they should know what to do in their role but feeling that they didn’t know how to always broach the topic of sex with older adults. Clinical psychology doctorate students have been shown to feel vulnerable whilst completing their training. One explanation for this is the concept of ‘imposter syndrome’. Imposter syndrome is conceptualised as the feeling of being an imposter due to high levels of pressure, anxiety and lack of confidence regardless of their academic and clinical achievements. Experiencing this feeling could place trainees at a higher risk of depression, anxiety and perfectionist standards (Tigranyan et al., 2021).

Trainees or newly qualified clinical psychologists experiencing feelings of imposter syndrome and then joining a new team often feel a need to fit in and one way to do this can be to follow and conform to the team narrative or ‘script’ that is already in existence. A ‘script’ within a working team acts similarly to a ‘script’ within a family; these scripts support the family dynamic of different roles which were often developed to keep the family members safe. Yet, the scripts can become unhelpful, inculcating negative beliefs that therapy can support families to become aware of and, with time, alter (Byng- Hall, 1988). The subtheme ‘Taboo’ described how participants felt that the topic of older adult sex, sexuality and sexual health was taboo and in some services they were not able to bring the topic up in the MDT, supervision or in therapy.

Groups often develop their own script that members follow and often truly believe in. Scripts can be passed down the generations and family members may not even be aware of

their existence or influence on values, attitudes and behaviours (Byng-Hall, 1988). Applying the concepts of scripts to the current example of clinicians working in groups or teams may suggest that members of the team learn and follow the script that has been developed by previous members and leaders of the group. Clinicians do have control of this and scripts can change and the ripple effects can influence other members of the groups. The subtheme of 'I feel quite like excited for the future' and 'Kind of just generally find that area interesting' showed the enthusiasm clinicians had for their future practice and the changes to come in services.

Heteronormative Value Existing in Older Adult Services

The theme of identity of 'Who am I and who are you?' detailed how clinicians try to understand the difference in the therapeutic relationship and the impact this has on what they are able to discuss. The findings in this study and the findings of the meta-ethnography review in the Introduction chapter found that clinicians struggle with difference and what is the correct way they should adapt their practice.

In the last 100 years, LGBTQ+ rights and awareness have increased in the UK and NHS services have worked to create a safe and equitable environment for the LGBTQ+ community. However, in the current study it became clear that Older Adult NHS services are not as progressive as they could be, with trainees on placements leading CPD sessions on LGBQT+ and older adults, whilst other clinicians shared that they never questioned whether an older adult's 'partner' was not of the opposite gender. This is a generation that has lived through the Vatican Council Statement (1976), Section 28 (1988) and the AIDS epidemic (Meyer, 2003) where they may have experienced shame, disgust and ostracization for being in a relationship with someone they love. Yet in 2024 members of the LGBQT+ exist in a society where value is placed on heteronormative relationships, even in NHS services.

Previous research has also identified the dominant heteronormative view held in older adult care, in which professionals have frequently been misinformed about the needs of the LGBTQ+ female community, leaving lesbian and bisexual older women more at risk of inadequate health care (Schaller et al., 2020). Meanwhile, stigma surrounding older adult men who identify as gay, or bisexual can result in them not receiving the same treatment as heterosexual men (Gott et al., 2004b). Transgender older adults have been shown to experience discrimination in services, and due to socioeconomic difficulties transgender older adults are thought to be more likely to need support from public services such as social care (Benbow & Kingston, 2022).

More recently, services have sought an inclusive stance towards the LGBTQ+ community, by inviting clinicians to share pronouns, wear rainbow lanyards and adopt a curious stance towards issues around gender identification (Huckridge et al., 2021). Yet it appears these developments towards inclusivity have not been translated into older adult services fully in 2023- 2024. The lack of consideration of LGBTQ+ perspectives raises the question of 'safety' in older adult services. Both for clinicians to feel that they can lead by example and model sharing their pronouns of sexuality to other members of their teams and the clients using the services. Examples include asking for and sharing pronouns or enquiring about sexual orientation or the sex of the partner. One participant in the current study shared their experience of working in an Older Adult service where they did not feel comfortable to share any details of their own sexuality in supervision or elsewhere in the service. They linked this experience to not thinking to ask clients about sexual wellbeing or their sexuality. This questions if clinicians not asking clients about their sexuality is a pattern across more services, and how to implement change into Older Adult services across the UK to be more welcoming to the LGBTQ+ community, both for clinicians working in these services and clients accessing the services. In the current study the subtheme 'I have permission in

supervision to be thinking about that' detailed that clinicians did not always feel safe to share their own sexuality and identity in teams which made considering the identity of clients even more complex.

It is important to situate this research in the historical context of today's older adults. Today's generation of older adults have lived through times when homosexuality was thought of as a mental health disorder (Bayer, 1987) and a reason for criminal prosecution until the introduction of the 1967 Sexual Offences Act in England and Wales (1980 in Scotland and 1982 in Northern Ireland). There are older adults in today's society who have not felt able to 'come out' and experienced internalised homophobia and stigma, which has been shown to increase in those over the age of 80 (Srinivasan et al., 2019). Pachnakis (2007) discussed that hiding and supressing one's sexual orientation can cause psychological suffering, demonstrating the importance for health practitioners to address sexuality in services, particularly in older adult services where there is shame around sexuality can be high. Meyer's Minority Stress Theory (2003) is important to consider in older adult services, in order to understand the experiences of this population. Meyer outlined how members of the LGBTQ+ social environment can experience higher levels of prejudice, judgement and discrimination, all of which influences how they view themselves and can lead to the concealment of their sexuality and internalised homophobia.

The evidence provided by previous research and the evidence provided by the current study suggests that services still have a long way to go in understanding the experiences of older adults in relation to LGBTQ+ rights, and individuals who do not fit into heteronormative expectations. This understanding of how this affects older adults' own views around their sexuality, and therefore highlights the importance of not solely formulating through a heteronormative lens. In order to encourage this understanding psychologists may

require additional training and the teaching trainee clinical psychologists receive may need to be adapted support their development into empathetic and thoughtful clinicians.

Difference and Power

The third theme ‘How can we possibly talk about this?’ has the underlying concept of clinicians not know always knowing how or when to start the conversation of sex with older adults. This was linked to feelings or embarrassment, not knowing the language to use and the myth that older adults no longer have sexual needs. Older adults have been thought to experience ageism in health care settings which can result in worse health outcomes for older adults. Yet research has shown that training for medical professionals now included teaching concerning language and how to reduce ageist views in services (Hussain et al., 2017). Older women have been reported to feel isolated in services where they feel their treatment is negatively impacted by ageist views (Hussain et al., 2017). As discussed earlier in this chapter, the identity of the clinician and the client impacts how the clinicians felt in broaching the topic of sex and sexual health. However, in this study the researcher did not speak to any clients about how the identity of the clinicians they work with impacted how they felt discussing sensitive topics such as sex, sexual difficulties or their sexual health.

Intersectionality (Atewologun, 2018; Thomas et al., 2021) is an important factor when considering the therapeutic alliance in 2024. Clinicians are generally convinced that it is more than one demographic that influences any given dynamic; it is multiple demographics in relation to each other. It therefore feels important to acknowledge that there is a higher proportion of young white woman accepted onto clinical psychology doctoral training in the UK (McCormack et al., 2022) than other demographics. Research has also shown that ethnic minorities are less likely to access NHS psychological services (Patel & Hanif, 2022) for a number of reasons.

Religion and culture can play a part in the shame and stigma individuals face, with what is viewed as 'normal' can be influenced by those around us (Ahmadi, 2003). Subthemes such as 'Impact of the church' and 'what is the script' highlighting clinicians' awareness of the impact of religion and culture on their discussions in therapy often without knowing how to articulate the discussions they want to have. Black individuals have been shown to be less likely to seek support for medical conditions (Khubchandani & Greenup, 2022). Race trauma is thought to be exacerbated by the medical system and medical professionals, which prompts questions about how these impacts clinical psychologists, with some avoiding conversations around sex and sexual health. Black women have been shown to be less likely to access smear tests, raising the question of how women from different communities are encouraged by healthcare professionals to go for their smear tests, or indeed whether there may be a reduced chance of healthcare professionals even broaching this topic due to the client not being white. Black women have higher rates of cervical cancer but lower rates of attending regular smear tests in the United States of America (USA; Hoyo et al., 2005). Women from different communities may not be having medical appointments where they are able to discuss their concerns around their sex lives, or possible sexual dysfunction. This is a concern as sexual dysfunction can be an early symptom of serious health conditions (Gendrano et al., 2005; Laumann et al., 2005). While not all clinical and trainee clinical psychologists will be working in health care settings many will be attend MDT discussions where they will support other disciplines to consider patients from different backgrounds. They may also provide formulation support, reflective practice and supervision for other healthcare professionals (BPS, 2024). Meaning that it is important that trainees and clinical psychologists understand and can reflect on the difficulties individuals from all backgrounds can experience in healthcare environments.

The underlying concept of the first theme is how the identity of the clinician and the identity of the client impacted how confident clinicians felt about broaching topics of sex, sexuality or sexual health. The theme detailed how clinicians often avoided the topics so that they did not cause offense or upset when they feel their identity is different from the client. This pattern may be in healthcare settings seen when black women experience racial bias when receiving and accessing healthcare. The distrust of the healthcare system may make certain communities feel that their voice is not heard in services or that they may not be given the same care as others due to their skin colour. The second theme details the role of psychologists therapeutically and in the MDT to support all disciplines to think about an individual holistically, in all areas of a person's health and identity to inform the formulation that clinicians complete and often share with the MDT.

The health inequalities black women face are important to consider for trainee and clinical psychologists. Evidence demonstrated the importance of clinicians working in culturally sensitive conversations with minority groups in order to achieve better outcomes in therapy (Depauw et al., 2021). Han et al., (2021) demonstrates the importance of everyone accessing services to be given the same opportunities, whilst maintaining awareness of an individual's culture and background to ensure that clinicians are attempting to engage with someone in a culturally competent way. Future research may want to consider the different training that trainee clinical psychologists receive on doctoral courses to work in a culturally competent way.

The model known as 'Cultural Competence' describes how services can support and adapt to the needs of individuals taking into account their cultural, religious background and beliefs (Cross et al., 1989). Cross et al. (1989) have discussed the complexity of ensuring health services work in a culturally competent way due to a lack of diversity in services

alongside training that rarely includes an adequate amount of teaching that considers cultural differences.

It is important to acknowledge the potential power imbalance that can exist in the therapeutic relationship and how this may make clients feel when the clinician introduces the topic of sex or sexual health. This could be with someone of a different ethnic background, religion, gender and age to the client and each of these could influence how both the client and clinician experience and feel about this conversation. A possible outcome of this power imbalance could be that clinicians fail to raise the topic, something which research has suggested is the biggest barrier for clients in having these conversations (Schaller, et al., 2020), especially when they want to talk about sex but are hesitant to initiate these conversations (Malta et al., 2018).

Female GPs have shared their experiences of male patients not wanting to discuss their sexual difficulties with a woman and their tendency to request to see a male GP (Malta et al., 2018). The negative experiences clinicians may have experienced or heard about may make clinicians less confident in broaching these topics with clients of a different gender. In the current study the subtheme of ‘Gender’ considered the surprise of clinicians when older adults of a different gender brought up the topic of sex. Highlighting the underlying preconceptions they held that older adults would not want to be discussing sex with a gender that is not their own.

Conversely, the theme identity in this current study demonstrated that clinicians could find it difficult to broach the topic of sex with a member of their own culture, especially an older member of their community due to their awareness of how sex is viewed in their cultural community. This contradictory experience highlights the importance of cultural competence regarding how the identity of the client impacts the clinicians and may shape the

nature of the support provided. It would appear that in this study and previous research, the majority of older adult clients want to talk about sex but they want the clinician to initiate the conversation (Malta et al., 2018; Schaller, et al., 2020).

Gender differences

It should be noted that differences in the current study were noted between female and male participants in their responses. Male participants described using humour when discussing sex, sexual health and sexual wellbeing, whereas women tended to adopt a more earnest approach with clients. Previous studies have shown that healthcare professionals use humour to cope with the difficult situations they experience at work; this can lead to them using euphemisms and humour to make light of the situation (Wanzer et al., 2005). Research has also demonstrated that, in traumatic work situations, humour can not only be used as a coping mechanism but as a way of facilitating bonding between staff members (Sliter et al., 2013). The non-verbal information conveyed in humour feels essential to consider as it demonstrates how this topic can make professionals uncomfortable even when they have volunteered to discuss the topic. However, this difference is not easily recognisable from the verbal analysis in this study. This finding may be something that could be considered in future research (Denham & Onwuegbuzie, 2013).

Two of the subthemes developed ‘What is the script’ and ‘Gender’ both acknowledge the difficulties trainee and clinical psychologists have in working with older adults they view to be different to themselves and not having a clear idea of how to articulate what they want to know. A common myth is that men continue to have sex until the end of their lives. The stigma older women face is they are more likely to suffer negative opinions of others in relation to their sex life (Gale et al., 2018; Morrissey Stahl et al., 2018; Yelland & Hosier, 2017). This links to a third subtheme of judgement clinicians experienced that the older

adults they were supporting were sexually active. The theory of Benevolent Sexism (Glick & Fiske, 1996) relates to the concept of older women being seen as purely loving and innocent individuals which the subtheme captured the feelings and connotations of judgment and shock.

Psychological Services

This section will consider the impact of the current study findings on the training of clinical psychologists in the UK and how sexuality and sexual health can be included in clinical formulation and future research. Findings will be linked to recommendations for clinical formulation, training and future research.

The Sexual Health NICE Guidance Published in 2019 and 2020 stated that more research and education was needed surrounding older adult sexuality. However, the guidance failed to indicate what topics need to be addressed in the training and education of staff, or what staff required additional training. The lack of clear guidance from NICE may explain why clinical practice and training for clinical psychologist trainees lacks specific teaching on older adult sexuality.

Implications for clinical practice

The findings in the current study provided recommendations for clinical formulation in older adult services in the UK. Analysis suggested that one of the most important factors in supporting how the topic is raised and discussed is the supervisee-supervisor relationship. If the supervisor is thoughtful about the topic and supports a safe environment for the supervisee to talk about sex, acknowledging their own values, morality, spiritual beliefs, religious practices and the historical context, then this supports clinicians' comfort levels.

From the findings in the current study and considering previous research that there are differing levels of comfort amongst clinicians when discussing sex. It may be important for

teams, and supervisors to support clinicians in becoming self-aware of their own values around sex thereby enabling them to explore congruent conversations on the topic. As psychologists, part of our role is to supervise other psychologists, trainee psychologists, assistant psychologists and MDT colleagues as well as how their own identity may impact the supervisory relationship. Therefore, training is required in how to initiate and facilitate conversations around sex.

It is essential to consider intersectionality when introducing the topic of sex and sexuality into professional supervision conversations, and to consider the professional's cultural, religious and familial background and how this may impact their feelings around discussing sex in a professional setting and what if any aspects of sex are shared (e.g. LGBTQ+, kinks, chemsex). This is not a criticism of differing views, but it is important to consider any feelings of shame that professionals may carry and the discomfort they may feel having these conversations so they can be reflected on and be supported.

Ford and Hendrick (2003) have discussed how the views clinicians hold regarding sex can impact the success of therapy and it is thought that this can impact the views clients themselves then hold on regarding their own sexuality. There is perhaps an underlying expectation of having to hold a liberal view of sex and sexuality as a clinician (Rogers, 1957), and even though therapists do aim to keep their personal values from their clients, it can be difficult to keep the personal and professional self-separate. All whilst allowing parts of the personal self to integrate into the professional self that has been created that an individual shows as a therapist is a complex balance. To both be a genuine representation of who they are to develop a therapeutic alliance whilst also remaining professional and integrating the two parts of a person into a congruent identity as a therapist. An added complexity is that over a career a therapist can evolve and change through personal and professional experiences (Schubert et al., 2006). Participants in the current study shared that they felt like

they were trying to catch up with other members of their cohorts so that they could be equally as literate in conversations around sex. This can be supported by supervisors through practice of these conversations, reflection on difficulties and honest conversations around the topic to build up clinicians' confidence. This would again imply clinicians using supervisors as their secure base.

Another recommendation is that by encouraging conversations around sex in supervision and in MDT discussions psychologists can create a culture of openness in services to normalise and thereby destigmatise sex. These conversations may initially require pioneering clinicians in services that have the position and courage to start these conversations. This modelling may pave the way for other clinicians to follow, thereby creating wider systemic change in our health services.

A third consideration to the introduction of sex, not only being discussed in services in MDT environments and therapy but to also be incorporated into the assessment process and consequently a topic that is prioritised by clinicians. This may require a more creative approach to incorporate conversations about sex in a non-threatening way for clients accessing services, by bringing the topic of sex into formulation and understanding of their needs and wants. It would be hoped that increasing the frequency of conversations would reduce the belief that conversations around sex can only be discussed in certain services and if sex is the 'problem' that the service is set up to address.

As discussed earlier in this chapter, the concept of shame surrounding sex and sexuality may be an important factor in understanding the internal shame some clients experience (Gilbert, 2010). Gilbert's CFT model of internal shame can be used in services to understand clients' traumatic, discriminatory or shame inducing experiences from a theoretical perspective. To understand to an extent how homophobia and stigma influence an individual's experiences and aid services understanding of a client's individual experience

and impact their current presentation. Clinicians should be asking questions to understand a client and aspects such as internalised homophobia and how that impacts the person's current presenting difficulties.

Whilst this study has discussed the importance of discussing sex and sexual health and ensuring that everyone has the possibility to discuss sex and sexual health. This does not mean that everyone must or should talk about sex in therapy. It is essential that if anyone does not want to talk about sex or to be sexually activity that this is not over-medicalised (Taylor & Gosney, 2011): previous research has demonstrated that some older women feel pressure from society to continue to be sexually active (Huang et al., 2009).

There may be a number of reasons why someone may not want to talk about sex and this decision should always be supported and validated. Individuals should always feel empowered and supported to discuss or not discuss sex and sexual health, and their own personal beliefs should always be supported. Considering the sexual trauma an individual may have experienced the introduction and discussion of the topics should therefore always be handled with care. The consideration of language used should also be reflected on and considered. It may be important to check in with the individual to ensure that the language used is fitting with their experience adapted for the individual is needed. Psychologists should consider adapting their practice to ensure interventions are trauma informed to support clients and prompt health equity (Han et al., 2021) as is detailed in NICE guidelines (2018).

Previous research has demonstrated the positive impact of the therapeutic alliance when individuals feel empowered and trust their therapist (Malhotra & Chauhan, 2020) therefore it is important when the topic of sex is broached that it is given as a choice, where an individual can share that they do not want to talk about it. They should also always be aware that by stating that they don't want to talk about sex or sexual health this will not

impact the service they will receive from the service. Whilst in some services, such as a sexual health service, this may not be the case in many NHS service this stance should be upheld.

The question of gender has been discussed throughout this piece of work with trainee and qualified psychologists sharing different experiences of working with individuals of different genders, and feedback they have received from clients about discussing sex and sexual health. It should be acknowledged that for some people accessing therapy the gender of the therapist is important. In NHS services individuals wishes for therapy are often upheld, however there are times in stretched services that people are offered a therapist who does not fit the criteria they hoped for. In the current climate in the NHS there is a possibility that individuals accessing services are not given as many choices, as they were historically. Therefore, it should be considered that some people accessing NHS services are having therapeutic input from someone they are struggling to build a positive therapeutic relationship. This may be impacting their ability, or comfort when talking about personal topics such as sex, sexual health or sexuality.

Implications for training

The training clinical psychologist trainees receive is, to an extent, dependent on which university they attend. Whilst all programmes are accredited by the British Psychology Society (BPS) and Health and Care Professions Council (HCPC) through compliance with specified standards of practice (SOPs), there is discretion as to how these SOPs are met. Universities will favour certain psychological models and areas of research due to the researchers and clinicians that work on the doctorate programmes, which can impact the level of emphasis that is placed on certain topics at that university. The BPS and HCPC periodically visit programmes as part of the ongoing accreditation process, and this routinely

leads to recommendations to programme teams for curriculum development. At the time of this study, neither the professional society nor the accreditation body have made any recommendations about including older adult sexuality in programme teaching. This is surprising when many clinicians are aware that the older adult population and the number of older adults is increasing in today's society (Laidlaw, 2013). Alongside the historical impact of what older adults have lived through regarding their sexuality such as lack of sex education, Section 28, the 1967 Abortion Act, the distribution of contraception, the Sexual Offences Act, Mother and Baby institutes and the AIDS epidemic (Clarke, 2021; Rostosky & Riggle, 2017).

Recommendations coming from this study and the surrounding literature included in this will now be provided. Based on the qualitative analysis in the current study, clinicians experience anxiety when talking about a new and stigmatised topic, but what could have made this easier would have been to have a 'script'. The participants felt that a script would have given them best practice in knowing what to say and how to say it. Whilst an official 'script' may not be realistic an increase in confidence and competence in having conversations around sex can be achieved. Clinicians reflected that by the end of a day of teaching on sex and sexual health they felt more comfortable discussing sex and using associated words in conversation compared with the start of the day when they had felt shy and embarrassed. The shame of talking about sex had decreased and allowed some of the clinicians to take the topic back to their placement to discuss with their colleagues and supervisors in supervision. This finding is an example of the ripple effect training on the doctorate can have on services in the area, and how one clinician talking about sex can support others to go on and do the same. The findings from the current study and the meta-ethnographical review that informed this study demonstrated the importance of the training

that health professionals received to feel confidence and that they had permission to explore the topic of older adults and sex.

The concept of a secure base for trainee and qualified psychologists has been discussed earlier in this chapter. It was suggested that clinicians can sometimes use their supervisor as their secure base. Psychologists throughout their career receive and provide supervision, highlighting the power of supervision in clinicians' practice. Yet clinicians also spoke about how they used the teaching and the programme to build their confidence to then share the knowledge gained with their placement, knowing they could return to their programme and cohort to seek reassurance if they needed to. This example demonstrated the importance of the education environment, including the teaching staff and positive cohort dynamic in order to be a secure base for trainees.

An understanding of how sexuality has been present and discussed over the older adult's lifetime is an important consideration when delivering training, especially when considering how older adults may view professionals asking about their sexual identity. The DSM previously classed homosexuality as a mental illness, so whilst it is important for clinicians to remain curious and open to who an older adult's sexual partners are, it is essential this is done with care and understanding of the impacts of identifying as LGBTQ+ may have had in the lifetime of the older adults of today. The historical, societal and cultural context in relation to sex and sexuality also provides clinicians with valuable information to be able to formulate the client's experiences and the role this could play in their current difficulties. For example, Meyers Minorities Stress theory (2003) and Gilberts concept of shame in Compassion Focused Therapy (2010) can provide insight into the complexities facing clients exploring their sexual identity. This insight into the internal world of clients who may experience shame, internalised homophobia or discrimination as a result of the

sexuality, allows clinicians to develop a more robust formulation to inform person-centred formulations.

The final two recommendations are more logistical in nature. Participants from a number of universities shared that whilst they found the teaching on sex and older adults engaging, this training was delivered after they had completed their older adult placement, so they were not able to put into practice what they had learned in teaching. A recommendation would be that courses consider when teaching takes place so that trainees can get the most out of the teaching, which would often mean they would be more engaged with the teaching.

The final point in this section is the how teaching regarding older adults and sex is presented to the trainee clinical psychologists. Participants shared that they had been looking forward to the sex and older adult teaching. However, on the day of the teaching facilitators shared that they were only teaching this topic as all the other topics in the module had already been allocated to other lecturers. A clinician in the current study shared that the facilitators appeared to express their confidence in discussing sex with older adults but appeared uncomfortable discussing the topic with trainees. It may be helpful for facilitators to consider how they present the topic and reflect on what this may indicate about their own assumptions and bias surrounding the topic. This reflection could also be shared with trainees to allow them to reflect on their own assumptions and judgments surrounding the topic that may come from their age, gender, culture or religion. Bringing a more reflexive stance to teaching may allow trainees to develop further, consider alternative perspectives and maintain a curious stance (Carmichael et al., 2020).

It should be noted that participants in this study also shared how helpful they had found their teaching on sex and sexual health, to the extent that it has shaped and developed their practice. This section has considered the constructive feedback provided in the current study.

Implications for future research

As stated throughout this work, there is a clear dearth of literature on the topic of sexual health and wellbeing in older adults. Future research could consider how older adults in the UK experience talking about or being given permission to talk about sex with their psychologists. An aspect that was briefly touched on by participants was female older adult's relief when the topic of sex was broached. It was explained that one of the reasons for this was even in their friendships this topic was taboo and couldn't be explored. The impact of this both on older adults' ability to discuss sex, but also the impact on their wellbeing and physical health as a result, could be explored through further qualitative research. As part of this work, it would be important to sample a range of older adults who represent different minority communities to fully address the compounding influence of intersectionality (Meyer, 2003). Both in the current study and in the meta-ethnography review (Gott et al., 2004b) in the Introduction section of this study clinicians shared their concerns about broaching the topic of sex with older adult whose identify differs from their own. This type of research would enable better case formulation guidance as it provides a way in which care can be devised while taking into account personal differences that can constitute barriers to traditional therapeutic models that may have been developed without taking into account cultural and gender differences (Joiner et al., 2022).

A question remains about the power of the stigma that surrounds older adults and the concept of them being sexually active. This has shown to be a neglected area in research and in guidelines (NICE, 2019; 2020). By failing to address misconceptions regarding how older adults express their sexuality and romantic connections, psychological services and health services in general will continue to perpetuate the taboos of raising such topics in older adult care. It is important to understand to what extent clinicians prioritise curiosity about older adults' sexuality and partners. Whilst this was not one of the aims of this study,

throughout interviews it became evident that there are different ways in which clinicians approach sexuality in older adults. Clinicians were not asking older adults about their pronouns or the gender of their partners, reinforcing a heteronormative perspective in the services that older adults are accessing. Future research could explore how older adults from the LGBTQ+ community experience these conversations and whether this makes it more difficult to enquire about, access services or have honest and comprehensive conversations with clinicians. A related area of enquiry would be to consider the impact of unconscious bias and internalised homophobia on the therapeutic alliance.

The concept of supervisor to supervisee relationships has been explored in this study. However, there is still more work needed to understand the way in which the supervisor relationship may be used in attachment terms as a 'secure base', allowing staff to explore and try new methods of working before returning to their base to process and explore their experiences. Alternatively, this could be investigated within training programmes through exploration of how relationships with the university allow trainees confidence in exploration of new models and methods of working on placement.

Strengths and limitations

This section will consider and critique the strengths and weaknesses of the current study. This will include consideration on methodology and considering cultural dynamics.

Strengths

The current study is unique in exploring trainee and qualified clinical psychologists' experiences of talking to older adults about their sexual health and wellbeing. This offers an insight into the training and therapeutic practice of training and newly qualified clinicians across the country. Whilst there is research on older adult experiences and other health

professionals' experiences, this is the first study to examine how clinical psychologists in the UK have navigated such experiences. The study therefore provides rich qualitative information on trainee and clinician experiences and can offer recommendations for clinical practice, research and training. For example, the study has highlighted the importance of training programmes taking the lead on introducing conversations around older adult sexuality and in supporting trainees to become literate on the topic, whilst supporting placement supervisors to support the development of trainees on clinical placements.

The sample size for the current study was in the suggested range for a reflexive thematic analysis (Braun & Clarke, 2013; 2022). It is important to also acknowledge that there was a range in the demographics of the participants with differing genders, sexualities and cultural backgrounds. Yet due to the small number of qualified clinical psychologists' and trainee clinical psychologists from a limited number of courses in the UK the findings are not generalisable to the experiences of all trainee and newly qualified clinical psychologists working in the UK today but they may be transferable to other trainee and clinical psychologists experiences (Braun & Clarke, 2022).

Participants were recruited from across the UK and were enrolled at or had attended a number of different universities for their doctoral training. By hearing from different students and graduates across the UK, comparisons and similarities in programme content could be questioned, for example the timing of related content, the number of sessions a client is allowed. Recruiting from across the country was made possible due to the practice over the last four years of doctoral qualitative interviews taking place online due to the Covid-19 Pandemic (Gruber et al, 2020). This means that the findings in the current study are reflective of multiple trainees' experiences at a number of universities around the UK.

The data was collected using a semi-structured interview schedule that was designed by the researcher and informed by previous research exploring older adult sexuality informed

by Braun and Clarke (2022). However, clinicians were given the opportunity to share their experiences without being limited on what they wanted to add regarding their experience of therapeutic work, indirect work and clinical training. A potential benefit could have been that the main researcher is a trainee clinical psychologist which allows the interviews to be conducted with an underlying understanding of the process of clinical trainee and clinical work which supports the development of rapport during interviews, and therefore allows rich interviews to be conducted.

A consideration when a clinician takes part in research is the differing of roles between researcher and therapist and maintaining the role of researcher and not therapist or peer (Thompson & Russo, 2012). Maintaining the current role appropriate to the situation raises ethical considerations such as privacy and ensuring participants can speak freely without fear. Responsibility of ensuring harm does not occur which in this case could include participants and those participants are working with. If concerns were raised in an interview the dual role of being a researcher but also of a clinician would have been raised, with a possible dilemma of how best to support the participant (BPS 2006; BPS, 2021).

A strength of this study was that a feminist lens was used to design, analyse the data and discuss the findings. Utilising this lens allowed the researcher to consider the inequalities and challenges older adults face in society in relation to their sexuality, sexual health and attitudes towards sex held by health professionals (Kelly & Gurr, 2019).

Limitations

A primary limitation in the current study is that participants volunteered for the study. Participants were recruited through university doctorate programmes, social media, word of mouth and snowball sampling. This approach could have resulted in a systematic sampling bias. For instance, programme staff may have determined whether to advertise the research

based on how receptive they were to the topic, leading to disproportionate involvement from universities engaged with issues connected to older adult sexuality.

Similarly, participants who contacted the researcher to take part in the study are likely to be clinicians who are more open to having conversations about sex and older adults compared with their colleagues who did not want to take part in the current study. This could mean that the views of clinicians who feel more uncomfortable, and possibly isolated by this difficulty, may not have been heard from in this current study. This prompts the question of how transferable (Braun & Clarke, 2022) the findings are to clinicians in general, especially clinicians who feel this topic is not relevant in psychological therapy and do not feel it should be discussed. It should be noted that, despite making repeated contact with all accredited providers in the UK, no enquires were from trainees or clinicians in Scotland or Northern Ireland.

A secondary consideration is the limited number of participants from minority backgrounds involved in the current study. The study was advertised in a minority trainee clinical psychologist group, but it may have been possible to advertise the study in more than one minority group. Linked to this limitation is the fact that some of the participants shared that the majority of the older adults they had worked with identified as 'White British' so they were not able to reflect on how working with older adults from different cultures and the difficulties that could arise from this. However, many participants were able to share their experiences of working with older adults from different cultures and even in some cases in other languages.

Part of the methodology of the current study stated that participants had to be trainees or psychologists who qualified in the last five years to take part in the study. The reason for

this was so that they were able to reflect on their training and how this supported them to talk about sex and sexuality with older adults. However, many of the participants reported that they couldn't remember the training they had received or felt that they did not have any thoughts on how future training provided by the course could be delivered or adapted.

Conversely, had the recruitment procedure permitted all qualified psychologists to take part, regardless of when they qualified, this may have allowed a more diverse population to take part in the study, such as psychologists of all ages, stages of careers and also provided valuable information on supervision and leading MDT discussions. This is not to say that the information provided by participants was not valuable but that the richness may have been increased by speaking to a range of clinicians when findings may be used to inform policies and procedures.

An important consideration is how the researcher's views and values may have influenced how the reflexive thematic analysis was conducted and whether underlying bias played a part in the themes and subthemes that were produced. To reduce the possibility of this the researcher met frequently with their supervisor to reflect on the interviews, how they were experienced, and the themes and subthemes produced. Papers by Braun and Clarke (2003; 2013; 2022) were consulted and considered to ensure the analysis was executed fully. The researcher reflected on their experience as a white, female, trainee and how this may have influenced their experiences of talking about sex with older adults and also the experience participants had talking to a young woman about sex in their interviews. It is possible that participants may have responded differently in their interviews had they been speaking to someone of a different gender. Relating this to an early example of men using humour, the male participants may have used less humour if they felt less embarrassed talking to a man or they could have used more to form an alliance (Amir et al., 2016).

Participants who took part in this study all had completed research or would be completing research at a doctorate level which may have influenced how they felt talking about sex, their manner of communication and their honesty in sharing experiences and personal embarrassment. Participants would have known that other trainees and qualified psychologists would be meeting with the researcher for interviews which may have resulted in them having concerns about being 'the only one who struggled' and activated a feeling of competitiveness that can exist between trainee clinical psychologists and has been linked to negative outcomes such as poorer mental health outcomes and self-esteem (Tazzini, 2023). Although some participants bravely shared that they did feel that they were behind their colleagues in their understanding and comfort level when discussing sex.

The meta-ethnography search that informed the current study had limited search terms which may have impacted the studies sourced. The search terms used were chosen to locate research that explored health professionals' experiences of supporting older adults in relation to being sexually active, their sexuality and their sexual health. The number of search terms used may have resulted in fewer studies being located, therefore meaning that valuable information was not found. No studies exploring clinical psychologists' experiences were found which would have been informative to support the design of the current study.

It may have been beneficial to explore older adults' experiences of talking to health professionals, when this has been a helpful experience and what has hindered these discussions. It would have been informative to have a deeper understanding of their experiences to inform this study, specifically the interview questions that participants were asked.

Research and Clinical Practice

Cultural taboos surrounding sex still exist in the UK and influence many people accessing psychological services, clinical psychologists and trainees. Whilst the participants who self-selected for the current study came from a variety of backgrounds it should be acknowledged that this is not representative of all the varieties of cultural backgrounds in the UK. A number of participants also shared that in the geographical areas they were working in were not culturally diverse and all of the older adults they worked with identified as 'white British'. Whilst this lack of cultural diversity does not detract from the value of the findings, it is not possible to claim this work encompasses the diverse population of the UK. If future research was to take place it would be beneficial to speak to clinicians from a variety of backgrounds and more clinicians who have worked in communities with greater diversity around the UK. Conversely, participants shared that they had worked within culturally diverse localities and had even conducted therapy in another language (not English). It would be valuable to know the impact this had on how clinician feel exploring more 'taboo' topics, and whether the language difference makes this more difficult across the lifespan as many clinicians in the UK are currently conducting therapy in more than one language.

Reflections

As advised by Braun and Clarke (2022), I kept a reflective diary throughout my time of planning interviews, conducting interviews and writing this up the current project. This was partly to ensure that bias did not influence how the results were analysed and therefore the themes produced.

I recognised that during the time I spent interviewing, analysing and writing up this study, I was aware of own view of sex and sexuality and how I feel that this is an important topic. However, I have become aware of how others in health services disagree. As a

clinician, I have become aware of this during the last three years of involvement in this project. I am passionate about the topic and have, at times, struggled to have my voice heard which has left me feeling frustrated. This realisation supported me to create a therapeutic and non-judgemental environment for the clinicians who took part in my study. I think it is important to share this experience and to state that I felt all the clinicians who took part in this study have been brave in sharing their stories of success, as well as their struggles, and their own personal reflections.

Throughout conversations with my thesis supervisor and my placement supervisors I have become aware that of how my own experiences growing up within a medical family. My family spoke openly about difficult topics such as health, periods, diseases and these discussions opened up more sensitive discussions around sex. These formative experiences have influenced how as a person I may, at times, feel more comfortable than others having conversations about sex. Throughout the interviews I realised what power our cultural backgrounds, school career and families have on our ability to have discussions and to reflect and explore areas of the topic that feel unknown. I can reflect on my own privilege of growing up in a place and time that I received sex education. I am able to speak to health professionals about my sexual and reproductive health and live a healthy life because of it.

Completing this project has demonstrated how important sex in general being talked about in services is, and how, in many cases, this can be supported by psychologists and psychological thinking. I believe this has reinforced the type of psychologist and supervisor I would like to be when I qualify, and how I can support services and other clinicians to consider the importance of sex.

So, in the words of Salt-N-Pepa:

'let's all talk about sex…

let's talk about all the good things and all bad things that may be,

let's talk about sex..

It keeps coming up anyhow, don't be coy, avoid, or make void the topic

Cuz that ain't gonna stop it

Now we talk about sex on the radio and video shows

Conclusions

The findings from this study have demonstrated how the identities of clinicians and clients, the MDT culture, differing clinical training and the supervisor supervisee dynamic all influence clinicians' experiences of broaching the topic of older adult sexuality. Findings highlighted how there is not a single factor that can be changed to make these conversations easier. Understanding the complexities and intersectionality of these conversations can support changes to be made in MDT situations, clinical training and clinical practice supported by supervisors.

To conclude, the findings of this study provide an initial insight into a field that has yet to be explored. Being the first study in the UK to explore clinicians' experiences talking about older adult sex and sexuality, this feels like the first step in researching a topic that is often avoided by clinicians due to prejudice and stigma. It is hoped that this study and future research will allow informed changes to be made to clinical psychology doctorate training and clinical practice.

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Appendices

Appendix 1. Participant Consent Form

University of Essex

University of Essex

School of Health & Social Care

Participant Consent Form

Project Title

The last taboo? Exploring clinical psychologists attitudes towards older adult sexuality

Research Team

Lead Researcher: Emily Sigston, Doctorate in Clinical Psychology (DClinPsych), School of Health & Social Care, University of Essex (es21361@essex.ac.uk)

Please initial box

1. I confirm that I have read and understand the Information Sheet dated xx for the above study. I have had an opportunity to consider the information, ask questions and have had these questions answered satisfactorily. ☐
2. I understand that my participation is voluntary and that I am free to withdraw from the project at any time without giving any reason and without penalty. I understand that any data collected up to the point of my withdrawal e.g. will be destroyed; cannot be withdrawn because it cannot be identified. ☐
3. I understand that some of the interview may be worrying or cause reflection ☐
4. I understand that the identifiable data provided will be securely stored and accessible only to the members of the research team directly involved in the project, and that confidentiality will be maintained. With the data deleted once the thesis is complete. ☐
5. I understand that my fully anonymised data will be used for Emily Sigston's thesis as part of her doctorate in clinical psychology, which may be used for a research publication. ☐
6. I understand that my fully anonymised data will be used for Emily Sigston's thesis as part of her doctorate in clinical psychology, which may be used for a research publication. ☐
7. I understand that a secure transcription service will be used to transcribe all interviews once they have been anonymised. ☐
8. I understand that the data collected about me will be used to support other research in the future, and may be shared anonymously with other researchers. ☐
9. I give consent to voluntarily take part in the above study. ☐

ERAMS Number: ETH2122-1464

University of Essex

Participant Name	Date	Participant Signature
_____	_____	_____

Researcher Name	Date	Researcher Signature
_____	_____	_____

Appendix 2. Participant Information sheet

University of Essex

Participant Information Sheet

Version 1

Project Title: *The last taboo? Exploring clinical psychologists' attitudes towards older adult sexuality*

My name is Emily Sigston and I am a Trainee Clinical Psychologist in the Department of Health and Social Care at the University of Essex. I would like to invite you to take part in a research study. Before you decide whether or not to take part, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully.

What is the purpose of the study?

The aim of the project is to explore how clinical psychologists and trainee clinical psychologists experience discussing sex and sexual health with older adult service users and with other clinicians.

Why have I been invited to participate?

We are interested in talking to trainee clinical psychologists from across the United Kingdom and clinical psychologists who have qualified from doctoral courses in the United Kingdom within the last 5 years. Whilst the main focus of the study is on discussions regarding sex and sexual health with older adults however time will also be taken to reflect on the training you received on these topics that have been beneficial, or training you would have liked.

Do I have to take part?

It is up to you to decide whether or not you wish to take part in this research study. If you do decide to take part you will be asked to provide written consent. You are free to withdraw at any time, without giving a reason. Withdrawal with have no impact on your marks, assessments or future studies.

What will happen to me if I take part?

If you would like to take part in the study then after you have provided written consent you will complete a short survey. You will then be interviewed over Zoom or Microsoft teams for approximately one hour.

What are the possible disadvantages and risks of taking part?

It is possible that some individuals may find the topics discussed uncomfortable, difficult or in some cases embarrassing. All participants will be signposted to available support services and will have time to debrief after the interview. However, we hope that the discussions will be interesting and provide a reflective space for clinicians to explore their experiences and feelings on a topic that is often avoided.

What are the possible benefits of taking part?

University of Essex

By taking part you are supporting the understanding of trainee and qualified psychologists supporting older adult service users directly, and indirectly through the development of knowledge supporting MDT meetings and supervision. We also hope that you find the interviews interesting.

What information will be collected?

A short amount of information will be collected prior to the interview, which includes but is not limited to questions regarding which university you trained at/or are training, your experience supporting older adults and what psychological models you favour.

Will my information be kept confidential?

After the interviews are complete they will be transcribed by a secure transcription service. The file where your interview will be saved will be password protected on a password protected laptop. Your interview file will also be given a pseudonym. The study is scheduled to finish in spring 2024 when your data will be deleted.

What is the legal basis for using the data and who is the Data Controller

No data will be used in the study without your informed consent. The Data Controller is the University of Essex at the University Information Assurance Manager (dpo@essex.ac.uk).

What should I do if I want to take part?

If you would like to take part in this study we will send you a consent form that must be completed before the interview takes place. If at any time you would like to withdraw from the study then please contact the lead researcher Emily Sigston (es21361@essex.ac.uk).

What will happen to the results of the research study?

The aim is to publish the results of the study in a journal article. It is also possible that the study will be shared at a conference through a poster or presentation.

Who is funding the research?

The study is being funded by the University of Essex. The clinical psychology doctorate course is funded by NHS England.

Who has reviewed the study?

Ethical approval for this study has been received from the University of Essex Ethics Committee. The study has also been reviewed by Dr Ruth Lowry.

Concerns and Complaints

If you have concern or a complaint to make regarding the study please contact the lead researcher Emily Sigston (es21361@essex.ac.uk). If this is not satisfactory or you feel that you cannot talk to the lead researcher then you can contact the supervisor of the project Dr Ruth Lowry (r.lowry@essex.ac.uk).

Name of the Researcher/Research Team Members

University of Essex

The main researcher is Emily Sigston (trainee clinical psychologist) who can be contacted on es21361@essex.ac.uk. The project is supervised by Dr Ruth Lowry who can be contacted on r.lowry@essex.ac.uk).

Appendix 3. Recruitment Advert

University of Essex

Research Participants Needed

The last taboo? Exploring clinical psychologists' attitudes towards older adult sexuality

I am looking for trainee or clinical psychologists to share their experiences of working therapeutically with older adults discussing their sexuality.

To take part in you must be:

- A trainee clinical psychologist or a clinical psychologist who has qualified in the last 5 years
- Have trained in the UK
- Have worked with older adults, your experiences could be before you were qualified

Would you like to support research exploring your experience?

Interviews will take place over Zoom or Microsoft Teams and last for approximately one hour.

If you have any questions or you would like to take part please contact Emily Sigston (Doctorate in Clinical Psychologist, School of Health and Social Care, University of Essex) at es21361@essex.ac.uk.

Project flyer- Version 1 Ethics- ETH2122-1464

Appendix 4. Interview Questions

Direct work

Tell me about experiences you have had to discuss sex/sexual health professionally/wellbeing with older adults?

Did this feel comfortable/awkward/embarrassing/shameful/listen to their words.

Did you broach this subject or did they? How did this arise?

It they brought this up how did this make you feel?

Who was this raised with couple/man/woman/non-binary (same different)

How long into therapy was this mentioned/this that impact.

What do you think supported/made this topic more difficult in that moment?

Do you think your style would have been different if you had been working with a younger adult?

What are your fears/anxieties about talking about sex with your clients/patients?

Do you have strong views, assumptions or notions about sex, sexual practices or sexual orientations that might limit your work with clients?

Supervision

Has this topic ever come up in supervision?

Were you the supervisee or the supervisor in this situation?

How did you feel having this discussion?

Who raised it and how far did that discussion go?

Do you feel confident in this discuss- if so why/why not (would this have been different with a younger adult)

Resources/training – where do you look

Would your concerns have been different have been different if it had been a younger adult

(Keep in mind same/difference. Examples)

(Reflexive/reflection- thoughts around this)

Multidisciplinary Team working

As an MDT has this topic been discussed in meetings or through formulation discussions?

What supported this topic/didn't?

Psychologists are often thought of as 'leaders' in NHS situations, did you feel equipped to be a leader in this situation? Or if it has never arisen would you?

Do you think these discussion support MDT working and an understanding of the individual?

Have adaptions been made to case formulation as a result of sexual health issues being raised?

What is your reason for not disclosing this in MDT working?

Would you feel more confident raising this topic about a different population?

(Own thought- medical model or more psychologically minded)

Teaching

Did you receive teaching/support around this whilst completing your clinical psychology doctorate training?

Have you received training from any other source?

What training did you find helpful or would you find helpful?

Resources and where have you got this

Modalities and formulation

What modalities do you favour in your work? Does this impact how you discuss these issues (does the model change)

Do you think this impacts your ability to include sexual health issue into both formulations and your clinical practice?

Anything else you would like to share, or something you thought I would ask that I didn't?

Appendix 5. Survey of demographic information

Survey information

1. Gender you identify as?

2. What year are you on the doctorate (Year 1, Year 2 or Year 3) or how any years post qualifying? Please clearly state doctorate or qualified.

3. Service you currently work in?

4. Previous experience working with older adults, this can be before the doctorate

5. University you attend or attended for the clinical psychology doctorate?

6. Main psychological model you use in your practice

7. Do you supervisee any assistant psychologists, trainees or psychologists?