SEX AND THE RECENTLY SINGLE: CULTURAL MODELS OF MATURE SEXUALITY AND HIV RISK BY PHYSICIANS AND MIDLIFE WOMEN

By

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by

Kathryn Elaine Grant
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This dissertation explored differing cultural models of midlife female sexuality by recently single women from a displaced homemaker program in north Florida versus primary care physicians in the same community. Research about clinical communication suggests that patients and physicians may differ in their perceptions to such a degree that effective health communication is hampered.

As baby boomers age, senior sexuality is becoming more socially and clinically important than it was previously. Additionally, throughout the 1990s and 2000s, the national HIV/AIDS infection rate has remained around 11% for those aged 50 and over, and in Florida that percentage is higher. The proportion of women infected continues to rise, particularly among African Americans. These statistical trends are of concern for women who are re-entering the dating scene after divorce, separation, or widowhood.
My study considered how 44 midlife women conceptualize sexuality and sexual health for themselves and other women their age, and how 31 physicians conceptualize sexuality and sexual health for older women patients. These sexual health conceptualizations included a focus on HIV/AIDS knowledge and risk perceptions, and their ideas about discussing sexual health in clinical contexts.

African American and Euro-American women between the ages of 45 and 68 completed demographic surveys, healthcare encounter vignette-based interviews, and one of three cultural consensus modeling techniques: free list, pile sort, and rating procedures. Attending and resident physicians, mostly from a family practice clinic completed a similar interview format.

Results showed that the recently single women and the physicians shared many of the same concepts about midlife sexuality for women, with a few notable exceptions. Most of the women believed that they were at-risk for HIV; whereas most physicians considered their younger patients to be at-risk and thought that risk declined with patients’ advancing age and with female status. Women believed that physicians should discuss sexual health issues with older patients, and create a clinical atmosphere conducive to discussing sensitive topics. Physicians felt that they should do a better job of talking about sexual health issues with older patients, but thought that time constraints and their own biases about aging and sexuality hindered their progress.
I argue that, in a basic sense, all medicine is cross-cultural -- that patient and healer inevitably conceive of the world, communicate, and behave in ways that cannot be reasonably or safely assumed to be similar or readily compatible. Use of a common language, concepts, and behavior between patient and physician gives the appearance of shared understandings and effective communication; but appearances may be deceptive. --Robert Hahn, 1995, p. 265

My study deals with the tension among differing constructions of clinical talk about sexual health, and the impact of that talk on health and well-being. The quote above suggest that patients and physicians may differ in their perceptions in such a way that effective health communication is hampered and effective health care is illusive. That is, although the physician and patient may share a common language, or for that matter share any other number of characteristics, they could understand and interpret the domain of health care in ways different enough to have an ineffectual interaction. For these actors, the cultural domain of health care may only be partially shared, and for patient health and well-being, these differences can be minor or critical.

I explored the cultural domain of sexuality for midlife and older women and if that domain is culturally shared between the women themselves and with primary care physicians. I considered how midlife and older women conceptualize sexuality and sexual health for themselves and other women their age, how primary care physicians conceptualize sexuality and sexual health for midlife and older women, and how these perceptions impact the clinical encounter. These sexual health conceptualizations include
a focus on Human Immunodeficiency Virus (HIV) knowledge and risk perceptions, and their ideas about discussing sexual health in clinical contexts.

In the wake of the HIV/AIDS (Acquired Immunodeficiency Syndrome) pandemic, research on provider-patient communication about sexuality issues has taken on a new significance. There are numerous studies with women and men of various ages, ethnicities, and sexual orientation, and with their health care providers, to determine how and if sexual health issues are addressed (Coates 1999; Epstein, Morse, Frankel, Frarey, Anderson, and Beckman 1998; Haas and Coe 1997; Makadon and Silin 1995; Metz and Seifert 1990; Kerr, Valdiserri, Loft, Bresolin, Holtgrave, Moore, MacGowan, Marder, and Rinaldi, 1996; Nusbaum, Gamble, Skinner, and Heiman 2000; Nusbaum, Gamble and Pathman 2002; Rich 2001; Sadovsky 2000; Skiest and Keiser 1997). Many studies have explored what physicians do in their practices with regard to HIV prevention as well as more general discussions of sexuality, sexual function, and sexual health. Unfortunately, despite a broad range of participants, many of these studies do not delineate their finding by age, class, ethnicity or sexual orientation; and large-scale studies on HIV and/or sexuality communication in clinical contexts usually focus on the younger, higher-risk groups, excluding midlife and older persons altogether.

Health care providers would be an ideal source of HIV prevention information since adults in the U.S. average almost three visits a year to a physician, and most people believe physicians are credible sources of health information (Makadon and Silin 1995). However, this resource usually goes untapped partly because of physicians’ narrow notions of what constitutes appropriate medical care, their discomfort with discussing sensitive issues such as sexuality and drug use, limited conceptions about who is at risk
for HIV/AIDS, and time and resource constraints (Strombeck and Levy 1998). Many providers were trained before HIV/AIDS became widespread, and/or the sociodemographic shift in risk groups took hold, compounding the issues mentioned above. Additionally, as is true of the general population, some physicians have ageist attitudes about older persons in terms of sexuality and other risk behaviors and do not perceive them as at risk for HIV infection (Strombeck and Levy 1998). However, the continuing rise of cases among those typically not considered "high risk" indicates that many physicians are (whether they know it or not) interacting "with HIV-positive patients and other patients who are at risk for infection that may not fall into the 'traditional' high-risk categories" (Haas and Coe 1997: 403).

**Objectives and Research Questions**

My study focused on midlife and older women's concepts of sexuality and aging, and their notions about HIV and STD risks, comparing those concepts with those of primary care physicians in an urban north Florida community. The primary objective was to describe cultural models of mature sexuality by analyzing semantic domains emerging from in-depth interviews with "recently single" (separated, divorced or widowed) midlife and older women (African American and Euro-American), and from interviews with primary-care physicians. The central research question is how two cultural models of mature sexuality might differ in such a way as to inhibit effective patient-physician communication. Do physicians hold age- and gender-based assumptions about discussing sexuality and/or HIV/STD-related topics with midlife and older women? Are physicians’ concepts about sexuality and aging different from women's own sexuality and aging concepts? What do women think about the impact of the age, gender, and ethnic characteristics of physicians on clinical communication? Are
there differences in women's perceptions about discussing sexuality issues in clinical contexts based on age, marital status and ethnic groups?

**Genesis of the Project**

My search for a research topic was not a search at all; rather it was the culmination of several research experiences, personal experiences, and a long-term interest in women’s issues. I became interested in health care communication about sexuality through several experiences and activities. First, the health care encounter stories from family and friends brought the ‘struggle to be heard over the noise of medicine’ to my attention. Not all of the stories were negative; the positive encounters were a relief and surprise me and to the participants.

Secondly, experience with several research projects shaped my interest in gerontology and health care communication. After completing my master’s degree, I worked as an interviewer on a project (through the University of Florida (UF), * Formal Services Project of NE Florida* in 1996) assessing older adults’ attitudes toward home health services. I gained experience using “vignettes” to explore respondents’ feelings and knowledge about available services, and what they believed to be the best path in solving difficult situations afflicting the elderly. Working on that project cultivated my interest in the health and well-being of older persons.

After a few years of teaching undergraduate courses in anthropology, sociology, and gender studies, I returned to UF to pursue my Ph.D. in applied medical anthropology with a focus on gerontology. As I pursued my coursework, I had the opportunity to work as an assistant on a nursing anthropological research project with prostate cancer survivors (*Gender Ideology and Prostate Cancer: Veteran’s Cultural Model of Masculinity*) that raised my concern about the lack of attention to quality-of-life issues in
healthcare, particularly sexuality issues for older persons. That project aimed to determine the impact of male gender roles on Veterans’ coping skills, health outcomes, and seeking of medical services.

My interest in clinical communication about sexuality was further developed when I served as a research associate on a project for the Association of Reproductive Health Professionals (*Mature Sexuality: Patient Realities and Provider Challenges*), reviewing the literature on physician-patient communication about sexuality. During that time I also assisted with the training of first-year medical students, and served as a standardized patient on local and national examinations through the Harrell Professional Development and Assessment Center, UF College of Medicine. That experience gave me a glimpse of the rigors of medical education and the ways that it shapes the perspectives of participants.

Finally, through my work and studies, I also came across the story of Jane P. Fowler, an average Midwestern woman who contracted HIV in her mid-50s while dating a few years after her divorce. She never thought of herself as at-risk, but once she had started dating again, she asked her doctor if she should be tested for HIV and other STDs; her doctor said “not you, you don't need that test” (Linsk, Fowler, and Klein 2003: S249; personal communication with Ms. Fowler). Two years later, an exam for health insurance revealed that she was HIV-positive. After reading this story and corresponding with Ms. Fowler, I searched for all I could find on HIV prevention (clinical and public health) for midlife and older women who were “recently single” due to divorce or widowhood. It was soon clear that this population was not considered in most research on HIV prevention, or in clinical communication research, particularly about sexuality.
Despite their growing numbers, midlife recently single women seemed to be largely ignored. Thus the research topic of clinical communication about sexuality and HIV/STD risk for recently single midlife women finally melded into focus. The next question was where to find a sample of women to work with.

**Preliminary Research and the Research Setting.** Because of my interests in gerontology, I had expected to stay in Florida for my dissertation research, since it is demographically the “oldest” state in the union. Although there are other areas with higher HIV infection rates, Florida ranks third highest according to the CDC. As it turned out, choosing a locale close to home for me was not a stretch theoretically, since Florida has higher rates of HIV/AIDS among women, minorities, and persons over 50 than the national average (Chapter 2).

In 2002, I had the good fortune, through my work at the UF Women’s Health Research Center in Gainesville, to meet the director of the local Displaced Homemakers Program. I told her about my research interests and she explained that most of the program participants were midlife and older women who were divorced or widowed. This was my window of opportunity, and provided my first entrée into the field. To gain a better understanding of both the Displaced Homemakers Program and its participants, I interviewed the director and her assistant about the program, and researched the program through the state website.

According to State of Florida documents,

The Displaced Homemaker Program was established by the Florida Legislature in 1976. . . . The Displaced Homemaker Program is a state funded program designed to address the job training and educational needs of Florida citizens who: are thirty-five years of age or older; have worked in the home providing unpaid household services for family members; are not adequately employed; likely will have difficulty securing adequate employment; and, have been dependent on the income
of another family member but is no longer supported by such income, or have been dependent on federal assistance. (State of Florida 2003)

The program’s goal is to help participants attain independence and economic security.
The program is administered through the Division of Community Colleges. There are rarely any male participants in the program, and most of the women are divorced, separated, or widowed.

In order to be sure that this was a reasonable sample for what I wanted to do, I conducted a preliminary pilot project with 18 women in a Displaced Homemakers Program. I gathered free-lists from several women in the Gainesville program to test the free list elicitation procedure and to explore the initial parameters of the cultural domain of aging and sexuality. For this pilot project, a very short anonymous survey was used to gather demographic information and free list data. The survey was handed out at a support group meeting and later returned to me. Participants were told that the survey was voluntary and that the data would never be published in any way. Using these surveys, I obtained information about the age, marital status and living arrangements, health status, educational level, and recentness of doctor visits of the respondents. The free lists on the surveys consisted of 4 to 10 words or phrases (and in few cases, a paragraph or two) about how they define aging and sexuality for midlife and older women.

Although there was not enough complete data for formal analysis, the results of that small pilot study showed the continued importance of sexuality for most of the women, particularly their desire to be considered sexual beings regardless of their age and marital status. Several women were sexually active or had recently been sexually active, though many lamented the difficulty of finding someone to share intimacy with.
This pilot study also indicated that there was a cultural domain that needed to be explored further.

The director of the program in Gainesville introduced me to a nearby program and the people involved there. This other north Florida program served a larger population with more minority women, which was ideal in providing a more diverse sample. The director of the nearby program was not as interested in my research topic as the other director who had helped me initially, but she finally agreed to allow me to visit the program from which I eventually recruited the recently single women of my sample (Chapter 3). Once I had the opportunity to interview the director and her assistant from this program, I understood a bit more about her reluctance to participate. She explained that the program used to focus more on the whole person, but that the state now wanted a stronger employment focus. She also found that in years past, the health-related topics were not well received by the participants and had been removed from the program’s content. She seemed to feel that the women would not be interested in my health related project, but would allow me to give it a try. Fortunately, many women in the program found the topic of interest and wanted to participate.

The director interviews generated some basic information about how the displaced homemaker programs operate and some informal demographic information about the participants. Although demographics vary from year to year, most of the women are in their 40s and 50s with a range from 35 to about 75 years old; and about 65-70% identify as White, 20-25% identify as Black, under 10% identify as being a member of a Latino subgroup, and the remaining 1 to 3% identify as one of the Asian nationalities, American Indian, and other. Most are either divorced or widowed; fewer are separated or married.
with a recently disabled spouse. Both directors defined their participants similarly in terms of why the women choose to join the program and the benefits of the program. The vast majority of the women come because they need to work and need to develop the skills and support to help them find work. Just under half continue in the support-group programs year after year or sporadically.

Once the site had been established for the women in my sample, I contacted the Research Coordinator in the department of a Family Practice Residency program (a friend of the director of the center where I worked) in the area to determine the protocols for working with the residents and the attending physicians in the department. We met for lunch and I explained the project to her, and we discussed how she could help. The research coordinator was extremely helpful, and eagerly introduced me to all of the physicians she could, each time I came by. I was very fortunate to find someone as helpful as she, and her utility became even clearer as I attempted to contact physicians in other departments. My success with recruiting other physicians was poor, and I believe that the lack of such a contact person as I had with the family medicine program was the main reason. Although the few physicians that I managed to recruit outside of the Family Practice program told me of the importance of the issue and their delight at seeing someone doing this kind of research, the lack of a contact person to serve as a go-between for the physicians and myself significantly hindered my ability to recruit doctors from other departments.

**Contributions of the Project**

My research project has applied contributions that can benefit physician-patient communication about sexual health concerns, and public health initiatives directed at midlife and older women concerning sexual health with culturally appropriate
educational campaigns. This project is important because it will inform improved health care communication about sexuality issues, as well as clinical HIV/STD prevention efforts with midlife and older women by dissemination of results to the research and clinical communities through medical and social science publications and presentations. Additionally, in the future I plan to use the results to develop physician-training modules on communicating about mature sexuality. My study explicitly focused on underrepresented groups because of its research/sampling location at a community college, its understudied sample of divorced, separated, and widowed women age 45 and over, and its balanced sampling of majority and minority groups. As a means of "giving something back" to the research participants (and to those who participate in the Displaced Homemakers Program, but who did not participate in the project) I will give post-project presentations of the results. I also plan to develop tip-cards that women can keep in their wallets with respondent recommendations on how to get the most out of their doctor-office visits.

My project also contributes to the larger body of scientific knowledge. An ethnographic investigation with a small sample provides an opportunity to explore the nuances alluded to in larger studies on physician-patient communication about sexual health topics and HIV risk perceptions. My project builds on the work of Weller and Baer (2001), Chavez and colleagues (2001), and Trotter and colleagues (1999) by exploring between-group and within-group variation in health beliefs. In addition to specifically comparing mature women with physicians in terms of their ideas about aging and sexuality, and HIV/STD risks using cultural consensus methods, the systematic cultural consensus data is woven with the interview and survey data to explore the
cultural and structural factors, and the issues related to interpersonal dynamics of the physician-patient dyad. This situates my micro-level exploration within macro-level phenomena, including the hierarchical nature of the medical interview and the hegemony of the biomedical model of disease that often structures healthcare interactions (Baer, Singer and Susser 1997).

Applied medical anthropology and other social science endeavors in the medical arena can serve to highlight social and cultural factors that affect health care outcomes and to incorporate better understandings of these factors in disease prevention. The anthropological tradition of collecting detailed data is well suited to situating micro-level events within their larger macro-level determinants. Epidemiologists and social scientists have shown repeatedly that the biological and social aspects of health are interrelated (Hahn 1995; McElroy and Townsend 1989). Unfortunately, most medical education minimizes the importance of social and cultural factors in health care (Good and Good 2000; Hahn 1995).

The body of research that specifically addresses physician-patient communication about sexual health concerns, including HIV risk, has been steadily growing, yet many questions remain unanswered. My study examined how physicians conceptualize sexuality for midlife and older women relative to how women conceptualize it for themselves, and how those concepts may affect health care interaction with regard to HIV/STD prevention. Despite the growing evidence that midlife and older persons are continuing to engage sexually (some in a high-risk manner), many physicians do not address sexual health issues with these patients. My study considered this issue and
related issues in an effort to raise awareness about physician biases and the social and cultural factors that contribute to them.

**Obtaining Institutional Review Board Approval**

Instruments and forms for my project were approved by the UF Institutional Review Board (Protocol# 2002-U-721) September 6, 2002. In compliance with standard Institutional Review Board (IRB) regulations, these materials were resubmitted on August 15, 2003 to extend the approval time period for data collection until August 25, 2004. Participation was voluntary and respondents were compensated for their time (Chapter 3).

**Funding**

I am very grateful for the funding to conduct the fieldwork for my research project. In February 2003, I received notification that I had been awarded two grants. Funding was provided by a dissertation improvement grant from the National Science Foundation (BCS-0241675) and a Woodrow Wilson/Johnson & Johnson Dissertation Grant in Women’s Health.

**Overview of Chapters**

The following pages provide an outline of the chapters in this dissertation. Chapter 2 is a literature review that focuses on issues in physician-patient communication about sexual health. The first section highlights some of the structural, cultural, and economic issues that broadly effect health care communication, focusing on the research studies and reviews that are most relevant for this dissertation research project. Following this introduction to health care communication issues, I focus on issues in physician-patient communication about sexual health. This includes a description of research findings on the role of patient-physician communication in HIV prevention. I reveal the disconnect
between patient and physician perspectives on clinical communication about sex, aging and sexuality, and HIV/STD prevention, particularly as it relates to midlife and older persons. Next, the relevance of this research project is clarified by situating it in the epidemiology of HIV/AIDS among persons aged 50 and older in the U.S., in Florida, and finally in Northeast Florida where the research takes place. I further show the project’s relevance by exploring age, gender and ethnic trends in HIV/AIDS transmission and HIV/AIDS-related knowledge. Finally, chapter two concludes with a brief discussion of the primary prevention strategies that shape the nation’s public health initiatives and how primary prevention models relate to older persons. My premise is that ethnographic research that looks at intra- and intercultural variation in health-related perspectives can contribute to the development of more effective health care communication and HIV prevention strategies.

Chapter 3 describes the methods used in this research. A brief introduction outlines the methods used and is followed by a more detailed discussion. The explanation of methods continually links back to the previous chapter by showing how the goals and design of the research comes out of the questions raised by previous research and epidemiological findings. I give a description of Cultural Consensus Modeling (CCM) and health beliefs and then show support for using CCM in combination with traditional qualitative data collection. The next section describes the surveys and interviews instruments and their strengths and weaknesses in terms of addressing the research questions in chapter one. I give a synopsis of the vignette-based interview and refer the reader to the appendices for more detail, and then discuss the CCM procedures and how they link with the other data collection methods. The sampling and the interview settings
are explained in this chapter. I explain how participants were recruited for the project, and how the selection of this sample is supported by the epidemiological data. Finally, I give a brief introduction to the final samples and their key characteristics.

Chapters 4, 5 and 6 present the research findings. Chapter 4 presents part one of the data analysis, focusing on sexuality conceptualizations. I provide a description of the types of analysis used, including software programs, and an explanation of the theoretical considerations for using these techniques. This chapter focuses on the Cultural Consensus Modeling data (CCM), presenting the data from the free lists, pile-sorts and the rating test with the women in the Displaced Homemaker Program (DHP) and the primary care physicians. These data are presented textually and graphically for their own merits and are linked to the data from the in-depth interviews in the following chapters. The interview data contextualizes the CCM data and shows how it is linked to the other issues in the research project, discussed in chapters five and six. The data on sexuality conceptualizations are considered in terms of their support of the hypotheses, as well as their shortcomings for support of the hypotheses.

Chapter 5 continues with part two of the data analysis, focusing on physician-patient communication regarding sexual health issues. After a brief introduction describing the various issues addressed and hypotheses, I introduce the data gathered on physician-patient communication. This chapter contrasts the views of women in the DHP program and the views of primary care physicians. This section starts with a focus on the responses to the first vignette and point out the differences and similarities between the two groups. This follow by gender-, age- and ethnicity related issues in physician-patient
communication about sexual health. I conclude with an overview of the findings presented in this chapter, their support of the hypotheses or lack of support.

Chapter 6 concludes the data analysis chapters with part three, which focuses on HIV risk and prevention issues. After an introduction to the topic of HIV risks, I present the data on HIV related knowledge from women in DHP program. I introduce some of the issues raised with the HIV vignette, and then follow it with their comments on personal risk perceptions and their perceptions of the risk for other women in their age group and partner status. Next I present the data on HIV risk perceptions from primary care physicians regarding their patient population. The risk for patients is further delineated by age, sex, ethnicity and then other various possible variables suggested by me or the physicians, such as drug use, sexual orientation, sex work, marital status, number of partners, and so on. This chapter concludes with a comparison of the views the women in the DHP program and the physicians, linking these findings with the CCM data.

Chapter 7 concludes the dissertation with an overview of the findings discussed in previous chapters and a discussion of how the findings square with the literature in chapter 2. The next section unites the CCM findings with the vignette-based interview, showing the utility of combined methods, and links the findings about HIV risk perceptions to other issues clinical communication about sexual health. Limitations of the research project are discussed on several levels: 1) some of the project goals were not achieved due sampling issues; 2) some of the data collection methods limit the generalizeablity of the results; 3) not all of the objective were addressed with the interview instrument, and 4) time and space limitations on analysis of all the data.
gathered. This project yielded a rich dataset despite its limitations; so rich that not all of the data could be analyzed at this time. This chapter concludes with a discussion of the significance of the data and its utility for improved health care communication regarding sexual health issues and HIV prevention in clinical context. Finally, the utility of the data is situated within the framework of anthropological methods and theory and how they are relevant to health care and health care communication.
CHAPTER 2
LITERATURE REVIEW

Introduction

The end of women’s reproductive lives and facile assumptions about their difficulties in finding partners frequently lead some health care providers to the mistaken conclusion that sexual issues are unimportant for midlife and older female patients, (particularly for those who are no longer married due to divorce, separation, or widowhood). However, evidence suggests that many mature women and men remain sexually active, some into their 80s and beyond, that some have multiple partners, and practice a full range of sexual behaviors (American Association of Retired Persons (AARP) 1999, 2003; Association of Reproductive Health Professionals (ARHP) 2000; Jacoby 1999; Janus and Janus 1993; Levy 1994; Levy and Albrecht 1989; National Council on Aging (NCOA) 1998; Stall and Catania 1994). As baby boomers age, senior sexuality is expected to become socially and clinically more important than it was previously perceived to be (ARHP 2000; Janus and Janus 1993; Yates, Stellato, Johannes and Avis 1999). Despite this projected trend, in American society sexuality is often viewed as a concern of the young. This cultural emphasis on sexuality in youth, and the concomitant implication that older persons should not be concerned about sexuality or the potential health risks associated with some sexual behaviors, is poor preparation for age-related changes in sexuality (Hotvedt 1983). Furthermore, it does not prepare older persons or their health care providers for clinical communication about sexual issues.
This literature review focuses on issues in physician-patient communication about sexual health. The first section highlights some of the structural, cultural, and economic issues that broadly effect health care communication, focusing on the research studies and reviews that are most relevant for this dissertation research project. Following this introduction to health care communication issues, I focus on studies that reveal the disconnect between patient and physician perspectives on clinical communication about sex, aging and sexuality, and HIV/STD prevention, particularly as it relates to midlife and older persons. Next, the relevance of this research project is clarified by situating it in the epidemiology of HIV/AIDS among persons aged 50 and older in the U.S., in Florida, and finally in Northeast Florida where the research takes place. I further show the project’s relevance by exploring age, gender and ethnic trends in HIV/AIDS transmission and HIV/AIDS-related knowledge. Finally, this chapter concludes with a brief discussion of the primary prevention strategies that shape the nation’s public health initiatives and how primary prevention models relate to older persons. My premise is that ethnographic research that looks at intra- and intercultural variation in health-related perspectives can contribute to the development of more effective health care communication and HIV prevention strategies.

My study focuses on midlife and older women, but it should be noted that the literature concerning aging and health care, aging and HIV related issues, and aging and sexuality issues is not consistent in how it frames the categories of “midlife”, “older”, and “elder.” Age ranges for what is considered midlife and what is considered older or elderly vary widely from one study to the next, making comparison between studies
difficult. In this literature review, whenever possible, I clarify the age groups considered in a given study.

**Part One: Issues in Clinical Communication for Midlife and Older Patients**

Physician-patient interaction is shaped and influenced by cultural, structural and institutional factors and the interpersonal dynamics of the physician-patient dyad. Physicians communicate with and react to patients differently on the basis of the patient’s age, gender, ethnicity, educational level, and social class. By the same token, patients also communicate with physicians differently based on a similar set of factors. Additionally, many of the difficulties patients face in their experiences of health care are related to some aspect of health care systems, which are becoming increasingly competitive and resorting to impersonal and routinized care to remain institutionally viable (Coulter and Fitzpatrick 2000).

Interactions between physicians and patients are often hierarchical as well as intercultural. These interactions may be construed as hierarchical because of the hegemony of the biomedical model of disease (Baer, Singer and Susser 1997) and the structural power dynamics of modern medicine (Baer et al. 1997; Cant and Sharma 2000; Henley 1977; Lorber 1997); and as intercultural because of sociodemographic and structural differences affecting the lived experiences of the participants (Cline and McKenzie 1998). The hierarchical and intercultural nature of the interaction is carried out in the medical discourse where patients struggle to be heard over the noise of medicine (Elgin 1999). “Patients enter medical interactions from a position of relative weakness . . . They enter unfamiliar surroundings in which all the participants seem to share a common language . . . Medical practitioners, on the other hand, are in their ‘home court’ in the medical setting” (Fisher 1993: 168).
Doctors have greater power in the medical encounter by virtue of the fact that they control access to health resources, as well as the dynamics of the health care interaction, and that control is institutionally regulated and sanctioned (Baer et al. 1997; Cant and Sharma 2000; Henley 1977; Lorber 1997). However, recognizing the asymmetry of the relationship does not mean that patients are passive objects in the exchange; rather they respond within the possibilities of the existing social structure by reacting to or resisting medical directives and procedures (Baer et al. 1997; Lazarus 1988). Additionally, the increasing medical pluralism of U.S. society offers alternatives to the dominant biomedical paradigm that sometimes serve to empower patients who may rely on multiple medical systems at one time (Cant and Sharma 2000).

There are a host of communication challenges in the interaction between midlife and older patients and their health care providers. Ageist, sexist, and racist attitudes and behaviors on the part of providers and patients, age-associated physiologic communication difficulties, generational, ethnic and gendered differences in communication patterns, and the influence of a third party all relate to the various layers of difference that may influence physician-patient interactions (Adler 1998; Cline and McKenzie 1998; Damron-Rodriguez 1998; Jackson and George 1998; Ikels 1998; Lorber 1997; Ryan and Butler 1996). The complexity of the interaction is often greater for older than for younger patients because they frequently present multiple medical problems that are mostly chronic, incurable, and thus contrary to the treatment paradigm in modern medical training (Adelman et al. 1991; Hahn 1995).

**Ageism and Health Care**

Ageism results in stereotypes of older individuals as a homogenous group with declining productivity, health, independence, sexuality, memory, and communication
skills (Ryan and Butler 1996). The ageist attitudes of care providers are complex and reflect a societal preoccupation with productivity and youth that effectively stigmatizes aging and illness (Kreps 1990). Ageist attitudes arise from fears about aging and death (Ryan and Butler 1996; Nussbaum, Thompson and Robinson 1989) and even the patient’s own ageist assumptions and behaviors (Adelman et al. 1991; Coupland and Coupland 1999; Ryan and Butler 1996). Ageist behaviors arise in clinical settings partly because providers there are more likely to encounter older adults who are ill, frail, confused, and hospitalized rather than vigorous, healthy older individuals (Adelman et al. 1991). Ageism among providers also results in attributing disease processes to normal aging, leading to inappropriate medical treatment (Chiang 1998; Davidhizar and Giger-Newman 1996; Ryan and Butler 1996).

The problems of ageism are compounded by age-related changes in communication skills, such as hearing and vision impairments, changes in the ability to process various types of information, and memory impairments (Ryan and Butler, 1996). Some hearing loss is common for 50% of adults over age 65, and some degree of visual impairment is also common (Adelman et al. 1991). The actual incidence of dementia increases with age from about 2.5% for people in their sixties, to about 22% for those in their eighties (Adelman et al. 1991). These sensory and cognitive difficulties have important implications for communication and can impose serious limitations on health related communication for otherwise healthy adults. Because these changes are socially stigmatized and seen as symbols of a generalized decline, they are also sometimes inappropriately assumed to be indicator of the patient’s capacities in other unrelated areas.
(Adelman et al. 1991). Adding to the complexity of ageist perceptions and physiologic changes are gender stereotypes, and racial and ethnic stereotypes.

**Gender Issues in Physician-Older Patient Communication**

Gender issues in physician-patient interactions are of tremendous importance for the aging patient due to the age differentials in longevity. Consequently the problems of aging are largely the problems of women (Allman et al. 1999). Women of all ages generally visit the doctor’s office more often than men for multiple reasons relating to health and social roles (Jenks 1993). A CDC report on women’s use of ambulatory medical care in 1997 and 1998 found that even after excluding pregnancy-related visits, regardless of race or ethnicity "women were 33 percent more likely than men to visit a doctor, although this difference decreased with age. The rate of doctor visits for such reasons as annual examinations and preventive services was 100 percent higher for women than for men and medication patterns differed significantly" (Brett and Burt 2001: 12). Women often see doctors in the process of caring for children, husbands, and parents as non-patient clients because of their social role of family caretaker (Jenks 1993).

Several studies and reviews suggest that both physicians and patients are influenced by gender stereotypes in the clinical encounter (Cline and McKenzie 1998; Hall and Roter 2002; Haug 1996; Jenks 1993; Street 2002). The gender of the physician relates to how they interact with patients and to how patients perceive them, and the gender of the patient impacts how physicians relate to them as well (Hall and Roter 2002; Street 2002). West (1984) found that doctors consistently underestimate the medical knowledge of their patients, and tend to talk "down" to their patients. They frequently underestimate the abilities of patients whose ethnicity, gender, or socioeconomic status differs
significantly from that of most physicians. Many physicians expect women to be difficult and demanding, and to have more psychosomatic illness episodes than men (Cline and McKenzie 1998; Haug 1996; Jenks 1993). Women frequently receive less thorough diagnostic work-ups and less aggressive treatment than men, and women typically also receive less technical/medical information (Adler 1998; Cline and McKenzie 1998; Lorber 1997). Female patients often must struggle to be considered competent individuals when interacting with male physicians, since their concerns are often taken less seriously than those of male patients (Cline and McKenzie 1998). Women spend more time asking questions of their doctors (Jenks 1993), but the amount of time women spend asking questions is "disproportionate to the information yielded" (Cline and McKenzie 1998: 64).

Women Physicians/Men Physicians

The vast majority of studies on the influence of the physician's gender on interaction patterns in the medical interview indicate that the gender of physicians and patients make a difference in medical practice (Adelman et al. 1991; Cline and McKenzie 1998; Hall and Roter 2002; Haug 1996; Lorber 1997; Roter and Hall 1998; Street 2002; West 1984). In most studies that consider the influence of the sex of the physician, female physicians appear more apt to provide support and information to their patients, are more egalitarian, and give more time to consultation than their male counterparts (Adelman et al. 1991; Haug 1996; Lorber 1997; Roter and Hall 1998). They also tend to interrupt their patients less than male physicians, and show more interest in what their patients are trying to communicate (Cooper-Patrick, Gallo, Gonzales, Ve, Powe, Nelson, and Ford 1999; Haug 1996; Lorber 1997; West 1984). West (1984) found distinct differences in interruption frequency between interactions with female patients and male
patients, as well as differences between male physicians and female physicians. Male physicians initiated 67% of interruptions, where as patients initiated 33%. When the gender and race of the patient was thrown into the equation the asymmetries were magnified.

Women physicians spend more time with patients and engage in more positive communication practices, such as agreement, approval and laughter, and are more likely to build partnerships with their patients by asking for their opinion, and expressing understanding (Lorber 1997). This has led to a preference for women physicians in primary care, as well as the traditional primary care specialties of obstetrics and gynecology, and pediatrics, where direct, hands-on, first-line care is needed.

Although the research indicates that communicative differences do exist between female and male physicians, the differences are typically not momentous, and on the whole women and men physicians are more alike than they are different (Roter and Hall 1998; Street 2002). These gender differences in communication styles are most likely an effect of life-long socialization and interaction patterns (Lorber 1997). Physician and patient gender stereotypes and attitudes likely generate a priori assumptions about their capacities and desires for both gender concordance and discordance in clinical communication (Street 2002). “For example, people generally believe that female physicians are less likely use aggressive communication strategies (commands, directives, negative opinions, controlling behaviors) than are male physicians” (Street 2002: 204). While women physicians also do not tend to interrupt their patients as often as their male counterparts, women physicians are interrupted more often than men physicians by their patients (Hall and Roter 2002; West 1984). Stereotypes and beliefs
about women and men physicians, combined with the assumption that women are more interested in psychosocial aspects of health (Roter and Hall 1998), could explain why patients tend to talk more, divulge more emotional and relational information, ask more questions, and are more involved in health care decisions when interacting with women physicians (Street 2002).

Some of the problems associated with frequent interruptions by physicians in the medical interview are related to contemporary time constraints imposed by HMOs and hospital administrators (Lazarus 1988; Paget 1993), but also because of the standard way that physicians shape the meaning of illness for their patients through their use of question and answer practices (Clark 1996; Good and Good 2000; Paget 1993).

“Importantly, in the traditional clinical encounter the representation of the reality of the patient’s condition is (re)defined in the cognitive structures of the discipline of medicine—a reality that may be very different from that understood by the patient” (Clark 1996: 751). This hierarchical exchange is in part developed in medical schools where students learn to reconstruct the clinical narrative in the context of diagnostic and therapeutic procedures (Good and Good 2000). Clark (1996) suggests that as the patient tells his or her “story” to the physician, the physician begins to manipulate the information conveyed by interrupting to pose strategic questions that shape the information to conform to the format of the medical report. These structural and institutional impediments to positive and empathetic health care communication are often magnified by racial/ethnic and socioeconomic differences of the participants.

**Gender, Ethnicity and Social Class in Medical Encounters**

The issue of social class intersects with age, ethnicity and gender, because minority/ethnic groups are more likely than the white majority to be in poverty, women
are more likely to be poor than men, and older ethnic/minority women, are the most impoverished of all (U.S. Bureau of the Census 1995). More older women than men are Medicare and Medicaid beneficiaries, and since Medicare pays for only 80 percent of physicians’ services, physicians do not have a “financial incentive for spending optimal time and delivering optimal care—employing optimal communication” with this class of patients (Allman et al. 1999: 334); and not all physicians accept Medicare payments effectively trapping some women in an unproductive physician-patient relationship.

A study of 20 female patients age 65 and older found that women who had only Medicare coverage had the perception that their physicians did not really care about them as individuals (Allman et al. 1999). Adler’s study (1998) of an ethnically and economically diverse group of older women with breast cancer, found that some women tended to behave more passively with their physicians because they lacked other health care options due financial constraints and poorer health leading to a sense of “forced reliance” on their physician. Some women may not attempt to assert themselves in the medical encounter and may feel trapped due to various social, situational and economic reasons. These issues of interpersonal dynamics and economics are perhaps most troublesome for ethnic/minority groups.

**Minority Elders and Health Communication:**

Not only is the elderly population growing, the older ethnic/minority population is growing faster than the majority elderly population (Damron-Rodriguez 1998; Jackson and George 1998; Tripp-Reimer 1999) and will likely reach 25% of the citizens aged 65 and older by the year 2030 (Davidhizar and Giger-Newman 1996). Recent studies show that for patients with similar clinical findings there are differences by ethnicity in treatment, amount of information provided, and empathy displayed by physicians (Adler
Jackson and George (1998) argue that Blacks, women and members of lower social classes are often assigned lower social worth by health care professionals, and receive the worst care in hospitals. As a result, more impoverished groups, including the elderly, often delay seeking treatment to avoid negative appraisals by health care providers (Jackson and George 1998, Lazarus 1988).

Cooper-Patrick et al. (1999), in their consideration of race and gender concordance and discordance and its impact on patients’ perceptions of physicians’ participatory decision-making (PDM) styles, found that patients aged 40-65 years rated their visits as more participatory than patients younger than 30 years. However, African Americans and other minorities rated their physicians as having lower PDM scores than did white patients. Although the differences were lessened when there was race and gender concordance between physician and patient, African Americans still rated their visits as less participatory than whites (Cooper-Patrick et al. 1999). Even after controlling for SES African American and other minority patients had less participatory visits with white physicians. Another more recent study confirms the above findings. In a cohort study using pre-visit and post-visit surveys and audiotape analysis, race-concordant visits tend to be longer and were rated as having more positive affect (Cooper, Roter, Johnson, Ford, Steinwachs and Powe 2003). However, race/ethnicity is not the only factor affecting the quality of physician-patient interactions. One nationally representative survey that oversampled for Black, Hispanic and Asian households found that the quality of interactions was lower for non-White patients, particularly Hispanics and Asians, even after controlling for differences between respondents with and without health insurance (Saha,
Arbelaez and Cooper 2003). Yet race/ethnicity discordance contributed minimally to the quality of these interactions, and was better explained by physicians’ behaviors such as treating patients with greater respect, spending more time with patients, listening and involving patients in the decision-making process.

Although communication may be enhanced when the physician and patient belong to the same ethnic group (or for that matter the same gender, or age group, or social class), this does not insure that both will have the same explanatory models of illness or the same expectations for the medical visit (Cooper-Patrick et al. 1999; Ikels 1998). A study by Green et al. (1994) of older patient satisfaction shows the interrelatedness of SES, racism and ageism in health encounters.

In this sample of mostly poor, non-white women patients...there may be little expectation that the young white physician working in the highly respected tertiary care medical center study site would share in decision-making. These data should not be construed to mean that older patients do not desire to participate in decision-making. Rather, these data may reflect the past experiences of these older patients with other physicians and their perceptions of what they can expect from physicians in this setting. (Greene et al. 1994a: 1284)

Therefore, differential interaction patterns between physicians and their patients are not only shaped by cultural, generational and gender differences; they are also constructed out of the experience and history of social inequality.

Although different genders, age groups and ethnic groups vary in their expectations regarding medical encounters, researchers should be cautious in making cultural value generalizations that do not consider how the experience of social inequality shaped those values. The health care system is itself culturally constructed and functions within the parameters of the larger society. Placing the health care transaction into its larger cultural context clarifies the social processes that shape the meaning and outcome of the encounter.
**Improving Health Communication**

Effective (and affective) communication is key to all human relationships and yet it is frequently not achieved in health care relationships. Despite good intentions, doctors often do not listen to or understand their patients’ concerns, and therefore, do not incorporate those concerns into the healing process. Regarding the physician-patient transaction as hierarchical and intercultural highlights the social and structural distinctions between individuals and groups within the larger society. Problems in the doctor-patient relationship have to be understood as a reflection of the power relations of the larger society (Rhodes 1996). Regardless of ethical pronouncements by the American Medical Association to treat “all of humanity without distinction by race, gender, age, religion, socioeconomic status, or sickness condition,” there is evidence of substantial institutionalized inequity (Hahn 1995: 143).

Health communication scholars, linguists and medical sociologists and anthropologists have suggested a multitude of ideas and techniques to improve health care communication and ultimately health care outcomes. The approach that appears to incorporate most of these suggestions is the shift from the traditional biomedical “problem-based” approach to a “goal-oriented” holistic approach (Clark 1996: 762). In the goal-based model, health is defined not as an outcome, but as a process, incorporating “the values of the individual—as embodied in his or her personal and life goals . . . which can best be determined through a dialogue” between patient and providers (Clark 1996: 763). This processual approach to health and health care empowers patients to assume greater responsibility for their health, and ideally allows both provider and patient to transcend some of the barriers of difference that separate them (Clark 1996). The key in this approach is listening. Medical professionals are often not taught how to listen and
believe that it amounts to something akin to good manners or note taking (Elgin 1999). Elgin, a linguist, argues that the crisis in health care is a crisis of language, because of misunderstandings, a failure to listen and believe the stories of patients, and not communicating effectively and empathetically. Kleinman suggest, “If we think of the clinical encounter as a transaction between patient and practitioner conceptualizations of sickness and ‘clinical reality,’ then a core clinical task becomes making these explanatory models explicit and thereafter translating and negotiating between them” (1979: 61). However, Kleinman cautions that this approach to health care may require practitioners to recognize that biomedical conceptualizations may be inappropriate in some circumstances or require adjustments to fit with the patient's experience. Thus culturally competent care is not about memorizing the attributes of different ethnic and cultural groups, but about learning to use a “patient-centered approach that incorporates fundamental skills and attitudes that may be applicable across ethnic boundaries” (Saha et al. 2003:1718). These skills are crucial to improving health care communication about sexual health issues, which the following section notes is poorly attended to for older persons.

**Part Two: Issues in Physician-Patient Communication About Sexual Health**

An interest in exploring the dynamics of provider-patient communication about sexuality issues has taken on new significance in the wake of the AIDS pandemic. This interest is manifest in numerous studies with women and men of all ages, and with their health care providers, to determine how and if they address topics that are sometimes difficult to articulate, embarrassing, and even stigmatizing (Epstein et al. 1998; Gerbert, Maguire, and Coates 1990; Haas and Coe 1997; Makadon and Silin 1995; Metz and Seifert 1990; Kerr et al., 1996; Nusbaum, Gamble, Skinner, and Heiman 2000; Nusbaum,

Health care practitioners have the potential to be an excellent source of HIV prevention information for a broad spectrum of persons since adults in the US average almost three visits a year to a physician (Makadon and Silin 1995). However, this is seldom the case. "In spite of the recognize need for provider involvement in prevention education, many obstacles exist, including clinicians' narrow conceptions of medical care, discomfort with discussing sexuality and drug use, attitudes about HIV/AIDS, and time and resource constraints" (Strombeck and Levy 1998: 918). Many physicians simply lack good interviewing skills, especially when dealing with the older patients (Putnam 1996). Furthermore, many providers practicing today were trained before the HIV/AIDS epidemic began, and thus lack sufficient knowledge and skills to address HIV risks. Additionally, as is true of the general population, some physicians have ageist attitudes and assume that those older patients are not at risk for HIV infection (Strombeck and Levy 1998: 918). However, the continuing rise of cases among those typically not considered "high risk", indicates that many primary care physicians are, whether they are aware of it or not, interacting "with HIV-positive patients and other patients who are at risk for infection that may not fall into the 'traditional' high-risk categories" (Haas and Coe 1997: 403).
Although many health care practitioners have begun to incorporate important
disease prevention issues into their practices, sex and drug-related discussions are still
relatively low.

In a recent study, the CDC reported that the overwhelming majority of primary-
care physicians 'usually' or 'always' asked their adult patients about cigarette
smoking (94%) and alcohol use (84%). In areas most directly related to HIV risks,
physicians were more reticent, however. Many fewer inquired about illicit drug use
(49%), condom use (31%), number of sexual partners (22%), or sexual orientation
(27%). (Strombeck and Levy 1998: 918-19)

Despite some improvement in preventive medicine, physician training has
traditionally given higher priority to immediate acute needs rather than to long-term
behavioral interventions. Narrow conceptualizations of the physician's role tend to focus
on patients' complaints rather than offering health promotion services (Makadon and Silin
1995).

**Patient Perspectives on Physician Communication About Sex and HIV Prevention**

The vast majority of patients surveyed and interviewed over the past decade have
indicated that they would like to talk with physicians about sexual health concerns, but
most have never done so. These studies show that most adult women and men want to
discuss sexual health issues, including HIV, with their health care providers, but would
prefer that their doctor raise the issue (Haas and Coe 1997; Loehr Verma and Seguin
1997; Makadon and Silin 1995; Marwick 1999; Metz and Seifert 1990; Nusbaum et al.
2002; Waterhouse 1993; Zweifler Padila and Schafer 1998). One nationwide survey of
patients revealed that only 15% reported that they had discussed HIV risks with their
doctors in the previous five years, even though 94% had visited a physician during that
time. Nearly three-quarters (72%) of the discussions about HIV that did take place were
at the patients' urging (Gerbert, Maguire, and Coates 1990). Other smaller studies
focusing on reports from both physicians and patients reveal similar finding with regard to clinical communication about sexual health issues.

In a nursing study, Waterhouse (1993) surveyed a convenience sample of 53 men and 20 women (age 29-58 years, mean 42 years) who were either current or retired university employees. This study examined the attitudes of healthy individuals toward physicians and nurses discussing sexual concerns with clients. The majority of this mostly white (96%), married (77%), and well-educated (68% with bachelor's degree or higher) sample thought discussing sexual concerns with nurses was appropriate, and all subjects thought that physicians should discuss sexual concerns with patients ($p \leq .0001$). Twenty-six percent felt nurses should "always" or "almost always" discuss sexual concerns with their patients, and 66% responded "always" or "almost always" that physicians should discuss sexual concerns with their patients. Women showed more positive attitudes towards discussion of sexual concerns by physicians and nurses than males, but this difference was not significant (data not shown). Age, marital status, and educational level had no significant influence on attitudes.

Nusbaum et al. (2002) assessed women's interest and experience with discussing sexual concerns with their doctors, and identified what they perceived to help or hinder this discussion. The 964 women who completed the questionnaires ranged in age from 18 to 87 years old and were seeking routine gynecological care. Most participants (78%) wanted to discuss their sexual concerns with their physicians, and 97.2% felt that their physicians should be knowledgeable about sexuality. More than half (57%) had discussed some of their sexual concerns with a physician, and 89.3% of these reported the discussion was helpful. Another 24% had been interested in discussing concerns but had
not done so, and 35% reported missed opportunities to discuss concerns when they attempted to raise the subject by physicians did not seem interested or to understand. Although most respondents (69.7%) reported feeling too embarrassed to bring up the topic; these women were over 10 times more likely to respond that they would have discussed their concerns if the physician had asked compared to those not reporting embarrassment. Patients reported feeling comfortable talking about sexual concerns with both female and male physicians, but physician gender was reported as effecting their willingness and ease in discussing these concerns.

In a much smaller, qualitative study, Loehr et al. (1997) investigated the attitudes of women over 60 toward sexuality and intimacy, including how the medical profession addresses sexuality and intimacy issues. Fourteen English-speaking women age 60 to 85 in Kingston, Ontario, Canada, from senior apartment complexes or nursing homes, senior community organizations and volunteer groups participated in focus groups to discuss sexuality issues. On the whole, the participants felt that sexuality is, and will continue to be, an important part of their lives. However, like the women in the Nusbaum et al. study there was uncertainty and hesitation about the prospect of volunteering sexual information in clinical context. The women in this study suggested that they would feel more apt to talk about sexuality with their physicians if they were not being rushed; if they felt their complaint was important to the doctor; if doctors used layman's terms to explain things, and; if they were not addressed by terms of endearment or age-related terms like "Granny".

Men's expectations about physician interactions mirrored those of women, particularly in the desire for physician-initiated communication about sexuality. Metz
and Seifert (1990) surveyed by mail a small sample of primarily white, middle-class, well-educated men (N = 62) ranging in age from 18 to 73 years. While 97% of the men reported prior sexual concerns, only 19% had discussed these issues with their doctor. However, 35% had consulted one or more professionals for assistance with a sexual concern (psychologists/ psychiatrists 26%, primary care physicians 19%, sex therapist 12%, marital and family therapist 8%, and the clergy 3%). Many were hesitant about talking to their doctors, but wanted to deal with sexual problems. Only 31% of the man reported that they were likely to initiate a conversation about sexual concerns with a physician. They overwhelmingly preferred that the physician initiate the discussion of sexuality issues (85%). Only 18% indicated they did not appreciate their physician inquiring about sexual matters. Fewer than a quarter of the men reported that their physicians had inquired about sexual matters, and only a quarter of the patients have raised sexual questions themselves.

Zweifler et al. (1998) also focused exclusively on men, exploring the reasons that diabetic Latino men do not discuss their sexual difficulties with their doctors. Zweifler and colleagues conducted interviews with 82 Latino (mostly Mexican-American) male patients who were diagnosed with diabetes mellitus. The men ranged in age from 19 to 86 years, with a median age of 56 years.

Most of the men reported erection difficulties, 59% always had erection difficulties and 82% indicated that they frequently (more than one-half the time) had erection difficulties. Only 47% of patients had discussed these issues with their physicians. Significantly, among the patients with frequent erectile dysfunction, 90% were interested in receiving information about impotence and 85% were interested in trying a new
method to improve erections. However, less than half of had discussed it with their physician. Men did not initiate discussion in most cases because they were either embarrassed or because they expected their physician to initiate the dialogue.

These studies indicate that in most cases half or fewer than half of patients had actually discussed any of their sexual concerns with their doctor. Repeatedly, one study after another indicates that most patients would like for their physician to provide a more comfortable environment for discussing sexuality issues by gently raising the topic. These studies also reveal that many women and men have sexual issues that they would like to discuss with a physician (Loehr et al. 1997; Nusbaum et al. 2002; Metz and Seifert 1990; Zweifler et al. 1998); in some cases a particular type of doctor, therapist, or nurse is felt to be more appropriate than others (Metz and Seifert 1990; Waterhouse 1993) and gender concordance between patient and physician was preferred more often than not (Nusbaum et al. 2002; Metz and Seifert 1990; Zweifler et al. 1998). Indeed, physicians are routinely credited as the most trusted source of healthcare information by the general public (Haas and Coe 1997; Makadon and Silin 1995). Although physicians can be good educators for their patients, most have little or no training in how to design, developed, and present information effectively to others (Haas and Coe 1997).

**What Physicians Do: Discussion of sexuality and Other HIV Exposure Possibilities in Clinical Contexts**

Several qualitative and quantitative studies, and review articles, indicate that physicians and other health care providers are uncomfortable talking about sexuality issues, including HIV, with their patients (Epstein et al. 1998; Kerr et al. 1996; Makadon and Silin 1995; Penson et al. 2000; Ross et al. 2000). In particular, primary care general practitioners, who increasingly have to address HIV prevention and sexual dysfunction
issues in their practices, report difficulty and discomfort in addressing their patients' sexual concerns (Epstein et al. 1998; Sadovsky 2000). This is particularly evident with older patients. In 1996 a survey of primary care physicians (n = 124; 72 internal medicine and 52 in family practice) in Dallas County, Texas, reported that most physicians rarely or never discussed HIV/AIDS with patients older than 50 years of age, and were less likely to discuss symptoms of HIV infection or to counsel older patients for HIV testing than their younger patients (Skiest and Keiser 1997).

Certainly the physician's specialty is predictive of their likelihood of engaging their patients about sexuality, but the sex and ethnicity of the physician and patient, as well as the recentness of medical training also appear to be important factors. A national random-sample survey of 2,545 primary care physicians to determine the extent to which they provide HIV prevention and clinical services found that male physicians and the physicians' perception that patients would be offended by sexual history questions were predictive of not asking new patients about their sexual behaviors and drug use (Kerr et al. 1996). OB/GYNs were the most likely to ask these questions, whereas GPs were the least likely to ask these questions. OB/GYNs were more than six times and those in Pediatric/Adolescent medicine were four times more likely to ask about condom use than all other specialties. Additionally, physicians who treated mostly White patients were less likely to report asking their patients about their sex and drug behaviors. Black and White physicians were less likely than Hispanic, Asian and other physicians to ask adults about sex partners. In general, White physicians, male physicians, physicians whose patients are mostly age 65 and older, physicians who treat mostly White patients, and physicians who believe that their patients would be offended if they asked questions
about sexual behaviors and/or drug use were less likely to engage their patients on HIV/AIDS related topics.

Although, physicians appear more likely to discuss sexual issues, including HIV prevention, with their younger patients than with their older patients, Epstein et al. (1998) found that physicians' discomfort with discussing these topics results in ineffective evaluation of the risk status of even their younger patients. In a convenience sample of 17 Family Physicians and Internists and 26 patients age 18-45 who indicated a concern about HIV risk on a pre-visit questionnaire, videotaped interaction revealed that physicians did not elicit enough information to characterize a patient's HIV risk status in 73% of the encounters. This appears to be directly related to physician discomfort with discussing sex related issues. “Nonverbal barriers to effective communication were frequent. For example, physicians were observed to shake their heads ‘no,’ avoid eye contact, or turn their back to the patient while asking about sexual behavior and to initiate discussions about HIV during a genital examination” (Epstein et al. 1998: 438).

Typically, physicians avoided HIV discussions by changing the subject or simply ignoring patients’ stated concerns and cues that they were interested in discussing HIV risks. “Patients in our study wanted their physicians to introduce the topic of HIV, but few physicians had a comfortable standard question or statement with which to introduce the topic” (Epstein et al. 1998: 440).

One 1990s study, however, indicates that more recently trained physicians may be more comfortable discussing sex and drug-related issues with their patients. The mail-in survey indicated that most (81%) recent medical school graduates indicate that they are moderately or very comfortable discussing HIV/AIDS topics, including sexual behavior
issues, with their patients, but assessed only 0-25% of their patients to be "at-risk" (Haas and Coe 1997). This survey included both recent medical school graduates and preceptors from all areas of medicine. The 103 physicians who graduated between 1950 and 1984 were less likely to discuss HIV-related topics than those who graduated after 1985. Both recent graduates and well-established physicians discuss HIV/AIDS with the patients they perceive as at risk, however recent medical school graduates consider more of their patients at risk, and felt more comfortable with HIV/AIDS topics, and discussed these topics with a higher percentage of their patients. For the patient discussion questions, most selected the 0-25 percentage of their patients category with which they discussed the following: general HIV/AIDS; HIV/AIDS risk factors; modes of transmission; "safe sex"; and, abstinence.

Only 9.8% answered 'None' for percentage of patients with whom they discussed general HIV/AIDS. However, this number increased to 10% did not discuss risk factors, 12.1% mode of transmission, 17.3% did not discuss 'safe sex' with patients, and 25% reported not discussing abstinence with patients. For all of these questions the [St. Louis University School of Medicine] alumni report discussing these HIV/AIDS-related topics with a higher percentage of their patients than the preceptors group. This only reached statistical significance in the risk factors and modes of transmission questions, however. (Haas and Coe 1997: 405)

It is encouraging to learn that more recent medical school graduates are more comfortable with discussing HIV/AIDS, though their misperceptions about who is at-risk is not so encouraging. The reluctance of health care providers to discuss HIV/AIDS with their patients, especially their older patients is a significant disadvantage to prevention efforts with midlife and older persons.

Indeed, larger quantitative studies indicate that Family Practice physicians (FPs) do not routinely recommend HIV testing for the majority of their sexually active patients. A survey of FPs in Rhode Island and Mississippi showed that although 93% tested their
“high risk” patients for HIV, only 7% of their sexually active patients aged 18-50 had been tested in the previous year (Simmons, Ma, Stumpff and Flanigan “Routine HIV Testing in the Primary Care Outpatient Setting,” poster presented at the October 2004, North American Primary Care Research Group (NAPCRG) annual meeting, Orlando, FL.). The difficulty appears to be narrow conceptualizations about which patients that are at-risk for HIV. These authors conclude, “In order to not stigmatize any specific risk groups, nor to miss any patients who are unable to be identified as being ‘at high risk’, routine testing in the primary care setting should be encouraged.”

These studies indicate that most primary care physicians who treat patients aged 45 and older do not discuss HIV prevention topics or sexuality topics with their older patients (Frank and Harvey 1996; Kerr et al. 1996; Skiest and Keiser 1997; Wilson and Kaplan 2000). However, those that consider the physician's gender (Frank and Harvey 1996; Kerr et al. 1996; Wilson and Kaplan 2000) noted that women physicians discuss sexuality issues more than men physicians regardless of physician specialty. These studies point to the fact that many physicians do not perceive of their older patients as sexual beings who may have sexual concerns or questions, or may be at risk for STDs. Indeed what often comes to mind when the dating scene for single women and men is mentioned are folks in their 20s and 30s. However, this perception is contrary to the reality as noted in a very recent AARP survey of 3,501 single women and men between ages 40-69. The survey focused on their lifestyles, dating and romance patterns, including risky behaviors. The study notes that over a third of all persons in the US ages 40-69 are single, and divorcees make-up a plurality of this group (AARP 2003). About a third of single women and men in the AARP study were in exclusive dating relationships,
and almost the same percentage (32%) were dating non-exclusively. Many others indicated an interest in finding a new relationship. This report shows how out-dated physician and even societal views are regarding sexuality and aging and HIV/STD risks for older individuals.

“In spite of the recognized need for provider involvement in prevention education, many obstacles exist, including clinicians’ narrow conceptions of medical care, discomfort with discussing sexuality and drug use, attitudes about HIV/AIDS, and time in resource constraints” (Strombeck and Levy 1998: 918). Although there are excellent articles (Dustow 1995; Wilson and Castillo 2004) and books (Miller, Mayer, and Makadon 1999; Ross et al. 2000) that offer practical suggestions for discussing the subjects of sex, sexuality, safer sex and HIV with a diverse population of patients, few providers appears to use them. Below is a review of the epidemiology of HIV/AIDS among midlife and older individuals and the trends in HIV/AIDS infection and HIV-related knowledge, indicating the salience and timeliness of incorporating these communication tools into clinical practice.

**Part Three: Epidemiology of HIV/AIDS Among Persons Aged 50+ and Age, Gender and Ethnicity in HIV/AIDS-Related Knowledge and Risk**

In 1989, Catania et al. argued persuasively that the prevention of HIV transmission "is the single most important AIDS-related public health goal," and that greater attention should be paid to preventing transmission of HIV among late-middle-age and elderly individuals (1989: 77). Since that time the need to target prevention efforts at mature persons, has only increased, with adults age 50 and older consistently representing approximately 10% of the cumulative AIDS caseload (Strombeck and Levy 1998). In 1998, Ory et al. continued this theme by pointing out that persons age 50 and older are
still largely ignored in both HIV/AIDS scientific research and intervention efforts, despite being among one of the fastest growing segments of the AIDS caseload.

In the mid-90s, when the number of adults diagnosed with AIDS showed their first-ever decline, new incident cases among the midlife and older population (50 years of age and older) rose twice as fast as those 49 years of age and younger (22% and 9% respectively) (Ory et al. 1998). Nevertheless, calls for prevention efforts, particularly among health care providers, go largely unheeded. Although sexuality issues are increasingly visible in the media, news and entertainment, as well as taught in schools of medicine, nursing, social work, public health and psychology, the skills for talking about sex and diagnosing sexual problems or counseling patients with sexual concerns remain under emphasized for many medical practitioners (Ross et al. 2000). Due to the lack of intervention efforts that have been directed toward midlife and older populations (see Strombeck and Levy 1998), both within and outside the clinic, it is not surprising that these populations tend to have less information and more misinformation about HIV/AIDS risks, and that physicians often underdiagnose and misdiagnose their older patients because they do not perceive them to be "at-risk" for HIV (Ory et al. 1998). As among individuals in other populations, gender issues, sexuality issues, structural, cultural, sociodemographic and economic issues impact how mature individuals are affected by the HIV/AIDS epidemic. Recognition of the diversity of the older adult population needs to replace ageist assumptions that misrepresent and homogenize this group for more effective intervention and prevention strategies.

**Surveillance Reports on HIV/AIDS Among Persons Age 50 and Over**

Surveillance data from the Centers for Disease Control and Prevention (CDC) estimates the number of persons living with AIDS increased 7.9% from 1999 to 2000
By the end of 2002, “an estimated 384,906 persons in the United States were known to be living with AIDS” (CDC 2002: 5). Death rates for persons with AIDS have continued to decline, mostly due to the use of highly active antiretroviral therapy (HAART). “During 1998–2002, the estimated number of deaths among persons with AIDS declined 14%” (CDC 2002:5)

Although the estimated number of AIDS cases diagnosed annually declined substantially from 1996 through 1999, the rate of decline observed between 1999 and 2000 slowed relative to previous years (CDC 2001b), by 2002, AIDS diagnoses increased two percent (CDC 2002). Additionally, these declines are not significant among all age, sex, ethnic and regional categories.

The leveling in overall AIDS incidence is occurring as the composition of the epidemic is changing. AIDS incidence declined in most populations but increases were observed in some groups, notably women and persons infected through heterosexual contact….From 1999 to 2000, the number of estimated deaths among persons with AIDS declined 11%; this decline, however, was less than that observed from 1996 to 1997 (42%)…when the widespread introduction of highly active antiretroviral therapy (HAART) had its greatest impact…Declines in deaths, which have been attributed in part to the impact of HAART, also reflect declines in AIDS incidence which in turn reflect both underlying trends in new HIV infections as well as delays in disease progression among HIV infected persons who are receiving treatment. Other factors associated with the slowing of declines in deaths from 1999 to 2000 compared with those previously observed may include delayed test seeking among certain populations, limited access to or use of health care services, and limitations of current therapies among persons in care. (CDC 2001b: 3)

Among the issues mentioned above, delayed test seeking and access to health services are particularly salient for minorities, older age groups, and women. Even with delays in testing and reporting, the percentages of minorities, minority seniors and women infected with HIV, and diagnosed with AIDS continue to increase (CDC 2001a, 2001b; Florida Department of Health 2003a, 2003b, 2003c). As of 1996, the estimated adult/adolescent AIDS incidence, by race/ethnicity was 46.1% for the White, non-
Hispanic population, Black, non-Hispanics accounted for 34.8%, and Hispanics accounted for 17.8%. However, by the year 2000, the incidence of AIDS cases had undergone a significant shift in ethnic make-up. The percentages for White, non-Hispanics dropped to 37.8% of all estimated cases, Black, non-Hispanics rose to 41.2%, and Hispanics rose to 19.6% (CDC 2001b: 30). Newer surveillance data from 30 areas in the U.S. and territories that have instituted confidential-name-based HIV infection reporting since 1998 through 2002, shows that the estimated number of diagnoses of HIV/AIDS by race is now 54% Black, 32% White, 13% Hispanic, and 1% other (CDC 2003).

From 1998 through 2002, “AIDS incidence decrease 61% among children and 24% in the age group 25–34 years, and remained stable in the age group 35–44 years. AIDS incidence increased in the following age groups: 13–14, 15–24, 45–54, 55–64, and 65 years and older” (CDC 2002: 6). In 2001, 10.9 % of all cumulative AIDS cases (based on age at diagnosis) were of men and women age 50 and older (20.7% of all persons age 45 and older). Women age 50 and over accounted for 9.5% of all reported AIDS cases in 2001; African American women alone accounted for 50% of this total. Men age 50 and over accounted for 11.2% of all reported cases (CDC 2001b). If we drop the cut off age down to 45, then women accounted for 17.3% of all reported AIDS cases in 2001, and men age 45 and over accounted for 21.4% of all reported cases (CDC 2001b). The numbers of midlife and older women and men infected, particularly minority women, is more significant in the southern United States. Throughout the epidemic Florida continues to be one of a handful of states with the highest HIV/AIDS rates.
Epidemiology in Florida

The South has remained the region with the highest estimated number of persons living with AIDS, accounting for 38.2% in 2000, though the Northeast follows with a close behind at 29.8% (CDC 2001b: 38). Florida ranks third behind New York and California in total adult/adolescent cases (Florida Department of Health 2003b). Florida accounts for about 11% of the estimated number of persons living with HIV/AIDS in the US (Florida Department of Health 2003b). However the gender and ethnic trends in HIV/AIDS incidence are notable. African Americans account for 55% of cumulative reported HIV cases in Florida compared to 40% nationally, and women account for 36% of cumulative reported HIV cases in Florida compared to 29% nationally (Florida Department of Health 2003b). Of women in Florida diagnosed with HIV and with AIDS through 2003, 72% were Black, 16% and 17% (respectively) were White, and 11% and 10% (respectively) were Hispanic (Florida Department of Health 2003c).

In Florida, through 2003, 14% of AIDS cases and 12% of HIV cases were reported in persons age 50 and over. The racial trend noted for all HIV/AIDS cases in Florida are mirrored in its midlife and older population. Significantly, Black, non-Hispanics account for almost half (51%) of all seniors (age 50 and over) that have been diagnosed with AIDS in Florida (Florida Department of Health 2003a). White, non-Hispanics account for 33% and Hispanics represent 16% of senior AIDS cases. Unfortunately, most persons age 50 and over have not been tested for HIV. This is in part related to age and ethnic trends in HIV/AIDS knowledge and risk perceptions.
Intersection of Age, Gender And Ethnicity in HIV/AIDS Risk & HIV/AIDS-Related Knowledge

In the early years of the HIV/AIDS epidemic, the source of infection for many older adults was often through the receipt of contaminated blood or blood products. This source of infection distinguished them from other age groups who were not as likely to be blood product recipients (Strombeck and Levy 1998). Unfortunately, when these older adults became infected through blood transfusions, many health care providers and policy makers falsely assumed that the infection would not spread based on the stereotype of older adults as disengaged from sexual activities (Laskin Siegal and Burke 1997). Laskin Siegal and Burke argue that "[t]his myth that older adults infected through transfusion would not go on to infect others sexually has been one basis for the lack of education of the older population regarding the risks from this phase of the epidemic." (1997:156).

The good news is, due to improved blood screening methods in place by 1985, the AIDS caseload of Americans diagnosed at age 50 and older who had become infected through blood transfusions, decreased from 17% in 1988 to approximately 6% by the end of 1996 (CDC 1988, 1996, as cited in Strombeck and Levy 1998). The bad news is, HIV transmission for newly identified AIDS cases in adults over 50 years of age is primarily through high-risk sexual behavior (Strombeck and Levy 1998), and despite this trend most midlife and older adults are largely still not targeted by clinical and public health prevention efforts (Ory et al. 1998, Linsk, Fowler and Klein 2003).

As for the general population, the trend towards more heterosexual transmission of the virus that causes AIDS appears to be increasing among both sexes and all ethnic groups. By comparing the most recent trend in AIDS incidence by exposure category
and race/ethnicity diagnosed in between 1998 and 2002, each ethnic group showed slight increases in the heterosexual mode of transmission and slight declines in intravenous drug use (IDU) transmission, with the exceptions of Asian/Pacific Islanders and female and American Indian/Alaska Native whose IDU mode of transmission increased (CDC 2003).

**HIV/AIDS in older persons**

Mack and Bland (1999) present four interrelated issues that tend to distinguish older persons from younger persons with regard to HIV/AIDS: 1) the progression from HIV infection to AIDS occurs faster among older persons, and the progression of AIDS opportunistic illnesses often progress at a faster rate as well; 2) AIDS, sometimes called the "new great imitator", causes many of the same symptoms typical of the chronic diseases that are common among older persons, making correct diagnose challenging; 3) health care workers do not expect their older patients to be “at-risk” for HIV/AIDS, and therefore miss many prevention and diagnosis opportunities, because of ageist assumptions about sexual and/or drug use behaviors among older persons; and 4) more older people die from AIDS related illnesses in the same month that they are diagnosed than younger people because of the three issues listed above.

The problem of late diagnosis and misdiagnosis is illustrated in some retrospective analyses of hospital records for older patients who died without HIV/AIDS diagnosis. Of 170 patients (ages 60 to 79) in Harlem Hospital Center in New York City, blood samples showed that 6% of the men and 9% of the women were HIV positive. “Nearly all the cases were misdiagnosed, and few had known risk factors for HIV” (AIDS Alert 1995:79). Another retrospective study at Grady Hospital in Atlanta found that 32 HIV-positive elderly patients (age 60 or older, mostly Black and male) that presented with
signs or symptoms of AIDS were not tested for HIV until months later (AIDS Alert 1995). “Most of the patients acquired HIV through sexual intercourse (38%), primarily through homosexual contact, and injection drug use (16%). Blood transfusions accounted for only 9% of the infections” (AIDS Alert 1995: 79).

Mack and Bland (1999) point out that age-related issues in HIV infection and diagnosis are perhaps more problematic for older women because of social and physiological factors that place them at greater risk of infection, and earlier death from infection. Physiologic changes in vaginal tissues make tearing during intercourse more likely, and this increases the risk of HIV infection, particularly when barrier methods are not used. Also, life expectancy for older women with AIDS is less than it is for older men, "in part, because older men tend to make more antibody that older women" (Mack and Bland 1999: 688).

Compounding these physiologic factors is the fact that older women are less likely than younger women to use condoms since they typically associate them with pregnancy prevention and/or they do not perceive themselves to be at risk for HIV and other STDs that barrier methods help to prevent (Mack and Bland 1999, Yates et al. 1999, Zaboltsky 1998). Additionally, women (of all ages) are sometimes at a disadvantage in protecting themselves from HIV because of their structural position in heterosexual relationships and cultural values defining their sexual interactions with men (Lear 1997). Financial dependency on a male partner may put some women at a disadvantage in negotiating condom use (Florida Department of Health 2003c), and the mere suggestion that condom protection is needed puts relationship trust into jeopardy.
Midlife and Older Women and HIV/AIDS

The trends in the AIDS incidence rate for midlife and older persons are especially troublesome for women. Strombeck and Levy (1998) report that from 1991 to 1996 the number of AIDS cases attributed to heterosexual contact increased 106% and IDU increased 75% for women age 50 and older, whereas the number of reported AIDS cases in older men attributed to heterosexual contact increased 94% and IDU increased 53%.

For mature women, particularly ethnic minority women, the trends of HIV/AIDS infection among those aged 50 and older are particularly devastating. Zaboltsky (1998) reports that in 1989, more than three-fourths (77%) of women age 65 and older with AIDS were White (non-Hispanic). This had declined to slightly less than half (48%) as of 1997. At the same time, the proportion of women in the same age group who were Black increased from 16% in 1989 to 38%, and Hispanic women increased from 7% to 12% over the same time period. Significantly, younger age groups in the 50+ category show similar patterns; from 1989 to 1997, non-Hispanic white women age 50-54 declined from 37% to 23%, whereas Black women increased from 47% to 54% and Hispanic women increased from 14% to 21%. This pattern is continued in each 50+ five-year age cohort in the number and percentage distribution of AIDS cases.

The reason for these patterns are unclear; they may be due to women of color aging with their infection and/or being diagnosed at older ages, or from more of these women contracting HIV later in life from an HIV-positive man (Zaboltsky 1998). Results from one national study of women age 50 and older, with heterosexually acquired AIDS, compared to those age 49 and younger (most of the women from both age groups were Black and with incomes below $10,000), found that the older women were more likely to be widowed, separated, or divorced; to live alone; to have less than 12 years of schooling;
and to report having been exposed to HIV through sex with a man whose risk of exposure was unknown (Schable, Chu, and Diaz 1996). Compared to younger women in the study, women 50 years of age and older were less likely to have had a male sex partner in the past year, less likely to have a history of other STDs, more likely to have never used condoms, and more likely to been tested for HIV while hospitalized. The age-related difference in condom use is consistent with other survey data indicating very low prevalence of condom use among midlife and older women and relates to age-related difference in perceived risk for HIV infection, and the use of barrier methods for disease prevention rather than pregnancy prevention (Binson, Pollack and Catania 1997; Theall, Elifson, Sterk and Klein 2003).

Among a subsample of women age 40-75 who participated in the 1990 (wave 1) and the follow-up 1992 (wave 2) National AIDS Behavioral Surveys (NABS), only 8% of women had any risk factors for HIV infection (Binson, Pollack and Catania 1997). While this means that 92% had no risk factors, the remaining 8% represents 4.5 million midlife and older women in the U.S. The findings were less optimistic for minority women, and African American women, in particular, had the highest prevalence of at least one risk factor (12.4%) if they lived in a "high-risk city" (high-risk city (HRC) refers to 23 metropolitan areas that have large numbers of AIDS cases and large Hispanic and African American populations, which were used to over-sample minorities). The length of sexual relationship had little relevance for risk behavior, because women who had been partnered for 40 years or more were equally as likely to report a risk behavior as women who had been partnered for less than 5 years. When this finding is combined with the fact that 13% in the national sample and 22% in the HRC sample did not know
the risk status of their primary sex partner the potential for exposure goes up. The authors note that when women who did not know the risk status of their primary partner are included in the definition of risk, "the prevalence of risk increased to 19.6% in the national sample and 22.7% in the HRC sample" (Binson, Pollack and Catania 1997: 350).

This study also points to a low perception of risk among these women; 90% reported never having been tested for HIV, and 90% reported never having used condoms (75% of those who lived in "high-risk cities"). "Moreover, about 90% of the women who did not know the risk status of their primary partner indicated that they were not at-risk for HIV" (Binson, Pollack and Catania 1997: 349)

In a study comparing two age cohorts (ages 18-29, and ages 40-71) of mostly unmarried African American women (85%) on their perception of HIV risk, found that most of the older women (55%) reported no chance of infection compared to 29% of the younger women (Theall et al. 2003). Several issues increased the perception of risk for both groups women including: those who had been cheated on by their most recent partner, or they had cheated on their partner; know someone with HIV/AIDS or someone who has died of AIDS; sexual preference for males only; having been tested for HIV; were treated for an STD in the past year; and perception of low efficacy of condoms or disliked male condoms. However, most of the women in the study regardless of age perceived themselves to have no risk or to be at low risk for contracting HIV, even those reporting at least one risk factor.

Although midlife and older women have been at relatively low risk of HIV infection throughout the epidemic, there overall rate of exposure has been climbing over the past decade and this is especially true for ethnic minority women. Age, gender,
ethnicity, and SES all play a role in determining risk behavior, but these demographic characteristics should not be the foundation for categorizing one group "at-risk" and another "not-at-risk", particularly for prevention education strategies. Instead, the prevalence of behaviors, along with the underlying beliefs, customs and behavioral history, should be understood so that intervention and prevention efforts are relevant.

**Midlife and Older African-Americans and HIV/AIDS**

Rodgers-Farmer (1999) examines the problem of categorizing an ethnic group as "at-risk" without contextualizing that risk in her analysis of AIDS knowledge, attitudes and behavior among African Americans aged 55 and older. Rodgers-Farmer points out, African-Americans are not disproportionately affected by AIDS because they are African-Americans, but because prevention programs aimed at this population have not been culturally specific…Nor have these programs adequately addressed pervasive beliefs in the African-American community that may prevent African-Americans from participating in AIDS prevention programs …(1999: 2)

African-Americans may be reluctant to participate in government-sponsored programs on HIV/AIDS because of common knowledge about past medical abuses, such as the Tuskegee experiment, and pervasive beliefs that AIDS is part of the white conspiracy to commit genocide against African-Americans (Rodgers-Farmer 1999). Additionally, misconceptions about who is "at-risk" for HIV also impede AIDS prevention efforts in this community (Rodgers-Farmer 1999).

Based on analysis of an African-American subsample (n= 745) from the National Health Interview Survey (NHIS-AIDS), which explored AIDS knowledge and attitudes from half of the families who participated in the NHIS, Rodgers-Farmer examined AIDS knowledge, prevalence of HIV antibody testing, and prevalence of HIV-related risk among those age 55 and older.
Ninety-eight percent of these respondents perceived their chances of getting infected with HIV as "low/no chance", and the same percentage perceived their chances of currently being infected with HIV as "low/no chance" (Rodgers-Farmer 1999). This may help explain why African-Americans at risk for HIV infection are underutilizing HIV antibody testing, with only 7.6% of those age 50 years and older with a risk factor for HIV having been tested compared to 28.9% of those 18-29 years and 26.4% of those age 30-49 (Grinstead et al. 1997). The Grinstead et al. study also used the NHIS-AIDS, but made comparisons using the whole sample of 2,717 heterosexual African-Americans between age 18 and 75. Only 14% of the NHIS-AIDS respondents age 55-75 reported that they had been tested for antibodies to HIV (Rodgers-Farmer 1999).

Overall, the results suggest that those persons with less than 12 years of education, those persons whose family income is less than $20,000.00 per year, and those persons who perceive themselves as not being at risk for HIV infection have low levels of AIDS knowledge… A substantial percentage of respondents failed to recognize that persons could still look healthy and have the AIDS virus. This particular finding is of interest because it has implications for engaging in unprotected sexual intercourse and the initiating of HIV antibody testing prior to engaging in sexual intercourse. (Rodgers-Farmer 1999: 11-12)

These African Americans tended to be very knowledgeable about the major modes of transmission (sexual intercourse, perinatal contact, and sharing needles for drug use), with 80% choosing the correct answers for questions about modes of HIV transmission. However, they still had many misconceptions about transmission through casual contact.

For example, over 90% believed that there was a possibility of contracting AIDS from being cared for by someone who had AIDS; from being bitten by mosquitoes or other insects; and from being coughed or sneezed on by someone who has AIDS. Moreover, 80% of the respondents believe that there was a possibility of contracting AIDS from eating and restaurant with a cook who has AIDS; from using public toilets; and from sharing eating utensils with someone who has AIDS. Finally, over 70% believed that there was a possibility of contracting AIDS from working near someone who has AIDS, and from attending school with a child who has AIDS. (Rodgers-Farmer 1999: 8)
Many respondents (45%) also believed that there was vaccine to prevent AIDS. Yet, few respondents had any knowledge about the available drugs to treat HIV, or knowledge about the benefits of testing and early treatment (Rodgers-Farmer 1999).

As for the perceived effectiveness of condoms, 40% indicated that they did not know if condoms were 'effective or not'; 35% believed that condoms were 'somewhat' effective; 21% believed that condoms were 'very effective'; and 4% believed that condoms were 'not at all' effective... Only 15 percent of the respondents knew the oil-based lubricants can cause latex condoms to break...(Rodgers-Farmer 1999: 8).

The implications of misinformation in HIV/AIDS knowledge are supported in the recent data on the incidence and prevalence of HIV/AIDS among African Americans. Although lack of income and lower education status appear to be correlated with lack of accurate knowledge about certain HIV/AIDS issues, an ethnic comparison of people with AIDS with different income levels and education suggest that misinformation is only one of many factors that affect HIV knowledge and transmission rates.

As noted in the previous section on epidemiology of HIV/AIDS, African Americans suffer disproportionately for this epidemic, particularly in Florida. A recent study that looked at basic demographic and social information about people with HIV/AIDS (PWA) over the age of 40 years in one Florida community, found some notable differences between middle-age and older African-Americans and Whites (Speer et al. 1999). Not surprisingly, the two groups differed significantly on several sociodemographic variables. Sixteen percent of the participants from both groups were 60 years of age or older, and 28% of the African Americans and 16% of the Whites were female. African-Americans were more likely to have high school education or less, whereas Whites were more likely to have college education. The average annual income of African-Americans is half that of Whites in the sample at $7,015, and 81% of African-
Americans fell below the poverty level versus 37% of Whites. As for sexual orientation, 82% of African-Americans described themselves as heterosexual, whereas only 28% of Whites described themselves this way, and 59% of Whites described themselves as homosexual or bisexual as opposed to 11% of African-Americans (Speer et al. 1999). More African-Americans thought they had been infected by an opposite-sex partner (20%), an infected sex worker (14%), a stranger (16%) or by sharing needles (29%), while most Whites thought they had been infected through sexual relations with the same-sex partner (44%), and a stranger (23%). Although the groups did not differ significantly on pre-infection HIV prevention education, 43% of African-Americans and 32% of Whites reported not receiving any prevention education (Speer et al. 1999).

The dramatic differences between these two groups on both socioeconomic factors and risk behavior factors, suggest that prevention education efforts need to be sensitive to social and ethnic differences in order to be effective. In particular, African Americans in this sample were concerned about being assumed to be gay because of their HIV status. The social stigma associated with HIV/AIDS may be stronger in certain communities and is often related to misconceptions about the virus and who is "at-risk".

The most recent data from the Behavioral Risk Factors Surveillance System (BRFSS) for the state of Florida suggest that in terms of HIV testing, African Americans are ahead of the other two major ethnoracial groups. The BRFSS shows that women in Florida are slightly more likely to have been tested for HIV than men (49.2%, 47% respectively) and 59.7% of Black, non-Hispanics reported have been tested, compared to 44.2% of White, non Hispanics, and 52.7% of Hispanics (Florida Department of Health 2003d). These data do not include persons over age 64, and age is clearly an important
factor in the likelihood of being tested in the percentages above with 57.3% of those ages 18-44 being tested, compared to 33.2% of those ages 45-64. Lower income and higher level of education were also correlated with a greater likelihood of being tested. Notable for this research project are the data on health professionals discussing STD prevention through condom use. In the past 12 months, only 14.9% of men and 17.5% of women reported that a health professional had talked to them about preventing STDs through condom use. Blacks and Hispanics reported more of this communication (29.9% and 29% respectively) than did Whites (10%), and Black women and Hispanic men reported the most (both 34%). Again, age is a significant factor with 21.3% of those ages 18 to 44 years reporting this communication compared to 8.8% of those 45 to 64 years of age. Income is also influencing the communication patterns of health care professional with 31.6% of those with incomes below $25,000 compared to 7% of those with $50,000 or more in annual household income reporting that their providers talked to them about STD prevention.

Clearly, health care professional are targeting specific age and ethnic groups, and poorer populations with this message. While it may be appropriate to target these groups, it should not be at the exclusion of other groups. This sort of focus tends to maintain the stereotypes about those “at-risk” and “not-at-risk” so that older, more affluent populations may be missing this important message.

Perception of Risk: The perils of the “at-risk” label

Misperceptions about HIV risks and transmission can be dangerous. Although national level data suggest that most older people in the general population do not engage in HIV-related risk behaviors, the approximately 10% who do are less likely to report using condoms during sex, to have ever been tested for HIV, or to of change their
behavior in the past 12 months than younger persons who are "at-risk" (Ory and Mack 1998). This behavior is due in part to older persons not being assigned to the “at-risk” category by public health campaigns to combat the spread of HIV.

At the closing of the second decade of the HIV/AIDS pandemic AIDS-related knowledge has increased for all ages, however older people are still less knowledgeable and younger people. For example, persons age 50 and older are more likely to think that HIV/AIDS can be contracted through casual contact; they are more likely to believe that they can be infected by being coughed on, sharing food utensils, or using public toilets than younger people (Ory and Mack 1998).

The studies detailed in the previous pages note that risks behaviors and perceptions are often incongruous for many midlife and older persons. Many women and minorities that are in the older age groups studied about do not think that they are at risk even when they are engaging in high-risk behaviors.

A study by Dancy (1996) on African American women and their AIDS-related knowledge, showed that despite adequate knowledge about HIV risks, these women often did not apply that knowledge to their own behaviors because they decided that it did not apply to them. Theall and colleagues, suggest that this is the case in their study of risk perceptions between two age cohorts of women. “Engagement in risky behavior despite HIV/AIDS knowledge and with no perceived risk of infection is likely a result of denial and rationalization of behavior” (Theall et al. 2003: 424).

These findings about the perceptions of HIV risks among midlife an older women are cautionary. As women in the baby boomer generation turn 50, it is unlikely that their sexual behaviors and attitudes will change radically (Yates et al. 1999). They will
probably continue to engage in more risky sexual and drug-related behaviors than those in older cohorts. However, “the effectiveness of prevention efforts targeted at younger adults may carryover into middle age” (Ory and Mack 1998: 661).

The question of how to change perceptions, encourage early testing and safer behaviors with a diverse population of midlife and older persons remains. Below some of the more common strategies are considered and how life-course stage may affect prevention strategies.

**Testing the Behavioral Change Theory for Older Adults**

There are several theoretical models that have strongly influenced the CDC’s AIDS prevention research: the health belief model, social cognitive theory, the theory of reasoned action, and the transtheoretical model of behavioral change (Fishbein and Guinan 1996). In general these models support the examination of beliefs underlying attitudes and behaviors, as well as the contextual factors that encourage individuals to behave in a certain way. "According to these models, individuals who are at greater risk, perceive themselves at greater risk, have more resources, and perceive or actually have health problems are more likely to be tested for HIV than their counterparts" (Mack and Bland 1999: 689). All of these models are focused on the individual rather than social groups, and therefore in many ways neglect the cultural and structural factors that affect beliefs and behaviors.

Mack and Bland (1999) tested the assumptions of the various models with two different age groups to assess whether theories of health behavior should take life-course stage into account. Their models test whether perceived risk, resources, and health problems affect the likelihood of being tested for HIV among persons age 50-64. Their analysis of data from the 1996 Behavioral Risk Factors Surveillance System (BRFSS)
compares adults aged 18-49 (77.6% of sample) with adults age 50-64 (22.4% of sample) on their self-reported chance of getting infected with HIV, change in sexual behavior the last 12 months, perspectives of condom efficacy in preventing HIV, and marital status.

The percentage of older adults who had ever been tested for HIV was 26.6% and for the younger adults was 46.8%. The percentage of adults aged 50-64 who are voluntarily tested was less than half that of adults aged 18-49. Much of this difference is due to the fact that pregnancy was not being given as a reason for the last test by older women… The percentage of respondents who report that their chance of getting HIV/AIDS is high or medium declines with age. The percentage of adults aged 50-64 who changed their sexual behavior the last 12 months because of what they know about HIV/AIDS is one-third of the percentage for adults aged 18-49 (5% versus 16.6%). (Mack and Bland 1999: 690-691)

Most older men and women did not rate their chance of getting AIDS as being high or medium (4.1% and 3.8% respectively). Consistent with other research findings, Blacks were more likely than Whites to have ever been tested for HIV (38.4% versus 24.4%). Older Blacks rated their chance of getting AIDS as high or medium only slightly more so than older Whites. "Perhaps the most notable difference by race for adults aged 50-64 was that 16.3% of Black respondents reported that they had changed their sexual behavior in the last 12 months on the basis of what they knew about HIV compared with only 3.4% of White respondents." (Mack and Bland 1999: 692). Although the model confirmed the research results for the younger portion of the sample, (males, Blacks, those who perceived themselves as having high or medium risk, those who have more resources, and who have health problems were all more likely to have been voluntarily tested for HIV other than respondents) the predictive model of health behavior was not very robust for older adults based on this analysis, as measures of resources and health status had to be dropped from the model because they made no significant contribution. Only perception of greater risk was predictive of being tested for HIV (Mack and Bland 1999). This suggest that life-course stage may be important when designing intervention
strategies, and that current programs directed at the general population are not reaching older persons.

Theall and her colleagues note that their study of risk perceptions among two age cohorts of women had implications for different types of intervention and prevention messages/efforts aimed at younger and older women. Among younger women, “HIV risk behaviors were associated with younger women's perception of risk, suggesting that knowledge is high but not related consistently to practice... in contrast to the preceding, our data revealed that HIV risk behavior was not as salient an issue for the older women's perception of HIV risk” they suggests that programs working with older women should focus on risky drug use behaviors and sexual orientation issues, since older women associated drug-related risk with their level of perceived HIV risk, suggesting that these women were aware of the risks associated with drug using behaviors. They also suggest that educational efforts for younger women “may include issues such as pregnancy, dating, and establishing new romantic/sexual relationships, whereas for older cohorts, topics such as partner communications/negotiation, dating/sex after divorces, and risks associated with HIV infection for older individuals may be highlighted” (Theall et al. 2003: 426).

Targeting Older Persons with HIV/AIDS Prevention Messages

Several experts in the field of prevention have noted that HIV/AIDS programs are seldom prepared to consider aging issues, and that most programs serving older adults are not prepared to address HIV infection as an issue (Linsk et al. 2003; Ory et al. 1998; Stall and Catania 1994; Strombeck and Levy 1998). Few local or national programs include screening for HIV-related risk behaviors, such as alcohol and substance abuse or STD history. Nor do they address the concerns of many older persons about life transitions,
such as loss of a partner through divorce or death, which can lead to changes in social and behavioral patterns. Although senior focused programs may serve many newly widowed or divorced individuals, there is little information available addressing the issues of socialization and intimacy.

Negotiating friendships with possible intimate partners is a new behavior for many, and educational and support programs may help older adults avoid detachment and withdrawal. A need exists for information for older adults about how to reduce HIV-related risk, maintain personal safety, and make decisions about sexual relationships. Given that older adults are vulnerable to STDs, a basic need exist for HIV/STDs prevention education integrated with information about meeting one's social needs safely and avoiding risks . . . HIV/AIDS service organizations, however, may have information about risk and even about making social contacts, but these materials may not be age sensitive or even may be overtly ageist by excluding the possibility of HIV infection/AIDS and older adults. (Linsk et al. 2003: S245)

One area where rapid change needs to occur is in the medical professions. Since older persons, particularly women, see health care providers more frequently than younger populations, this is an ideal place to target older persons with HIV prevention and testing messages. Clearly from the studies reviewed in section two of this chapter, physicians rarely assess their midlife and older patients as “at-risk” for HIV and other STDs. Many also express discomfort in discussing sensitive issues, including sexuality issues, with this class of patients. Linsk and colleagues urge the better education of primary care physicians and other providers, which are the front line of care and services for many older persons in the community, to understand and address the fact that HIV and other STDs can and do infect older people. “Good patient care for sexually active older persons includes discussions about STDs (e.g., chlamydial infections, gonorrhea, and syphilis) as well as HIV and how to prevent infection. Health practitioners should do routine risk assessments and offer HIV/STDs testing to older as well as younger patients who may be at risk and also should support patient requests for such testing.” However,
this practice is rarely the reality. Providers and patients have described how older persons are routinely discouraged or even ridiculed when trying to initiate such services. One well-publicized story of a 54-year-old heterosexual woman, who asked her longtime family practitioner if she should be tested for HIV because she had engaged in a few intimate relationships after her divorce, only to be told “not you, you don't need that test.” Two years later, when she applied for new medical insurance “but was rejected because a routine blood tests... revealed a ‘significant blood abnormality.’” It was then left to the family practitioner to inform her patient that [it] was, indeed, HIV infection” (Linsk et al. 2003: S246).

In general, based on the information presented in the preceding pages, the rate of HIV infection and AIDS diagnosis in the U.S. is growing among those who engage primarily in heterosexual activity; this is most significant for women and minorities particularly midlife and older women minorities. This is compounded by higher rates of poverty, age-related social and biological factors, gender-power dynamics, ethnic and cultural perceptions of sexuality, HIV/AIDS risks and public health initiatives. The lack of accurate knowledge about HIV transmission and prevention practices among midlife and older persons points to the need for better education efforts directed at a diverse aging population. While there is an obvious need for broad public health efforts to target a general population of seniors through retirement organizations and more specific regional populations through community outreach; there is also a need to bring health care providers in to the front line of prevention education in the course of their work.

Although HIV/AIDS and aging often are not perceived as being interrelated, the increase in the number of cases of HIV infection/AIDS in older adults indicates that elders are often overlooked in terms of HIV prevention efforts.... As individuals live longer with HIV infection/AIDS, this new group of long-term survivors will
join those affected by HIV infection/AIDS in their later years. Service models for older persons and HIV/AIDS service models can benefit from targeted education and better integration of prevention, care, and supportive services. (Linsk et al. 2003: S249).
CHAPTER 3
DATA COLLECTION: THEORIES AND METHODS

Theoretical Considerations

Introduction

Many cultural anthropologists, linguistically trained or not, focus their attention on what people say and the words they use to express themselves, in their efforts to explain culture and cultural patterns. James Spradley noted in 1979, in his treatise on ethnographic interviewing, that in most ethnographic fieldwork, researchers make cultural inferences from what people say; the way people act; and the artifacts people use. Since both tacit and explicit culture are revealed in language, ethnographers routinely focus much of their efforts on what people say, in both casual conversation and lengthy interviews, in their work to describe culture (Spradley 1979). Linguistic anthropologist, Deborah Cameron, likewise notes that many anthropologists regard language as a key to understanding certain aspects of culture, with vocabulary sometimes serving as a summary of a people’s concerns and beliefs about the world around them (1992).

This project relies on what people say to reveal their cultural perceptions. I combine qualitative and quantitative ethnographic methods to describe cultural models of mature female sexuality. Data collection includes a short demographic survey; in-depth interviews following the presentation of health care encounter vignettes; and cultural consensus modeling techniques including free-list, pile-sort, and rating procedures.

In the first sections of this chapter I explain the rationale for the methods used and discuss some examples of these methods that relate to the study of health perceptions.
Secondly, I describe the methodology, the sampling and setting and why it was an appropriate choice. Finally, I describe the entrée to the multiple research settings and provide some basic information about the participants.

**Ethnography**

Ethnographic interviews begin with the ethnographer talking to one person and then going to the next, usually finding something different, as well as many things in common (Handwerker 2001).

We keep track of similarities, note variability, and keep data until we decide that we've exhaustively identified significant cultural variation... Then, we construct a story from the inferential generalizations we've arrived at about the people we worked with, their lives, and the circumstances in which they have lived; about what those people now think, feel, and do; about who agreed with whom about what to and to what extent; and, so, about who is similar to whom and to what extent and how they differ from others and to what extent. (2001: 11-12)

To accomplish the activities described in this passage this project combine structured and unstructured interview techniques. Bernard (1995) describes unstructured interviews as the best for getting people to open up and express themselves on their own terms. However, he suggests that in situations where you might only get one chance to interview someone, a semistructured interview is best. “It has much of the freewheeling quality of unstructured interviewing, and requires all the same skills, but semistructured interviewing is based on the use of an interview guide. This is a written list of questions and topics that need to be covered in a particular order” (Bernard 1995: 210). This approach proved to be the best fit for the project I undertook, since in most cases I would only meet with each informant once. I will provide more detail about the interviewing techniques in second half of this chapter. As a cognitive anthropology project I also included the cognitive methods of cultural consensus modeling, which rely on structured interview techniques to reveal cultural domains.
Cognitive Theory and Methods

This project employs the cognitive method and theory of Cultural Consensus Modeling (CCM). CCM is based on using mathematical models that simultaneously record an estimate of a respondent's cultural knowledge about a particular domain and an estimate of how much they agree with other respondents on what is culturally known about the domain (Bernard 1995; Weller and Romney 1988). The central theme of consensus theory is that the correspondence between any two informants is a function of the extent to which each has knowledge of the culturally appropriate responses for the interview questions (Weller and Romney 1988).

Owing to its cognitive science foundations the concept of culture in cultural consensus theory is one that emphasizes what people know and how it affects what they do, with less emphasis on behavior itself. Handwerker (2002) draws attention to what he describes as the “largely overlooked and undervalued implications” of Edward Tylor’s 1871 definition of culture: “(1) the culture that specific people use to live their lives constitutes an evolving configuration of cognition, emotions, and behavior unique to themselves; and (2) cultures consist of evolving configurations of cognition, emotion, and behavior at the intersection of individually unique cultural sets” (2002:106). He goes on to explain that while culture is learned and shared by groups of people, “only individuals learn, and individuals embody and constitute the only source of cultural data. To make the world we live in sensible, all of us assemble out of our individual sensory experiences ways of thinking about what we have experienced” (109). In other words, while culture is shared by groups of people, the experience of knowing one’s culture is unique for each individual.
CCM builds on the concept of culture as shared "cultural model" (D'Andrade 1995; Dessler and Bindon 2000). Dressler and Bindon (2000) describe a cultural model as a “highly schematized, skeletal representation of some cultural domain” in that it defines the elements that make up a cultural domain. A semantic or cultural domain is basically any subject matter that can be coherently defined (Weller and Romney 1988). According to Weller and Romney a domain is “an organized set of words, concepts, or sentences, all on the same level of contrast, that jointly refer to a single conceptual sphere” (1988:9). Cultural domains can be organized around almost anything; they can be kinship terms, animal categories, beliefs about symptoms of disease and so on. Among other things, understanding a domain helps us understand how the world around us works and how to function in it. Dessler and Bindon describe it this way,

In deciding what to do in any given situation, or in deciding what the behaviors of others mean in any given situation, we draw on our understanding of the world as that understanding is structured by our cultural model. So, if we are heading off to the bait shop, or a baseball game, or a graduation ceremony, or a committee meeting, we have a pretty good idea what, in broad outlines, to anticipate in others' behaviors, and what repertoire of behaviors we will draw on. (2000: 247)

Individuals are part of multiple cultural groups, in the sense that they may at any given time occupy several social roles that require them to have specific cultural knowledge about several domains. Each individual draws on a large set of cultural models, models they have learned and shared with others—however incompletely—to get through each day (Dressler and Bindon 2000). From one person to another, there is variation in the knowledge of the elements of any given in cultural model, because models, although shared, their components are also shaped and understood through individual experience (Handwerker 2001, 2002; Dressler and Bindon 2000).

There are three sources of variability in cultural models within a society. First, as noted, we incompletely share cultural models; therefore, some people will know
more (or less) about some domain than others. Second, there may be systematic variability in cultural models across social contexts … Third, individuals may be limited for a variety of reasons in their abilities to act on cultural models; that is, they may know the model, but they may be unable to act in accordance with it (by economic constraints, for example). (Dressler and Bindon 2000: 248).

The techniques of CCM provide a systematic way to highlight the shape and scope of cultural domains and the degree of agreement and variability within them.

Since 1986, when Romney, Weller and Batchelder introduced the consensus model of culture, several other researchers have used and added to the theory and techniques (Chavez Hubbell, McMullin, Martinez, and Mishra 1995; Chavez, McMullin, Martinez, Mishra, and Hubbell 2001; Dressler 1996; Garro 1986, 2000; Handwerker 1997, 2002; Weller and Baer 2001; Weller and Romney 1988). The consensus model of culture has contributed to anthropological theory by highlighting the shared nature of culture as a defining feature of cultural knowledge (Dressler and Bindon 2000).

For this research project I use cultural consensus modeling (CCM) to explore if there is a shared cultural domain of sexuality for midlife and older women, and if primary care physicians also share that domain, or to what degree they share it. The cultural domain of sexuality, or sex-life as some preferred to describe it, for midlife and older women is a bit of a departure from traditional uses of CCM. However, several other researchers have used consensus theory and methods on abstract concepts and have used the concept of schemas to shed light on the reasons for cultural variation highlighted through CCM.

Consensus Theory and Cultural Schemas

As stated above, CCM focuses on shared knowledge and helps to show the variability within what is shared but not the reasons for the variability. To explore the factors associated with intra-cultural variation it is helpful draw on traditional qualitative
methods to illuminate the reasons for variation. Ethnographic interviews provide a useful complement to CCM data collection and analysis. Below is a brief discussion of how several researchers have successfully combined the quantitative and qualitative features of CCM with more traditional ethnographic methods.

Linda Garro (2000) used consensus theory to look for patterns and variation when she studied a group of Ojibway's beliefs about hypertension, but unlike her earlier work using CCM to examine the shared knowledge of curers and non-curers in Mexico (1986), this time she used combined methods to get at the nuances of intra-cultural variation. Using interviews along with CCM, and drawing on Kleinman’s work on explanatory models, she mapped the consensus model for the causes of hypertension among the Ojibway. However in doing so she also revealed the patterns of variation in the model, notably demonstrating how individual experience cause some to reject specific elements of the model or to reframe it based on differing criteria. Garro’s work with the Ojibway led her to develop an analytical approach to some of the shortcomings of consensus theory. With its focus on what is shared, CCM has limited utility for describing the elements of difference within a domain; differences do not just indicate variation in cultural knowledge about a domain, but perhaps a different way of using the domain or putting the domain together. Garro describes this in terms of schemas or cultural models theory where variation between individuals reflects different schemas or different aspects of the same schemas.

CCM and schemas are not in conflict; rather they are complementary tools for understanding cultural similarity and variation. In a study of gender schemas and prostate cancer among veterans Stansbury et al. (2003) used CCM to examine cognitive
schemas about gender. With a reliance on primarily emic categories of masculinity the researchers mapped the masculine ideology of the veterans, showing both the shared ideology between prostate cancer patients and non-patients, and the variation in that ideology brought about by the experience of disease. This research did not have the rich ethnographic data to explore the nuances of the variation that Garro was able to investigate. Nevertheless the data are supported by schema theory in cognitive anthropology (D’Andrade 1995; Garro 2000), by showing how the findings support earlier more qualitative research on the affect of illness on gender constructs. The research lends support to contention that schemas are “flexible interpretive states that reflect the mixture of past experience and present circumstances” (D’Andrade 1995: 142).

Several other researchers have used CCM to consider health and health care beliefs, and some have ventured to determine if beliefs are related to health care behavior. Hurwicz (1995) compared physicians with elderly patients to see if the two shared similar ideas about what illness symptoms necessitated office visits. She also explored how the patients’ models of when to visit the doctor’s office related to their behavior. The two groups did share a similar domain about doctor visits, however the patient behavior did not conform to the health-care seeking norms described in their model. Her analysis of the health seeking behavior showed that “treatment choices…were more a result of the characteristics of the [illness] episodes than of the different criteria being applied to the decision” (1995: 232). Hurwicz’s analysis of this difference between the model and the behavior points lends further support to the theory that models of cultural domains are
shaped by a life-time of experience and the factors of current circumstance, influencing how individuals interpret cultural models and react to them.

Chavez et al. (2001) also address the topic of cultural beliefs and behavior in their analysis of beliefs about cervical cancer risk factors and the use of Pap exams. For this, they drew on their 1995 research that looked at intra-cultural variation in beliefs about the risk factors for breast and cervical cancer among three sub-groups of Latinas, Anglo women and physicians. They found Latinas, particularly immigrants as opposed to Chicanas born in the US, held beliefs about cervical cancer that diverged from those of physicians and those held by Anglo women. In the 2001 report, they found that the closer the Latinas’ beliefs were to Anglo women the more likely they were to have had a Pap test in the last two years, yet the closer their beliefs mirrored the physicians’ the less likely they were to have had and exam. The distinction here appears to be related to the emphasis that physicians put on sex-related behavior as an important risk factor vs. Anglo women who down-play sex-related factors in favor of other factors, such as heredity. The researchers’ earlier ethnographic data show that the immigrant Latinas hold more conservative moral values about sexual behavior than Chicana and Anglo women, and this influences their health-seeking beliefs and behaviors. However the researchers are quick to point out the strong influence of structural factors on health-seeking behaviors such as lack of health insurance, educational level, and acculturation.

These findings point to the importance of the complementarity between structural and cultural explanations in understanding health beliefs and behavior. Chavez et al. also credit their early ethnographic interviews with a small sample of Latinas for the richness of the data and its usefulness in clarifying the reasons for the intra-cultural variation in
the cultural model, and the generalizability of ethnographic findings on health-beliefs to much larger populations based on smaller ethnographic studies.

The measurement of shared cultural knowledge has been operationalized in the cultural consensus model and verified for small sample sizes by several anthropological researchers (Chavez et al. 1995, 2001; Garro 1986; Handwerker 2002; Handwerker and Wozniak 1997; Romney, Weller and Batchelder 1986; Weller and Romney 1988). This project uses a relatively small sample as well to explore the domain of sexuality for midlife and older women. To address the nuances of intra-cultural variation within the model the CCM data is combined with an interpretive analysis of the vignette-based interview data to contextualize the domain. What follows is a description of the methods used in this project.

**Methods and Sampling**

**Introduction**

I created vignette-based interviews to address women’s and physicians' ideas about the clinical encounter, as well as general perspectives on aging and sexuality. These semistructured interviews relied on open-ended questions and probes to elicit a broad understanding of similarity and variation in aging and sexuality concepts among the “recently single” women in a displaced homemaker program (DHP) and among primary care physicians (referred to as physicians) in the same city. The vignette-based interviews with both samples explored variation in ideas about provider-patient communication, beliefs about aging and sexuality, and individual and social factors that may enhance or inhibit communication about sexuality issues, including HIV/STD issues in clinical context.
I also administered a survey (Appendix A) with the women that gathered demographic data on age, ethnicity, marital status, number of children, number in current household, level of education, years lived in the area, health status, recentness of doctor visits, and type of doctor visited. Surveys gathered from physicians (Appendix B) provided information on the physician's age, recentness of medical training, type of practice, demographic profile of their patient population, perceptions of time constraints on patient-physician interaction, perceptions of HIV risk for their patients, sources of information on sexuality and aging, and ideas about patient and physician responsibility regarding discussing sexual health issues.

**Vignette-based interviews**

I read each DHP woman two vignettes involving a women and her clinical encounter, 1) a story about a women who undergoes a hysterectomy and suffers painful intercourse after the surgery, and 2) a story about a women not being tested for HIV by her primary care physician and only being tested after she is hospitalized. After each story, I asked the respondents to tell me their opinion of the case, other more detail questions, and then general questions about health care communication and sexuality and aging (Appendix C).

Physicians participated by either completing the survey and one of the CCM procedures, or were interviewed using the same vignettes discussed above (Appendix D). However, in order to save time I divided the interview schedule into two parts: the first group of physicians who completed the full interview (n=9) was read the HIV story, and the second group was read the hysterectomy story (n=8). Some of the interview questions were similar to those asked of the DHP women sample, but several medical
practice questions were also asked concerning their current views and practices regarding communication about sexual health issues with midlife and older women.

**Analysis of the interview and survey data**

All of the survey data and key responses from the interview data were coded and input into the Statistical Package for the Social Sciences (SPSS, v.12.0, 2003). The interview data were coded for text units in N6 (QSR N6, v 6.0, 2002) so that the appropriate context of the aggregate responses could be explored. In several instances I sorted the interview data in N6 so that it could be added to SPSS. For example, the question about whether or not the DHP thought that other women their age were aware of the risk for HIV/STDs was an interview question and generated long responses, which were analyzed and grouped under “yes”, “yes, most”, “no”, “no, not most”, and “don’t know.” This interpretive analysis was applied to all interview responses that could be ordered in such a way based on the aggregate of replies.

The SPSS data are analyzed for frequencies of the survey and interview questions and presented graphically in chapters five and six. The two samples are analyzed separately using frequencies and Chi-square tests to measure internal agreement, and the samples are combined on variables that are common to both groups to measure agreement between groups. For the DHP women, marital status, age groups, ethnic groups, and health status are used to determine if these variables influence their responses to the vignette interview questions. The physician sample is analyzed in much the same way as the DHP women, but on fewer variables (residency status, age groups, and gender). The coded N6 text data are used to highlight the nuances of the statistical data. The text data also provides crucial insights to understanding the consensus data,
described below, ultimately linking the various data sets to reveal the cultural schemas of mature sexuality.

**Cultural consensus modeling techniques**

The interview format for the women and the physicians also included the cultural consensus modeling (CCM) procedures. Approximately half of the physician sample participated in the survey/interviews/CCM procedure and the other half were only asked to participate in the CCM procedures and complete the survey.

The respondents were asked to participate in one of three systematic data collection procedures for CCM. The first procedure, free listing (qualitative) of terms and phrases associated with the domain of mature sexuality, occurred with the first group of DHP women interviewed (n=18), and physicians (n=14). These free-lists were then be combined and distilled into a shorter version of the lists by collapsing repeated terms into a single term and/or removing terms and phrases mentioned by only one respondent (see Borgatti 1999), to be used in the second step, pile sorting. This second procedure the next group of DHP women (n=15) and physicians (n=7) to sort the terms and phrases into categories or "piles." The list is then used in the final step, the rating procedure. The remaining participants (n=14 DHP women and n=10 physicians) were asked to rate the relevance of the terms to describe sexuality for women age 45 and older. However, due to the small sample size for this study, I asked three of the DHP women who completed the free list procedure to assist me by also completing the rating procedure. These procedures and their results are described in chapter four.

**Analysis of cultural consensus data**

The results of the CCM data are analyzed using a variety of methods, all of which are described in greater detail along side the results in chapter four. All of the CCM data
are imported and analyzed using ANTHROPAC (Borgatti 1996a). The initial free listing techniques elicits each individual’s notions about the particular domain in question without imposing the researcher’s own concepts. The results of the combined lists from all of the respondents that completed the free list task are then analyzed for frequency and salience of terms to find the core of the domain.

The pile sort and ratings data are used to highlight the structure of the domain and help to determine if there is one cohesive domain and/or if there are subdomains and multiple domains. The single pile-sort task (Borgatti 1999; Weller and Romney 1988)) elicits the way that the individual respondents organize the 48 most frequently mentioned terms from the earlier freelist data. The results provide the coordinates for a two-dimensional representation, using multidimensional scaling (MDS); showing how the respondents believe the domain ought to be structured. These results are also analyzed with cluster analysis, which is another way to show how items are grouped together.

The ratings data are used to show the degree of agreement among the respondents, in this case, their perception of the relevance of the terms for describing women’s midlife sexuality. The results of this task generate a profile matrix for cultural consensus analysis (Romney, Weller and Batchelder 1986). This provides a way to systematically measure the degree of shared perceptions among respondents and ascertain the reliability of the data from the average intercorrelation among respondents (Weller and Romney 1988). Additionally, this analysis can be used to determine degree of agreement within and between groups; in this case between the DHP women and the physicians.

Finally, the ratings and pile-sort data can be used together to test hypotheses about the characteristics that shape respondents’ notions about the similarities among the items
tested using property-fitting (PROFIT) (Borgatti 1996b). PROFIT is a multiple regression technique that uses the coordinates from the MDS pile-sort data as independent variables and the attribute used in the ratings test as the dependent variable. This analysis assesses whether or not the hypothesized attribute was influencing the suspected similarity among the items. These methods and their analyses will be described in greater detail in the next chapter.

**Suitability of Methodology**

Due to the sensitive nature of this research topic, the combined methods of cultural domain analysis and in-depth interviews with the vignettes were appropriate for this project and this population because they permit respondents to depersonalize their responses if they so choose, on this highly personal topic. This is because the vignettes describing a hypothetical encounter were followed with general questions regarding respondent opinions on the pros and cons of the encounter. Respondents were also told that their responses would be kept confidential, that there were no right or wrong answers, and that their responses did not need to be based on their personal experience, but instead may just reflect their general knowledge and opinions about doctor-patient communication. In this way the respondents were able to choose for themselves how much or how little personal information they wished to provide. The cultural consensus procedures, which revolve around questions about salient elements of sexuality and aging generally, not individually, were also designed to limit personal information.

Additionally, although it may seem counterintuitive to suggest that face-to-face interviews are an ideal data collection strategy for talking with mature women about sexuality, because they are presumed to be more uncomfortable discussing sexual issues, several researchers report the contrary (Gibble, Rogers, Miller and Turner 1998; Herzog...
and Rogers 1988; Levy and Albrecht 1989). Preliminary findings suggest that the utility of self-administered surveys for younger respondents is not duplicated with older respondents (Gibble, et al. 1998; Herzog and Rogers 1988; Levy and Albrecht 1989). Gibble et al. (1998) analyzed data from a large survey experiment investigating the impact of the privacy of self-administered vs. interviewer administered survey modes. The experimental results hint that it may be unwise to generalize findings on survey mode effects on younger populations to older populations. In-person interviews have the advantage of allowing the researcher to build an empathetic relationship with a respondent in the course of gathering information. The use of open-ended questions in unstructured or semi-structured format also allows the researcher to probe for information that may otherwise be neglected, and to clarify the meaning of responses (Bernard 1995; Levy and Albrecht 1989; Spradley 1979).

**Sampling Frame**

As an ethnographic research endeavor that includes cultural consensus modeling this project is an exploration about cultural patterns that are expected to have high agreement. It therefore does not need a random sample to serve as a valid measure of cultural pattern. Although each individual assembles out of their own experience ways of thinking about those experiences and construct an understanding of the world around them, their various ideas, emotions, and behaviors intersect in multiple ways with the culture of other individuals that have shared similar experiences (Handwerker 2001). This is the point of a sampling frame that encompasses certain life experiences— in this case midlife and older women becoming single again after divorce or widowhood— “that may influence the patterns of social interaction through which people construct culture that include explicitly measured internal validity confounds (Handwerker 2001: 99).
number needed to ascertain the cultural domains depends on the degree of cultural consensus in the population considered. Borgatti notes that "if every informant gives the exact same answers, you only need one," but since this is unlikely he suggest computing the frequency counts of free-list data after obtaining about 20 or so lists until the frequencies of the top items remain the same as informants are added (1999:122-123).

The age range, ethnic makeup, marital status and gender specific focus of this project is deemed appropriate based on epidemiological data showing a growing number of women, particularly ethnic minority women, in this age range as HIV+ through heterosexual transmission, and due to the lack of prevention programs targeted at people age 50 and older (Rich 2001; Levy 1998; Ory and Mack 1998; Zabolotsky 1998). The age range is also deemed appropriate for cohort comparisons because as women baby boomers enter middle-age, it is predicted that they will be more sexually active and engage in more high risk behaviors than what is occurring in the current older populations (AARP 2003; Levy 1998; Yates et al. 1999).

Five factors combine to make women age 45 and older who join the Displaced Homemakers Program in North Florida an ideal sample and location for investigating patient and physician beliefs about aging and sexuality, and HIV issues:

- Florida as a whole is the Bellwether state for aging issues due to the fact that it is the oldest state in the union in terms of demographics, which means that it is an ideal place to study concepts about aging and sexuality among physicians and patients;
- The spread of HIV/AIDS among midlife and older persons, particularly among women and minorities has been increasing over the last decade, and this is particularly true in Florida;
- The African American population in this area accounts for almost 30 percent of the total population, far exceeding the national average of 12 percent, and the Florida average of 14.6 percent (U.S. Census Bureau 2001), thus providing a larger sample of minority participants;
• Many recently divorced, separated and widowed women are reentering the arena of sexual activity in an age very different from the years before the discovery of HIV and its routes of transmission (Rich 2001), which suggest that their beliefs about aging and sexuality are not only of clinical importance, but that their views may be quite different from that of physicians; and

• The percentage of persons divorced and separated in this area slightly exceeds that of the state as a whole (United States Census Bureau 2001), although the widowed population is smaller (Table 3-1). The number of women in each of these categories exceeds men. All of which suggests that the issues of this project may be salient for this population.

Table 3-1. Disrupted Marital Status of State and Research Community

<table>
<thead>
<tr>
<th></th>
<th>Florida</th>
<th>Metropolitan North Florida</th>
</tr>
</thead>
<tbody>
<tr>
<td>Divorced %</td>
<td>11.6</td>
<td>13.4</td>
</tr>
<tr>
<td>Separated %</td>
<td>2.4</td>
<td>2.9</td>
</tr>
<tr>
<td>Widowed %</td>
<td>7.9</td>
<td>6.4</td>
</tr>
</tbody>
</table>

Therefore the ideas about aging and sexuality are relevant and timely for this community, and the findings will serve the clinical communication and HIV prevention needs this underserved population.

Additionally, primary care physicians working in general practice or family medicine are generally the most frequently visited care providers. Drawing physician participants from a hospital-based clinic that serve an older, poor, largely minority and mostly female population, was appropriate for addressing the issues in this project.

The in-depth approach of this qualitative project made the use of a very large, randomly selected sample prohibitive. Although cultural consensus modeling is an astonishingly powerful method with a small number of respondents, the results cannot be generalized to a national cohort of "recently single" women between the ages of 45-70, nor to a general population of primary care physicians. Additionally, relationships among some demographic variables are expected to be anecdotal because of sample size and the lack of applicability of some standard statistical analysis.
Sampling and Recruitment

The DHP women participants for this project were selected through a purposive sampling method aimed at women age 45 to 70 who participated in the state sponsored Displaced Homemakers Program in a large, north Florida city between October 2002 to June 2004.

Women were recruited in-person at group meetings at the community college where the Displaced Homemakers Program meeting takes place. I introduced myself and explained my student status and what my research was about. I passed around a paper for the women to write their names and contact information if they were interested in participating. I explained that the interviews could occur in their homes, at the college or an alternative location of their choosing. Participants were compensated for their time with a $20 grocery gift certificate as an incentive to participate.

The research plan initially proposed to select 60 or more DHP women over the duration of the project (20 African-American, 20 Latino, and 20 Euro-American women), however the number of Latinas attending the program during the year and a half that I recruited subjects was extremely low, and of those in attendance few met the age (45 or older) and marital status criteria (divorce, separated, widowed or the equivalent of these statuses for a long-term consensual union). Therefore the final sample of DHP women respondents is 20 self-identified Black/African American women and 23 self identified White/Euro-American women, and one “other”. The ethnic group percentages of this sample generally reflect the attendees of this program, except that the Latinas tended to be younger during the research time period. The primary demographic difference is that the program caters to women age 35 and older whereas this research project included only those age 45 and older. The average age of my final sample was 52, whereas the
average for the program tends to be closer to 45 (personal communication with program
director). (Tables 3-2 and 3-3 show characteristics of the DHP participants).

The research plan initially proposed to select a physician sample of 40 in order to
have enough participants to complete the CCM procedures. The final sample ended up at
31 due to the difficulty of recruiting physician participants. I ultimately accepted lower
than ideal numbers of participants to run the CCM analyses.

Thirty-one primary care medical residents and physicians were recruited to assess
current physician views and practices regarding aging and sexuality. Almost two-thirds
of the physicians participated by completing a short survey, in-person interview and one
of the CCM procedures, and the rest were asked to participate by completing the survey
and a CCM procedures only. For their time they received either a $10 or $20 restaurant
gift certificate, depending on whether they chose the long or short interview format.

**Research Setting**

The setting of this research project is not isolated to one small community as is
often typical of anthropological research. Rather the setting of this research occurs in a
multitude of locations. The primary entrée into the “field” begins at one of the buildings
of the campus of the community college for the DHP women, or at the family practice
clinic for the physicians. The community college is where the displaced homemakers
program meets for three-week sessions every other month.

<table>
<thead>
<tr>
<th>Age at interview</th>
<th>Mean (SD)</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>52.23 (5.31)</td>
<td>45-68</td>
</tr>
<tr>
<td>White/Euro-American</td>
<td>52.48 (5.59)</td>
<td>45-68</td>
</tr>
<tr>
<td>Black/African-American</td>
<td>51.95 (5.24)</td>
<td>47-65</td>
</tr>
<tr>
<td>Other</td>
<td>52 (NA)</td>
<td>NA</td>
</tr>
</tbody>
</table>

| Years in marital union | 18.05 (9.58) | 1-34 |
| Household composition  | 1.97 (0.99)  | 1-4  |
Table 3-3. Frequencies and Percentages of DHP Women Sample (n=44)

<table>
<thead>
<tr>
<th>Self-Defined Ethnicity</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>White/Euro-American</td>
<td>23</td>
<td>52.3</td>
</tr>
<tr>
<td>Black/African-American</td>
<td>20</td>
<td>45.5</td>
</tr>
<tr>
<td>Other (Middle East Nationality)</td>
<td>1</td>
<td>2.3</td>
</tr>
</tbody>
</table>

**Latino Identity**

| White-Puerto Rican | 1 | 2.3 |
| Non-Latino | 43 | 97.7 |

**Age at interview**

<table>
<thead>
<tr>
<th>Age at interview</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>45-49</td>
<td>17</td>
<td>38.6</td>
</tr>
<tr>
<td>50-55</td>
<td>17</td>
<td>38.6</td>
</tr>
<tr>
<td>56-60</td>
<td>7</td>
<td>15.9</td>
</tr>
<tr>
<td>61-70</td>
<td>3</td>
<td>6.8</td>
</tr>
</tbody>
</table>

**Marital Status**

<table>
<thead>
<tr>
<th>Marital Status</th>
<th>Total</th>
<th>White</th>
<th>Black</th>
<th>Total</th>
<th>White</th>
<th>Black</th>
</tr>
</thead>
<tbody>
<tr>
<td>Divorced</td>
<td>22 (1&quot;other&quot;)</td>
<td>15</td>
<td>6</td>
<td>50</td>
<td>65.2</td>
<td>30</td>
</tr>
<tr>
<td>Widowed</td>
<td>11</td>
<td>4</td>
<td>7</td>
<td>25</td>
<td>17.4</td>
<td>35</td>
</tr>
<tr>
<td>Separated</td>
<td>9</td>
<td>4</td>
<td>5</td>
<td>20.5</td>
<td>17.4</td>
<td>25</td>
</tr>
<tr>
<td>Ended Consensual Union</td>
<td>2</td>
<td>0</td>
<td>2</td>
<td>4.5</td>
<td>0</td>
<td>10</td>
</tr>
</tbody>
</table>

**Educational level**

<table>
<thead>
<tr>
<th>Educational level</th>
<th>Total</th>
<th>White</th>
<th>Black</th>
<th>Total</th>
<th>White</th>
<th>Black</th>
</tr>
</thead>
<tbody>
<tr>
<td>Some High school</td>
<td>8</td>
<td>1</td>
<td>4</td>
<td>11.4</td>
<td>4.3</td>
<td>20</td>
</tr>
<tr>
<td>High school/GED</td>
<td>8</td>
<td>7</td>
<td>1</td>
<td>18.1</td>
<td>30.4</td>
<td>5</td>
</tr>
<tr>
<td>Vocational ED/college</td>
<td>23 (1“other”)</td>
<td>10</td>
<td>12</td>
<td>52.3</td>
<td>43.5</td>
<td>60</td>
</tr>
<tr>
<td>College grad/grad school</td>
<td>8</td>
<td>5</td>
<td>3</td>
<td>18.2</td>
<td>21.7</td>
<td>15</td>
</tr>
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</table>

**Household composition**

<table>
<thead>
<tr>
<th>Household composition</th>
<th>Total</th>
<th>White</th>
<th>Black</th>
<th>Total</th>
<th>White</th>
<th>Black</th>
</tr>
</thead>
<tbody>
<tr>
<td>Live alone</td>
<td>17 (1“other”)</td>
<td>10</td>
<td>6</td>
<td>38.6</td>
<td>43.5</td>
<td>30</td>
</tr>
<tr>
<td>2 in household</td>
<td>16</td>
<td>10</td>
<td>6</td>
<td>36.4</td>
<td>43.5</td>
<td>30</td>
</tr>
<tr>
<td>3 in household</td>
<td>6</td>
<td>1</td>
<td>5</td>
<td>13.6</td>
<td>4.2</td>
<td>25</td>
</tr>
<tr>
<td>4 in household</td>
<td>5</td>
<td>2</td>
<td>3</td>
<td>11.4</td>
<td>8.7</td>
<td>15</td>
</tr>
</tbody>
</table>

**Self-rated health status**

<table>
<thead>
<tr>
<th>Self-rated health status</th>
<th>Total</th>
<th>White</th>
<th>Black</th>
<th>Total</th>
<th>White</th>
<th>Black</th>
</tr>
</thead>
<tbody>
<tr>
<td>Excellent</td>
<td>9 (1“other”)</td>
<td>6</td>
<td>2</td>
<td>20.5</td>
<td>26.1</td>
<td>10</td>
</tr>
<tr>
<td>Good</td>
<td>19</td>
<td>9</td>
<td>10</td>
<td>43.2</td>
<td>39.1</td>
<td>50</td>
</tr>
<tr>
<td>Average</td>
<td>8</td>
<td>5</td>
<td>3</td>
<td>18.2</td>
<td>21.7</td>
<td>15</td>
</tr>
<tr>
<td>Fair</td>
<td>5</td>
<td>2</td>
<td>3</td>
<td>11.4</td>
<td>8.7</td>
<td>15</td>
</tr>
<tr>
<td>Poor</td>
<td>3</td>
<td>1</td>
<td>2</td>
<td>6.8</td>
<td>4.3</td>
<td>10</td>
</tr>
</tbody>
</table>

**Employment status**

<table>
<thead>
<tr>
<th>Employment status</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full-time</td>
<td>13</td>
<td>29.5</td>
</tr>
<tr>
<td>Part-time</td>
<td>6</td>
<td>13.6</td>
</tr>
<tr>
<td>Retired</td>
<td>1</td>
<td>2.3</td>
</tr>
<tr>
<td>Unemployed</td>
<td>18</td>
<td>40.9</td>
</tr>
<tr>
<td>SSI</td>
<td>5</td>
<td>11.4</td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
<td>2.3</td>
</tr>
</tbody>
</table>

**Time lived in N.E. FL**

<table>
<thead>
<tr>
<th>Time lived in N.E. FL</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Entire life</td>
<td>13</td>
<td>29.5</td>
</tr>
<tr>
<td>20 yrs. or more</td>
<td>13</td>
<td>29.5</td>
</tr>
<tr>
<td>5-15 years</td>
<td>8</td>
<td>18.2</td>
</tr>
<tr>
<td>Less than 5 years</td>
<td>10</td>
<td>22.7</td>
</tr>
</tbody>
</table>

Most of the physicians were recruited through a community health and family practice clinic of the university-based hospital. The behavioral science coordinator on
staff there facilitated this recruitment, by introducing me to attending physicians and giving me access to the noon meetings for the residents. I was unable to duplicate this useful relationship in any of the other residency programs in the area. A few other physicians were recruited through an email announcement that went to primary care physicians in multiple specialties at the hospital, but this sort of recruitment strategy was of very limited utility and cancellations were much more frequent with those that expressed interest. Interviews with physicians occurred in their office or clinic.

The physician sample consisted of 13 attending physicians, and 18 resident physicians. Naturally, attending physicians were, on average, older than residents, but they were also more predominately males. Women have begun to predominate in the enrollment in the residency program in recent years, and my sample reflects this trend somewhat with 10 women and 8 men in the residency portion of the sample. There has been a trend of increasing numbers of women medical doctors since the 1970s and 1980s, but the earlier male dominance in the profession is seen in the attending physician portion of the sample with only four women attending physicians. Additionally the female participation in my study was low compared to the female-male ratio in the overall residency program, which was just slightly less than 2:1 for 2003 and 2004. (Tables 3-4 and 3-5 show characteristics of the physician participants).

Most of the DHP meetings took place in a room located at the end of the hall on the second or third floor, where slight ramp leads up to the door of the end room. A small vertical rectangular window in the door reveals a large U-shaped table arrangement, and the diversity of women seated at the bottom of the U, who turn to see that me peering through the window in the door. The room is bright and large with windows flanking the
South and East sides of the room. Invited in by the program coordinator, I would sit quietly off to the side of the table waiting for a break in the program.

Table 3-4. Frequencies and Percentages of Physician Sample (n=31)

<table>
<thead>
<tr>
<th>Full interview or Survey</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interview/survey</td>
<td>18</td>
<td>58.1</td>
</tr>
<tr>
<td>Partial interview/survey</td>
<td>1</td>
<td>3.2</td>
</tr>
<tr>
<td>Survey only</td>
<td>12</td>
<td>38.7</td>
</tr>
<tr>
<td><strong>Attending/Resident</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Attending Physician</td>
<td>13</td>
<td>41.9</td>
</tr>
<tr>
<td>Resident Physician</td>
<td>18</td>
<td>58.1</td>
</tr>
<tr>
<td><strong>Resident Physician Detail</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1st year resident</td>
<td>8</td>
<td>25.8</td>
</tr>
<tr>
<td>2nd year resident</td>
<td>7</td>
<td>22.6</td>
</tr>
<tr>
<td>3rd year resident</td>
<td>3</td>
<td>9.7</td>
</tr>
<tr>
<td><strong>Sex/Gender</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>14</td>
<td>45.2</td>
</tr>
<tr>
<td>Male</td>
<td>17</td>
<td>54.8</td>
</tr>
<tr>
<td><strong>Self-reported Ethnicity</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>White/Euro-American</td>
<td>17</td>
<td>54.8</td>
</tr>
<tr>
<td>Black/African-American</td>
<td>2</td>
<td>6.5</td>
</tr>
<tr>
<td>Asian/Pacific Islander</td>
<td>7</td>
<td>22.6</td>
</tr>
<tr>
<td>Other</td>
<td>5</td>
<td>16.1</td>
</tr>
<tr>
<td><strong>Latino Ethnicity</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cuban</td>
<td>1</td>
<td>3.2</td>
</tr>
<tr>
<td>South American</td>
<td>2</td>
<td>6.4</td>
</tr>
<tr>
<td>Non-Latino</td>
<td>28</td>
<td>90.3</td>
</tr>
<tr>
<td><strong>Other Ethnicity</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Guyanese-West Indian</td>
<td>1</td>
<td>3.2</td>
</tr>
<tr>
<td>Hispanic (South American)</td>
<td>1</td>
<td>3.2</td>
</tr>
<tr>
<td>Venezuelan</td>
<td>1</td>
<td>3.2</td>
</tr>
<tr>
<td>Iranian</td>
<td>1</td>
<td>3.2</td>
</tr>
<tr>
<td>Pakistani</td>
<td>1</td>
<td>3.2</td>
</tr>
</tbody>
</table>

Table 3-5. Mean Age of Physicians and Year of Medical School Completion

<table>
<thead>
<tr>
<th>Age at interview</th>
<th>Mean (SD)</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total (N=31)</td>
<td>39.42 (8.71)</td>
<td>27-57</td>
</tr>
<tr>
<td>Attending (N=13)</td>
<td>47.62 (6.37)</td>
<td>39-57</td>
</tr>
<tr>
<td>Resident (N=18)</td>
<td>33.50 (4.09)</td>
<td>27-42</td>
</tr>
<tr>
<td>Year completed med school</td>
<td>1991.87 (9.64)</td>
<td>1972-2002</td>
</tr>
</tbody>
</table>

Once the program director or coordinator of the class found a place to take a break, she introduced me by name and my UF affiliation. I passed a one-page description of the project with my contact information around to all of the participants and then proceeded to summarize the information on the handout by telling them the title of the project, what
they would need to do to participate and how long it will take, the age and marital status
criteria and that they would be compensated with a $20 grocery store gift-certificate.
Then I passed around a sheet of paper and asked that anyone that was interested in
participating give me their name and phone number. I always brought a copy of the
informed consent with me for anyone who wanted to read it over. I also let them know
that if they were uncertain at the moment that my contact info was on the handout and
they could contact me in the future if they wanted to. This only happened once; usually I
had to call the participants to find a time to meet.

Most of the women attending the displaced homemaker program were suffering
either emotionally, financially, and/or spiritually, but they came to this free program to
get their lives back on track, or to learn new skills, or to simply improve their self-
esteem. I attended several of the class sessions, but each group differs from the one
before it, just like any teacher knows that every class has its own collective personality.
All of the women I spoke with said that they benefited from the program in some way.

Once in a while, when I visited the program to recruit new participants, I would get
a very inquisitive group that asked lots of questions, like why I am doing the research,
why the specific ages, what will I do with my degree once I have it and so on. Other
times, there would be no questions and only one person signed-up. I found it useful when
the timing worked to my advantage to ask if anyone would like to schedule a time to
meet right then, though this was not always appropriate and I tried very hard not to
interfere with the program.

The field setting changed every time I scheduled an interview. Scheduling
interviews often proved difficult since many were not available when I called and several
never returned my phone calls. This was true for both DHP women and physicians.

Sometimes I visited the homes for the participants, other times we met at the college or some other location. The physicians were all interviewed in their offices.

The homes I visited in this research encompassed a range of economic levels and the locations stretched to the outer edges of the service area of the displaced homemaker program. Most of the participants live in urban or urban-suburban areas whereas only a handful lived in more rural areas of the region. In some cases I visited homes in up-scale gated communities, others lived in very modest homes and apartments. Sometimes the homes were spotless, and it was obvious that the occupants had taken great care in decorating their home. Other times the homes were in total disarray (perhaps a testament to the difficult transition some of the women were undergoing) and I was instructed to climb over boxes to get to a seating area. However, not all of the interviews took place at participants homes; I met one woman at her place of work on her lunch break, and about a third of the DHP participants chose to meet me in the building where the DHP classes took place. This was convenient for both of us since we knew the place and the kind people at the community college helped us find a quiet place to talk.

Unlike the interviews with the DHP women, the physician interview location was fairly static. I interviewed all of the physicians at their place of work, whether this was their clinic office, hospital office, or in the case of the residents, in a quiet meeting room at the clinic or the office of the behavioral science coordinator that was assisting me. As for the physicians that only completed the survey and CCM procedure, I met with them when they had a few minutes between meetings or patients at the clinic. I also was given access to 20 minutes of one of the noon meetings and convinced six residents to complete
the survey and the rating procedure. It was not uncommon for the physician to delay or cancel our scheduled meetings. I made several trips to the clinic and hospital that yielded little more than a chance to reschedule.

Most of the physicians in my study were residents or attending physicians in a family practice clinic that is in a largely African-American neighborhood. The building consists of two wings, one side is the clinic itself and the other is where the residency program resides. The clinic itself opens with the reception staff to the right and with a large waiting area to the right. The waiting area is stocked with countless brochures on every conceivable health issue. There are two TVs and a play area filled with toys for children. On my first visit there, the coordinator who was assisting me gave me a grand tour and introduced me to several physicians. Most of the physician offices are located on the residency side, and this was my primary point of entrée.

The interview process typically followed the same pattern for both DHP women and physicians. For the DHP women, I gave them the informed consent to read and sign, explaining any elements that they needed clarified. I always offered to read it to them if that was their preference, to save them any embarrassment if they had difficulty reading. Once the informed consent was taken care of, I proceeded to the survey, which usually only took a couple of minutes, then I began the vignette-based interview. Before reading the first story, I made clear that the stories were fictional, that there were no right or wrong answers to the questions that followed the stories, and that they could make their responses as personal or impersonal as they wished. All of the interviews were audio taped with the participants’ permission, and initialed on the informed consent. The interview section of the encounter usually took from 30 minutes to an hour. One of the
CCM procedures concluded the encounter. The interview process with the physicians followed the same format, more or less, though the focus on the informed consent was not usually needed and they process went quicker since I only read them one vignette.

Almost every woman I interviewed told me that she enjoyed the process much more than she expected. It was not uncommon for the women to divulge intimate details about themselves and their lives. Many just seemed happy to have someone that was interested in what they had to say.

The next chapter begins with the analysis of the data gathered. Chapters 4, 5 and 6 present the research findings. Chapter 4 presents part one of the data analysis, focusing on sexuality conceptualizations using the Cultural Consensus Modeling techniques. I provide a description of the types of analysis used and the theory behind them. These data are presented textually and graphically for their own merits. In chapters 5 and 6 these data are linked to the data from the in-depth interviews. The data on sexuality conceptualizations are considered in terms of their support of the hypotheses, as well as their shortcomings for support of the hypotheses.
CHAPTER 4
CULTURAL CONSENSUS DATA AND ANALYSIS

Cognitive scientists believe that the less tangible aspects of culture, such as beliefs and ideas, can be made more accessible with cognitive models (Borgatti 1997). Borgatti asserts that mathematical models representing cultural domains can make accurate predictions about particular cultural groups, but notes that every representation is uniquely situated in the current concepts and language of the groups. He also notes that representations are just that--representations of cultural models not the models themselves. In keeping with Borgatti and other cognitive scientists, Dessler and Bindon (2000) contend that it can be inferred from these representations that individuals are relying on a shared model of the same cultural domain.

Free listing is frequently the first step in gathering data about a cultural domain. It is often the prelude to other types of data collection such as piles sorts, triads, and other systematic data collection techniques (Borgatti 1996b, 1999; Weller and Romney 1988). However, the free list itself also provides useful data on its own (Bernard 1996). For example, free listing identifies the parameters of the cultural domain using both the frequency of terms and their salience, determined by their rank-order in individual lists. Free lists are gathered from informants to determine if individuals are using some of the same terms to describe the domain, and are therefore sharing cultural knowledge about the domain; they help to determine what belongs in a domain and how it is structured (Weller and Romney 1988). Free listing is an emic task since it draws on the language, ideas, and categories of those being studied. It is generally assumed that the more salient
terms are also the ones that are listed most frequently (Bernard 1996; Borgatti 1999). Additionally, salience is also represented by list order, with more salient terms listed closer to the beginning of lists.

In the case of this research project, I asked a set of respondents to "tell me all the words and phrases they could think of to describe sexuality for women age 45 and up?" This was a systematic way of eliciting the emic concepts and categories that belong in the domain of sexuality for midlife and older women. I asked this of the women themselves and then asked the same question to a group of Family Practice physicians to see if they were using some of the same descriptors. The free lists provided only the parameters of the domain. To determine how people perceive the similarity among items in a domain, that is, the way that the domain is configured, I use piled sorts, and a ratings test.

**Free listing**

The initial free-listing procedure with both the DHP women and the physicians yielded a total of 271 terms and short phrases from 32 respondents (183 terms from 18 DHP women and 88 from 14 physicians). The free-list data was entered into a text file and analyzed for frequency in ANTHROPAC (Borgatti 1996a) using a low soundex setting to highlight similar sounding words that may be collapsed under one term. This list was reduced to 209 when synonyms and related items were taken into consideration, with 48 items repeated more than once (Table 4-1). For example, several of the respondents stated either the phrase “lack of desire” or “decreased libido,” both of which I collapsed under the phrase “lack of desire” for the 48 repeated items later used in the pile-sorts and ratings tests. Although terms and phrases related to decreased sexual activity were common, several respondents also mentioned that sex-life improved with age with terms and phrases including “sex better than when in 20s”, “sex is better”,

“hotter,” “more pleasurable”, and so on. There are perhaps many more synonyms within the 48 terms and the remaining terms mentioned by only one individual, however, I preferred to err on the side of caution and limit the combination to only very obvious synonyms.

Many of the terms describing some level of improvement in sexuality appear to be more salient in terms of their rank order in the individual lists. Smith’s Salience (Table 4-1) is automatically calculated in ANTHROPAC (Borgatti 1996a). Smith’s Salience calculates two relevant measures of salience: 1) is the position of a given item on a list (e.g., first, second, third and so on); and 2) the frequency that the item appears across all of the free lists (Weller and Romney 1988). Repeated frequency is the most commonly used measure of salience, but studies looking at these measures have shown that terms that appear earlier on a list are usually more important or better known than items further down the list (Borgatti 1999; Weller and Romney 1988). Smith’s formula uses both the order in each individual list and the frequency of the item in the lists to get the gross mean percentile rank of each item across all the free lists. For the results presented here, “lack of desire” has the highest salience rank, but “more pleasurable” “comfortable” and “freeing” are also highly salient to these informants. The salience of these terms and why they are more salient is better considered with the other CCM techniques that follow.

I continued to collect informal free list data by asking my informants the same free list question above, but did not urge them to give me this response in list form. Rather some gave me lists of terms, while others described their ideas in sentence form and in this case word list was abstracted from their statements with their assistance. From this
Table 4-1. Free List Frequencies with Both Samples.

<table>
<thead>
<tr>
<th>Item</th>
<th>Freq</th>
<th>Resp PCT</th>
<th>Avg Rank</th>
<th>Smith S</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 lack of desire</td>
<td>8</td>
<td>25</td>
<td>3.5</td>
<td>0.185</td>
</tr>
<tr>
<td>2 comfortable</td>
<td>3</td>
<td>9</td>
<td>2</td>
<td>0.078</td>
</tr>
<tr>
<td>3 more pleasurable</td>
<td>3</td>
<td>9</td>
<td>1.333</td>
<td>0.089</td>
</tr>
<tr>
<td>4 non-existent</td>
<td>3</td>
<td>9</td>
<td>5.333</td>
<td>0.076</td>
</tr>
<tr>
<td>5 more responsible</td>
<td>3</td>
<td>9</td>
<td>5</td>
<td>0.037</td>
</tr>
<tr>
<td>6 better</td>
<td>3</td>
<td>9</td>
<td>4</td>
<td>0.069</td>
</tr>
<tr>
<td>7 fun</td>
<td>3</td>
<td>9</td>
<td>4</td>
<td>0.058</td>
</tr>
<tr>
<td>8 sexy</td>
<td>3</td>
<td>9</td>
<td>5.667</td>
<td>0.044</td>
</tr>
<tr>
<td>9 freeing</td>
<td>3</td>
<td>9</td>
<td>2</td>
<td>0.078</td>
</tr>
<tr>
<td>10 renewed interest</td>
<td>2</td>
<td>6</td>
<td>8</td>
<td>0.024</td>
</tr>
<tr>
<td>11 happy</td>
<td>2</td>
<td>6</td>
<td>5</td>
<td>0.023</td>
</tr>
<tr>
<td>12 more mature</td>
<td>2</td>
<td>6</td>
<td>12</td>
<td>0.037</td>
</tr>
<tr>
<td>13 intimacy</td>
<td>2</td>
<td>6</td>
<td>4</td>
<td>0.044</td>
</tr>
<tr>
<td>14 don't bother</td>
<td>2</td>
<td>6</td>
<td>7</td>
<td>0.031</td>
</tr>
<tr>
<td>15 satisfying</td>
<td>2</td>
<td>6</td>
<td>2</td>
<td>0.055</td>
</tr>
<tr>
<td>16 menopausal problems</td>
<td>2</td>
<td>6</td>
<td>3.5</td>
<td>0.034</td>
</tr>
<tr>
<td>17 monogamous</td>
<td>2</td>
<td>6</td>
<td>6</td>
<td>0.023</td>
</tr>
<tr>
<td>18 desirable</td>
<td>2</td>
<td>6</td>
<td>3</td>
<td>0.05</td>
</tr>
<tr>
<td>19 menopausal</td>
<td>2</td>
<td>6</td>
<td>2.5</td>
<td>0.056</td>
</tr>
<tr>
<td>20 caring</td>
<td>2</td>
<td>6</td>
<td>5</td>
<td>0.043</td>
</tr>
<tr>
<td>21 use protection</td>
<td>2</td>
<td>6</td>
<td>3.5</td>
<td>0.045</td>
</tr>
<tr>
<td>22 hotter</td>
<td>2</td>
<td>6</td>
<td>10</td>
<td>0.029</td>
</tr>
<tr>
<td>23 be left alone</td>
<td>2</td>
<td>6</td>
<td>7</td>
<td>0.023</td>
</tr>
<tr>
<td>24 disease risk</td>
<td>2</td>
<td>6</td>
<td>8</td>
<td>0.021</td>
</tr>
<tr>
<td>25 on-going</td>
<td>2</td>
<td>6</td>
<td>1</td>
<td>0.063</td>
</tr>
<tr>
<td>26 ignorance</td>
<td>2</td>
<td>6</td>
<td>15.5</td>
<td>0.028</td>
</tr>
<tr>
<td>27 talks freely</td>
<td>2</td>
<td>6</td>
<td>3</td>
<td>0.049</td>
</tr>
<tr>
<td>28 medical effects on sexual function</td>
<td>2</td>
<td>6</td>
<td>2.5</td>
<td>0.047</td>
</tr>
<tr>
<td>29 less active</td>
<td>2</td>
<td>6</td>
<td>4</td>
<td>0.027</td>
</tr>
<tr>
<td>30 beautiful</td>
<td>2</td>
<td>6</td>
<td>2</td>
<td>0.058</td>
</tr>
<tr>
<td>31 body changing rapidly</td>
<td>2</td>
<td>6</td>
<td>9</td>
<td>0.04</td>
</tr>
<tr>
<td>32 more careful</td>
<td>2</td>
<td>6</td>
<td>9.5</td>
<td>0.017</td>
</tr>
<tr>
<td>33 been around the block</td>
<td>2</td>
<td>6</td>
<td>7.5</td>
<td>0.029</td>
</tr>
<tr>
<td>34 kind of lonely</td>
<td>2</td>
<td>6</td>
<td>8</td>
<td>0.026</td>
</tr>
<tr>
<td>35 comfortable in their own skin</td>
<td>2</td>
<td>6</td>
<td>18</td>
<td>0.009</td>
</tr>
<tr>
<td>36 dangerous</td>
<td>2</td>
<td>6</td>
<td>3</td>
<td>0.042</td>
</tr>
<tr>
<td>37 explorative</td>
<td>2</td>
<td>6</td>
<td>8</td>
<td>0.021</td>
</tr>
<tr>
<td>38 confident</td>
<td>2</td>
<td>6</td>
<td>3</td>
<td>0.052</td>
</tr>
<tr>
<td>39 sex better than when in 20s</td>
<td>2</td>
<td>6</td>
<td>6</td>
<td>0.039</td>
</tr>
<tr>
<td>40 got to have somebody</td>
<td>2</td>
<td>6</td>
<td>3.5</td>
<td>0.048</td>
</tr>
<tr>
<td>41 uncomfortable</td>
<td>2</td>
<td>6</td>
<td>3.5</td>
<td>0.036</td>
</tr>
<tr>
<td>42 special</td>
<td>2</td>
<td>6</td>
<td>3.5</td>
<td>0.041</td>
</tr>
<tr>
<td>43 sensitive</td>
<td>2</td>
<td>6</td>
<td>3.5</td>
<td>0.045</td>
</tr>
<tr>
<td>44 good once a week</td>
<td>2</td>
<td>6</td>
<td>3.5</td>
<td>0.043</td>
</tr>
<tr>
<td>45 too busy</td>
<td>2</td>
<td>6</td>
<td>4.5</td>
<td>0.026</td>
</tr>
<tr>
<td>46 enjoyable</td>
<td>2</td>
<td>6</td>
<td>3.5</td>
<td>0.053</td>
</tr>
<tr>
<td>47 companionship with financial help</td>
<td>2</td>
<td>6</td>
<td>8.5</td>
<td>0.037</td>
</tr>
<tr>
<td>48 uninhibited</td>
<td>2</td>
<td>6</td>
<td>3</td>
<td>0.042</td>
</tr>
</tbody>
</table>
continued questioning I obtained 27 more lists from both samples and it was heartening to see that several of the terms found in the first procedure were the same. When these new lists were adjusted for synonyms and combined with the original free list data, there were 55 repeated terms and a total was 325 words and phrases. The new repeated terms were “in-a-rut”, “compatibility more important than sex”, “mature”, “hot flashes”, “painful”, “less sexually active” and “more selective.” These were not new terms, rather they were terms mentioned by only one person in the first group. The original shortened list of 48 repeated terms was used to analyze the domain further by incorporating it into the pile-sort and rating procedures.

**Pile Sort Procedure**

Pile sorts are tabulated and interpreted by measures of similarity, that is each time a respondent puts two items together in the same pile, it is counted as an indication that the respondent believes those two items are similar (Borgatti 1999). Pile sorts are used to elicit the structure of the domain. The more respondents that put any given two items together the stronger the interpretation that they are drawing on one cultural domain and that they perceive it in similar ways. By using an item-by-item matrix the pile sort data can be represented spatially with non-metric multidimensional scaling (MDS) and cluster analysis (Borgatti 1999). The MDS serves to reveal the perceptual dimensions that individuals use to distinguish one item from another. The cluster analysis groups items together that share attributes or in some cases constitute subdomains (Borgatti 1999).

For the pile sorting procedure, respondents were asked to organize the 48 terms and phrases—which had been written on individual cards and numbered on the back for coding—in what ever way seemed appropriate to them. This approach is referred to as single “unconstrained” pile sorts (Weller and Romney 1988). Unfortunately this method
results in the “lumper/splitter” problem, where, for example, two people have similar views on which items go together, but one takes the time to sort out the finer distinctions between the items and makes numerous piles, and the other makes only a few piles with the broadest distinctions (Borgatti 1999). This problem can skew the results since the differences between the lumpers and splitters can eclipse the other differences among the pile-sorts (Weller and Romney 1988). However, efforts to avoid this problem are time consuming and sometimes complicated for the respondents. Additionally, some of the more constrained methods can negate the emic nature of the unconstrained pile sort since they impose a structure that may be inappropriate for the domain. I opted for less precise data on this point since I was asking participants to also engage in a long interview and to fill-out a survey.

I collected 21 pile sorts (15 from DHP women and 7 from physicians). This is a small number of pile-sorts since a sample of 30 to 40 is recommended to reach reliabilities above .90 (Weller and Romney 1988). However, time constraints and the difficulty in obtaining a larger physician sample limited my options in this regard, particularly since I wanted the opportunity to run ratings tests on the sample as well. This low number of pile sorts, particularly with the physician sample, is somewhat ameliorated by the fact that physicians as a group are expected to have more internal consensus as a result of their training and socialization as health care providers. The analysis below appears to support this contention.

When there was time, I asked respondents to tell me why they grouped certain words and phrases together, however there was rarely time for such questions with the physicians. Several of the women mentioned that they put words together that described
themselves or grouped words together that described others. For example, several mentioned that they separated out terms that described themselves (i.e., “relates to me”, “me at this age”, etc.), particularly related to relationships, explaining that a pile described “a new relationship after divorce” or some other event. Other pile descriptions included words that described things that are “bad”, “wrong” or “careless”; piles that include things that are “happy” or “good”; and “no reason” piles. These descriptions were very helpful in deciphering the multidimensional scaling (MDS) maps and the cluster analysis for the DHP women.

**Multidimensional Scaling of Pile Sort Data**

Multidimensional Scaling (MDS) shows similarities by placing items together that are similar and interpretation relies on looking for patterns in the clusters of items. The pile sort data imported into ANTHROPAC produced an item-by-item aggregate proximity matrix; each cell indicating the number of times a given two items were “piled” together. The algorithm for multidimensional scaling in ANTHROPAC computes the euclidian distances (geometric distance in multidimensional space) among all the pairs in the matrix and adjusts coordinates of each point in dimensional space that maximally reduces stress (Borgatti 1996b). MDS measures similarity in “stress,” which is the “measure of how far off the graph is from one that is perfectly proportional” (Bernard 1996: 502). MDS is typically run in two dimensions, since it is easier to read and manage the data, however it is usually not perfect and typically creates more stress than multiple dimensions. Borgatti notes that it is not necessary to have zero stress in an MDS map for it to be useful.

The rule of thumb we use is that anything under 0.1 is excellent and anything over 0.15 is unacceptable. Care must be exercised in interpreting any map that has non-zero stress since, by definition, non-zero stress means that some or all of the
distances in the map are, to some degree, distortions of the input data. … In general, however, longer distances tend to be more accurate than shorter distances, so larger patterns are still visible even when stress is high. (Borgatti 1996b: 33).

However, Sturrock and Rocha (2000) note that the stress values they generated from their research using random matrices produced much higher levels of stress with only a 1% chance that the objects were arranged randomly. They showed that as the number of items increased in two dimensions that the stress values began to level off so that the stress generated for 100 items was not much worse than the stress for 40 items. The stress for each of the matrices of this project fall below the 0.15 cut-off noted by Borgatti (1996b). When the analyses were run in three and four dimensions for each sample the stress reduced as expected and each permutation reduced the stress by about a one-third.

**MDS Results**

The MDS map derived from the aggregate proximity data of the DHP women pile-sorts appears in Figure 4-1 and the proximity data of the physicians appears in Figure 4-2. The stress in two dimensions for Figure 4-1 is .129 and .095 for Figure 4-2, below the accepted criterion noted by Borgatti, and reflects the degree of agreement among the participants. These two representations are strikingly similar in the way that each group organized the words in much the same way, though with a few significant differences.

Generally, clusters of items appearing on the map very close together tend to represent words that are more semantically similar, whereas clusters with words that are more dispersed tend to represent items that are related topically (Stansbury and Sierra 2004). “The assumption is that proximity represents aggregate psychological relatedness, clustered items frequently ‘pointing to’ nearby items” (Stansbury and Sierra 2004: 460).

For this project the cluster analysis (see next section) served as an ideal companion to the MDS analysis, since the items appeared to be ordered similarly. Additionally, in
order to get a better picture of how and why terms were grouped together, I dissected the pile sort data into groupings based on what women had told me each pile meant to them. I then ran cluster analyses on topics like “new relationship” or “careless behavior” and so on, so I could see exactly which terms were grouped together under which category and how closely they were connected. To accomplish this I had to allow items to appear more than once and allow for missing items. This use of clustering proved very helpful in identifying meaningful clusters in the MDS.

In the lower left portion of Figure 4-1 are core terms that most participants grouped together to varying degrees of inclusion that were described as “new relationship” characteristics, and as terms that described their “sexuality at this time in their life” (or their ideal for it). Terms such as happy, enjoyable, satisfying, etc. were all grouped closely together and share a similar semantic meaning for describing what the women wanted to find in their relationships after divorce, or what they had already found with new partners after divorce or widowhood. The inclusion or exclusion of various terms reflects the intracultural variation in their relationship experiences. Since some women expressed no interest in developing a new relationship, these terms and phrases reflected their sense of what is ideal in a mature sexual relationship.

In interviews, women were not reluctant to express concern about the risk of sexually transmitted infections from new partners, which explains why use protection, more careful and more responsible are in this grouping. It was not uncommon for respondents to describe themselves as behaving in a safer manner than women in younger cohorts. Also, the combining of such terms as happy, sexy and beautiful with use
protection and more careful points towards the tension between the ideals of intimate relationships and the realities of the possible risks involved with dating.

In the upper right corner of Figure 4-1 are terms that were often grouped together to describe careless behavior. Interestingly, the phrase been around the block was grouped in this area perhaps because for some it denotes promiscuity. However, the women who included it in their free-lists appeared to be expressing “experienced” without moral connotations. The phrases in this grouping were not typically associated with themselves; rather they attributed these to other women, and often to younger women.

In the lower left of Figure 4-1 are negative descriptors, and typically terms they referred to as “not me” or “bad”. Phrases such as too busy or don’t bother were described as excuses “other women” use when they do not want to engage with a partner or with life in general. Interestingly, physicians grouped many of the same words together as the DHP women, although there are notable differences. In the physician MDS map, (Figure 4-2) the stress is lower even though the map is based on only six pile sorts. Since physicians are expected to be more homogenous than are the group of women, this is not surprising.

The grouping in the upper right corner of Figure 4-2 represents patients who are poorly informed about STD risks or behave recklessly. Interview and survey data with the physicians confirms that they believe that many of their patients are poorly informed in this regard, and that certain subgroups of their patients live dangerous life-styles (Chapter 6). These are the same terms that the DHP women grouped together that some described as “careless behavior,” suggesting that the women and the physicians
Figure 4-1. MDS for DHP Women Pile Sorts.
OLDER WOMEN PATIENTS IN RELATIONSHIPS
COMPAERED TO YOUNGER PATIENTS

- uninhibited
- explorative
- sex better than when in 20s
- on-going
- freeing
- beautiful
- sexy
- fun
- renewed interest
- enjoyable
- desirable
- confident
- satisfying
- comfortable in their own skins
- special
- happy
- intimacy
- more mature
- comfortable
- caring
- more responsible
- monogamous
- more pleasurable
- sensitive
- use protection
- good once a week

PATIENTS WHO ARE POORLY INFORMED ABOUT DISEASE RISK and/or BEHAVE RECKLESSLY

- been around the block
- got to have somebody
- disease risk
- dangerous
- ignorance
- kind of lonely
- companionship w/ financial help
- uncomfortable
- don't bother

MENOPAUSAL PATIENTS WHOSE SYMPTOMS ARE CAUSING CONCERN and/or NEGATIVELY AFFECTING THEIR SEXUALITY

- less active
- too busy
- be left alone
- non-existant
- lack of desire
- menopausal problems
- medical effects on sexual functioning
- more careful
- body
- changing rapidly

Figure 4-2. MDS for Physician Pile Sorts.
conceptualize this part of the domain in much the same way. The word *uninhibited* is
closely positioned with this grouping in both MDS figures, but is closer to the
“relationships” theme for the physicians and closer to “careless” theme for the women.

The lower left area of Figure 4-2 appears to describe relationships for older women
patients, and the cluster contains many of the same terms as those in the DHP women’s
grouping for new relationships. Again there are a few notable differences between the
two MDS representations. The physicians do not appear to be grouping *use protection*
and *more careful* within this topic and this reflects their emphasis on younger cohorts
when considering STD and HIV risks. When physicians were asked which of their
patients they considered “at-risk” for HIV, they overwhelmingly focused on those in their
20s and 30s, with the perception of risk declining with age.

The two groups appear to be furthest apart on their notions regarding menopause
and the terms and phrases that combine with it. The physicians have a coherent grouping
of terms for menopausal patients who are having difficulties or discomforts, with
*menopausal, menopausal problems, medical effects on sexual functioning,* and *body
changing rapidly* grouped together. The DHP women did not develop a coherent
grouping on this topic, with the terms listed above widely dispersed, suggesting that there
may be wide-ranging experiences regarding menopause. This may be due to age
differences since the average age of those doing the pile sort task is 52, ranging from 46
to 61 years of age. With this age distribution it is likely that some women have not begun
to experience the menopause transition, some experiencing changes that may or may not
be uncomfortable, and others are past it. There were no significant differences in how the
words were arranged when the respondents were divided into older and younger groups
or when the two major ethnic groups were compared, which may be due to the small sample size.

Figures 4-1 and 4-2 are remarkably similar, suggesting that the two groups conceptualize the domain in much the same way. The representations of the cluster analysis below closely resemble those in each MDS, and lend support to the notion that the groups are in agreement.

**Clustering of Pile Sort Data**

Cluster analysis is another descriptive tool for exploring relationships among matrix items; it shows which items go together and in what order they go together (Bernard 1995). Much like MDS, analyzing a cluster is somewhat subjective since it groups items together, but does not reveal what the clusters mean. Cluster analysis is used as an exploratory tool, and since the algorithm systematically finds the most significant solution possible, tests of statistical significance are not necessary (StatSoft 2004).

Johnson's Hierarchical Clustering in ANTHROPC computes the distance (or similarity) between all the items (Borgatti 1996b). For this analysis I used average link clustering. Borgatti explains, “In *average-link* clustering, we consider the distance between one cluster and another cluster to be equal to the *average* distance from any member of one cluster to any member of the other cluster” (Borgatti 1994: 78). That is, the distance between two clusters is calculated as the average distance between all pairs of items (StatSoft 2004) that were grouped together in the pile sorts.

In the hierarchical clustering output from ANTHROPAC, the columns represent the items from the pile sorts and the rows indicate the level of relatedness between the items. Figure 4.3 represents the cluster analysis for the DHP women, and Figure 4-4 represents
the clusters analysis for the physicians. The 'Xs' mark the place between any given two
columns in a given row when corresponding items are merged together (Borgatti 1994).
The lower any two items are connected along the rows the further apart they are from
each other.

In Figure 4-3, there is a marked division about midway along the columns between
#47 sensitive and #14 medical effects on sexual functioning. This first large cluster in
shaded in pink includes all the same terms that were grouped together in the MDS under
“new relationship”. Clearly some items are grouped together in the pile sorts by most of
the women. For example, #34 enjoyable, #12 caring, and # 39 happy were piled together
by most participants. Whereas other terms were not grouped together with these other
terms as frequently, such as #3 more responsible, and #10 renewed interest, though they
are still part of the overall cluster.

The next sharp division is between #46 disease risk and #29 less active. This last
cluster shaded in yellow contains the terms that were described as “bad” or “wrong” in
the MDS. Less active (#29) is connected with this grouping at a very low level indicating
that it was not always considered similar to the other items in the group. One obvious
difference between the MDS and the cluster analysis appears to be the connection
between terms related to menopause. On the MDS map in Figure 4-1 these items did not
make a coherent grouping, whereas in the cluster analysis they are grouped together.
However, this cluster shaded in peach links #14 medical effects on sexual functioning and
#15 menopausal problems together at a high level, but the other items are at a lower level
of connectedness, which shows that they were not grouped together by everyone
Figure 4-3. Hierarchical Clustering of DHP Women
Figure 4-4. Hierarchical Clustering of Physicians
participating, supporting the contention that this issue is experienced differently among this sample.

The green cluster represents the “careless” theme that was shown in Figure 4-1, where #36 dangerous and #46 disease risk were not closely positioned but were part of the same group. In the cluster they are linked at a relatively high level showing that items that are positioned tightly together in the MDS may not be as important as would be expected in terms of showing patterns of agreement.

Figure 4-4 represents the cluster analysis for the physician sample. Just like in Figure 4-3, this cluster analysis follows the similar patterns as those found in the MDS in Figure 4-2. The distinctions that are apparent in this cluster are the significant sub categories within the clusters and the links with peripheral items not grouped together in the MDS. The cluster with the “relationship” theme is shaded in two shades of pink to show an interesting division between the first grouping that ends with #43 explorative and the next one that starts with #21 use protection. In the physician MDS (Figure 4-2) use protection was near the “relationship” grouping, but did not appear to be part of it. The cluster analysis here shows that it is part of this grouping, yet it is linked at a very low level, suggesting that it was infrequently combined with these other relationship terms.

The peach cluster representing part of the menopausal issues grouping presents a similar case as the one above, with #44 good once a week weakly connected to this cluster and not part of the grouping in the MDS (Figure 4-2). It also shows how the physicians were consistently in agreement about the clearly menopausal terms with #14 medical effects on sexual functioning, #37 body changing rapidly, #15 menopausal
problems, and #33 menopausal all together at a very high level of connectedness. There was much less agreement about the other terms in this cluster as all were weakly connected to the menopausal terms, which was not clear in the MDS.

Unlike the DHP women that linked #36 dangerous and #46 disease risk at a high level of connectedness, the physicians demonstrate much less agreement on these terms with low levels of connectedness. Compared to the DHP women, the physicians appear to be in agreement about which items are similar since the cluster analysis shows high levels of connectedness in almost all of the clusters. Although the MDS and the cluster analysis appear to indicate that the physicians and the DHP women share similar concepts about the domain, the ratings test reveals that they do not share the same culture.

Ratings Procedure

The ratings procedure shows the pattern of agreement, or consensus, among respondents in order to make inferences about their knowledge of the domain. In this case, I asked 24 respondents (14 DHP women and 10 physicians) to rate the 48 items on a scale of 1 to 4 in terms of relevance for describing sexuality for women age 45 and older (1=least relevant, 4= most relevant). Three of the women who were asked to complete the free listing exercise were also asked to complete the ratings test.

The notion of relevance as a critical dimension that respondents were using to organize the items was revealed in the process of conducting the pile sort procedure. Several of the DHP women participants, and a few of the physicians, noted that some of the terms seemed very apt for describing women’s midlife sexuality, while other terms were considered inappropriate. Some terms were easily organized into piles relevant to some aspect of women’s sexuality, whereas it was a struggled to find a suitable pile for
other terms. The analysis of the data from this procedure turned out to be useful in many ways.

The analysis of these data uses Cultural Consensus Analysis, a type of reliability theory that assesses the patterns of agreement among individuals. The first step in the analysis was to create a matrix of correlations between people, based on their responses to the ratings test. In consensus theory individuals are used as variables and their responses are used as cases, whereas typically individuals are cases and their responses are the variables (Weller and Romney 1988). This is a form of reliability testing using the Spearman-Brown Prophesy on respondents rather than items. The individual’s responses are coded as “RESPONSE data, that is, a 1 if the informant said yes and a 0 if the informant said no” rather than as “PERFORMANCE data,” which measures item reliability, coding the data as 1 for correct and 0 for incorrect (Weller and Romney 1988: 75). In item reliability, it is assumed that the correct answers are known, whereas in consensus theory, the correct answers are unknown and the responses from the participants are used to determine the culturally correct answers.

The program in ANTHROPAC uses the respondents’ input in the form of a correlation matrix to create a key to the “culturally correct” responses, and factor analyzes the pattern of respondent-by-respondent similarities to show if there is support for the consensus agreement (Borgatti 1996b). Agreement between any two respondents (similarity of their answers) is held to be a function of the extent to which each has knowledge of the culturally appropriate responses: those who responded similarly to others in the group were given more weight in the analysis (Weller and Romney 1988).
Cultural consensus is said to exist when the ratio between the eigenvalues of the first factor is three times larger than the second factor or greater, indicating a single factor solution. The factor loadings are a correlation of each respondent with the underlying pattern of cultural knowledge about the domain. Therefore, if the factor loading on the first factor is less than three times the loading on the second factor, then the results indicate the presence of more than one culture and the consensus model does not apply.

The One Culture assumption is inconsistent with the existence of more than one large eigenvalue. Two large eigenvalues, for instance, is strong evidence that (at least) two truths (two systematically different patterns of responses) are governing the responses of informants. The program prints the ratio of the first eigenvalue to the second. The rule of thumb is that if the ratio is less than 3 to 1, the assumption of One Culture is indefensible. (Borgatti 1996b: 45)

Not surprisingly, the consensus analysis results for the sample as a whole (physician sample and DHP women sample combined) did not support the assumption of “one culture.” The first factor eigenvalue was 2.67 and the second was 2.45, suggesting the presence of two cultures. The first factor explained only 45 % of the variance, and the second factor explained 39%. The average respondent knowledge was extremely low at .129 (SD .308). This was not unanticipated since my original hypothesis was that women and physicians would not conceptualize the domain in the same way. Although the pile sort data appeared to show that the two groups were organizing elements of the domain in a similar fashion, the ratings data dispute that finding.

When the samples were considered separately, the DHP women had sufficient internal consensus, but the physicians did not. The consensus for the physicians violated the rule of the 3:1 ratio on the factor loadings, although they had more internal agreement with each other than when their responses were combined with the DHP women. The factor loading for the physicians was 1.895 on factor one, and .793 on factor two, leaving
a ratio of 2.389 to 1.940. This violation of one culture suggests that individual physicians conceptualize the domain differently, indicating that there are two or more subdomains among this group. It was suspected that this was due to age or gender differences in the sample, but closer inspection of the results did not reveal a pattern along these lines.

According to the consensus analysis for the DHP women who participated in the ratings procedure, there is the existence of one culture. The ratio of the first factor eigenvalue 2.403 to that of the second factor 0.797 is 3.016 to 1.203, indicating a single factor solution, but not a very strong one. The first factor accounts for 62.2% of the variance. Fourteen respondents were interviewed for this procedure and the average level of expertise was .33 (SD .25) on factor one, with the pseudo-reliability coefficient of 0.638 for this application.

Given that these data support the one culture theory, I looked at some of the nuances in the data for clues about how the domain is structured. There is more agreement among the DHP women on certain points than is immediately obvious from the analysis above. Even when the women did not exactly agree on the ratings level of a certain term, they tended to consistently rate it at the higher or lower end of the 4-point rating scale. For example, all of the DPH respondents indicated that caring was very relevant to describing sexuality for women age 45 and older, with 13 of 14 checking level 4 (highest possible rate) and one checking level 3. Although only nine indicated that more responsible merited level 4, the rest selected level 3. Table 4-2 shows the terms with the most agreement among the women. Table 4-2 shows the overall level of agreement on selected terms, as well as giving clues as to which terms were most salient thought their shared agreement. Comparing the terms they agree on with those that the
physicians agree on provides clues as to how they are organizing elements of the domain (Table 4-3).

Table 4-2. Terms Rating Highest Level of Agreement for DHP Women

<table>
<thead>
<tr>
<th>Term or phrase</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Caring</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>13</td>
</tr>
<tr>
<td>More careful</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>12</td>
</tr>
<tr>
<td>Sensitive</td>
<td>0</td>
<td>2</td>
<td>2</td>
<td>10</td>
</tr>
<tr>
<td>More responsible</td>
<td>0</td>
<td>0</td>
<td>5</td>
<td>9</td>
</tr>
<tr>
<td>More mature</td>
<td>0</td>
<td>0</td>
<td>6</td>
<td>8</td>
</tr>
<tr>
<td>Special</td>
<td>0</td>
<td>1</td>
<td>4</td>
<td>9</td>
</tr>
<tr>
<td>Enjoyable</td>
<td>0</td>
<td>2</td>
<td>3</td>
<td>9</td>
</tr>
<tr>
<td>Fun</td>
<td>0</td>
<td>1</td>
<td>8</td>
<td>5</td>
</tr>
<tr>
<td>Satisfying</td>
<td>0</td>
<td>1</td>
<td>9</td>
<td>4</td>
</tr>
<tr>
<td>Ignorance</td>
<td>9</td>
<td>2</td>
<td>3</td>
<td>0</td>
</tr>
</tbody>
</table>

Another noteworthy finding in the consensus analysis of the ratings data is that the DPH women appear to be considered more decisive. The women were much more likely to rate a term or phrase as a 1 or 4, whereas the physicians were more likely to use the mid-range levels of 2 or 3. Table 4.3 shows an item-by-item comparison of the DHP Women Answer Key with the Physician Answer Key (labeled Med Key), generated with the consensus analysis in ANTHROPAC.

Table 4-3. Comparison of Ratings Keys

| Item | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 |
|------|---|---|---|---|---|---|---|---|---|----|----|----|----|----|----|----|----|----|----|----|----|----|----|
| DHP Key | 2 | 4 | 4 | 1 | 4 | 4 | 4 | 4 | 2 | 4 | 4 | 4 | 4 | 3 | 3 | 3 | 3 | 3 | 3 | 2 | 3 | 4 | 4 | 3 | 4 |
| Med Key | 3 | 3 | 3 | 2 | 3 | 3 | 2 | 2 | 2 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 2 | 3 | 2 | 3 | 2 | 3 |

| Item | 25 | 26 | 27 | 28 | 29 | 30 | 31 | 32 | 33 | 34 | 35 | 36 | 37 | 38 | 39 | 40 | 41 | 42 | 43 | 44 | 45 | 46 | 47 | 48 |
|------|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|
| DHP Key | 1 | 1 | 4 | 4 | 1 | 4 | 4 | 4 | 2 | 4 | 4 | 1 | 3 | 4 | 1 | 1 | 3 | 3 | 1 | 3 | 4 | 4 | 2 |
| Med Key | 3 | 2 | 3 | 2 | 3 | 3 | 3 | 4 | 3 | 3 | 2 | 2 | 3 | 3 | 2 | 3 | 3 | 3 | 2 | 3 | 3 | 3 | 3 | 3 |

Perhaps the most significant aspect of the ratings data is what it conveys about the how much DHP women and physicians differ about the nature of sexuality for midlife
and older women. Both groups were in complete agreement on 10 of the 48 terms as shown in Table 4-4, which list the terms of agreements and how they were rated. This suggests that physicians are somewhat aware of what is relevant for aging women and their sexuality. However, the two groups were in marked disagreement on another 10 of the 48 terms, shown in Table 4-5.

Table 4-4. Terms of Agreement between Physicians and DHP Women

<table>
<thead>
<tr>
<th>Item #</th>
<th>Item</th>
<th>Rating Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>9</td>
<td>Don’t’ Bother</td>
<td>2</td>
</tr>
<tr>
<td>12</td>
<td>Caring</td>
<td>4</td>
</tr>
<tr>
<td>14</td>
<td>Medical Effects On Sexual Functioning</td>
<td>3</td>
</tr>
<tr>
<td>15</td>
<td>Satisfying</td>
<td>3</td>
</tr>
<tr>
<td>22</td>
<td>Uninhibited</td>
<td>3</td>
</tr>
<tr>
<td>37</td>
<td>Body Changing Rapidly</td>
<td>3</td>
</tr>
<tr>
<td>42</td>
<td>Beautiful</td>
<td>3</td>
</tr>
<tr>
<td>43</td>
<td>Explorative</td>
<td>3</td>
</tr>
<tr>
<td>45</td>
<td>Companionship With Financial Help</td>
<td>3</td>
</tr>
<tr>
<td>48</td>
<td>Too Busy</td>
<td>2</td>
</tr>
</tbody>
</table>

Table 4-5. Terms of Disagreement Between Physicians and DHP Women

<table>
<thead>
<tr>
<th>Item #</th>
<th>Item</th>
<th>DHP Rating Level</th>
<th>Physician Rating Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>7</td>
<td>Sexy</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>8</td>
<td>Freeing</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>16</td>
<td>Menopausal Problems</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>19</td>
<td>Kind Of Lonely</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>21</td>
<td>Use Protection</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>25</td>
<td>Been Around The Block</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>28</td>
<td>Hotter</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>29</td>
<td>Less Active</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>33</td>
<td>Menopausal</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>35</td>
<td>Comfortable In Their Own Skins</td>
<td>4</td>
<td>2</td>
</tr>
</tbody>
</table>

Of interest are the different themes that appear in how each group conceptualized the issue by comparing the terms of agreement with the terms of disagreement. For example, both rated terms referring to bodily changes and changes in sexual function were rated as relevant (medical effects on sexual functioning and body changing rapidly
rated 3 in Table 4-4). However, analysis of the results in Table 4-5 on terms of disagreement, show that physicians are more likely to consider those bodily changes as problematic than are the women, even though both noted changes as relevant. A particularly noteworthy finding is that the women consistently indicated that terms referring to less sexual activity and menopausal problems were not relevant to describing mature sexuality.

To summarize the findings, women appear to describe sexuality in very positive terms, as well as safe and careful with regard to the risks associated with dating. On the other hand, physicians tend to focus on the problematic aspects of sex and aging, with much more emphasis on lack of sexual activity due to physical or medical problems. This is likely due to the fact that physicians in the course of their work tend to encounter midlife and older women who are having difficulties in that area. The physicians do note some positive aspects as well, but they are more likely to disagree with the women on these elements of sexuality.

These data provide useful clues as to what physicians need to know about midlife and older women. Women believe that mature women are sexy and beautiful and that sexuality is an important aspect of their identity. They are also concerned with personal safety and their well-being as they enter new relationships after divorce or widowhood. The women in this sample may be describing more of their ideal for sexuality in later life than their personal reality, since the interview data reveal a few are not interested in finding a new partner, though some conceded that they would be interested if the right person came along. This topic will be explored in greater detail in chapter six.
Although the ratings data made it clear that the consensus on one culture is apparent for the DHP women, but not for the physicians or the combined samples, the consensus is not very robust. Given that the consensus appears to exist with the women, I used Property Fitting analysis to assess whether or not the dimension tested in the ratings was the dimension motivating the participants’ perceptions.

**Property Fitting of Ratings and Pile Sorts**

Similar to cluster analysis and dimension testing such as ratings tests or paired comparisons (Borgatti 1996b), PROFIT (PROperty-FITting) is a way of looking at an MDS for groupings of meaning. PROFIT is a multiple regression technique that uses the coordinates from the aggregate proximity matrix of the pile sort data as the independent variables and the attribute, in this case “relevance of terms” used in the ratings test, as the dependent variable (Borgatti 1996b). PROFIT merges the ratings data with the pile sort data and the result indicates if cultural consensus around the dimension used in the ratings test can be supported or refuted. The results of the regression are represented by means of a directional vector in the configuration.

The PROFIT output in ANTHROPAC gives coordinates for the regression line with the centroid point (0,0) and another point (MEAN) from which to form the PROFIT line (regression line). The regression line is literally drawn on top of the MDS. In Figure 4-7, the regression line crosses through the Centroid point, indicated with a plus (+), and through the MEAN out to the other side. The arrowhead of the line shows the direction on which the attribute (in this case, “relevance for describing sexuality for women 45+”) increases. The relevance increases going south and west on the map. Closeness to the line does not indicate anything about the significance of any given item. Rather what is
Figure 4-5. PROFIT Analysis on DHP Women Pile sorts and Ratings
meaningful is where the perpendicular line connecting the terms and phrases to the PROFIT line, fall in relation to the PROFIT line. For example, got to have somebody is less relevant to respondents than disease risk or too busy. The terms happy, sexy, and more responsible are more important than body changing rapidly, and so on.

The regression line expresses the best prediction of the dependent variable (ratings data), given the independent variables (pile sort data). However, these things are usually not perfectly predictable, and there is often substantial variation of the observed points around the regression line. The r-square of this analysis examines if the arrays in the MDS are representing what was tested for in the rating procedure, the higher the r-square, the more accurate or real the dimension. The r-square indicates how well the model fits the data, such that an r-square closer to 1.0 indicates that the model accounts for almost all of the variability considered with the data. A low r-square value may be caused by there being too many dimensions within the cultural domain, or a simple lack of dimension, that it, the dimension that appeared to be there, or the patterns in the MDS are not really representing what they seemed to be representing.

In this case the r-square is 0.699, signifying that this model explains 70% of the original variance and only 30% residual variance is unexplained. Naturally, it would be better if the model explained 90% or more of the original variance. However, the significance level (p-value=.001) calculated for the correlation is an indicator about the reliability of the correlation, and the significance changes depending on the number of items computed (Borgatti 1996b). Borgatti (1996b) suggest that for domains with less than 20 items, an r-square of at least .80 is needed to support the conclusions that the attribute was an important factor in determining the similarity among the items. With a
larger number of items, in this case 48 items, the r-square may be slightly lower and still support the hypothesis (StatSoft 2004).

**Conclusion**

The Cultural Consensus data presented in this chapter revealed a few unexpected findings. I originally hypothesized that the DHP women and the physicians would differ substantially in how they conceptualize the domain of mature sexuality for women. The free list and pile sort data suggested otherwise. Although there were differences between the two samples, there was more agreement than expected. It was interesting to find that the two samples shared more terms and phrases when the samples were combined than when they were analyzed separately. The physician free lists had a particularly low frequency of repeated terms, but they had more in common with the women than with each other. I expected that to be the other way around, with greater consensus of terms for what was expected to be a homogenous group of physicians, and less agreement from women with differing backgrounds.

The MDS and cluster analysis of the pile sorts showed that the two samples organized the items in much the same way, save for with a few notable exceptions. The most significant exception related to risks associated with dating a new partner. The DHP women considered this an important relationship element, whereas physician did not. This finding is congruent with the results on notions about HIV risk that will be presented in Chapter 6.

The physicians developed a coherent grouping on menopause in the MDS and cluster analysis, suggestive of their training and experience in clinical practice, but the women did not link all of the menopause related terms together perhaps because of intracultural differences with menopause related to age.
Despite the apparent degree of shared cultural knowledge between the samples, the ratings data clearly indicated that the participants in this exercise were drawing on more than one cultural understanding of the topic. The ratings data however, showed more than just their differences. Closer inspection of their responses revealed how they were constructing the domain, with women focusing on more positive aspects of midlife sexuality and physicians focusing on more negative or medical aspects.

Finally, the property fitting analysis supported the conclusion that the women were considering relevance of terms to describe themselves, and others in their cohort, when they organized the terms and phrases. Although the DHP women in this sample come from a range of backgrounds and range in age from 45 to 68, they share certain concepts about aging and sexuality. The next chapters expand on how they view aging and sexuality in terms of communication with physicians about sexual issues (Chapter 5), including age and ethnic divisions, and their views on HIV and STD risks after divorce and widowhood, and talking about those risks in clinical contexts (Chapter 6).
CHAPTER 5
AGE, GENDER AND ETHNICITY IN CLINICAL TALK

The major focus of this project is how mature women and physicians describe sexuality and aging, and how their perceptions about it may affect physician-patient communication. Questions this research sought to answer included: Are physicians’ ideas about women's midlife sexuality significantly different for women’s concepts about midlife sexuality? Do physicians hold age- and gender-based assumptions about discussing sexuality that impact their practices? Is women's comfort with discussing sexuality issues in clinical contexts impacted by the age, gender and/or ethnicity of physicians?

Hypotheses

Based on the literature reviews I hypothesized that physicians and DHP women would conceptualize mature female sexuality differently and have different views on how it is addressed in the clinical encounter. Physicians were expected to view older women as sexually inactive if unpartnered. They would assume them to be in mutually monogamous relationships if they were partnered, and not perceive them to be at risk for HIV/STDs through heterosexual contact. Additionally, age and ethnicity variables of both patients and physicians were also likely impact the clinical encounter.

Sexually active DHP women were not expected to perceive themselves to be at risk for HIV/STDs because of their age, because their providers had not discussed it, and because they have not been targeted by public health campaigns. Women would not want to raise the topic of sexuality with their physicians and would prefer that their physicians
raise sexuality issues. I also expected age, ethnicity, and level of education to be important variables in women's perception of their HIV/STD risk. I anticipated that younger women and minority women would have had more exposure to HIV/AIDS issues. Women were expected to express a preference for female physicians and/or physicians of the same ethnicity. Finally, cultural consensus modeling was expected to show that the domain of sexuality in later life would differ between DHP women and primary care physicians, but that there would be a high degree of internal consensus within each sample.

Some of these issues have already been touched on in the previous chapter. The cultural domains revealed through CCM procedures were different between the samples, though not to the degree expected. The samples shared more terms when combined together than they did separately. However, the way that each sample conceptualized the domain differed in significant ways, and the results were instructive as to what physicians need to know to be more competent when talking to mature women patients about sexual health issues. This chapter expands on the findings of chapter four, and addresses many of the hypotheses above that deal with physician patient communication including how it is impacted by the age, gender and ethnicity of the social actors. Chapter six addresses the hypotheses dealing with HIV/AIDS risk perceptions and related issues for clinical communication.

**Age and Gender Constructs: Reactions to the Hysterectomy Vignette**

One of the ways I explored the attitudes of DHP women and physicians was to read them vignettes about a health care encounter and then solicit their opinions about them. The story of a woman who needed a hysterectomy for fibroids was the first health care encounter vignette. The story relates a situation of a 64-year-old woman who undergoes
a hysterectomy and suffers painful intercourse after the surgery (see Appendices C and D). She is very troubled by the impact on her sex life and when she sees the doctor about it he tells her she just needs to have sex more often and it will get better. This response is very disheartening to her and she fears that she may not have a pleasurable sex life again.

Most of the DHP women felt that this was a typical story (n=32, 72.7%) in the sense that it depicted something lacking on the part of the physician (Figure 5-1). Just under 10% thought it was unusual. When I asked what could be done to improve the encounter most mentioned that the doctor should have given her more information before the surgery about what to expect afterwards and that he should have shown more compassion.

Figure 5-1. DHP Women’s Views of the Hysterectomy Story

A 49-year-old widow felt that the doctor should have been more specific about what to expect. She also pointed out that patients don’t necessarily know what questions to ask to get at the answers they need, saying, “I mean it sounded like she asked the basic question, you know, ‘will I be normal?’ And you don't always know these specific
questions… because the women haven't been through this before.” Another said, “I think he could have asked her more questions to understand what is important to her . . .” Some thought that the physician was hampered by time constraints. A woman in her early 50s said, “The doctor needs to be more compassionate and I know it's a business and they have to watch their time and everything else, but sometimes a little suggestion that a patient can do, [for a patient] that is active seeking healing and getting better--it's so important.” Another woman in her mid-50s supported this sentiment about the hurried schedule of physicians, and how it impacts the physician-patient interaction.

He doesn't seem to be responsive to her, or concerned, you know. He seems like, doctors nowadays, they're just cut and dried, they'll get you in and out, and maybe she needs to find another doctor…because having more sex when it is hurting like that she's going to be scared to death. . . . A woman wants comfort; she wants somebody who cares about her situation and can tell her up front what can happen afterwards, what she needs to do and I don't think he did that.

While most focused on what the physician needed to do differently, about a third focused on what the patient should have done differently. Several thought she should be more assertive and/or seek out another physician, and get a second opinion. One 61 year old said, “Well number one, she should have gone to two other doctors before having that knife cut on her, because anyway, it's an incision in your body. That lady should have thought a little better.” Another said, “She needs to be more open with him, you know…I think she should have communicated with him more. And if he didn't respond to her then she needs to go get a second opinion.”

A few reasoned that the patient’s lack of initiative was due to her age, and norms for physician-patient interaction during the era that she was raised. A woman in her mid-40s said,

I think that…she didn't push him hard enough. I think it might be an old world issue that I came across with my mother-in-law, that the doctor's always right and
[you’re] not supposed to question him. It has a lot to do with your age and what you believe, or how you were brought up. . . . I think she should have questioned a great deal more and - the 'you'll be fine, don't worry about' is rather condescending, and that would be my first tip off that you need more information and she should have sought it.

Others not only suggested that she find a new doctor, but that she should find a woman physician. A woman in her early 50s said, “I think she should be able to talk with her doctor comfortably about anything concerning her health. . . . So I think she should change doctors and get a woman doctor.”

The vignettes often served to raise topics that I planned to address later in the interview. For example, the hysterectomy vignette led some of the women to comment on age and gender issues in physician-patient communication, such as in the quotes above. Gender came up more often than age, and both the physician and patients’ gender were salient issues.

One woman who was very forthcoming with her opinions said, “I think it sounds typical and to me it sounds like it's a man doctor - that's my opinion. For him to say, ‘well that's not unusual and have sex more often,’ he should have told her there may be ways that might ease your pain or you know, if more sex would be good then you have to get beyond the pain or otherwise what's the point.” Others focused on the gender of the patient and how physicians make assumptions about their patients based on age and gender stereotypes. One said, “[D]octors have a tendency to blow off women and their concerns sometimes. It sounds like he didn't really inform her fully of what was going to happen with her sex life.” Another said, “I think a lot of times the doctors will, in their profession, they'll basically classify females alike to a certain extent.” Another felt that both the age and gender of the patient shaped the physician approach to patient care, saying, “I think he was just thinking at her age, why not just take it all out.”
The focus on gender, as well as considering the person as a whole, was brought up a few times. One said, “he needs to go to some more classes and learn more about, that women are real people, too, and that the issues of sex and, you know, emotionally, physically whatever, and that he needs to pay more attention to the whole person.” A woman in her mid-50s who has suffered numerous gynecological problems in recent years, and interacted with several different types of physicians as a result said,

I think it's very poor on the part of the physician. I think he's very poorly educated on the complete picture of a patient as a total person. My experience is that this is a common phenomenon with doctors, particularly in the age of specialization, because they are very attuned to their narrow specialty. And oftentimes their training does not include this wider view of the entire person and how the consequences of whatever the illness is will affect that person in all of the other areas of their life.

For some this story described a reality analogous to their own. Of the 44 women interviewed 17 (38.6%) volunteered that they had had a hysterectomy and referenced their own experience to respond to the story. Several others mentioned friends or family who had the surgery when replying to my questions. One said, “Well actually I have had that surgery - I had fibroids, so I can definitely relate to the story. From my perspective, visiting OB/GYNs, I feel more comfortable dealing with the nurse practitioners and talking to them.” A widow in her late 60s replied “Laughable,” when I asked her what she thought of the story. She continued, “I experienced something similar to this at the age of 34. First of all there is a difference after surgery. Also the doctors are not too much interested to hear about what you're situation is after this has taken place.” A concern that some physicians are not interested in their patients’ views, and do not show enough compassion, was raised by some of the physicians in their reactions to the hysterectomy story.
Physician Views of the Hysterectomy Vignette

Physicians shared some of the same concerns voiced by the women. Physicians were quick to mention that the doctor in the story did not appear to ask open-ended questions that may have clued him into what was important to the patient. A few said that he lacked or did not show empathy for his patient. Like the DHP women, several physicians pointed out gender and communication issues, but none of them raised the topic of a second opinion like so many of the women did. However, on the whole, they viewed the scenario in much the same way as the women.

Only eight physicians heard the hysterectomy story, seven attending physicians and one resident. The rest heard the HIV story or participated by only doing the survey and one of the CCM procedures. All of the physicians who heard this story said it was either typical or sort of typical. Several of the physicians, not surprisingly, focused on the procedural aspects of the story, but most were also attuned to the psychosocial aspects as well. One attending physician said,

Just the fact that we tend to be focused more on the technical aspects of the procedure and not as focused on the psychological or physical long-term effects… I've had some women tell me after a hysterectomy it's very liberating because they don't have to worry about getting pregnant anymore, and if they were having lots of pain before, the pain is gone. . . . So it can live up to its billing in other words, that everything does go well and everybody's happy afterwards. [But] I think we have to be aware that doesn't happen in every case.

A couple of the female attending physicians mentioned gender issues in physician-patient communication. One thought that the case was only sort of typical, but that it did not sound extreme either, and that it may have more to do with the physician’s specialty and gender.

I would think it might depend on if you're talking to a male surgeon specialist, as opposed to a female. I think it probably does make a little bit of difference because they're coming from such a different point of view, as far as their own experience.
We do have an advantage being a female taking care of females because you know what a vagina is and how it feels to be a woman and men just don't... Do I think this happens? Yes. Do I think it's real common, I would like to think not real common, but does it happen, yes.

Several physicians mentioned how they would have address the situation, usually mentioning the use of different types of questioning to ascertain that the patient understands what they have told them, and to learn what is important to the patient. The physician quoted above continued describing her own approach to talking to patients, saying

It sounds like he covered himself as far as legally what she can expect as possible complications. . . . But then there's this undercurrent of her concern about her human sexuality and potential complications, so it sounds like he should have explored that some more--I personally like to try to give people examples of situations that have developed and how people handle things. . . . The follow-up, seemed to me to be rather cold. . . . It sounds a little terse to say just have intercourse more frequently.

Another female attending physician was very bothered by the story, saying, “I think it's probably pretty common, up until the point where somebody says, ‘oh, you just need to have more sex.’” She continued, “I mean, that just really bugs me that he would say that... I think she needs to be reassured and hopefully he, you know, he remembers that she had concerns about her sex life before surgery and can really take a little more time and explain to her that this is not uncommon and that having more sex is not the answer at this point.”

Another physician reaffirmed this, and concurred with many of the DHP women who felt the physician in the story lacked compassion for his patient, saying it was “very inappropriate, inconsiderate, not responding really to her needs, and probably very paternalistic.” He felt it was typical from the patient's perspective, and continued “and typical also from the physician's perspective, in that I think physicians probably don't
spend as much time addressing these issues, as you demonstrated in the scenario.” A couple of physicians mentioned time issues impacting the scenario, saying that time constraints limited his ability to address his patient’s questions fully.

Another noticed that the doctor in the story used some medical jargon in his explanations, saying, “As a physician, I try to avoid terminology like that because people don’t know what you mean and they don’t know what questions to ask.” Only one physician said that he thought that, except for being more specific about the healing process, that both the patient and physician handled the situation well.

The fact that most of the physicians that were asked about their opinions of this story were family practice physicians may be indicative of their greater competency with psychosocial issues, since their training includes a broader focus on the whole patient and the patient across the life span. However, since these physicians found the story to be typical as well as troubling suggests that they recognize that many primary care physicians are not considering the “whole patient” in their practices.

The topic of considering the patient as a whole person and not just the ailment that they are seeking treatment for was also addressed with questions about physician sensitivity to the sexual side-effects of therapy or drugs.

**Sensitivity to Treatment Effects on Sex-life.**

The hysterectomy story was used to highlight the issue of post-treatment effects on sexuality. Following the story I asked respondents if they thought physicians were sensitive to how medical treatments or drug treatments affected their patient’s sex life. There is a possibility that this question was somewhat leading following a story in which the physician appeared insensitive to his patient’s sexual concerns. However, this
concern is ameliorated by the fact that the story elicited comments about the physician’s lack of compassion from both physician and DHP women before I asked this question.

Figure 5-2 shows that more than half of the DHP women felt that physicians were not sensitive (n=15, 34.1%), or most of them were not sensitive (n=12, 27.3%), to how medical treatments or drug treatments affected a patient’s sex life, and two-thirds of the physicians felt that way (12.5% and 50% respectively). However, only eight physicians were asked this question, so 50% only represents the views of four respondents.

![Bar Chart]

**Figure 5-2. Physicians Sensitive to How Medical and Drug Treatments Effect Sex-life.**

Time constraints were brought up frequently by both samples on this topic. One physician noted that bringing-up sexuality issues can be very time consuming and therefore physicians try to avoid the topic. He explained,

I think that's an issue; I think many times today we--and I'm probably guilty at times--don't spend enough time, don't feel we have enough time with our patients. We kind of circumvent some of these issues. Some of them, like sexuality, you're kind of opening a can of worms once you get into it - it can be a long discussion…it can really kind of set you back in terms of your schedule that afternoon or whatever. So I think many times. . . too many times it's avoided.
DHP women considered the issue of time constraints as well, one saying that oftentimes there are too many competing issues, saying, “No, I just think they're more or less concerned about your health and if you're not going to be sick anymore. They'd really have the time to think about ‘Oh my patient's not having enjoyable sex.’”

Other DHP women felt that women patients in particular were shortchanged on this issue. One in her mid-50s said, “Not if it's a woman. If it's a man, they're going to do everything—but if it's a woman, they think that it's just all supposed to work. ‘Cause you don't have to get it up, you just have to spread your legs.” Another felt is was more of a problem related to the patient’s age. “I think it's still a hard subject to discuss and if you're not going to they're not going to either, especially with older people.” A physician had a similar response, saying, “I think there's definitely an ageism. We find a young couple, newly married; of course we're going to bring it up every time. When we see an older woman with breast cancer or starting chemotherapy for something, or an older woman past menopause, we wait for her to bring it up.”

Another of the physicians also raised the subject of age, but felt that it had more to do the physician age and maturity, and their background. One of the attending physicians said,

It has a lot to do with the maturity level of the individual [physician], maybe the spiritual background or the interpersonal dynamics. . . . I don't think many of them, whether they're residents or attendings, talk to the patients about the side effect and how that impacts patient's life. I think there's probably few and far between that actually talk about that or have any idea how much that can impact a couple's life.

Another attending physician expressed something similar. “I think amongst the older residents it's a little bit more relaxed. I think the kids who come right from high school to college to medical school, I think it does make a difference whether you're married or not, whether you've got kids or not, what your own personal sexual experience is.”
A 65-year-old widow raised the issues of time, money, age and gender in how these subjects are addressed when she answered this question, saying,

Not all the time, because they're not dealing in that area, because they mostly thinking about helping you otherwise, not thinking about sex. You know that's the last thing on their mind when they get busy, and making money. And they just like give you something quick to fix it, then get onto the next one. They're not thinking about how this might affect me, they're thinking that a woman when she gets over 45 she don't need sex. She's on the change anyway, you see.

Not all of the DHP women thought that physicians lacked sensitivity on this subject. One said that she is very happy with her physician, but said that she knows that if she wants information about side effects she has to ask about them specifically. Another confirmed this sentiment, saying, “I feel like doctors more or less expect patients to ask specific questions - I don't feel like doctors are thorough enough in explaining things to their patients. I think they more or less leave it up to the patient to be assertive and to ask questions.”

Clearly, from the responses to this question and to the vignette questions, many of the respondents expect patients to be pro-active, even though they realize that some older patients might be reluctant to raise the topic with their physician. As far as physicians are concerned their failure to raise the topic or even to make patients aware that it is safe to talk about sexuality is related to whether or not they perceive their patients as sexually active. In addition, perceptions of whether a patient is sexually active or not is most often centered on gender and age, and on a patient’s current partner status. However, partner status and level (or type) of sexual activity can change from one day to the next, meaning what may have no relevance for a patient today, may have relevance for the patient tomorrow.
Assuming Older Patients Are Sexually Active

I asked both sets of participants if they thought physicians should assume that mature patients are sexually active. Since not all patients are sexually active, some respondents found this question difficult to answer. This was not a survey question, so only the physicians that participated in the interviews were asked this question (n=18). Additionally, I neglected to ask one of the DHP women this question. Physicians overwhelmingly responded, “yes” to this question, whereas DHP women were split down the middle. The comparison of the two groups on this topic is statistically significant (Table 5-1).

Table 5-1. Cross-Tabulation of DHP Women and Physicians and Assuming Older Patients Are Sexually Active

<table>
<thead>
<tr>
<th></th>
<th>Yes, Assume number (%)</th>
<th>No, or Don’t Assume, Ask number (%)</th>
<th>Fisher’s Exact Test 2-sided exact significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>DHP Women</td>
<td>22 (51.2)</td>
<td>21 (48.8)</td>
<td>.023</td>
</tr>
<tr>
<td>Physicians</td>
<td>15 (83.3)</td>
<td>3 (16.7)</td>
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The distinction centers on physicians wanting to err on the side of assuming patients are sexually active so that they do not miss something important to a diagnosis, and half of the women wanting physicians to ask about patients’ sexual activity so that they understand their patients as individuals, rather than assuming something that might not be true. One of the DHP women explained her difficulty in answering this question.

You know, that is hard to say. Because I know, as I get older, I'm not as sexually active as I was earlier. But you know, I know other people older than me, and they've got a new boyfriend and all. . . . I don't know how to answer that. Put it like this, I don't think the doctor should assume that. They should just go along with the doctor patient relationship, find out what's what and go on from there. But they should never assume because you never know when it comes to sex.

Some of the DHP women who responded “yes” to this question pointed out that appearances may be deceiving, and that current situations are not necessarily indicative
of what their futures hold. A widow in her late 40s who has a new partner explained this well using her own situation.

I would think that any doctor should think that their patient is sexually active unless they're told otherwise. I would think that—all right, take my situation. I'm widowed and a doctor might just automatically—people might automatically assume that I'm not sexually active because of it. But that would be the wrong way to look at it. I think a doctor should assume you're active unless they're told otherwise, that way they're not missing something.

One of the attending physicians supported this point of view, and acknowledged that he had made the wrong assumption sometimes and that he catches himself stereotyping older patients as sexually inactive. “I think you should assume that. I don't think they all are, but you should assume that. . . . I tend to assume too often that they are not sexually active. I think this is kind of a stereotype that goes on in my mind.” Another attending physician concurred, drawing on her own clinical experiences and misjudgments on this issue, saying, “I think we should assume it because . . . we've had older patients with HIV that people just assumed weren't sexually active. And you know, I had a patient with syphilis and I just assumed that she wasn't sexually active.” These types of scenarios are what the physicians that supported the practice of assuming older patients are sexually active are hoping to avoid. She continued to describe her point of view on the matter, “I think it's a dangerous thing to assume that there's a certain age at which people—sex becomes no longer important or people are no longer able to do it, because I think it's a real important part of who we are as people.” Finally, one of the DHP women raised the issue of on-going changes in an individual’s sexual activity. She is separated and does not have a current partner, but expects to begin dating soon. She said, “Yes. We're all human. . . . Yes, they should assume that they're sexually active. They may not be, but if they're not right now they probably will be later.”
Many of the DHP women were bothered with the notion of physicians making assumptions, and most felt that physicians should ask their patients about it to be sure. One divorced woman in her late 40s was quite adamant, saying, “Never assume anything. Period. Nobody should ever assume anything.” Another said, “No, because like I said, in assuming, you don't really know. . . . It's better to be sure than assume, because with assumptions sometimes you miss out on something that's important. So you just need to know.” Several were very clear that they thought that physicians should raise the issue to be sure. One said, “Some are and some aren't, so I don't think a doctor should make that assumption. But I think they could bring [it] up, then the patient could say, ‘well you know, doctor, I don't have any sexual partners.’ But raising the issues, I think it's important to raise the issues, certainly.”

Only three of the physicians thought that it was inappropriate to assume that older patients are sexually active, and one resident said that it was a matter of asking patients about it. Another resident was more reticent and worried about irritating patients, saying, “No. Because you'll really tick off that one person who's not to no end.” However an attending physician who thought it was good to assume patients are sexually active, but that it was important to ask to be sure, was not concerned about upsetting his patients, saying, “Yes, I think that's a good place to start and you can always laugh. I haven't had anybody ever be offended by me asking.”

In some cases assumptions about sexual inactivity based on a patient’s advanced age proved to be erroneous. This type of stereotyping can be dangerous to a patient’s health, as can other kinds of stereotyping. The physicians’ and DHP women’s comments about the hysterectomy story, and their assumptions about sexual activity or inactivity of
older patients, indicate that age and gender stereotypes are problematic in many encounters.

**Physician Gender**

The literature suggests that women and men physicians talk to their patients differently. Although not always the case, women physicians are generally thought to be better listeners, to interrupt their patients less often, and to be more empathetic (Adelman et al. 1991; Cline and McKenzie 1998; Hall and Roter 2002; Haug 1996; Lorber 1997; Roter and Hall 1998; Street 2002; West 1984). To get a better understanding of how gender impacts the clinical encounter, I asked the DHP women if they thought that women physicians and men physicians communicated to their women patients in the same way. Their comments about the hysterectomy vignette showed that they have strong opinions about differences between women and men physicians. Two-thirds (n=29, 66%) thought that women physician used different communication styles (Figure 5-3). However, their comments on the topic reveal that the issue is much more nuanced than these figures indicate.

![Figure 5-3. Female and Male Doctors Talk to Their Women Patients in the Same Way.](image-url)
Six of the respondents (14%) thought that there was no difference between women and men physicians. A woman in her late 40s thought that she had ample experience with physicians to answer the question because she has four children and has undergone a hysterectomy for fibroids. She felt that women and men physician relate to their women patients in much the same way. “I used to think men didn't understand… I used to think that men were rougher or harder to talk to, but I think that was me being tense. Well, maybe it's a new generation of men too, they've grown as I've grown, and they're more open…” A few women echoed this sentiment, and several said that it was more of an individual personality issue than a gender issue. Just over 15% felt that sometimes it can be helpful to speak with a woman physician, and sometimes it makes no difference. A 45-year-old woman said, “I've been to both and I think that that is a definite individual thing. You can get an individual male doctor who's very attentive and caring, you can get a woman doctor who's very, very professional and all that. . . . I don't think it matters.” A couple pointed out that since they undergo the same training they often behave in much the same way. One woman in her mid-50s related the story of how she felt after an encounter with a male and female physician.

Talking about sexuality issues . . . I mean it's easier for me to open up and start talking when it's a woman than a man, but the woman is still busy and she--you know, and the guy is busy and the woman's busy, and it seems like they weren't really hearing what I was saying and I went away feeling like, well did I appear to be a fool, you know. . . . So I come away feeling misunderstood-- and maybe she did understand a little bit more, but she still felt a little cold and distant, to the point where I came away I didn't feel totally comfortable about the whole thing.

Another in her early 50s seemed to have a similar feeling as the one above saying,

I don't know. I've mainly had male doctors. . . . I would hope the women doctors would be more sensitive to female issues and listening, but I remember years ago going to a female gynecologist and she wasn't any different from the male ones. I think it's just an individual thing, finding the person who will listen to you and make you feel comfortable.
This theme of feeling comfortable was brought up often. Many women mentioned that they wanted to be listened to, and to feel like their physician cared about them as an individual. Most often this sense of being listened to and feeling comfortable was linked with interactions with female physicians, but not always. A widow that came from a military background said that she felt more comfortable with female doctors, but that in the military she often did not have a choice, and was grateful to some of the compassionate male physician she had encountered.

There are some male doctors that are just as warm and caring--everybody's different, everybody's not the same. I feel more comfortable with a female doctor because I think they understand, although being in the military I didn't have lots of choices like that. . . . The last doctor that I did see on the base he was very good and he made me feel comfortable with him. . . . He looked me straight in the eye. He was just very good and as a military doctor I appreciated that more than they'll know.

Most felt that a woman physician could understand or relate to them better by virtue of being a woman. Many repeated something similar to the following statement by a 47-year-old, “I think a female doctor could probably relate to female health problems more than a man could. A man can go to medical school but he's not really experienced what it's like to be a woman. I don't think that can be explained.” Some were concerned with male physicians thinking that all women are alike, as this woman in her late 40s pointed out, “You don't want him to think that you're in a category, 'cause everybody doesn't feel the same. Just, I'm different from Jane who just came in and Mary that's going to come in after me. . . . I don't care what you tell me, a guy doesn't know how you feel.”

There was a clear preference for female physicians, particularly for GYN visits. A widow in her late 60s said she’d prefer not to go to any physician, but continued, “it would depend, if it was a female area, I would go to a female. If it was my heart or my
intestinal whatever, it wouldn't bother me to go to a man. But if it's GYN, then I would prefer a female, only because they would be more in tune to what you're trying to say.”

A few women factored in the age of the physician. One woman in her mid-40s said,

I think that a female doctor can usually understand issues better because they're women themselves. In my personal case, it would be if the doctor's a female instead of male, and be of like age. I don't really think . . . I'd feel as comfortable speaking to a woman who was just out of medical school in her early 20s… I prefer a woman who's at least as old as I am or slightly older, who's been there and done that.

Another said,

I haven't really met a doctor that's very sensitive. But then, most of your gynecologists and stuff that you go to are men . . . I don't think women are comfortable, really, talking to men about any sexual problems or whatever. But then again it could be a question of age in that situation, whether it's male or female. A female would be more likely to understand but if she has not been through menopause . . . then they're not going to understand as well either.

Some felt that women physicians did not seem as rushed as men physicians. One said, “I think female doctors are just a little bit more understanding, and a little bit more comfortable. Male doctors I think—and not all of them, some of them--they just get in, examine, diagnose, treat, and move on.” A few took the issue a step further, saying that they prefer seeing a female nurse practitioner, saying that they don’t seem as hurried as physicians, and since they are usually female, it is more comfortable to interact with them. One explained how she felt about the clinical encounter with physicians versus nurse practitioners.

Well you're there in the examining room. . . . I think you're basically at a disadvantage in that you're usually sitting there with no clothes on, basically undressed, waiting to talk to a doctor, so that's intimidating. And the doctor rushes in and says something to you, then examines you, so that can be also intimidating and disconcerting. I personally feel more comfortable with nurse practitioners than I do with male physicians. . . . The nurse practitioners that I've dealt with—I've just been able to communicate and to feel more comfortable, and feel more warmth, and even though . . . they're as busy as sometimes the doctors are, but I just feel they're more gentle, more caring.
Only three DHP women mentioned nurse practitioners, though it is possible that some women were not aware that they were visiting a nurse when they were referring to women physicians. I usually asked them if they were sure that they had seen a physician and not a nurse practitioner, and most felt certain that they had seen physicians.

These comments about differences between women and men physicians are consistent with previous research (Nusbaum et al. 2002) on gender issues in clinical talk about sexuality. This project confirms that women can feel comfortable discussing sexuality topics with both women and men physicians, but that they were more likely to discuss them with women and with physicians that create a comfortable atmosphere, one that’s conducive to discussing sensitive issues.

**Preferences for women physicians.** Twenty of the DHP women expressed a preference for women physicians (45.5%), but just over a quarter (n=12, 27.3%) said they had no preference. I neglected to ask this question to three of the respondents and five were unclear about their preference. African American women were a little less likely to have visited a female physician, but their views about differences between men and women physicians were similar to those of the Euro-American women. However, four of the African Americans said that they preferred male physicians, whereas none of the Euro-American women expressed this preference (Figure 5-4). These distinctions, though interesting, may be more a function of the small sample size than of any real ethnic differences. It may also be related to age and SES influences on the number and type of physicians they have seen.

The Black women espousing this preference were those who had little to no experience interacting with female physicians. Distinctions by age, educational level and
other variables were unremarkable. One African American widow in her mid-50s described her experiences this way, “I've never had a female doctor--I've always had a male doctor, and I find that I get along better with a male physician, 'cause I've never had a female, so I don't know how to accept a female, but I think I could talk to her.” However, most African American women expressed a preference for a woman physician and reasoned that women could relate better to other women than men. One put it this way, “A female doctor tends to be more empathetic because she's a female and I'm a female so we understand each other. I can relax more with a female doctor when I'm having to discuss personal things, like sexuality and stuff like that.”

Figure 5-4. DHP Women’s Preferences Regarding Physician Gender by Ethnicity.

These perceptions about physicians’ gender correlate with previous research on the topic. Most studies on the influence of the physician's gender on interaction patterns indicate that the gender of physicians and patients make a difference in medical practice (Adelman et al. 1991; Cline and McKenzie 1998; Hall and Roter 2002; Haug 1996; Lorber 1997; Roter and Hall 1998; Street 2002; West 1984). Just as in the statements
from most of the DHP women, other research shows that female physicians are thought to be more apt to provide support to their patients, to be more egalitarian, and to give more time to consultation than their male counterparts (Adelman et al. 1991; Haug 1996; Lorber 1997; Roter and Hall 1998).

According to Lorber (1997) gender differences in communication styles are likely related to life-long socialization and interaction patterns. Street (2002) writes that physician and patient gender stereotypes and attitudes likely generate a priori assumptions about the capacities of each other for both gender concordance and discordance in clinical communication. Many of the women in this study appear to support Street’s thesis in their assumptions about the nature and interaction patterns of women and men physicians. However, some reported that these notions based on gender stereotypes were not always supported in practice. Some of these women also volunteered that they believed that age concordance was also an important factor for being able to relate to the woman physician, yet the issue of ethnoracial concordance in physician interactions was not volunteered. Nevertheless, the question about the physician gender easily flowed into questions about the physician’s ethnicity.

**Ethnicity Concordance in the Clinical Encounter**

Studies show that for patients with similar clinical findings there are differences by ethnicity in treatment, amount of information provided, and empathy displayed by physicians (Adler 1998; Cline and McKenzie 1998; Cooper-Patrick et al. 1999; Schneider et al. 2002; Woo et al. 2004). Race-concordant visits tend to be longer and are often rated as having more positive affect (Cooper et al. 2003). However, the comments from the women in my study do not tend to support the findings from previous studies. The studies often included pre- and post surveys as well and audiotape analysis of the actual
encounters, whereas my study asked respondents 1) if they thought the ethnicity of either
actor impacted the interaction; 2) if they thought Blacks and Whites were treated the
same; and 3) if they thought they were treated as well as anyone else (Appendix C). The
differences between my study design and the designs of those in the literature review, as
well as race concordant interviews may be an explanation for the different results.
However, as I will describe in the following section, some of my research experiences
with this project suggest that there may not have been a strong interviewer effect on this
topic. The question that physicians were asked about the race/ethnicity (Do you think the
ethnic background (or race) of a patient affects how physicians communicate with them?)
is not readily comparable to the DHP women data and is therefore not addressed here.
This and other similar topics will be discussed under the limitations section in chapter
seven.

One nationally representative survey found that race/ethnicity is not the only factor
affecting the quality of physician-patient interactions. The survey over-sampled for
Black, Hispanic and Asian households and found that race/ethnicity discordance
contributed minimally to the quality of interactions, and was better explained by
differences in physician’s cultural sensitivity and in patients’ health literacy (Saha,
Arbelaez, and Cooper 2003). Some of the comments in this study suggest that the
physician’s demeanor and patient expectations may be as important or more important
than race/ethnicity concordance. My study shows that cultural and language differences
are also important issues in race/ethnicity discordant encounters, and for some more
important than racial concordance.
Over a third (n=17) of the DHP women thought that the race or ethnicity of the physician did not impact physician-patient communication (Figure 5-5), but 18% (n=8) thought that it was an important factor. The question, “Does the race or ethnicity of the doctor effect how they communicate with their women patients?” elicited a lot of comments about physicians from other countries and their English language skills. Many of the women had encountered “foreign doctors” and expressed a range of opinions about them. This is actually the reason that many of the White women and a few of the Black women mentioned as a reason for ethnic differences.

Interestingly, Black women were twice as likely as White women to think that race/ethnicity did not matter (55% and 26% respectively). This finding is contrary to most previous findings on the topic of race concordance. Even though there were some marked ethnic differences between respondents on this question, the differences were not statistically significant due to the small sample size (Figure 5-6).
One Black woman in her late 40s said, “Well the only thing I think in the doctor field [is] if it's a foreign person; sometimes you can't understand what they're saying as far as their words, but I mean you know if you speak plain English you shouldn't have no fear” She continued, “No, cause if you're going to a doctor and you want to get well you shouldn't care who he is.” But then she conceded, “Yeah, I imagine it is in some places, some issues, some people still got that old mentality in them and so, they probably do have a racial issue.” This back and forth between affirmative and negative responses about race/ethnicity discordance was common, and several made the distinction between themselves and others they know on the issue.

A White woman in her mid-40s who thought that it made a difference sometimes, explained “Well older people--it doesn't bother me about race--but older people it's really an issue with. Because my granny she would say, ‘I'm not going to see a Black doctor’ and I'm like ‘you might have to, this is today.’ ‘Yeah it would bother her real bad.”
About a quarter of all the women, mentioned the issue of language or culture in response to this question. Many made the distinction between doctors with different nationalities and their English language skills did not mention differences between African-American and Euro-American doctors.

A White woman in her late 40s said,

I would say it's probably just because different cultures treat older people differently. Plus, I think, and if you can't understand the doctor, their English or whatever, that would cause problems as well because I have been to a doctor that I could not understand a thing that he said.

Another said, “Well I prefer not to have a foreign doctor. I've had a few [and] sometimes it's kind of hard to understand their dialect.” A White woman in her early 60s was very direct about it, saying, “No, it has nothing to do with it. Except for, sorry if you are, anybody with the last name of Patel, I will not go to them… I don't know I don't like them.” This reticence to seeing a foreign doctor came up a few other times.

A White woman in her mid-40s pointed to how cultural issues intertwine with gender issues in the interaction, saying, “I'm only guessing there are certain cultures that have a different place in mind for women. They aren't necessary thinking of them as equals and if they hadn't worked through that then maybe they'd be more condescending and less open.”

As in the case of gender differences, a few women felt that personality was more important than race/ethnicity. A Black woman in her early 50s, who thought that it depended on the individual physician, not their ethnic background, said, “I've had them all and some of the make you feel comfortable and others, it's just a job. So I don't really think it matters.” Another said, “Not really, if…you really enjoy being a doctor and you know you can help someone it shouldn't matter.” A Black woman in her late 50s echoed
this sentiment saying, “No, I'm going to say no, and their ethnic background shouldn't have anything to do with it. I've had one Black doctor, I've had foreign doctors, I've had White doctors [and] so far they're okay.”

Even though race/ethnicity concordance in physician visits was not an issue to most of these women, about a third of the African American women related unpleasant experiences to me that had to do with the physician’s race or the physician’s competence in interracial clinical encounters. Whether or not an African American interviewer would have heard more of these stories remains an open question. However, the fact that a third of the Black women felt comfortable enough to tell me about their unpleasant experiences, suggest that my ethnicity did not always unduly influence these interviews. One case in point on this is when I interviewed two African American women in the same room together, one right after the other. These women were friends and had shared a ride to the interview. Each, if she was interested, could listen to the responses of the other.

On the whole they had very different responses to the interview questions, and on the racial topics as well. The woman in her early 50s related this story to me about a White doctor that she felt unfairly judged her based on her color, gender and economic status.

I have had experiences in that area where I was eligible for a service, but I really feel like with me being Black and a female--and [I] ended up filing a claim, because of the way the doctor talked to me and he had given me injections and, [saying]... ‘you can't feel [it].’ So he was saying, ‘well there's no way you can still feel it.’ It was like he was saying I just wanted something because the service was free… I just got up and left because of the way he was talking to me and I let him know that I was going to take action because of the way he had talked to me. Because if you fall eligible for something--then I still have my rights, and I'm not going to allow anyone to talk to me or belittle me [just] because I'm in this situation. You're not just going to disrespect me and take my integrity from me.
Her friend, on the other hand, had never had such an experience and felt that race and ethnicity were not important factors in clinical interactions.

The story above was not the only one that demonstrated socioeconomic and race/ethnicity stereotyping. Some told stories about how physicians did not understand cultural differences in dealing with illness and death. Others told of personal account of how they felt they had been treated poorly, as in the case of the woman above, and reacting proactively to maintain their dignity. A woman in her late 40s talked about how the interaction patterns of the physicians exposes their biases.

Yeah...you can just feel it from the tone of their voice, if they are being short with you, don't want to touch you, you know then right off the bat that they are not comfortable treating me. . . . Some people don't speak up... but I just stop the appointment right there. . . . If I am spending my money for a service then I should get what ever, I should feel comfortable...

Another woman in her late 40s gave me a detailed account of a racist White doctor and how the experience made her feel.

Well let's just say I've had--the story I was telling you about is. He was a White doctor... I don't know if they were using me for a guinea pig or whatever, but he treated me as though I was somebody just found off the street and my whole body was ridden with a disease. This was what really got me when...he says 'you people' and I've always had a thing, because when I was growing up that we're 'you people' and it always has a stigma with me. ‘What do you mean you people--they're categorizing people. He says ‘you people go out and do things with your body.’ I'm like gosh, I'm in pain and he was adding pain onto top of pain. He was demoralizing me. . . . It might not be like that now, because like I said, that was in the . . . late 70s, early 80s. It's probably not like that now, but when you have one bad incident you kind of carry it with you. You don't forget, you forgive, but now I'm very particular about a doctor that would categorize [me] as ‘you people.’

Her candor with me, and that of others, indicates that race concordant interviewing may not always be as crucial as some researchers have suggested. Additionally, the wording of the interview questions, and the demeanor of the interviewer may ameliorate some of the interviewer effects. As a cultural anthropologist, I endeavored to always take
the approach that I am seeking to learn from my informants—they are the teachers and I am the student, eager to learn about their lives and views of the world around them. This is a time-tested approach to cross-cultural interactions, which ideally yields emic accounts of the topic under study. However, it is likely that my approach did not provide a sufficient comfort zone to all of the women in this study, and some women may have told an African American interviewer very different stories.

While a third of the African American women openly told me about unpleasant interracial patient-physician encounters, just over a quarter of White women told me they lacked experience in this area due to their race. The White women were much more likely than Black women to say they did not know if there were differences or not with regard to interracial clinical encounters (26% and 10% respectively), explaining that they had not had any experience with that situation. This issue of feeling like they lacked the requisite experience to answer this question also came up when I asked if Blacks and Whites were treated the same.

**Blacks and Whites treated the same in clinical encounters.** The DHP women were relatively evenly split on the topic of whether or not Blacks and Whites are treated the same in clinical settings. Just over a quarter think Blacks and Whites are treated differently (25.6%), 23.3% think they are treated the same, and the same amount said they are sometimes treated differently and sometimes the same, and 27.9% said that they did not know. I neglected to ask this question of the first African American woman I interviewed.

The relative balance in responses is lost, however, when the ethnic groups are compared. Cross-tabulation of ethnicity by their opinions on this issue showed that close
to half of the White women responded “don’t know”, usually based on lack of exposure to the issue. Chi-square analysis showed that these differences were significant (Table 5-2). These are interesting findings in that they further refute the previous studies on race and physician-patient interactions. Although I have not found any studies that ask this specific question or one similar to it, the studies on racial issues in health care suggest that African Americans are often less satisfied with their interactions than Whites.

Several of the White women said something similar to the following statement by a woman in her mid-40s. “I'd like to say no, but I'm honestly not sure of that, and being Caucasian and not faced with a lot of prejudice I don't think I'm really knowledgeable enough to answer that accurately.” This sense of not having sufficient experience was common, however others were much less reticent.

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Yes, same Number (%)</th>
<th>No, different Number (%)</th>
<th>Sometimes yes/no Number (%)</th>
<th>Don’t know Number (%)</th>
<th>Likelihood Ratio Value (2-sided sig.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blk/African-American</td>
<td>8 (42.1)</td>
<td>5 (26.3)</td>
<td>5 (26.3)</td>
<td>1 (5.3)</td>
<td>13.427 (.004) df=3</td>
</tr>
<tr>
<td>Wht/Euro-American</td>
<td>2 (8.7)</td>
<td>6 (26.1)</td>
<td>4 (17.4)</td>
<td>11 (47.8)</td>
<td></td>
</tr>
</tbody>
</table>

Some of the women, regardless of ethnicity, raised the issue of SES as a more important factor than racial group, or as a factor linked to ethnicity. One White woman in her early 50s said, “If you have somebody who seems to be uneducated, they kind of tend to talk down to you, whereas if you seem educated they get into a more conversation with you.” One of the Black women who related one of the stories about maltreatment by a White doctor in the previous section, also brought up socioeconomic issues, saying,

Patients are intimidated by those who are well educated. It's just possible that they could come from a poverty area and not know how to address the issue. . . . Financial, insurance, there's a lot of things that contribute to how a physician would
address or help a patient. There are those who are truly dedicated, through the oath that they take, and then are those that, for money.

Several women, including the woman who selected “other” for ethnic identity, raised the issue of finances and insurance. “So everything is money and what kind of insurance you have, they treat you differently depending on that.” However, she continued that ethnicity had also been an important factor in her treatment. “Like I said, I'm an American citizen but I wasn't born in America and I have accent. People show reaction toward this and they treated me differently. In some cases I've been target of prejudice and ignorance and discrimination and it was very frustrating and painful for me.” A White woman also mentioned insurance coverage, saying, “Yes, [they are treated the same] if they're have insurance. [If not,] you can forget it, they're not going to talk to you.”

The fact that 42% (n=8) of the Black women thought that Blacks and Whites were treated the same is well qualified by this statement about income level and color from a Black woman in her late 40s,

Yes, I think they treat them the same, but I think your economic value is different. I mean you're treated different according to your income level. So I don't think it's a color thing, I think it's an income thing. Because I feel that people that are on the poverty level are treated different than the people are who have a higher income. I don't think it's anything about color.

Another woman the same age based her ideas on this issue on her personal experiences. “I've actually never seen a case where they were treated any differently because of their color. I really haven't seen that because we've all got the same body. So if there are some that have treated me any different because I'm Black--I really haven't gone through that.” Another Black woman in her late 50s had a similar response, saying, “I believe that from the experience I've had, yes [they are treated the same]. Yeah, I've talked to
people who have been in the offices of my doctor, but the women all say the same thing. White women, Chinese women; they love him.”

However not all of the Black women were so positive, explaining that they believed that their were still problematic issues in interracial clinical encounters. A 48 year old Black woman said, “I think they take more time to listen to a White person… Some of them don't listen to your problem 'cause I know I had a doctor that...tell me it's in my mind, before I even get it out of my mouth.” Another Black woman described an experience she had where she was treated differently than a White woman patient.

I have noticed different cases where, as far as how they greet you when you come up to the desk for your appointment. Maybe if you arrived a little bit late and you were trying to explain to them your situation and they may tell me, ‘well you're just going to have to reschedule and make another appointment.’ Then someone else comes in late of a different race and they'll say, ‘okay, I'm going to see what I can do.’ And being a single parent 27 years I've noticed a whole lot. It's getting better but it's still there.

Several of the DHP women recognized that prejudice and discrimination still exist in physician-patient relations, and some based this on personal experiences such as the story above. Many had the notion that socioeconomic factors were more important than racial factors, and others thought that the issues were some amalgam of racial influences, income level, insurance coverage, and educational background. On the other hand, some had never experienced the effects of racial stereotypes, leaving them feeling ill equipped to respond to the question. Still others felt it was not a problem, or usually not a problem. One African American woman didn’t see this as so much of a discrimination issue as simply one of cultural differences, saying “Different people have been taught different things in their cultures…and there are a lot of things in your culture--that you use different terminology for different things and they may not feel comfortable discussing certain things with the doctor.” She appeared to feel that racial concordance was an ideal
situation, particularly for discussing sensitive issues, noting that patients may not raise sensitive topics they are concerned about with physicians with other ethnic backgrounds. This issue of comfort level in discussing sensitive issues is shaped by the clinical atmosphere, SES, gender, age and ethnicity issues, as well as by expectations about the roles of physicians and patients.

Physician/Patient Responsibility to Raise Sexual Health Topics

Previous research indicates that most patients want their physicians to create an atmosphere favorable to discussing sensitive issues, if not outright asking them about such issues (Loehr et al. 1997; Metz and Seifert 1990; Nusbaum et al. 2002; Waterhouse 1993). Ideas regarding whether or not it was the physician’s or the patient’s responsibility to raise sexual health topics yielded some unexpected findings. The DHP women were much more inclined to think that it was the patient’s responsibility to bring up sexual health topics than were physicians. A comparison between the two groups was significant (Table 5-3). It was surprising to see almost half of the DHP women place the onus of responsibility on the patient. However, their comments following their response to this question showed that they place the responsibility of providing an atmosphere conducive to discuss sensitive topics on the physicians.

Table 5-3. Cross-Tabulation of Physician/Patient Responsibility.

<table>
<thead>
<tr>
<th>ID</th>
<th>Physician’s Responsibility Number (%)</th>
<th>Patients Responsibility Number (%)</th>
<th>Both Responsible Number (%)</th>
<th>Likelihood Ratio Value (2-sided sig.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>DHP women</td>
<td>12 (27.9)</td>
<td>19 (44.2)</td>
<td>12 (27.9)</td>
<td>26.003 (.000)</td>
</tr>
<tr>
<td>Physicians</td>
<td>7 (25.9)</td>
<td>0 (0)</td>
<td>20 (74.1)</td>
<td>df =2</td>
</tr>
</tbody>
</table>

Many of the women that said they thought it was the responsibility of the patient to raise sexual health topics also said that physicians needed to “open the door” to make patients feel it was “OK” to talk about it. A woman in her late 40s, put it this way,
I think it's the patient's [responsibility], but I wish the doctors would ask more inviting questions. Invite people or show that they're open, even if it is a shy older woman, 'cause he's being paid and he's educated and maybe she's not asking or is ignorant, and he won't know if he doesn't ask; it's his job.

Another pointed out that patients have to ask questions, because the physician is not going to bring it up, saying “If you have a specific question, don't wait for them to ask you, you're just going to have to either write it down and ask and open up the dialogue yourself.” Although, at first glance, it appears that the DHP women are placing more responsibility on patients, closer inspection reveals that this is linked to expectations about physician behavior.

Over a quarter (27.9%) of the DHP women thought that it was the physician’s responsibility to raise the topic, and the same percentage thought it was the responsibility of both parties. Whereas almost three-quarters (74.1%) of physicians thought that both were responsible, and over a quarter (25.9%) thought that it was the physician’s role to raise the issue. Those that said “both” usually felt that it was either more the physician’s role to raise the topic, or they placed a little more of the onus on the patient. For example, one of the DHP women said,

I think it's a little of both. I mean because, if the patient is--has any concerns she needs to ask the doctor, but then again…it would depend on what they were there for. If it was anything that had to do with sexual stuff I would think the doctor should bring something up, or offer a booklet or at least have them available in his office, so that if you're curious you can pick something up and go home and read it at your leisure.

Another woman said, “I want to say both, but I think that the patient, where they may be intimidated or embarrassed, that I think the doctor might need to take a little bit of that into their hands.” One woman in her mid-50s, who has unfortunately had a lot of recent experiences with physicians, explained her response this way.
In a sense, both parties are [responsible], but we can't do anything about every woman out there that going to come to the doctor. The population we can actually affect is the physician population; so let's look at a short list of what we can actually do with these physicians so that they can take the bulk of the responsibility. That may not be fair, but once the doctor's prepared to realize that this is an important part of a woman's life and all that kind of stuff . . .

This suggestion about physician training is of particular interest since most of the physicians in this study are part of a family practice residency program. The vast majority of both resident and attending physicians thought that both parties were responsible for bringing up sexual health concerns, but most place more of the responsibility on the physician. One attending said, “It's both. But I think a physician has to be a leader in opening the door for that, and make the patient feel comfortable with it--not just that but other personal issues. I think it's the physician's responsibility to make the setting or the situation conducive to that type of discussion. Otherwise it won't take place.” One of the residents was less obliging, saying, “The physician can't be expected to just dig for everything. It's got to be understood from the beginning that it is a team effort and your physician's there to help you if you give him the opportunity.” Another resident said,

That's tough. I think the patient will bring it up if there's an issue. . . . But I think it's the physician's obligation to bring out that subject. I think the physician has the duty to bring this issue, whenever they talk with the patient. . . . Sometimes it's difficult to bring that up, busy schedule in the clinic each day, and sometimes you don't think of it And that's the truth-- you don't think of it.

Several physicians, not surprisingly considered time an important factor in shaping which issues they discussed with patients. One attending physician explained that she thinks both parties are responsible and that time issues limit the number of topics that a physician can raise.

I think we are very remiss in doing it. And again, part of it has to do with one of your other questions, you know, ‘do we have time?’ . . . When we have a 15-minute session we have three or four chronic medical problems that we must address,
sometimes you know, that's just like a luxury question that you don't have time to cover. . . . So I think time is a big issue there.

She continued, explaining that she believes patients also have an important role to play in the exchange.

I do think it is also the patient has responsibility, because if it is something that is worrying them or concerning them, and we see this all too often where they have a vaginal discharge but it's almost like they're waiting for me to by mental telepathy figure out that they have a problem. And so I do think that they have a responsibility particularly if they have questions or concerns or they're having an issue to bring it to the physician's attention and not expect us to be a magician, genie, you know, person to try to figure it out without and that happens quite a bit.

However another attending physician agreed that both were responsible, but considered the physician more obligated to raise the issue, particularly with older patients, saying,

I would say definitely the older the patient the more the onus is on the doctor to do that. Again it goes back to cultural and generational differences I think are there. So I think it is more important for me to bring up with my older patients because . . . the older the patient is the less likely they would be to be comfortable bringing it up. . . Overall I would say it's the physician's responsibility.

Many of the DHP women would agree with the statement above, in that in the end it is the role of the doctor to create a setting where these issues can be discussed. One said, “I think it would be more comfortable if the doctor brought it up--at least they would open the door and you would feel more comfortable talking about it.” Another said “I think it is the doctors [responsibility]. He should be trained to do that, and knowing that the average person will not bring that up . . . he should initiate it.”

Although close analysis of the comments from both samples suggest that most believe that physicians are obligated to create an environment conducive to discussing sensitive issues, it is clear that time limitations and notions that patients will bring it up if they need to, limit the actual discussion of sexual health topics. It is also related to
institutional constraints, in that, clinical practice norms dictate that physicians focus on only one or two ailments rather than considering their patients as individual wholes.

**Discussion and Conclusion**

In the process of discussing the vignette and responding to my questions about gender and race/ethnicity, several broader topics were exposed. Several of the DHP women made observations about the patient-provider dynamic, which support the findings in previous literature. One such point was the power dynamic inherent in the dyad, that patients are at a relative disadvantage in the clinical encounter. That is, they may be only partially clothed and feel vulnerable as a result, they are in unfamiliar territory where the language of clinical practice keeps them in the dark, and the provider dictates the rules of engagement. Health care communication scholars often describe the physician-patient exchange as hierarchical and intercultural, due to the hegemony of the biomedicine (Baer, Singer and Susser 1997); the structural power dynamics of modern medicine that places the physician as the pinnacle of the interaction structure (Baer et al. 1997; Cant and Sharma 2000; Henley 1977; Lorber 1997), and due to sociodemographic and structural differences between the participants, creating distance and misunderstandings (Cline and McKenzie 1998).

The DHP women and the physicians both pointed to structural aspects of health care interaction that impinge on the effectiveness of a clinical visit. Both raised the issue of time constraints. Physicians pointed out how time issues affected the number of topics they can talk about with patients, particularly older patients that are presenting with multiple illnesses, whereas many of the women focused on the hurried disposition physicians, and how this behavior leaves them feeling like the doctor is not interested in them as individuals. The increasing competitiveness of the health care system is leading
to institutionalization of impersonal and routinized care (Coulter and Fitzpatrick 2000),
which only compounds the time and financial pressures on physicians, and leaves
patients feeling neglected.

Doctors have greater power in the medical encounter by virtue of the fact that they
control access to health resources, as well as the dynamics of the health care interaction,
and that control is institutionally regulated and sanctioned (Cant and Sharma 2000;
Henley 1977; Lorber 1997). Some of the problems associated with physician-patient
interactions are related to contemporary time and financial constraints imposed by the
current health care systems, HMOs and clinic/hospital administrators (Lazarus 1988;
Paget 1993), but also because of the standard way that physicians manipulate the flow of
talk and ultimately the meaning of illness for their patients via constrictive
communication practices (Clark 1996; Good and Good 2000; Paget 1993). This
hierarchical exchange is in part developed in medical schools and residency programs,
where students and neophyte physicians learn to reconstruct the patient’s narrative in the
context of biomedical practice (Good and Good 2000).

Despite the inherent asymmetry of the physician-patient relationship, the DHP
women pointed out that patients are not passive objects in the exchange. They place a
heavy emphasis on patient responsibility in the clinical interaction, but tempered this
emphasis with what they perceived as the role of the physician in terms of providing a
safe environment for discussing sensitive issues. These women, while recognizing that
the system places constraints on how much physicians can do in a single visit, assert that
doctors need to find meaningful ways to show that they are interested in their patients
concerns. Physicians appear to be aware of what they need to do, but they note that they are sometimes remiss.

Some critical medical anthropologists point out that many patients react with what means they have to the existing social structure of the current health care system (Baer et al. 1997). Several of the stories in the pages of this chapter uncover such proactive behaviors or attitudes, such as women seeking second and third opinions, reporting maltreatment due to economic or racial discrimination, and seeking health information on their own.

Physician and patient stereotypes based on age, gender and ethnicity were extensive. This is consistent with previous research showing that both parties are influenced by gender, age and ethnoracial stereotypes in the clinical encounter (Cline and McKenzie 1998; Cooper-Patrick et al. 1999; Green et al. 1994; Hall and Roter 2002; Haug 1996; Ikels 1998; Jenks 1993; Street 2002). As hypothesized most DHP women considered the gender of the physician important and generally preferred women physicians, particularly to talk to about sexual health topics. They tended to think that most female physicians were more knowledgeable about female health issues, and that they were easier to talk to. Several felt strongly that a patient’s gender impacted how physicians related to them. The responses from some of the physicians appear to support the hypothesis that many will not consider sexual health issues relevant for older women patients. However, age and gender stereotypes are intertwined with time constraints and it is difficult to say which is most influential in clinical practice.

Their ideas about ethnic stereotypes were largely inconsistent with previous research. Except for a small proportion of African American women, few had
experienced racial stereotyping, though several thought that it still occurred in clinical practice. On the other hand, the impact of financial issues came up a number of times. Many of these women were very much aware that educational and economic status affected how physicians interact with patients. This is consistent with previous research showing that if physicians do not have a financial incentive for spending optimal time with a certain class of patients they are unlikely to do so (Allman et al. 1999). Jackson and George (1998) argue that minorities and members of lower socioeconomic classes are frequently assigned lower social value by health care providers, and that they tend to receive the substandard care. Some of the experiences of the women in this study support this contention. The physicians in this study, even though they treat a largely low-income population, did not appear cognizant of this issue in their practice. Perhaps this is due to the fact that most of their patients are poor and reflections about differences in treatment are moot since there is no frame of comparison.

This chapter shows that women and physicians share some common expectations about the clinical encounter, particularly in terms of the role patients and physicians should take in clinical talk about sexual health. Unfortunately, structural and institutional factors impede the communication process, perhaps as much as age-, gender-, SES-, and ethnicity-based assumptions.

Several of the women and physicians mentioned time issues in their comments about physician-patient communication. This topic, along with comments about physicians listening to their patients, interruptions in discourse, and concerns about the impact of financial issues in health care were all discussed. There are clues to how the respondents felt about these topics in the discussion of physician-patient responsibility,
assumptions about sexual activity of patients, and reactions to the vignette, but there is much more detail contained in these data that there was not ample space or time to explore here. The next chapter addresses the HIV-related data in this project, and links that data with the CCM data and clinical communication about sexual health.
CHAPTER 6
PERCEPTIONS OF HIV RISK

Introduction

The last chapter briefly raised the issue of physician-patient communication about HIV and other STDs, and HIV risk perceptions among the DHP women, under the topic of sexuality and aging. This chapter focuses on the data gathered through this project that specifically deals with HIV risk perceptions among midlife and older women, physicians’ notions about HIV risk for their aging patients, and further explores the topic of clinical communication about sexual health.

As pointed out in Chapter 2, HIV infection rates are remaining steady among persons over age 50. However notions about who is “at-risk” for HIV continues to focus on younger age groups, drug users, sex-workers and other high-risk groups. A large percentage of HIV infection in the 50 and over group is from heterosexual activity, and that is particularly true for women. Despite the trends, the perception of risk for midlife and older persons continues to be low among health care providers. For this project I asked both DHP women and physician about their perceptions of HIV risk. For the women this included personal risk perceptions, and their notions about whether or not other women their age seemed to perceive of the risks associated with developing new sexual relationships after divorce or widowhood. Physicians were asked what percentage of their patients they felt were at-risk for HIV and other STDs, and were asked to delineate who was at-risk by age, gender, ethnicity, socioeconomic status (SES), and other categories they deemed relevant.
HIV Vignette

The HIV-related vignette introduced the HIV topic to the interviewees (Appendices C and D), except for physician who only completed the survey; there are specific HIV related questions on the survey (Appendix B). Briefly, the HIV vignette is the story of a woman who divorces a cheating husband, remarries, and soon after her new marriage becomes ill. She visits the doctor often, but continues to suffer various problems with yeast infections, urinary tract infections, fevers, and fatigue. She is never tested for HIV because her physician assumes her health problems are not a result of sexual exposure to disease due to her age, marital status and religious activities. She is ultimately diagnosed with HIV when she is hospitalized for pneumonia. After the story, I ask the respondents to tell me their opinion of the case, along with other more detailed questions, and then asked them general questions about HIV risk perceptions.

The respondents were less likely to find this story to be a typical physician-patient scenario than the hysterectomy story discussed in Chapter 5. Only 39% (n=16) of the DHP women thought that this story was “typical” (Figure 6-1), and another 17.1% (n=7) felt that it was “sort of typical,” whereas over 80% (n=38) felt that the hysterectomy story was “typical” or “sort of typical” (Chapter 5). Over a third (n=14) thought that this story was “unusual” and did not think it was representative of what typically occurs, particularly in today’s health care interactions. The nine physicians that heard this story had similar reactions to those of the DHP women, and a comparison of the differences between both samples was not statistically significant. However, the physicians were a bit more likely to consider it “typical” (44.4%, n=4) or “sort of typical” (22.2%, n=2), and less likely to consider it “unusual” (22.2%, n=2).
DHP Women’s Views of the HIV Vignette

There were no remarkable differences in how women viewed this story based on ethnicity, age, educational level, self-rated health status or marital status. The DHP women who thought the story was typical explained that physicians might not be inclined to test everyone for HIV, particularly in this case because the character in the story did not seem to belong to a high-risk group. The following comments demonstrate that these women are knowledgeable about what constitutes a high-risk group for HIV/AIDS. A 45-year-old woman said,

I can almost see where an older woman [wouldn’t be] tested for HIV . . . I can see where they're not going to HIV test everybody who walks in the door. I can understand that, especially since she wasn't a real, or didn't appear to be a real sexually active person. But in this day and age, there definitely should be a question asked. It should be part of the interview.

Another woman in her mid-40s said “Maybe if she was living on the street or a drug user, maybe they would consider maybe you're at risk for AIDS so they'd look for that, but
since she didn't have that type of lifestyle--isn't that just what they go by--she wasn't considered at risk for that.”

A 60-year-old divorced woman could see how the physician might not think of STDs, but thought that some of his other assumptions were erroneous.

I think it just sounded like a typical--what a doctor would do. He wouldn't automatically jump to the conclusion that she might have an STD, but church and marriage doesn't have anything to do with STDs. To me it doesn't anyway. There's still the chance. And if they're sexually active, there's always a risk when somebody's not monogamous.

The impression that the physician was closed-minded was not uncommon, and the issue of marriage not guaranteeing monogamy and relative safety also came up often. One brought up the misplaced emphasis on religion, saying, “First of all I think he pre-judged her based on her environment and her age, because she was a church-going woman, and was married. . . . But he should of run different tests because the first thing you want to eliminate are any STDs.”

Several women felt that the physician should have asked more questions, but also that the patient should have volunteered more details about her life. There was a consistently strong theme of patient responsibility from many of the women. A woman in her late 40s remarked that the patient could have been more pro-active in finding out what was wrong, saying “There's so many resources out there now that you can do better than just use your own doctor--have more of an idea what's going on with you.” Another commented, “I think Jenkins should have said something to her doctor. I mean you're as responsible for your health care as your doctor is.” A woman in the same age group echoed this sentiment,

I think the doctor should have asked her about what her previous life was like, and maybe they would have checked sooner and maybe she would have been treated sooner. I think the patient also should have volunteered her information also
because she knows what her life was like . . . That's her responsibility--the patients are more responsible than they think because the doctors aren't psychic.

Many of the women were disturbed that the physician made assumptions about his patient that caused him to miss an HIV diagnosis, showing their knowledge of the importance of an early diagnosis for HIV treatment. Some had intimate knowledge of HIV/AIDS from people they know with the disease or who had died from the disease. Three of the African American women describe events or personal issues that the story reminded them of. A widow in her mid-50s related an almost identical story to me that this scenario reminded her of.

I had a friend that his wife got sick and he kept taking her back and forth to the doctor and they couldn't find out what was wrong with her and she went to the hospital with pneumonia and she died and when they performed the autopsy, that's when he found out that she had HIV. He had never known it, and . . . he had it. A woman in her late 40's who has undergone treatment for substance abuse, said, “You know, I've heard about some things like that through rehab, so yes, it does remind me, but not like that because you know nowadays they do so much more, they've got so much more testing, you know the free HIV testing, and all that.” A divorced woman in her late-40s; she seemed to feel that she had been fortunate to avoid the same experience as the woman in the story. “That's a hard one. I mean this is a difficult story because any one of us could be in the situation . . . I could be that person because I was married. I got a divorce. And then 15 years--But you know what, I have a brother who died from AIDS . . . I'm just blessed that way, you know, about AIDS, but it could be me, you know?”

Many of the themes that pervade the interviews with the women were common among the physicians as well. The theme of stereotyping patients based on various characteristics, the problem with the lack of questioning by the doctor, and the sense that
this type of problem is less common now than it used to be, though still occurring, were all topics that the physicians shared with the DHP women.

**Physicians’ Views of the HIV Vignette**

Only nine physicians heard the HIV vignette, two attending and seven resident physicians. There was no analysis by gender since all of the physicians were male, and ethnic distinctions were not possible with such a small number of participants.

The two attending physicians thought the story was typical. One attending physician in his late 40s explained that he felt the story was “fairly typical” because physician are so influenced by SES and other social characteristics. A resident physician in his mid-30s thought that the type of scenario presented in the story occurs less often these days, but that the practice of “judging someone by how they are dressed” or by their gender still happens among some physicians.

The resident physicians were a little less inclined to think that the story was typical. Two felt it was “typical,” two thought it was “sort of typical,” two said it was “unusual,” and one said he didn’t know how to characterize it. Several of the resident physicians noted that the education in their current program stresses that anyone can have an STD, and that they are encouraged to avoid stereotypes that might cause them to miss something important to a diagnosis. A resident in his mid-30s said “I think it's unusual; I don't see too many doctors going that far without doing other tests.”

A few used the phrase “treating the whole person,” observing that the physician in the story only focused on one aspect of his patient causing him to overlook important clues to an accurate diagnosis. Others said that there was an obvious communication problem, since it was clear that the physician did not get a complete sexual history. A
resident in his early 30’s felt that the physician neglected the possibility that his patient’s problems could be sexually transmitted because of age-related stereotypes,

Basically, it sounds that the physician really wasn't open to the notion that someone of that age could be sexually active and/or with multiple people. . . . I think it would be related to the age of the physician, as well. Because I would assume if you were a physician in your 50s approaching someone else in their 50s, you might have a different notion of it, versus a physician in their 20s thinking of grandma and projecting your own personal notions of people having-- being sexually active later. I think a younger physician would have a tendency to maybe not pursue the sexual route as much as someone who is a physician closer to the age of the patient who realizes that probably sex doesn't stop at age 50.

A widow in her late 60s also thought that the age of the physician could be a factor, but in the reverse of what the resident physician above suggested. She thought that a younger physician would be more likely to be aware of HIV issues than an older physician. Other than this consideration about the physician’s age, the main difference between the physicians and the DHP women was the focus on patient responsibility. As mentioned in Chapter 5, the DHP women were much more likely to place the onus of communicating important health information on the patient. Physicians were likely to consider both parties responsible, but none felt that patients bore most of the responsibility. Despite their emphasis on patients being more pro-active with their health care interactions, the DHP women overwhelmingly thought that physicians had a responsibility to address the topic of STDs with their older patients (88.6%, n=39). This is likely due to their perception that sexuality is an important part of life regardless of age.

**Single, But Not for Long**

The tremendous support for physicians discussing HIV and STD’s with their midlife and older patients is testament to the importance of sexuality in later life for these women. Many were in new sexual relationships after divorce or widowhood, or they expressed an interest in finding a companion. Their comments about the HIV vignette
revealed that many are aware of the risks associated with dating, as well as noting that both partners must share a commitment to monogamy to eliminate risk.

The AARP study of midlife dating introduced in chapter two reported that over a third of women and men in the US between age 40 and 69 are single, and most are divorced. About a third of single women and men are in exclusive dating relationships, and almost the same percentage (32%) are dating non-exclusively. A little over 10 percent of those without a current partner or dating are interested in finding a date, another 12% or so are what the AARP study calls “daters-in waiting,” that is they would be interested if the right person happens to come along, while the rest do not have any interest in dating or finding a partner (AARP 2003: 2). Just under a quarter (22.7%, n=10) of the women I interviewed have a steady partner, and 15.9% (n=7) are dating, 6.8% (n=3) have recently ended a relationship and fall into the AARP category of “interested daters”, 36.4% (n=16) are “daters-in waiting,” and only 15.9% (n=7) expressed no interest in finding a new partner or dating (Figure 6-2). It is important to point out that men are included in the AARP study and that they are more likely than women to be dating. Men also made up a large proportion of “interested daters” and “daters-in waiting.” Some of the women in my study were content with their single status, enjoying the freedom associated with being on your own, but most indicated that they were very interested in finding a partner, or had recently stopped dating someone. The fact that so many midlife and older singles are dating or interested in dating suggests that sexual health issues are relevant topics for clinical communication.

Not surprisingly, the younger participants in both the AARP study and my study are the ones most likely to be involved with someone. The difference by age had
marginal statistical significance (Table 6-1), but the fact that women age 45 to 55 outnumber older women more than 3 to 1, may have affected this and other comparisons by age.

![Figure 6-2. Partner Status and Dating Interest (Percents)](image)

<table>
<thead>
<tr>
<th>Table 6-1. Cross-Tabulation of Age Range and Partner Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age range</td>
</tr>
<tr>
<td>-------------</td>
</tr>
<tr>
<td>45-55 years</td>
</tr>
<tr>
<td>56-68 years</td>
</tr>
</tbody>
</table>

Differences by ethnic group and age group were not statistically significant in partner status and interest in dating, however some of the differences are interesting, nonetheless (Figure 6-3). Proportionately, more women over age 55 indicate that they are not interested in finding a partner or dating (30%, n=3) than those 55 and younger (11.8%, n=4), though not numerically. Half of the older women indicated that they are “dater-in-waiting”, compared to a third of the younger women. Proportionately, more African American women are partnered or dating (45%, n=9) than are Euro-American women (34.8%, n=8), and more Euro American women indicated that they are a “dater-
in-waiting” than did African American women (43.5% and 30% respectively). The woman who selected “other” for ethnic identity was excluded from this analysis and all other cross-tabulations using ethnicity.

![Figure 6-3. Frequency of Partner Status by Age Group and Ethnicity](image)

The AARP study and its parallels to my study are notable because they clearly indicate that dating and sexual relationships are important to a large proportion of midlife and older singles, yet this continues to not be represented in the general cultural perception. As a result perceptions regarding HIV risks are still relegated to younger cohorts by the general population, including many physicians. However, the DHP women have a relatively high perception of personal HIV risks, and this perception seems to correlate with the interest in dating.

**Dating and HIV/STD Risks**

Perceptions of personal risk for HIV were quite high for this sample. Almost two-thirds (63.6%, n=28) said that they considered themselves to be “at-risk.” Predictably, partner status had a noteworthy impact on individual’s risk perception (Table 6-2). Those
with a partner or dating are the most likely to believe that they are at-risk for HIV and STDs.

Table 6-2. Cross-Tabulation of Partner Status and Personal HIV Risk Perception

<table>
<thead>
<tr>
<th>Partner status</th>
<th>Yes, at-risk Number (%)</th>
<th>No, not at-risk Number (%)</th>
<th>Fisher’s Exact Test 2-sided exact significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Partner/dating</td>
<td>14 (82.4%)</td>
<td>3 (17.6%)</td>
<td>.057</td>
</tr>
<tr>
<td>No partner</td>
<td>14 (51.9%)</td>
<td>13 (48.1%)</td>
<td></td>
</tr>
</tbody>
</table>

This finding also coincides with age; since more women aged 45 to 55 are partnered, and they are also more likely to think of themselves at risk (70.6%, n=24) compared to women aged 55 to 68 (40%, n=4). However, this is still a much higher risk perception than reported in other studies. From studies conducted in the early 1990s, Binson, Pollack and Catania (1997) found that 90% of women aged 40 to 75 felt they were not at risk for HIV. Part of this higher perception may be due to changes that have occurred in the demographics in the spread of the disease since the early 1990s. It may also be a result of the particular marital and social circumstances of the women that I interviewed for my project.

Equal numbers of African American (n=14) and Euro American women (n=14) considered themselves at risk, but a slightly higher proportion of African American women thought themselves as at risk than Euro-American women (70% and 60.9% respectively). However this high risk perception among Black women is higher than the perceptions reported by Rogers-Farmer (1999), who found that 98% African Americans (men and women) age 55 and over rate their risk as “low” or “no chance.” Theall et al. (2003) reported on age differences among African American women and HIV risk perception, noting that 55% of those aged 40-71 thought there was no chance of infection, compared to 29% of those aged 18-29.
Interestingly, 51.9% of women without a current partner or dating feel that they are at-risk for HIV or other STDs (Table 6-2). The reason that some of the women without current companions mentioned for their sense of HIV/STD risk was that they did not intend to remain single. A 54-year-old woman who is separated, said “Yes, I will be [at-risk], 'cause I'm planning on getting back in the into the game.” A widow in her late 50’s without a current partner said, “AIDS doesn't pick its victims--anybody's susceptible to it. I don't care if it's the archbishop, I wouldn't sleep with anybody who wasn't wearing a Trojan. Yeah, I would be at risk if I didn't take care of myself, of course.”

**Marriage Doesn’t Always Mean Monogamy**

Those who said that they were at-risk also talked about how you never really know the status of another person, “for sure.” A 55-year-old divorced woman, who has dated a bit since her divorce and currently has a steady partner said, “[E]ven if you're in a monogamous relationship, just because you are doesn't mean that the person you think is your partner isn't, you know, going someplace.” A 50-year-old divorced woman who does not have a partner said,

> I know my situation when I found out my husband cheated on me for six months; both of us were tested, because it came out that he was having sex with someone from a foreign country. And because I did have serious bacterial infections, and ironically enough, now that I'm not with him or having sex with him, I don't have any infections. Fancy that.

Another comment about unfaithful partners and HIV testing came from a 52-year-old divorced woman. “I think the first time I took an HIV test I felt kind of ooh, you know, but after a while I just say whatever, I would have to kill him anyway (laughs). One way or another it's gotta be all right cuz he will be dying first!”
Interestingly all of the women who are separated described themselves as at-risk (Table 6-3). The cross-tabulation of HIV risk and marital status shows that being separated rather than divorced or widowed may be significant in shaping risk perception.

<table>
<thead>
<tr>
<th>Marital status</th>
<th>Yes, at-risk Number (%)</th>
<th>No, not at-risk Number (%)</th>
<th>Likelihood Ratio Value (2-sided sig.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Divorced/ Ended Union</td>
<td>12 (50.0)</td>
<td>12 (50.0)</td>
<td>9.991 (.007)</td>
</tr>
<tr>
<td>Widowed</td>
<td>7 (63.6)</td>
<td>4 (36.4)</td>
<td>df = 2</td>
</tr>
<tr>
<td>Separated</td>
<td>9 (100)</td>
<td>0 (0)</td>
<td></td>
</tr>
</tbody>
</table>

A 53-year-old woman was concerned about the fidelity of her husband that she clearly expects to unite with, saying, “Right now I'm separated from my husband and he's overseas. I have this fear in my heart that--you know--I know within myself he can get carried away. So I am concerned [that he could put me at risk]. Yes, I'm concerned about that.” Several of the women, indicated that they may reconcile and that there may have been sexual risk taking during the separation, or they separated due to infidelity and fear they may be infected. Either way, their circumstances have heightened their sense of risk.

Of course, almost half of the women without partners (48.1%, n=13) did not consider themselves to be at risk for HIV/STDs. Some said this quite matter-of-factly, noting that were not engaging in any sexual activity and they were not planning to do so in the future. This was sometimes due to a lack of not interest in finding a companion, or because they were too fearful of all the new diseases that one has to be concerned about now. One divorced woman in her late 50’s said, “No ma'am, because it's like I told you, I'm scared and I don't want to be bothered. And um, I don't like, what do you call it, protection [condoms]? I don't care for that.” This sentiment about condoms corresponds with other research that has found low rates of condom use among older women (Binson
et al. 1997; Mack and Bland 1999; Theall et al. 2003; Yates et al. 1999; and Zaboltsky 1998). Although a large percentage of the DHP women believe they are at risk for HIV and other STDs, that does not necessarily mean they are practicing safer sex. This is not unusual, as heightened risk perceptions have been shown to have a weak connection to risk behaviors in the case of HIV/AIDS prevention (Poppen and Reisen 1997; Stall and Catania 1994; Theall et al. 2003).

The Issue of Practicing Safer Sex

Although my research did not focus on actual sexual activity, several of my informants volunteered information about their sexual activities, both currently and in the past. A 55-year-old divorced woman, who is actively dating confessed that she is at risk for HIV and other STDs, because she doesn’t always practice safer sex. One 45-year-old woman, who is separated but trying to reconcile with her husband, said “I've had other partners, during the separation and I think there always is a risk. I think the risk comes down tremendously when you make a commitment to each other.” Another separated woman in her mid-50s brought up the newness of practicing safer sex. She does not have a current partner but talked about her concerns over condom use for dating in the future. She said,

Well, I have never had sex with a condom--never had to . . . That's going to be a whole new experience for me when that comes to pass. Asking, you know, ‘let's use protection,’ [or] do you have any?’, or going to a store and buying some condoms to keep in my nightstand--totally something that I have never done and never expected to do.

The issue of practicing safer sex was an interesting finding in the AARP study as well. The report notes that a minority of singles (21%) uses protection regularly when having sex. This is thought to be related the fact that the danger of pregnancy is past for many of them, and many probably do not think they are risk from disease. Women in the
AARP study are more assiduous about protecting themselves than men, with about half (48%) always-using condoms. However since this is especially true for 40-49 year old women the authors suspect that it may have more to do with pregnancy prevention than HIV/STD prevention. A particularly disturbing finding is that the “[n]on-exclusive daters (28%) are more likely to have unprotected sex than other groups” in the study (AARP 2003: 39).

The issue of sexual safety is a tricky one. Most psychosocial models of health behavior place the onus of responsibility on the individual as though other cultural and relational factors are absent. These models ignore the affective relational expectations and gendered power dynamics that impact the behaviors of social actors the exercise of safer sex (Sobo 1995; Ragsdale 2002; Stansbury and Sierra 2004). The research by these authors on women from disparate ethnic, socioeconomic and cultural groups showed that the women appeared to be relying on similar cultural models of affective relationships that resulted in risk denial and ultimately higher risk sexual relations. The cultural consensus data presented in chapter four showed that the issue of safety in new dating relationships is an important element in the domain of sexuality for the DHP women, but also highlighted the ideal aspects of affective relations.

**Cultural Consensus Data Related to HIV/STD Risk**

The domain of sexuality for midlife and older women that are newly single contained several elements that pointed to their concerns about HIV and STDs. The free-lists included such repeated terms as *dangerous, use protection, disease risk,* and *more careful*. There were also many idiosyncratic terms and phrases that focused specifically on the HIV/STD risks associated with dating and finding a new sexual partner. The multidimensional scaling (MDS) representation of the pile-sort data revealed that they
linked some of these terms in significant ways. The core terms shown in Figure 4.1 (Chapter 4, p.103), that most participants grouped together to varying degrees of inclusion to describe “new relationship” characteristics, paired such terms as sexy, beautiful, and desirable with use protection and more careful within the topic. This combination reflects the tension between ideals and realities of dating and new sexual relationships. The physicians, on the other hand, did not include use protection and more careful within a similar topic on relationships and this reflects their emphasis on younger cohorts when considering STD and HIV risks.

The ratings data also support the notion that the physicians and the DHP women differ in their ideas about sexuality and dating in later life. It is interesting to note the different themes that appear in how these samples were conceptualizing the issue by comparing the terms of agreement with the terms of disagreement. The women describe sexuality in very positive terms, as well as focusing on safety and being careful with regard to the risks associated with dating. Whereas physicians tend to focus on the problematic aspects of sex and aging, with much more emphasis on lack of sexual activity due to physical or medical problems. These data provide useful clues as to what physicians need to know about midlife and older women. DHP women believe that mature women are sexy and beautiful and but they are also concerned with personal safety as they enter new relationships after divorce or widowhood. The fact that these women rated use protection as highly relevant and that physicians rated it as less relevant, supports the other findings in this research about HIV/STD risk perceptions.

**Higher Than Expected Perceptions of Risk**

Personal HIV risk perception is relatively high for this group, and this may have several reasons. First of all, I posed the questions about HIV after reading the HIV
vignette. This was a tough call in terms of research design. I was concerned about alienating participants if they felt the main focus of the study was HIV. Since this project has a broader focus of clinical communication about sexual health, it seemed wise to keep the HIV component “low-key.” Some of the comments from these women regarding infidelity by husbands and lovers suggest that their perception of risk may not necessarily be tainted by the HIV story, but rather by their feeling that their partner has put them at risk. This perception of risk seems to also be tied to being separated more so than to the other marital status categories. It is also related to their lack of experience and/or reluctance in using condoms. In addition, several women had personal knowledge of a friend or family member with HIV/AIDS, or who had died of AIDS. Any of these factors or some combination of them could explain the high rate of HIV risk awareness, as opposed to the influence of the HIV vignette. Another factor that suggest that the HIV vignette did not unduly affect their perceptions of HIV risk is the relatively high proportion of women who revealed that they had be tested for HIV.

**Testing for HIV/AIDS**

Although I did not systematically ask the women if they had ever been tested for HIV, several volunteered information that they had been tested. When the interview flowed in the direction of personal risk and testing, I did ask the question, but did not include it in my list of questions to ask everyone. Just over 40% (n=18) of the DHP women I interviewed revealed that they had been tested for HIV. There are also some interesting differences by ethnicity and age range (Figure 6-4). Younger women (n=16) and Black women (n=11) were the most likely to reveal that they had been tested. This is consistent with other research findings delineated in Chapter 2 showing that younger
persons and African Americans are generally more likely to have been tested (Mack and Bland 1999; and Florida Department of Health 2003d).

![Figure 6-4. Percentage Tested for HIV by Ethnicity and Age Range (Self-Reported)](image)

Some who revealed that they had been tested for HIV remarked that they had done so after finding out that a spouse or lover had been “unfaithful.” A woman in her mid-50s, said, “Oh definitely. I've had my test. A couple of months ago I went, because my husband had an affair with the woman. So I went and had the test done just to make sure.” A divorced White woman in her early 60s talked about the testing, other’s risks, personal risk, relationships, unsafe sex, and not trusting men.

So many people like me are divorced and we date and we're not always careful. We don't like condoms. We hardly ever use them. I mean it's just, we take chances, thinking that well it doesn't happen in my age group or in my class, but it does. But when you have a steady boyfriend, you don't think of yourself, and you don't know what he's doing on the days he's not seeing you, and I don't trust men anymore, so I figure they're going to be out doing something. No matter what they say, they lie. I just flat don't trust them, because I know them. I know myself, and I've lied to men before about other men, so if I'll do it, then I'm sure they'll do it 'cause I'm not that different. . . . But I've had myself tested.
A divorced Black woman in her mid-40s, who has a current partner, said, “Even with me, with my ex-partner, there was a point in our relationship where he did cheat on me. And I don't know if he used protection to this day or not. So therefore, I'm not ashamed to get an HIV test.” A couple of Black women mentioned that they get tested for HIV regularly. A separated woman in her early 50s, said, “I see ‘Free HIV,’ I go. This lady was asking me, ‘How many times you going to come in?’ I say ‘I want to know.’”

The relatively high percentage of women who have been tested may be due to fear of exposure, as in the quotes above. However, in some cases it may also relate to having personal knowledge of someone with HIV or who has died of AIDS.

Know or Knew Someone with HIV/AIDS and HIV Testing

In addition to revealing they had been tested for HIV, several women mentioned that they knew someone with HIV/AIDS, or knew someone who had died of AIDS. In some cases the person was a family member. Just under a quarter of the DHP women (n=10, 22.7%) know someone with HIV/AIDS or who had died of AIDS. Of those, four had a family member die with the disease. Although I did not ask them if they knew anyone with HIV/AIDS, several of my questions could lead to this topic. For example, after the HIV story, I asked them if the story reminded them of any similar events or stories that they knew of from family or friends, or even in the media. I also asked them to tell me a little bit about what they knew about HIV/AIDS. These questions were what led some of the women to reveal their personal experiences with the disease.

Since HIV/AIDS is disproportionately devastating the African American community, it is not unexpected to find more African American women in my study with family or friends who have HIV/AIDS or who have died with AIDS. Cross-tabulation of
ethnicity (“other” ethnic identity excluded) and “know/knew someone with HIV/AIDS,” and a cross-tabulation of “Tested for HIV” and “know/knew someone with HIV/AIDS,” revealed statistically significant distinctions between groups (Table 6-4).

Table 6-4. Cross-Tabulation of Know/knew Someone with HIV and Ethnicity and Tested for HIV

<table>
<thead>
<tr>
<th>Knows/knew someone with HIV/AIDS number (%)</th>
<th>Does Not know anyone number (%)</th>
<th>Fisher’s Exact Test 2-sided exact significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Black/African-American</td>
<td>8 (40.0)</td>
<td>12 (60.0)</td>
</tr>
<tr>
<td>White/Euro-American</td>
<td>2 (8.7)</td>
<td>21 (91.7)</td>
</tr>
<tr>
<td>Tested for HIV/AIDS</td>
<td>9 (50.0)</td>
<td>9 (50.0)</td>
</tr>
<tr>
<td>No HIV test mentioned</td>
<td>1 (3.8)</td>
<td>25 (96.2)</td>
</tr>
</tbody>
</table>

Far fewer White women know someone who has or had HIV/AIDS (8.7%, n=2) than Black women (40%, n=8). This percentage appears to also be strongly related to whether or not they have been tested for HIV. The relationship here is striking, with most who know of someone with HIV/AIDS having been tested for the disease.

These comparisons are significant and appear to signal an important rationale in motivating HIV testing. The high-risk perception for many of these women is motivating some to get tested, however it may not be motivating safer sex practices as is evident in some of their comments above about themselves, and even more so in the comments below about other women’s risk perceptions and behaviors.

**Other Women in Age Group and Perception of HIV/STD Risk**

The notion that many singles in this cohort do not regularly practice safer sex is most evident in my study when I asked them what they thought of other women’s perceptions of risk for HIV and other STDs. Although the women in this sample appear to have a relatively high perception of risk, they tend to think that only slightly more than half of women their age, that are divorced, separated or widowed, think they are at-risk. Figure 6-5 shows that a slight majority said “yes” or “yes, most” to the question “do you
think that other recently single women your age and older think that they are at-risk for HIV?” and slightly less than half said “no” or “no, not most” to this question.

Figure 6-5. Percentage Who Think Other Recently Single Women Know of HIV Risk

Figure 6-6 shows the percentages of those who thought others were aware of HIV/STD risk by age group, ethnicity and marital status. These percentages are more useful for considering trends within sub-groups rather than for intergroup comparisons because of the small sample size.

Since the question about “other’s” perception of risk was framed around other women their age, it is not surprising that women over age 55 were more likely to say “no” or “no, not most” since older women were less likely to think of themselves as “at risk.” Younger women thought that over half (55.9%, n=19) of others in their cohort were aware of the risk, whereas older women only thought that 40% (n=4) of women their age were aware of the risk. Separated women overwhelmingly thought that other women were cognizant of the risk (88.9%, n=8), and since they were the most likely to think of themselves at risk they may feel that more women share their perspective.
Finally, Black women tended to think there was a high perception of the risk in their cohort (60%, n=12), but this was just slightly higher than the perceptions of White women (47.8, n=11). Slightly higher perceptions among Black women are possibly related to the fact more of them know someone with HIV/AIDS or simply because HIV is more prevalent in their community.

![Figure 6-6. Others At Risk by Ethnicity, Age Group, and Marital Status (Percents)](image)

Most often these respondents qualified their ideas about the perceptions of others by saying that they think that others know of the risk, but don’t do much about it, or that they are too new to negotiating safer-sex. That is, they often made the distinction between knowledge and actions. They also think that other women think they are “too old” to be at risk or are “in denial” about the risk.

One 50 year old divorced White woman said, “Probably in the back of their minds [they know of the risk], but they really don't, when it comes right down to it, think that it can happen to them. They don't want to face reality, 'cause they want to live for the moment. You're in that situation and you don't think about that.” Referring to her own
circle of friends separated White woman in her mid-40s said, “I think we're a lot more cognizant than any of us would have been 10 years ago. Maybe not as vigilant as we probably should be, but certainly it would never occur to me 10 years ago to worry about that stuff.”

The issue of age as a factor in risk perception also came up a few times. A 52 year old divorced Black woman remarked, “Yeah, because that is the one thing we probably [say] ‘Oh, that is not going to happen to me cause I'm too old for that.’” She continued, “Most of these old man now are out there with the young girls that's given them everything. And here they come back to us and we be thinking that they ain't doing anything. So we're in denial thinking that he ain't bringing anything back to me.”

On the other hand, there was also a notion that older women are more responsible and knowledgeable as a Black 65 year old widow noted, “The older they are the safer they are because they've got the experience.” A widowed White woman in her early 50’s said, “Yes, I think they're pretty well versed in general.”

However this greater knowledge did not necessarily translate into action. A separated woman in her mid-50s said, “I think that most of the women in this age group are aware, that I know. But I think they need to be more conscious of having to take action to protect themselves.” Another divorced woman aged 55, echoed this sentiment and even acknowledged her own lack of follow through. “Most of the women I know are a little younger than me and they are very aware. Now whether they practice safe sex or not I think that varies, and I found the same with myself--I've been careless.”

A separated woman in her mid-40’s said,

We're more uneducated than the youth. If we are divorced, separated, widowed, it becomes an issue and we have to educate ourselves all over again on sexually
transmitted diseases. I know less than my daughter - she's in her 20s. Because I felt I wouldn't ever have to know that. But when I talk to my friends and acquaintances that have found a new partner and are having sex, they're not doing anything [to protect themselves].

A widow in her late 40s who lost her daughter to AIDS, felt that a person's socioeconomic status, and emotional state greatly affected sexual risk-taking. “Yes, I think we're more at risk than some of these young people because we're more settled and sometimes now, the way the world is now. Then especially when you're unemployed, lost a loved one, and depression, low self-esteem, sometimes you can just fall into a lurch where you just don’t think sometimes.” This comment and the ones above point to some of the cultural and psychosocial issues in women’s negotiation of safer sex, in that there can be significant constraints on sexual practices, including how safer sex practices correspond to relationship ideals, gender constructs and socioeconomic limitations. The fact that many of these women mentioned the disconnect between knowledge and action with regard to safer sex, did not inhibit them from urging physicians to educate older patients about the risks.

**Suggestions for Physicians**

Another way that I addressed their perceptions about other’s risk want to ask whether or not they thought physicians should address HIV/STDs with their older patients. Most gave short, yes or no responses to this, but some elaborated a bit more. A divorced 60-year-old woman said, “I just think that when you go for your annual mammogram and Pap smear . . . it would be a good time to bring it up, because so many husbands are unfaithful, so many people like me are divorced and we date and we're not always careful.” Another divorced woman in her early 60’s said, “Oh no, it's a hidden
issue, nobody talks about it. Doctors are not addressing anything because they don't want to rock the boat - they don't say anything.”

A 55 year old widow, said “And I think that HIV should be stressed in older patients more so than the young, because we just fail to realize because we have one sexual partner, that that sexual partner may see someone else that's younger than us and they may contact it from someone else, at which in turn they give it to you and you never know you have it.” The idea that age impacted either their knowledge or actions was frequent, and was cited as a reason for physicians to address sexual health risks topics with their older patients. Physicians also considered age an important factor in patient HIV knowledge and risk. However, many did not think their older patients were at risk, and they considered them to have lower levels of HIV knowledge than younger patients.

**Physicians’ Perceptions of HIV Risk for Their Patients**

I asked the physicians “How well informed are the majority of your patients (age 45 and older) about HIV and other STDs?” They seem to think that the vast majority of their midlife and older patients are poorly or partially informed (Figure 6-7).

The differences between attending and resident physicians were slight. Attending physicians thought 75% of their midlife and older patients are partially or poorly informed compared to 83.3% of resident physician. Despite their sense that many of their patients lack adequate knowledge about HIV risk, many tend to consider their older patients as not being at risk for HIV. The interviews showed that there is a tendency to think that younger adults are both more knowledgeable and more at-risk.

One of the survey questions (Appendix B), and one of the interview questions (Appendix D) asked the percentage of their adult male and female patients they considered at risk. However, because I redesigned the survey mid-way through the
of the physicians were not asked this question. They generally rated their women patients at slightly lower risk than their male patients (Figure 6-8). Averages of their responses showed that physicians’ considered 51.43% of their adult male patients to be at-risk for HIV, (range 15-100%; SD 25.5), and 50.18% of adult female patients to be at-risk, (range 10-100%; SD 24.7).

Figure 6-7. Patients Aged 45+ Informed about HIV/STD risk.

Figure 6-8. Percentage of Males and Females At Risk.
Several said that they thought that males typically had more sexual partners than women, but others remarked that they treat mostly women and that women are more likely than men to present with STD symptoms.

**Overall Physician Perception for HIV/STD Risk for Patient Population.**

- Doctors consider 52% of their adult male patients to be at-risk for HIV/STDs
- Doctors consider 51% of their adult female patients to be at-risk for HIV/STDs
- The most at-risk groups are those in their late teens and ages 20s-30s
- Perception of risk declines with advancing age, female status, and intact marriage
- Most risk focused on persons with multiple partners, sex workers/clients, and drug users

Since most of these physicians treat low-income, inner city patients, their focus on higher risk groups such as sex workers and their clients, and drug-users is not surprising.

Given that the highest risk populations tend to be younger, their focus on youth is also understandable. However, several acknowledged that they should do a better job of talking about sexual health issues with their older patients. Their focus on high-risk populations also lead some to give more attention to ethnicity in their explanations of who is “at-risk.”

**Racial/Ethnic Perceptions**

Perceptions of patient risk were often linked age, marital status, and behavioral issues (i.e., drug use, prostitution, and multiple sex partners), but also to ethnicity and SES. As stated in previously, the physicians in this sample treat a largely lower income, African American population. Several of the physicians mentioned this in reference to which patients they perceived as at-risk for HIV and other STDs. A resident acknowledged that the largely poor, African American community they serve might affect their views about who is at risk. “The majority of our patients are African
American so it might skew a little bit and it's also our community, it's more African American and it's different cultural, ethnicity and maybe financial situations.”

A resident physician in his mid-30s said, “In this community it's very high risk living here. Many patients have multiple partners and many patients are using drugs in this community and it's a problem. . . . For 18 and above Black population, low social economic status, it has a more higher risk of sexuality and promiscuous activity . . .”

An African American resident physician made a point of saying that she does not distinguish between ethnic groups. “As long as you are coming through that door you are getting that question [about safer sex].” However, she also noted that the area has a higher rate of HIV than other parts of the area. “Apparently in this zip code it's one out of three women are HIV positive. I just think everybody needs to be aware of it--you just can't any chances anymore, it doesn't matter how old or how young you are, I'm bringing it up.” An attending physician in his mid-50s agreed that ethnicity was not a factor, but further clarified that younger age groups would be at greater risk than older ones, and that he did not consider married persons at-risk.

An attending physician in his late 40’s explained that his perception of risk centered on the characteristics of the patients he sees and the trends he’s seen in STD rates.

Well I see a very diverse population . . . I do take care of drug addicts, I do have prostitutes in my practice, I do have HIV positive patients in my practice. But I'm just very aware of the fact that there is an awful lot of multiple sex partners, unprotected sex, and actually I think we're not in a particularly high risk area of the country--nothing compared to New York City or Dade County, but we've been seeing increasing STD levels for the last 10 or 15 years I think, maybe even longer. So it's certainly not something to be ignored.
Age and Marital Issues

Patient age and marital status had a considerable impact on physician ideas about HIV risk. An attending physician in her mid-40s suggested that all of her patients are at-risk, but that she feels that younger patients are more at-risk, because they are more likely to have multiple sexual partners.

However, I've got a number of older people who are widowed or divorced and you know, and some of, most of my older people, most of them would be at risk from sexual contact. And so I do have a, you know, some older people who are playing the field, so to speak. Yeah, for me it's not [effected by ethnic group or sexual orientation]. It's, you know, it's an age thing. It's like, you're young, you're healthy you're out there. You know. Whatever, so for me it's probably more age and general physical abilities, you know, although I have had a patient who was in her 80's in a wheelchair with a chronic Foley catheter who was still having intercourse and I just wasn't frankly thinking that that was in her in her life, but it was.

An attending physician in his early 50s distinguished married persons from single ones, but also factored in age when categorizing their risks.

Older people I have in my practice I'm assuming are sexually active or are sexually active in a monogamous relationship, and some of them I've known for probably over 15 years, and I guess I'd be very surprised if they were not in a monogamous relationship... In that patient population, I just don't ask [about multiple partners or safer sex practices] at all. . . . I guess because you'd like to assume that everybody's who's married and in a monogamous relationship isn't doing anything outside of the marriage or outside of that relationship, so I'd probably make the assumption there that they're not at risk.

Another attending physician in his late 40s looks at it differently, based partly on what he has experienced. He gave a resounding “One hundred percent!” He explained that he feels that way because he was placed at risk through no fault of his own, saying “but I never thought it would be me, so.” Before he was placed at risk he says he would have probably responded “50%” to the question.
One attending physician felt that younger physicians would be reluctant to address sexuality issues with their older patients “because they assume that they're older and they're not having sex anymore, which is totally ludicrous.” He continued,

I think the range of normal for sexual desire and sexual behavior in the geriatric population is amazingly diverse, but it takes a mature physician to sit with an 80 year old and ask her if she is sexually active or engaged in any kind of high-risk activity. . . . But those risk factors are there and if a person is at risk it's a physician's job to make sure that they're educated as to how they should protect themselves. So I tend the raise the issue with most of my geriatric patients, unless I perceive that it's something that they might not be very comfortable with, or unless it's a non-issue because there are elderly patients where they're not sexually active and there's no real issue with AIDS. [Like for the woman who says] ‘my husband died 20 years ago and I haven't had sex since he died.’ Then you don't have to worry about STD risk or talking about condoms . . . unless they come back later and say I met this person, and it's amazing how often it happens.

Overall, these physicians tend to think that most of their married patients and older patients are generally not at risk for HIV/STDs or are at lower risk compared to younger age groups, but many are aware that they might be missing prevention opportunities because of their assumptions.

### Medical Education and HIV Prevention Readiness

I was also curious about how physicians felt about how their education prepared them for HIV issues. Over half felt that they were well prepared, while others seemed to feel they could be better prepared (Figure 6-9).

To get an overall sense of the how much the residents differed from the faculty, I collapse the Likert scale values to put “agree” and “strongly agree” together, but it was not necessary for “disagree” and “strongly disagree” because no one selected “strongly disagree.” Resident physicians were less likely than attending physicians to select disagree for this question (11.1% and 38.5 % respectively). The recentness of education seems a reasonable explanation for that. However, almost two-thirds (61.5%) of the
attending physicians agree that they have been well prepared, and this was not affected
by age or year of medical education, so continuing medical education, including
individual efforts to stay current with the literature, is likely a factor here. Chi-square
analysis showed that these differences were significant (Table 6-5). There were no
significant differences by gender, though females were a bit more likely to select neutral
(28.6%, n=4) compared to males (11.8%, n=2), and they were also less likely to select
agree (50%, n=7) compared to males (64.7%, n=11).

![Figure 6-9. Medical Education and HIV Preparedness](image)

<table>
<thead>
<tr>
<th>Physician status</th>
<th>Agree Number (%)</th>
<th>Disagree Number (%)</th>
<th>Neutral Number (%)</th>
<th>Likelihood Ratio Value (2-sided sig.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attending Physician</td>
<td>8 (61.5)</td>
<td>5 (38.5)</td>
<td>0 (0)</td>
<td>9.059 (.011) df = 2</td>
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<tr>
<td>Resident Physician</td>
<td>10 (55.6)</td>
<td>2 (11.1)</td>
<td>6 (33.3)</td>
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</tr>
</tbody>
</table>

Still most of the physicians, both attending and resident, acknowledged in the
interviews that participating in this research project has broaden their view of HIV risks
and made them aware of their own age-related perceptions about sexuality. However,
this acknowledgement may have little impact on their behaviors in regard to talking about sexual health with more of their older patients.

Talking About HIV Risk

The practice of routinely talking to patients about sexual risk was brought up by a few of the physician in response to my questions about how they address sexual health issues with a variety of patients. One of the residents in his early 30s felt that it was “always appropriate” to talk about HIV/STDs with his patients, particularly if he is aware that they are sexually active.

I guess in my approach I always ask them how their sex life is first--basically if they've been sexually active or not. . . . I don't think that I need to spend more time on sexuality or STDs if they don't have sex at all. . . . Twenty year olds or 30 year olds, single patients; I tend to ask them bluntly as well. Married couples I tend not to. My widows or elderly if they're asking for Viagra or some other estrogen vaginal cream, who are either widowed or separated, I do talk to them about sexually transmitted diseases and I'm pretty much blunt with them. Only the married people... like I said I can see how that can happen where you just lose track and assume that they are monogamous.

The comment above is typical of what many of the physicians said. They mostly talk to those they think are at risk, which tends to be younger, unmarried patients, and those they suspect might engage in some high-risk behavior. A few physicians mentioned that they were concerned about offending older patients and this is consistent with previous research on why physician do not discuss sexual health issues with older patients. Indeed, the perceptions and practices of these physicians were similar to those in other studies in terms of risk perception being relegated to younger age groups and a reluctance to discuss sexual issues with older patients (Epstein, et al. 1998; Frank and Harvey 1996; Haas and Coe 1997; Kerr, et al. 1996; Makadon and Silin 1995; Skiest and Keiser 1997; Ross, et al. 2000).
Results from the non-physician sample of this research suggest that concerns about offending patients might be misplaced. The DHP women overwhelmingly agreed that the physicians should talk to their midlife and older patients about HIV and STDs. When those that said “yes” (88.6%) are combined with those that qualified their answer saying “yes, if they think something’s wrong” a whopping 94.5% think that the issue should be addressed. One of the DHP women said

I would suggest that all women or men, if you're out there during that time, if you're spouse has died, if you're separated, be careful, you go to the doctor, you got to talk about this with your doctor and be tested, and don't be afraid to ask your doctor questions about your sexuality because it's a wonderful thing. And I don't think we should have to give it up because we're getting older.

Some of the women made clear that it was not always appropriate to raise sexual health topics, but they were also unambiguous on the point that physicians should not assume someone was not sexually active simply because they were older or unmarried.

**Discussion and Conclusion**

The findings presented in this chapter reveal both consistencies and inconsistencies with previous research on the topics of HIV risk perceptions among women and the factors involved with perceived risk, physicians’ notions of patient risks, and talking to patients about sexual health issues. DHP women and physicians were in agreement about the HIV vignette, with both raising the theme of stereotyping patients based on various characteristics, the problem with the lack of questioning by the doctor in the story, and the notion that this type of scenario is less common now than it used to be. The one clear difference was that the DHP women put more communication responsibility on the patient. The topic of stereotyping is of interest since it was clearly an important factor in shaping these physicians’ ideas about who is at risk for HIV and other STDs, and appears to influence their practices regarding talking about sexual health issues.
Risk perceptions among the DPH women were quite high, particularly in comparison to previous research. Although these findings followed previous trends in age and ethnic differences, there was still a much higher risk perception than reported in other studies. Part of this higher perception may be due to changes that have occurred in the demographics in the spread of the disease since some of the earlier studies were conducted in the early 1990s. It may also be a result of the particular circumstances of the women interviewed for this project, in that this study focused on “recently single” women, who might be more likely to have experienced marital infidelity, or partner infidelity, than women in previous studies. Additionally, some researchers have noted that there are multiple domains of HIV risk perception such as a perceived likelihood of becoming HIV infected as opposed to or combined with the level of worrying about being infected, which make it difficult to compare findings across studies (Theall et al. 2003).

My project did not explore all of the possible domains of risk. However, some of the responses about personal risk and the risk of others revealed interesting distinctions regarding knowledge and behavior, complacency in using protection, partner and dating status, denial of risk status due to age cohort, general distrust of men, and a sense of risk related to knowing someone with HIV/AIDS. Their comments also pointed to some of the cultural and psychosocial constraints in negotiating safer sex, and risk denial and how safer sex practices do not necessarily correspond to the ideals of personal relationships. These choices are not always so straightforward, and socioeconomic issues, relationship power dynamics and maintaining intimate connections are important influences.
The cultural consensus data from chapter 4 also hinted at the tension between relationship ideals and the risks associated with finding a new partner. The fact that many women, whether partnered or not, thought that new relationships brought with them greater HIV/STD risk is congruent with the cultural consensus findings. The DHP women included risks associated with dating a new partner as an important relationship element in shaping their domain, whereas physicians did not. The women also showed more awareness to the fact that marriage is not always a guarantee for monogamy. Most physicians, on the other hand, tended to characterize married persons as not at risk for HIV or STDs.

Finally, perhaps the most striking finding here is the significant number of women tested for HIV, and the relationship of being tested to knowing someone with HIV/AIDS. This issue was also impacted by ethnicity, with more Black women being tested than White women, and more Black women knowing someone who has HIV or has died of AIDS. Since HIV/AIDS is devastating so many African American communities, these differences between ethnic groups in this regard are not unexpected. However, the importance of knowing someone with HIV/AIDS appears to be significant and may signal an important impetus in motivating HIV testing.

These research findings show that age, ethnicity and marital status are significant variables in physicians’ notions about HIV risk for their patients, influencing discussion of sexual issues in clinical contexts. Their ideas about who is most “at-risk” appear to limit their perceptions such that they neglect important primary prevention opportunities. This study supports and enhances on previous research about risk perceptions and reveals what physicians need to know and incorporate into their practices to better address HIV
risks for midlife and older women patients. The primary points that physicians should learn from these findings are: 1) that lower overall risk for older persons in general does not equate to “no risk” for older individuals; 2) that sexuality continues to be important for persons as they age, including for those who may not have a current steady partner, and; 3) that their fears about offending older patients with discussion of sexual health topics are largely unsupported by these empirical results.

The next and final chapter summarizes the project findings and further triangulates the different types of data and analysis used. The limitations of the project are delineated, and it concludes with a discussion of the significance of the data and its utility for improved health care communication regarding sexual health issues and HIV prevention in clinical context.
This project explored differing conceptions of mature female sexuality by recently single women and primary care physicians. Research about clinical communication suggests that patients and physicians may differ in their perceptions to such an extent that effective health communication is hindered (Cline and McKenzie 1998; Fisher 1993; Hahn 1995). Although the physician and patient may share much of the same social and cultural makeup, the specific cultural domain of health care may or may not be shared.

My research explored the cultural domain of sexuality for mature women that are recently single. I investigated midlife and older women’s concepts of sexuality and sexual health for themselves and other women their age. I also looked at how primary care physicians conceptualize sexuality and sexual health for midlife and older patients, and how these perceptions are shaped by age- and gender-based assumptions and their impact the clinical encounter. The main concern for primary prevention in clinical practice was how and if women’s sexuality concepts, and those of physicians for their patients, related to HIV risk perceptions, and their ideas about discussing sexual health in clinical contexts.

This final chapter provides an overview of the research findings, a discussion of the limitations of the project, the projects’ significance and suggestions for future research. The next section reviews the demographic information about the samples in this project and is followed by an overview of the findings presented in the previous chapters.
Synopsis of Demographic Data and Overview of Chapters

This project interviewed 44 “recently single” women attending a state sponsored displaced homemaker program, and 31 primary care physicians in the same urban area of north Florida. Data collection included demographic surveys; vignette-based interviews; and cultural consensus modeling techniques from cognitive anthropology. The women were recruited in-person at group meetings at the community college where the displaced homemakers program (DHP) meetings took place, from October 2002 to June 2004, and the physicians were recruited at their place of work between April 2003 and June 2004.

DHP Sample

The final sample of DHP women respondents included 20 self-identified black/African American women and 23 self-identified white/Euro-American women, and one self identified as “other”. Three also noted another aspect of their identity, but out of respect for their primary choice, they were situated within their chosen category for all analyses.

The women ranged in age from 45 to 68 and the average age was 52. Most of the women were divorced (50%), a quarter were separated, 20% were widowed, and those remaining had ended long-term consensual unions. Differences in educational levels were not remarkable. Half had received vocational training or had attended some college, and 18% were college graduates or had advanced degrees. Black women were more likely to have not completed high school, but they were also more likely to have some college training than were white women. A slight majority of women lived alone (38%) relative to those with two to four person households, and more black women reported 3-4 person households than white women. Most rated their health as good (43%) or excellent (21%), but more black women rated their health as fair (15%) or poor
(10%) than white women (9% and 4% respectively). A slight majority were unemployed or on SSI (52%), and 43% of them were working either part- or full-time. Since the primary purpose of the displaced homemaker program is to assist women with getting their lives back on track after marital disruption, with a concentration on employment readiness, the low employment rate is not surprising. Several were enrolled in educational programs to further career goals, or were planning to enroll soon.

Of particular interest for this study was the number of women in new dating relationships after their marital disruption, and the large percentage that expressed and interest in dating again. Almost 39% were in relationships or dating, and 43% expressed an interest in finding a partner. These high percentages suggest that sexual health issues are important topics for health care communication.

**Physician Sample**

Most of the 31 physicians were recruited through a community health and family practice clinic of the university-based hospital. Three physicians from other primary care specialties were recruited through an email announcement at the area hospital. The physician sample consisted of 13 attending physicians, and 18 resident physicians. The average age of physicians was 39 years, but attending physicians’ average age was 48 years and residents’ average age was 34 years. Male physicians slightly out numbered female physicians (55% and 45% respectively). Women have begun to predominate in the enrollment in family practice residency programs in recent years, and my sample follows this trend with ten women and eight men making up the residency portion of the sample. However, female participation in my study was low compared to the female-male ratio in the overall residency program, which was just slightly less than 2:1 for
2003/2004 academic year. Just over half of the physicians were white/Euro-American (55%), 23% were Asian, 7% were black/African American and the rest selected “other”.

Of the 31 physician participants, 18 completed the full interview with one of the two vignettes, the demographic/practice characteristics survey and a CCM procedure. One participated by completing the interview without a vignette, and the remaining 13 physicians completed the survey and a CCM procedure. In the next section I review the most important findings presented in chapters four, five and six.

**Synopsis of Findings**

The primary findings from this project were presented in three separate chapters, each with its own specific focus. This project focused on sexuality and aging concepts in and of themselves, as well as on how those concepts intertwined with age- and gender-based assumptions in clinical interactions. Additionally, through the vignettes and multilayered questioning, social-structural issues were addressed having to do with interracial/interethnic clinical encounters, perceptions of HIV/STD risk and knowledge and other issues. In this chapter I review the data presented in the separate chapters, linking the data from the different chapters together where associations are significant.

**Cultural Models of Mature Sexuality and HIV**

The cultural consensus data provided a foundation from which to work with emic concepts about midlife sexuality. The CCM results presented in chapter four uncovered some unanticipated findings. I hypothesized that the DHP women and physicians would differ substantially in their concepts of sexuality for midlife and older women. The free list data suggested otherwise, with the two samples sharing more terms and phrases when combined than when they were analyzed separately. The physician free lists had a particularly low frequency of repeated terms, and when their free lists were combined
with those from the women they had more in common with the women than with each other. This is contrary to what I expected to find, which was greater agreement of listed terms from a group of physicians with similar training, and less agreement from women with differing backgrounds.

One of the possible explanations for this was the relatively short lists provided by the physicians which gave them less opportunity to find agreement with one another. The lists from the DHP women tended to be longer, and longer lists increase the possibility that more items will be shared. It is also possible that the age range of physicians doing the free list procedure impacted their internal agreement, such that older physicians were more likely to list terms in keeping with the midlife and older women than with younger physicians. This second possibility was not explored in greater detail, in part, because the pile sort task showed greater internal agreement among the physicians, and that may mean that the first explanation about free list length is a more reasonable explanation.

The multidimensional scaling (MDS) analysis of the pile sort data provided evidence that the two samples were drawing on similar concepts to organize the domain items, with a few very important distinctions. The most significant exception related to risks associated with dating a new partner. Although both samples created groupings along similar dimensions, the inclusion and exclusion of key items was significant in showing critical differences between how DHP women and physicians constructed the domain. The elements of a new relationship for the women included terms associated with the risk (use protection and more careful) involved in the dating world today, whereas the physician did not associate terms related to risk avoidance within their
descriptions of later-life relationships for their patients. This finding is congruent with the results on notions about HIV risk presented in chapter six, showing that DHP women are extremely cognizant of the risk associated with dating, and that physicians’ perceptions of HIV/STD risk declines with patients’ increasing age, female status and intact marriage.

Two-thirds of the women thought that they were at-risk for HIV and other STDs, and this was correlated to their current dating status. However, their combination of terms like sexy, beautiful, and desirable describing idyllic relationships with the terms use protection and more careful reflects the tension between the ideals and realities of dating for these newly single women.

The cluster analysis of the pile sort data supported the MDS analysis in chapter 4, but provided some additional detail about the nature of the domains for each sample. One point related to the discussion in the paragraph above was that use protection was at a lower level of connectedness than more careful and more mature. This indicates that several women did not combine these terms, and this is in keeping with other significant finding in chapter six concerning the disconnect between knowledge and behavior regarding risk.

Analysis of the in-depth interview data showed that although the DHP women were highly cognizant of the risks, many admitted to not always practicing safer sex, and their notions about what other women their age do indicated the same lack of follow through. This distinction between knowledge and action regarding condom use corresponds to other research with older women (and younger ones, for that matter), pointing to the psychosocial issues in sexual negotiation.
Researchers and prevention specialists may be in danger of becoming overly “condom centric” in their approach to stemming the tide of HIV infection, as noted scholar, Bryan Page, Ph.D., suggested at the Society for Applied Anthropology meeting in Santa Fe, NM, April 2005. He encouraged researchers to move beyond an exclusive focus on condom usage and to consider the larger social forces that contribute to the spread of HIV. Some of those forces, such as labor migration and limited access to health resources in developing countries are not readily applicable here. But other social and cultural factors are relevant, including gendered power dynamics, and culturally shaped affective relationship expectations.

Research on women from different ethnic, socioeconomic and cultural groups illustrates that similar models of romantic relationships influence women’s behaviors in sexual negotiation, sometimes resulting in risk denial and higher risk sexual relations (Ragsdale 2002; Sobo 1995; Stansbury and Sierra 2004). Relationship factors such as duration and perceived seriousness, along with the newness of condom use interweave with entrenched gender roles of cultural domains or schemas, leaving women with few alternatives that meet their own expectations and those of others about how to negotiate new relationships.

Referring back to cultural domain theory as described by Dressler and Bindon (2000) in chapter 3, cultural models are abstractions of a given domain that help individuals know what to say or do in a given situation. Yet as abstractions of ever changing cultural scenarios they are oftentimes necessarily vague and malleable. Thus what may be a very straightforward choice for one woman may be a complex social struggle woven with financial or emotional considerations for another. The story from
one woman interviewed for this project is instructive on this point. After the death of a loved one, she described the difficulties she faced with depression and low self-esteem, and that despite knowing the risk associated with unprotected sex, she found herself in a renewed relationship with her children’s father that placed her at risk. The long-term relationship- and gender-dynamics of this liaison, and the emotional and financial void that it filled were important issues in her sexual negotiation. “Condom centricity” is of limited value when one considers the social complexities and alternative outcomes that are part of such a multifaceted cultural domain.

The women in my project appeared to be acutely aware of some of the constraints on practicing safer sex, particularly when they described other women their age. They talked about out-right risk denial, age-based risk denial, “living for the moment” and other emotional responses, self-esteem issues, dislike of condoms, newness of negotiating condom use, buying condoms, and so on. Additionally, many talked about HIV testing for themselves and their partners, thus avoiding the issues associated with “condom centricity” for personal protection. The issue of HIV testing was significant and all the more remarkable that it came up at all since it was not included in the research design.

Over a third of the recently single women volunteered that they had been tested for HIV. Since this was not a specific question that I asked, I do not know if many more had been tested and did not volunteer the information. The rate of testing was significantly correlated with knowing someone with HIV/AIDS. It is not surprising that knowing someone with HIV/AIDS or someone who has died of AIDS would motivate testing, however this degree of correlation may signal an important incentive for HIV testing to be considered in other research projects. Germane to the other objectives in this project,
this motivation for HIV testing may be a useful avenue to open discussion about sexual health issues with certain patients.

**Issues in the Physician-Patient Dyad**

Unfortunately, this project confirmed the findings from previous studies regarding physician-initiated discussion of HIV and other sexual health topics. Research has repeatedly shown that physicians rarely discuss sexual health issues, including HIV, and often do so at the patient’s urging (Makadon and Silin 1995; Gerbert, Maguire, and Coates 1990; Haas and Coe 1997). The vignettes were useful for discovering their overall views about physician-patient communication on sexual health. Clearly, the vignettes often served to raise topics that I had planned to address later in the interview.

Both physicians and DHP women made observations about the patient-provider dynamic in the vignettes that related to social, cultural and structural issues in clinical communication, several of which support previous research findings. One such point raised by some of the DHP women was the power dynamic inherent in the dyad, and relative disadvantage of patients due to being only partially clothed, and in unfamiliar territory where the language and norms of clinical practice sometimes leave them feeling vulnerable. They also felt that time and financial issues were important determinants in patient care.

The DHP women and the physicians talked about how time constraints interfere with the effectiveness of clinical visits. Physicians pointed out how time issues affected the number of topics they can talk about with patients, particularly older patients that are presenting with multiple illnesses. Several noted that sexuality issues are not addressed because they are forgotten in the rush to cover other pressing health issues. Training that typically focuses physician attention to one or two presenting problems, and a
concomitant emphasis on sexuality in youth with the implication that older persons should not be concerned about sexuality (or the potential health risks associated with some sexual behaviors), do not leave older patients with much hope that sexual health issues will be addressed in standard health care settings.

Many of the women focused on the hurried nature of the clinical visit, and how physicians often appear disinterested in them, and always “with one foot out the door.” Several of the women felt that visiting a woman physician would ameliorate this problem, whereas others thought that women physicians had the same rushed disposition as men physicians.

Consistent with previous research, physician and patient stereotypes based on age, and gender were extensive (Cline and McKenzie 1998; Hall and Roter 2002; Haug 1996; Jenks 1993; Street 2002). Most DHP women preferred women physicians to talk to about sexual health topics, and they thought female physicians were more knowledgeable about female health issues, especially women physicians close to their age. Several women felt strongly that a patient’s gender influenced how physicians related to them generally as well as regarding sexual health issues. Physicians appeared to back this up by noting that either they typically do not consider sexual health issues relevant (or as relevant) for older women patients, or that they feel that is the perspective of many other physicians.

Some of the cultural consensus data support this contention by revealing the differences in how women conceptualize their own sexuality and how physician conceptualize it. For example, the ratings data clearly showed that the physicians and DHP women had very different cultural understandings of mature sexuality for women.
Close inspection revealed that women focused on the more positive aspects of maturing sexuality, whereas physicians focused on more negative or medical aspects. Both rated terms referring to bodily changes and changes in sexual function as relevant to describing midlife female sexuality. However, physicians were much more likely to consider those changes as problematic than were women. Unlike the physicians, the DHP women consistently indicated that terms less active and menopausal problems were not relevant to describing mature sexuality. Rather they emphasized terms like caring, satisfying, sensitive and enjoyable in their choices.

The cluster analysis and MDS data further demonstrate how the two samples have very different views about women’s mature sexuality in particular areas. These data showed that the physicians developed a coherent grouping of terms for menopausal patients who are having difficulties or discomforts. Whereas there was much less agreement about menopause-related terms for the women, suggesting that there may be wide-ranging experiences regarding menopause. These differences also point to the fact that physicians in the course of their work are more often faced with biomedical problems of midlife aging and sexuality, whereas the women have a much broader range of experiences to draw on, many of which may be very positive. These differences in perceptions are informative as to what physicians need to understand about midlife and older women to better serve their patients.

Despite the clear differences between the samples on several important points, the data also showed that women and physicians share some common expectations about the clinical encounter, mainly in terms of the role patients and physicians should take in clinical talk about sexual health. Although several women talked about patients being
more pro-active in clinical settings, this mainly took the form of seeking second and third opinions, reporting maltreatment due to economic or racial discrimination, and seeking health information on their own, rather than confronting the inherent asymmetry of the physician-patient relationship.

The DHP women put a lot of emphasis on patient responsibility in the clinical interaction, however this was assuaged by their ideas about the role of the physician to provide a safe environment for discussing sensitive issues. Physicians largely agreed with this perspective, but noted that they were often remiss in providing such an atmosphere simply through the neglect of raising sensitive topics so that patients know that it is “safe” to discuss them. Even though the women and physicians have similar perspectives about the ideal clinical encounter, regrettably, structural and institutional factors appear to hamper the communication process, possibly as often as age-, gender-, SES-, and ethnicity-based assumptions do.

The DHP women’s perceptions about race and ethnic stereotypes were mostly not in agreement with previous research. Except for a fraction of African American women, few had experienced racial stereotyping, though several believed that it was still a common occurrence. However, those who had experienced such maltreatment, told devastating stories about events in clinical settings that had left long lasting emotional scars.

When the topic of race/ethnicity was brought up, several women said they thought the impact of socioeconomic status was more important than ethnicity. Many DHP women felt that educational and economic status significantly affected the way physicians react to patients. Previous studies have shown that many physicians need a
financial incentive to spend optimal time with patients, thus leaving poorer patients inadequately attended to (Allman et al. 1999; Jackson and George 1998, Lazarus 1988). Some of the DHP women expressed the sentiment that if one does not have money or the “right type” of insurance, they can forget getting fair, let alone optimum, treatment. The physicians in this study, even though they treat a largely low-income population, did not appear very mindful of this issue and this could be because most of their patients are poor and therefore they have no frame of comparison for reflections about differences in treatment. However, more fine-grained analysis of the physician data may show greater cognizance of this issue than was presented here.

This dissertation touched on several important topics in clinical communication generally, and about sexual health in particular. However, not all of the data that collected for this project were fully explored. Several of the women and physicians made comments about physicians listening to their patients, interruptions in discourse, and recommendations for improving patient care, but there is more to be investigated on these and other topics within the data collected.

**Limitations**

The limitations of this research project are discussed on several levels: 1) some of the data collection methods limit the generalizeability of the results; 2) some of the project goals were not achieved due sampling issues; 3) not all of the hypotheses were addressed with the interview instrument, and 4) time and space limitations on analysis of all the data gathered. This project yielded a rich dataset despite its limitations; so rich that not all of the data could be analyzed at this time.
Generalizations to Larger Groups

The results from this project have several important caveats, particularly in terms of generalizations to larger populations. This is a largely ethnographic endeavor, and as such it focuses on a group of people that may or may not be representative of larger groups of people. In order to generalize to populations beyond those that were directly studied requires the use of representative samples (Bernard 1995). This study used what Bernard calls “purposive” or “judgment” sampling, where the researcher decides the purpose that the respondents will serve. Judgment samples are ideal for qualitative research on special populations. In this case, “recently single” midlife and older women were an ideal such population, so that I could understand how they conceptualize sexuality and HIV/STD risk for themselves and others their age and in similar circumstances. Women in such a situation have rarely been considered for HIV prevention research, yet their numbers are continuing to grow among those infected with the disease.

Although non-random sampling is regularly used in qualitative studies (Bernard, 1995; Handwerker, 2001), care is needed when generalizing results to other recently single women and other primary care physicians. Given that the recently single participants were seeking guidance through a state sponsored program, these findings may not be representative of other recently single women who do not choose to participate in such programs. Although the study participants represented the predominant ethnic groups in the area, and had varied backgrounds in terms of education and living arrangements, women from different ethnic groups and in other areas of the state or country may have very different views from the ones presented here.
Handwerker argues that good ethnography blends numerical analysis with textual analysis to look for interconnections between respondents, so that ethnographers can interpret the linkages to make inferences that reach beyond the few people they had the chance to learn from (2001). The work of Chavez and colleagues (2001), show that ethnographic results can be successfully generalized to larger groups with similar characteristic, and should not be discounted as isolated or idiosyncratic musings. Thus, while this study may not adequately characterize the universe of “recently single” women, I would argue the findings are instructive as to what topics are important for physician training and future prevention efforts directed at this population.

**Sampling Issues**

The research plan proposed to select 60 women from the displaced homemaker program over the duration of the project (20 African-American, 20 Latino, and 20 Euro-American women). Although I anticipated that the Latina sample might be smaller than this based on my communication with the program director and the fact that the Latino population in the area is about 5%, I hoped to have a sufficient number to include them in this project. Unfortunately the numbers of Latinas attending the program during the year and a half that I recruited subjects was lower than usual, and of those attending most were younger than the 45 years of age minimum or they were still married. Recruitment into the displaced homemaker program in this area does not actively target Latinos with its limited budget, a fact I became aware of only mid-way through the project. This was disappointing, and leaves a void in terms of how this larger segment of Florida’s population would have responded to this research.

A related sampling issue with the DHP women was that I was not able to determine refusal rates. My method of recruitment rarely left me the opportunity to inquire why a
given potential participant chose not to participate. Most often women in the meetings I attended, who did not sign up, were those that did not meet the demographic requirements (age, marital status). The program caters to women age 35 and older, whereas my project focused on women age 45 and older. According to conversations with the program director the average age of program participants is 45 and some years closer to 40. Women who met the age criteria of any given meeting tend to average about a quarter or a third of the participants.

On the occasions that I was able to ask the older women who did not sign-up about why they had not signed-up, I was simply told they were not interested with no further explanation or that they did not have time to participate. The only other refusal information that I gathered was from those that had signed-up, but that I was never able to meet with. Reasons ranged from moving out of the area, wrong telephone numbers, but most commonly they did not return my calls.

The project also fell short on the number of physicians. The research plan proposed a physician sample of 40 in order to have enough participants to complete the CCM procedures. The final sample ended up at 31 due to the difficulty of recruiting physician participants. Physicians are notoriously difficult to recruit for research projects, particularly projects that take more than a few minutes to complete. Several email announcements that went to a hospital-wide primary care listserv, yielded only three additional physicians over the 28 recruited with the help of the behavioral medicine educator at the family practice clinic. I had to accept lower than ideal numbers of participants to run the CCM analyses. However, since the reliability from cultural consensus is not just a matter of sample size, but also a function of agreement among
respondents (Weller and Romney 1988) the results are defensible. The difficulties I faced with recruiting a physician sample are testament to the importance of having the help of an on-staff go-between.

**Objectives and Interview Instrument Limitations**

A few of the project objectives were not adequately assessed through the interview instrument. Although I asked women if they thought that blacks and whites were treated the same in clinical encounters, I neglected to ask this of the physicians. Race/ethnicity focused questions were too distinct between the two samples to provide adequate comparisons. Although the topic of physician age came up in many interviews with both women and physicians, mostly in response to the vignettes, and from the open-ended nature of the questioning, I did not specifically ask about the impact of physician age to address this objective as I did with physician ethnicity and gender. I was also interested in how these issues relate to women’s comfort level in talking to physicians. Although I managed to get a great deal about physician gender, I was less successful in gathering information about the impact of ethnicity and age on comfort levels. Some of this relates to my expectations regarding the amount of information that would be elicited from the vignettes. Explicit descriptions of these characteristics for the actors in the stories would have been prudent on this matter.

**Limitations on Analysis and the Problem of Too Much Data**

Finally, this project with in-depth interviews with 62 participants yielded a very large amount of data. There are numerous issues that could be further developed with more analysis. Some of these include: more on time issues in clinical talk; comments about physicians listening to their patients; more on concerns about the impact of financial issues and health insurance in health care; and more on HIV/AIDS related
knowledge such that it could be compared to other research more directly. In addition, I asked all of the respondents what they recommended for improving physician-patient communication, and an analysis of this data and the data collected from medical educators is needed. There was simply not time to review all of this data with the attention to detail that it deserves for this report.

**Significance and Future Research Considerations**

This is an important project for improving health care communication about sexuality issues, as well as clinical HIV/STD prevention efforts with midlife and older women that are newly single. These research findings have clinical and educational utility. Physicians and other health care practitioners need practical skills for addressing their mature patients' sexuality concerns, as well as practical solutions for minimizing the hierarchical dynamics of clinical interactions. Since sexuality is simultaneously individual and social, greater knowledge about how it is culturally framed will be useful for implementing culturally competent care. Ideally these results will be used to develop physician-training modules on communicating about mature sexuality. These modules will address the real-life concerns of midlife and older women regarding sexuality issues. These data showed that although physicians and recently single mature women share many concepts about mature sexuality, the lived reality that the women brought to the study showed that there were also significant differences in how mature sexuality is conceptualized. The most significant differences highlight the need to steer physicians away from age-, gender-, ethnicity- and marital status-based assumptions about sexuality.

Based on the analysis of the data contained in this report there are several concrete suggestions to improve clinical communication about mature sexuality: (a) clinical settings need to display visual aids (pamphlets, posters, etc.) about sexuality and sexual
health so that patients will feel like it is “OK” to ask their doctor about these topics; (b) physicians should use open-ended questions about relationships and sexual activity; (c) physicians should not make assumptions about patients’ sexual activity based on age, marital status, or health status; and (d) physicians should not assume that patients will bring up sexual health topics with their doctors if they have concerns. Time and resource constraints sometimes limit the number of topics that physicians can address in an encounter, it is therefore important to make other resources available to patients, such as: recommending other office staff that can be helpful in addressing patient concerns; and directing literate patients to reading materials on various topics. Further analysis of the data gathered for this project is expected to add to this list of suggestions.

This project’s focus on an understudied sample of divorced, separated, and widowed midlife and older women, provided unique information about an often forgotten segment of the population, particularly with regards to sexuality and sexual health risk. This is instructive to programs, such as the one used for sample recruitment, that sexual health issues are not only important to the women, but also relevant for their continued health and well-being. In addition, the findings may also be useful for public health approaches to HIV/STD prevention because some of the views sexuality issues for mature women can be extended beyond the clinic, and into targeted prevention campaigns.

The project builds on the body of cultural consensus theory work regarding health beliefs. With further analysis of the HIV/AIDS related knowledge in this data, I can add to and compare to the existing data by Trotter and colleagues (1999), and Weller and

Furthermore, future research could use the ethnographic data from this project to develop a study with a larger, more representative sample of mature recently single women, and a larger, more representative sample of physicians. A questionnaire that focuses on a few major findings presented here would lend greater credibility to physician training suggestions.

Finally, this project reached beyond the interpersonal dynamics of the physician-patient dyad to examine the cultural and structural factors impacting clinical communication, situating a micro-level exploration within macro-level phenomena. Many of the structural and institutional issues raised here are beyond the scope of this investigation. However, the research reveals the endurance of long held beliefs about the hierarchical nature of the medical encounter and how it is impacted by gender, age and ethnicity. Future research could seek avenues of training and institutional structure that could minimize these impacts, such as including more physician education on the problem of stereotyping patients based on age, gender and ethnicity; and improving history taking skills and techniques to enhance physicians’ understanding of their patients’ needs and concerns. The incorporation of patient viewpoints and greater patient involvement in the therapeutic process results in higher quality of care, and better health outcomes.
APPENDIX A
SHORT DEMOGRAPHIC SURVEY FOR DHP WOMEN

1. Age ___ Birth date ___/___/19___

2. Which race or ethnic group do you identify with?
   ___ White/Euro-American    ___ American Indian
   ___ Black/African-American ___ Asian/Pacific Islander
   ___ Other (write-in) _______________

3. Are you Spanish, Latino, or Hispanic
   ___ yes: please specify heritage _______________________________________
   ___ no

4. What is the highest level of education you have completed?
   ___ 8th grade or less   ___ Trade School
   ___ Some High School    ___ Some College
   ___ High School Graduate ___ College Graduate
   ___ GED                ___ Advanced Graduate training

5. Marital Status/Partner Status:
   ___ Divorced (months/years married ___)
   ___ Widowed (months/years married ___)
   ___ Separated (months/years married ___)
   ___ Living together with a boyfriend/girlfriend (months/years ___)

6. Do you currently have a dating partner (boyfriend/girlfriend)?
   Yes __ No __, or dating w/out commitment __

7. Do you have any children? Yes___ No___, If yes, how many still live with you ___

8. How many persons live in your household ______

9. Religious/Spiritual Affiliation: ___________________________________________

10. Employment status
    ___ working full-time (40 hours or more) ___ retired
    ___ working part-time (30 hours or less) ___ unemployed
    ___ other (specify ____________________) ___ disability income (SSI)

11. How long have you lived in the Jacksonville area (north FL/south GA)
    ___ entire life ___ 20 yrs or more ___ 10-15 yrs ___ 5-10 yrs ___ <5 yrs
12. Please rate your current health status.
   ___ excellent  ___ good  ___ average  ___ fair  ___ poor

13. When did you last visit a doctor?
   ___ within the last month  ___ within the last 2 years
   ___ within the last six months  ___ have not seen a doctor in over 2 years
   ___ within the last year

14. Type of doctor you visited ______________________________________________

15. Do you have any chronic health conditions that require periodic or continuous medical care (such as heart problems, high blood pressure, diabetes, arthritis, etc.)?
   ___ yes  ___ no  ___ not sure

16. Do you consider yourself disabled?
   ___ yes, totally  ___ yes, partially  ___ no
Circle one: attending resident (Circle appropriate year: 1, 2 or 3)

1. Age ___ Birth date ___/___/19___

2. Which race or ethnic group do you identify with?
   ___ White/Euro-American   ___ American Indian
   ___ Black/African-American   ___ Asian
   ___ Other (write-in) ____________________________________________________

3. Are you Spanish, Latino, or Hispanic?
   ___ yes: please specify heritage ___________________________________________
   ___ no

4. Do you speak any languages other than English, fluently?
   ___ yes: please list _____________________________________________________
   ___ no

5. Do you have bilingual (trilingual, etc.) staff in your office (clinic)? ___ yes ___ no

6. What year did you complete medical school _______

7. Please provide a rough estimate of the percentage of persons you treat annually in each age range:
   ___ under age 10   ___ age 35-44
   ___ age 10-19   ___ age 45-59
   ___ age 20-34   ___ age 60-74   ___ age 75+

8. What percentage (estimate) of your patients are women?
   ___ less than 10 %   ___ 50-70%
   ___ 10-30%   ___ more than 70%
   ___ 30-50%

9. What percentage (estimate) of your patients are:
   ___ White/Euro-American   ___ American Indian
   ___ Black/African-American   ___ Asian
   ___ Other (write-in) __________________________

10. What percentage (estimate) of your patients are Hispanic/Latino?
    ___ less than 10 %   ___ 50-70%
11. How often do time constraints affect your ability to take a thorough history with your patients? (circle one)

- Always
- Almost always
- Half the time
- Almost never
- Never

Comments
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________

12. Do you feel that your medical education adequately prepared you for addressing current sexuality issues (including STDs/HIV) with a wide range of patients?

- Strongly Agree
- Agree
- Neutral
- Disagree
- Strongly Disagree

Comments
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________

13. Where do you access updated information on aging and sexual health? __________

____________________________________________________________________
____________________________________________________________________
____________________________________________________________________

14. How well informed are the majority of your adult patients (age 45 and older) about HIV and other STDs? (circle one)

- Well-informed

1  2  3  4  5 --- not at all informed

15. Generally, what percentage of your adult patients do you consider at-risk for HIV or other STDs? (Note: This question was not included until the survey was revised and was only administered to half of the physician participants)

- % males
- % females

By age group: (Note: This question was not included until the survey was revised and was only administered to half of the physician participants)

- % males age 18-30
- % females age 18-30
- % males age 31-45
- % females age 31-45
- % males age 46-64
- % females age 46-64
____% males age 65+       ____% females age 65+

Comments
_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________

16. Do you think it is primarily the patient's or the physician's responsibility to bring up sex life issues in a clinical encounter?

___ patient  ___ physician  ___ both  ___ neither  ___ don’t know

Please explain WHY you made the choice you did for question 16. ____________________________
_____________________________________________________________________
_____________________________________________________________________

(Note: This question was not included until the survey was revised and was only administered to half of the physician participants)

Other comments:
_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________
APPENDIX C
VIGNETTE INTERVIEW FOR DHP WOMEN

Vignettes and Interview Questions

I'm going to read you [or play a recording of] two stories about doctor-patient interaction. The people in the stories are not real people, but you may find their situation to be familiar. After I read [play] each story, I'll ask you some questions on your opinions about their situation. There are no right or wrong answers. Your responses to my questions do not need to be based on your personal experience, but instead may just reflect your general knowledge and opinions about doctor-patient communication. Please do not hesitate to ask me to repeat any of the questions or the stories.

Story one (read aloud)
Cynthia Cooper, has back pain because of growths (fibroids) in her uterus, but at age 64 she is in good health otherwise.

When Ms. Cooper's GYN diagnosed her with fibroids 6 months ago, he suggested that she may need to have a hysterectomy to remove them to relieve the discomfort and to avoid future cancer risk. Now that the pain is getting worse Ms. Cooper has made an appointment to visit with her doctor to talk about the Hysterectomy.

She recently read a magazine article about a woman who experienced sexual problems after a Hysterectomy and is worried, but she feels uncomfortable bringing up this issue to her doctor. Her doctor suggests removing her uterus for the fibroids, as well as her cervix and ovaries to prevent future cancers, and since she is well past menopause she does not need these organs anymore.

She asks, "Are there any complications I should be concerned about?" The doctor explains, "It is major surgery, but it is also very common. There is the remote possibility that you could have post-surgical difficulties with incontinence and other urogenital problems, but the risk is very low." He continues, "It does have the risks associated with any major surgery" and then spends another 15 minutes explaining the procedure and all of the possible risks to Mrs. Cooper, in detail.

Afterwards she still has concerns and asks, "But won't the removal of these organs (affect my sex drive…or…make me less feminine…or…affect my sex-life)?" "No," the doctor responds, "though some women may have difficulties because they believe that they will." Ms. Cooper is reassured, and feels that the doctor knows best about her health and cancer risks.
She has the surgery and is out of the hospital in a few days, and is told she should be "back to normal in about 6 weeks." On her one-month follow-up visit the doctor says she is healing just fine, and on the two-month follow-up he says she has healed, and can resume her life as normal. When she tries to have sex for the first time after the surgery, it is extremely painful and she has some bleeding. She calls the doctor's office and makes an appointment. When she explains what happened during sex the doctor says, "Oh, that's not unusual. You just need to have sex more often and it will get better." Ms. Cooper is very troubled as she remembers the pain and wonders if she will ever be able to enjoy making love again.

What is your opinion about this doctor-patient communication?

Probes: Was it typical, unusual, normal, good, bad, positive or negative?

How do you think this doctor-patient exchange could be improved?

Do you think doctors are usually sensitive to how medical treatments (or drug treatments) may affect a patient's sex life?

Does this story remind you of any of your experiences, or perhaps experiences of your friends that you have been told about?

**Story two**

When Wanda Johnson began dating in the mid-1990s, she was a little rusty, having gone through a divorce in 1992 after 31 years of marriage to an unfaithful husband. She did not frequent singles bars. She dated a few men she met through friends and at church. But Carl Jenkins, a long time friend from her church, was different. He was handsome, funny and someone she thought she could get serious with. They began spending more and more time together; Wanda felt she had found love like she had never known before, and after a year they were married in the church where they met.

A year later, Wanda Jenkins began feeling very sick. She had had an annoying cough for weeks, and was now running a fever and felt achy all over. She went to see the primary care doctor, Dr. Lewis, on her health insurance plan. After taking her temperature and discussing her symptoms, Dr. Lewis said, "You appear to have a bacterial infection, but antibiotics should clear it up in a week or two."

Mrs. Jenkins did improve over the next few weeks, but began feeling poorly again soon after. She began having yeast infections, which were not clearing up with the over-the-counter medicines. Dr. Lewis prescribed something stronger (fluconazole). He explained that the reason she was having difficulty curing the infection was because of her earlier dose of antibiotics.

She improved, only to get a urinary track infection a few weeks later. Carl was worried and the constant medical bills and Wanda's poor health was putting a strain on both of them. Over a 10-month period, Wanda was prescribed various antibiotics and anti-fungals. Although Mrs. Jenkins' chronic difficulties were typical of immune disorders
like HIV/AIDS, Dr. Lewis knew that his patient was a married, church-going woman, and he did not think her problems were sexually transmitted.

Dr. Lewis attributed Mrs. Jenkins' fevers and night sweats to menopause and to a rough bout with chronic fungal and bacterial infections. He put her on hormone therapy, but there was no improvement. She was very fatigued and ached all over, and Dr. Lewis suggested, "You may have chronic fatigue syndrome, Lupus, or Rheumatoid Arthritis, and we can start running some tests for these." After a year of chronic infections and general malaise, Mrs. Jenkins was rushed to the hospital with pneumonia, where she was finally tested for HIV/AIDS. No one ever thought she was at risk.

What is your opinion about this doctor-patient communication?

*Probes:* Was it typical, unusual, normal, good, bad, positive or negative?

How do you think this doctor-patient exchange could be improved?

Do you think doctors ought to address the topic sexually transmitted infections with their mature patients? *Probe:* When? Why?

Does this story remind you of any of your experiences, or perhaps experiences of your friends that you have been told about?

Do you think that other recently single women your age and older think that they are at-risk for HIV or other STDs? *Probe:* Why? Why not?

What about doctors? Do you think that they think of women your age and older as being at-risk for HIV or other STDs? *Probe:* Why? Why not?

Tell me a little bit about what you know about AIDS/HIV? Perhaps things that you have picked-up from TV, magazines, etc.

Do you think that you are at-risk for HIV or other STDs? *Probe:* Why? Why not?

**General questions for your opinions about patient-doctor communications:**

What are the most common communication issues that women face when they talk to their doctors?

What makes it easier to discuss important sexuality (or sex life) issues with doctors?

What makes it more difficult to discuss important sexuality (or sex life) issues with doctors?

Do you think that male doctors and female doctor talk with their mature women patients in the same way?

*Probe:* What about when they discuss sexuality issues?
Do you think that the ethnic background (race) of a doctor affect how they talk with mature women patients?

Do you think that the ethnic background (race) of a patient affect how the doctor talks with mature women patients?

Do you think that it is the patient's or the doctor's responsibility to bring up sex life issues?

How do you think sexuality issues should be addressed between doctor and patient?

Do you think that doctors should assume their mature patients are sexually active?  
Probes: Even if they are divorced or widowed?

How do you define "sex life" or "sexuality" for women aged 45 and older? (use only for pile-sort and ratings test participants)

Has your definition of sexuality changed over time?
Story (read aloud): When Wanda Johnson began dating in the mid-1990s, she was a little rusty, having gone through a divorce in 1992 after 31 years of marriage to an unfaithful husband. She did not frequent singles bars. She dated a few men she met through friends and at church. But Carl Jenkins, a long time friend from her church, was different. He was handsome, funny and someone she thought she could get serious with. They began spending more and more time together; Wanda felt she had found love like she had never known before, and after a year they were married in the church where they met.

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Mrs. Jenkins did improve over the next few weeks, but began feeling poorly again soon after. She began having yeast infections, which were not clearing up with the over-the-counter medicines. Dr. Lewis prescribed something stronger (fluconazole). He explained that the reason she was having difficulty curing the infection was because of her earlier dose of antibiotics.

She improved, only to get a urinary track infection a few weeks later. Carl was worried and the constant medical bills and Wanda's poor health was putting a strain on both of them. Over a 10-month period, Wanda was prescribed various antibiotics and antifungals. Although Mrs. Jenkins' chronic difficulties were typical of immune disorders like HIV/AIDS, Dr. Lewis knew that his patient was a married, church-going woman, and he did not think her problems were sexually transmitted.

Dr. Lewis attributed Mrs. Jenkins' fevers and night sweats to menopause and to a rough bout with chronic fungal and bacterial infections. He put her on hormone therapy, but there was no improvement. After a year of chronic infections and general malaise, Mrs. Jenkins was rushed to the hospital with pneumonia, where she was finally tested for HIV/AIDS. No one ever thought she was at risk.

Interview Questions:

What is you opinion about this physician-patient exchange?

Probes: Was it typical, unusual, normal, good, bad, positive or negative?
How do you think this physician-patient exchange could be improved?

When do you think sexuality issues should be addressed between physician and patient?

Should physicians assume that all of their adult patients are sexually active?
   *Probes: Even if they are divorced or widowed? Older Patients*

How should physicians address the topic sexually transmitted diseases with their mature patients?

Do you think the sex (male or female) of a patient affect how physicians communicate with them?
   *Probes: Does this affect how they discuss sexuality issues?*

Do you think the ethnic background (race) of a patient affects how physicians communicate with them?

Does the age of a patient affect how the physician communicates with them?

**General Interview Questions:**

What are the most difficult communication issues that physicians face when they talk to their mature female patients about sensitive topics?

What makes it easier to discuss important sexuality (or sex life) issues with patients?

What makes it more difficult to discuss important sexuality (or sex life) issues with patients?

** (only for those not doing free-list) How do you define "sex life" or "sexuality" for women as they age?

Do you think it the patient's or the physician's responsibility to bring up sex life issues?

What percentage of your patient do you consider at-risk for HIV or other STDs?

Where do you get updated ethnic sensitive healthcare information?
   *Probe: How often?*

What are your suggestions for improvements in clinical communication with mature female patients?
Vignette and Interview Questions for Second Group of Physicians

Story (read aloud): Cynthia Cooper, has back pain because of fibroids in her uterus, but at age 64 she is in good health otherwise.

When Ms. Cooper's GYN diagnosed her with fibroids 6 months ago, he suggested that she may need to have a hysterectomy to remove them to relieve the discomfort and to avoid future cancer risk. Now that the pain is getting worse Ms. Cooper has made an appointment to visit with her doctor to talk about the Hysterectomy.

She recently read a magazine article about a woman who experienced sexual problems after a Hysterectomy and is worried, but she feels uncomfortable bringing up this issue to her doctor. Her doctor suggests removing her uterus for the fibroids, as well as her cervix and ovaries to prevent future cancers, and since she is well past menopause she does not need these organs anymore.

She asks, "Are there any complications I should be concerned about?" The doctor explains, "It is major surgery, but it is also very common. There is the remote possibility that you could have post-surgical difficulties with incontinence and other urogenital problems, but the risk is very low." He continues, "It does have the risks associated with any major surgery" and then spends another 10 minutes explaining the procedure and all of the possible risks to Mrs. Cooper, in detail.

Afterwards she still has concerns and asks, "But won't the removal of these organs (affect my sex drive…or…make me less feminine…or…affect my sex-life)?" "No," the doctor responds, "though some women may have difficulties because they believe that they will." Ms. Cooper is reassured, and feels that the doctor knows best about her health and cancer risks.

She has the surgery and is out of the hospital in a few days, and is told she should be "back to normal in about 6 weeks." On her one-month follow-up visit the doctor says she is healing just fine, and on the two-month follow-up he says she has healed, and can resume her life as normal. When she tries to have sex for the first time after the surgery, it is extremely painful and she has some bleeding. She calls the doctor's office and makes an appointment. When she explains what happened during sex the doctor says, "Oh, that's not unusual. You just need to have sex more often and it will get better." Ms. Cooper is very troubled as she remembers the pain and wonders if she will ever be able to enjoy making love again.

Interview Questions:
What is your opinion about this physician-patient exchange?

  Probes: Was it typical, unusual, normal, good, bad, positive or negative?

How do you think this physician-patient exchange could be improved?
Do you think physicians are usually sensitive to how medical treatments (or drug treatments) may affect a patient's sex life?

Do you think the sex (male or female) of a patient affect how physicians communicate with them?

*Probes:* Does this affect how they discuss sexuality issues?

Do you think the ethnic background (race) of a patient affects how physicians communicate with their patients?

Does the age of a patient affect how the physician communicates with them?

When do you think sexuality issues should be addressed between physician and patient?

Do you think physicians should assume that all of their adult patients are sexually active?

*Probes:* Even if they are divorced or widowed? Older patients?

How should physicians address the topic sexually transmitted diseases with their mature patients?

**General Interview Questions:**

What are the most difficult communication issues that physicians face when they talk to their mid-life and older female patients about sensitive topics?

What makes it easier (and more difficult) to discuss important sexuality (or sex life) issues with patients?

** (only for those not doing free-list procedure) How do you define "sex life" or "sexuality" for women as they age?

*Probe:* Does this definition change over time (marital/partner status)?

Do you think it is the patient's or the physician's responsibility to bring up sex life issues?

What percentage of your patient do you consider at-risk for HIV or other STDs?


Where do you get updated ethnic sensitive healthcare information?

*Probe:* How often?

What are your suggestions for improvements in clinical communication with mature female patients?
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BIOGRAPHICAL SKETCH

Kathryn Elaine Grant received her Bachelor of Arts degree in sociology/anthropology from Florida International University in 1992, where she graduated with honors. She received her Master of Arts degree in Latin American Studies with a concentration in anthropology from the University of Florida in 1995. Her research focused on generational and ethnic identity issues among first and second generation Cuban American women in Miami. After completing her M.A. she worked as an instructor of anthropology, sociology and gender studies at Flagler College, and taught anthropology courses at the University of North Florida. She also worked on a research project assessing older adults’ attitudes about home health services, cultivating her interest in the health and well-being of older persons.

Ms. Grant returned to the University of Florida in 1998 to pursue a doctorate in medical anthropology with a health and aging focus. Through her educational and professional experiences she explored the interplay between biomedicine and the cultural context of modern medical care in the course of her work with prostate cancer patients, medical students, and as a research associate on a project about mature sexuality. Her current work focuses on physician-patients communication issues for midlife women. She has presented academic papers and posters on her current and previous research, and has several research publications.

Ms. Grant is currently the Center Coordinator for the UF Women's Health Research Center, where she plans local and national educational activities focused on women's
health issues and conducts women’s health research. She resides in St. Augustine Florida, with her husband, Pedro Montes de Oca.