

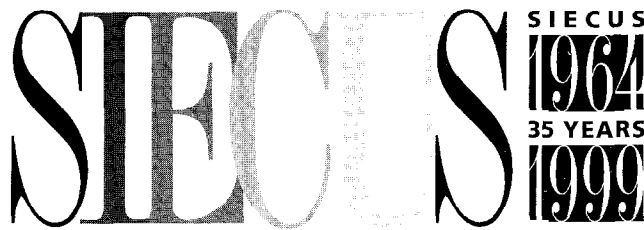
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R E P O R T

SEXUALITY THROUGH MIDLIFE AND AGING

FEBRUARY/MARCH 1999



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INTIMATE RELATIONSHIPS IN LATER LIFE

Mac Edwards

A highlight of my summers growing up in Virginia in the 1950s was the two-week vacation that I spent with my Granny Scarborough. I was able to live in town with her—I grew up on a farm, so living in town was something special. We'd buy groceries (Mr. Altizer, the elderly man who owned the tiny market on Main Street, had our grocery order ready for us when we arrived), watch soap operas ("Search for Tomorrow" was her favorite), and visit her lady friends (I particularly liked Mrs. Stewart and Mrs. Lane, and I think they enjoyed having me around, too).

All of those widows or widowers were probably in their late 60s or early 70s. As far as I knew, they had no significant others and no romantic interests. They spent time with each other and talked mostly about the other people in town or, of course, their grandchildren.

Today I live with my partner and his 86-year-old father, Les, in a small town about an hour from New York City. Even though Les is a widower nearly 20 years older than my Granny Scarborough was when I visited her as a child, my understanding of his life is as different from my understanding of her and her friends as night and day. Les has a girl friend in Florida with whom he talks on the phone every night. He vacations with her every winter, and she spends two weeks with us every summer. They love and enjoy each other even though neither wants to marry. I sometimes find it hard to believe that Les is more than 30 years older than I am. He has such a full life and is so young at heart.

I am telling you about these personal experiences because I think they reflect the remarkably different way that people today have come to understand the lives of people in their 70s, 80s, and 90s. Full, meaningful—and often sexual—relationships in later life are as important today as they are for people in their 20s, 30s, and 40s.

A FULLER LATER LIFE

I am extremely proud of this issue of the *SIECUS Report*. It is filled with articles that reflect the energy with which people approach their later years. Specifically, it includes:

- Research from Stephanie Sanders of The Kinsey Institute on "Mid-Life Sexuality: The Need to Integrate Biological, Psychological, and Social Perspectives." She makes the point that there is no age limit on sexuality and sexual activity.

- An article from writer Elizabeth Pope on "When Illness Takes Sex Out of a Relationship." She emphasizes that the need to be sexually intimate never goes away.
- A report from Sharon Broom of the American Social Health Association on "Sex Happens After 50, and So Do Sexually Transmitted Diseases." She interviews local agencies in Florida that are tackling this problem.
- An article by Carolyn Altman of Senior Action in a Gay Environment on the "Unique Challenges of Coming Out in Later Life." She points out that closeted invisibility compounds the isolation of old age and loss.
- A question-and-answer article by Dr. Domeena Renshaw of Loyola University Chicago called "Viagra 1999" provides insight on the impact of this drug on relationships.
- A conversation with 78-year-old Dr. Helen Greenblatt about her advice column called "Ask Dr. Helen." She talks about the "wonderful time it is to be a senior."
- A new bibliography on "Sexuality and Health." Although not limited to information for older people, this bibliography offers them many valuable sexuality-related resources.

NEW SIECUS INITIATIVE

As part of our Initiative on Sexuality Through Midlife and Aging, SIECUS will hold a research and policy colloquium this spring with The Kinsey Institute to bring together experts to discuss initiatives on this subject.

Our goal is to foster cross-disciplinary dialogue and to suggest future directions for research, policy, and education. Topics will include "The Impact of Aging on Sexuality," "Sexuality and Relationships As We Age," "The Effects of Physical Health on Sexuality and Relationships," "Midlife Sexuality Education," "Current Health Care Coverage Related to Sexuality," and "Sexuality and Quality of Life: Implications for Public Policy."

CONCLUSION

The SIECUS staff dedicates this issue of the *SIECUS Report* to Board member Elma Cole. Elma was the leading proponent for SIECUS' new Midlife and Aging Initiative. We are grateful for her insight, inspiration, and direction.

MIDLIFE SEXUALITY: THE NEED TO INTEGRATE BIOLOGICAL, PSYCHOLOGICAL, AND SOCIAL PERSPECTIVES

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In the past, people believed that sexual desire and sexual functioning became unimportant with age. This is no longer the prevailing view.¹ Although there is a gradual decline in sexual activity and sexual interest beginning in midlife at approximately the age of 50 and accelerating after the age of 70, sexuality remains an important aspect of life into old age. A minority of people in their 80s or 90s do, however, remain sexually active and have sexual intercourse as often as once a week or once a month.²

Even relatively healthy adults experience a decline in sexual activity and interest as they age.³ A number of factors associated with age can contribute to this decline such as: availability of a sexual partner; interest of a sexual partner; negative stereotypes about aging; and, of course, diseases and their treatment. For women, menopause and hormone replacement therapy may also play a part. Thus, a complex set of biological, psychological, and social variables (only some of which are cited here) can influence sexuality in midlife and beyond.

The reality of this interplay among biological, psychological, and social factors is complicated. Research tends to focus on this aspect or that aspect, with individual studies focusing only on a handful of factors at a time. But a truly comprehensive understanding of sexuality in midlife and beyond necessitates consideration of many dimensions within each of these domains as well as an understanding of their overlap and interaction.

People are simultaneously the product of biological, psychological, and social influences. Sexual functioning involves a complex interaction of these influences.⁴ Sexual expression and the meaning of sexuality go far beyond the procreation needs of the human species.

BIOLOGICAL BEINGS

All people are beings with physical bodies that are sexed. Anatomy, basic biological, and physiological processes and states are always part of who people are and how people feel. Every thought is a neurochemical process. Sexuality is clearly related to physicality. Anatomical, physiological, and health-related influences all play their part in midlife sexuality.

Physical, hormonal, neural, and vascular changes associated with aging can affect sexual functioning and behavior. Age is often associated with a decline in health that can have effects on sexuality. It is difficult to study the effects of aging independent of the consequences of disease or the gradual degenerative processes that occur with age.⁵

PSYCHOLOGICAL BEINGS

All people are psychological beings with a gender identity, personality traits and characteristics, preferences and attitudes, concepts of themselves and others, cognitive abilities, different life experiences, and varying moods. Their states of mind—as well as what happens to them—can influence their hormonal state and their psychological well-being. Whether a person is single or in a relationship and whether a relationship is traditional or non-traditional, socially sanctioned or not, may affect the degree to which individuals feel entitled to express their sexuality, their willingness to seek assistance for sexual problems, and the response of professionals to them. All of these factors affect their sexual self-concept and sexual expression. Reproductive hormone levels can affect mood, cognition, and libido. In some cases, changes in hormones across the life cycle can affect the onset and recurrence of affective and other psychiatric disorders.⁶

*“There is no
age limit on
sexuality and
sexual activity.”*

SOCIAL BEINGS

All people are social beings who interact with others. Their interpersonal, familial, and community relationships, the institutions with which they interface, the society and culture at large, the media, and gender-role expectations can all contribute to their sexual self-concepts and shape their sexual interactions. The importance of love and intimacy to midlife sexuality have been described by Steven Levine in his recent book *Sexuality in Mid-Life*.⁷ The influence of family, partner, society, and culture are not less important than the impact of hormones on sexuality.⁸

In the predominant culture of the Western hemisphere in the twentieth century, penile-vaginal intercourse that relies on an erection has privileged status relative to other sexual behaviors traditionally labeled “foreplay” and often

not considered the “real thing.” Although there is little scientific data on the subject, opinions vary about what constitutes having sex.⁹ Views about what constitutes normal sexual expression can affect how people feel about age-related changes in sexuality.

What partners want from one another may change as people age. For example, Phyllis Mansfield and Patricia Koch reported in a study they conducted that women frequently noted desiring more nongenital touching. These women were more likely to report desiring to change their own sexual qualities than those of their partner. The researchers noted that the desire for changes in the sexual qualities of themselves or their partner was significantly related to the women’s reported changes in sexual responsiveness associated with menopause.¹⁰

RESEARCH LIMITATIONS

A clear understanding of the relationship between aging and sexuality is constrained by the number of studies on the topic as well as methodological limitations.

Norma McCoy has reviewed the methodological problems with studies on sexuality and the menopause.¹¹ Her critiques apply more broadly to studies examining other aspects of aging and sexuality. Large studies of representative samples generally include only a few sexual variables. More comprehensive studies tend to be with smaller convenience samples that are often not representative of the general population.

Data on variables known to affect sexuality are often either not collected or are not utilized in analyses. Many studies rely on retrospective data. Asking subjects directly about the relationship between aspects of aging and sexuality may affect findings because many subjects respond with answers biased by their beliefs about what that relationship should be or what they believe the researcher wants to hear. Sometimes methodology and measures are inadequately described and/or statistical analyses are not included. Some infer causation from statistical correlations—biological variables are often assumed to be causal.

To these, I would add that few studies employ a multidimensional or interdisciplinary perspective that would create a fuller picture of the interplay among biological, psychological, and social variables in terms of midlife sexuality. Also, little research has focused on gay men or lesbians as they age.

In the next two sections—one on “Female Sexuality” and one on “Male Sexuality”—I will give examples that highlight the need for an integrated biopsychosocial perspective to understand midlife sexuality.

FEMALE SEXUALITY AND AGING

A decline in sexual activity with age is reported in virtually all studies.¹² As part of the Midlife Women’s Health Survey, 40 percent of a sample of 280 women between 38 and 56 years

of age reported a change in sexual response with more reporting decreases than increases.¹³ Researchers often try to link biological factors, particularly those related to menopause, to these changes. Lay persons often believe that menopause and the related changes in hormone levels have a substantial causal impact on sexuality and mood. Yet, scientific studies indicate that menopause and hormones do not have a simple or consistent relationship with sexual functioning.¹⁴ Other psychological and social factors also play an important role.

Menopausal status. Various studies have associated menopause with a decrease in vaginal lubrication and a decline in sexual interest and frequency of intercourse. Fewer studies have examined the capacity for orgasm, satisfaction with sexual partner, and vaginal pain or discomfort. The results are somewhat conflicting for these dimensions.¹⁵ It is estimated that a third of women experience a decrease in sexual desire during menopause.¹⁶ It is not uncommon to attribute the age-related decline in frequency of sexual activity to the hormonal changes of menopause.¹⁷ But there are conflicting findings.

Elizabeth Cawood and John Bancroft reported on a community sample of 141 sexually partnered women 40 to 60 years of age who were not using hormone replacement therapy or steroidal contraceptives.¹⁸ Research participants were evaluated through interviews, questionnaires, and hormonal assays. Multiple regression analysis included age, menopausal status, estradiol (E2) and estrone (E1), body mass index, depression, hostility, positive affect and sensation seeking, vaginal dryness, smoking, social class, and two sexual attitude scales. Menopausal status and hormonal variables did not significantly predict sexuality variables such as frequency of sexual intercourse, frequency of sexual thoughts, a negative sexual feeling factor, a positive sexual response factor, a psychosexual stimulation scale, and a sexual stimulation scale. These variables were best predicted by quality of sexual relationships, sexual attitudes, and well-being.

In a sample of 201 Australian-born women 48 to 58 years of age that assessed hormone levels and sexual functioning, the authors concluded that most aspects of sexual functioning were not affected by age, menopausal status, or hormone level.¹⁹

Hormone Replacement Therapy (HRT). Estrogen replacement therapy alleviates hot flashes, night sweats, and vaginal dryness and, thus, may help sexual functioning in women for whom these factors interfere. But estrogen alone or in combination with progesterone may not alleviate complaints of loss of libido. In fact, estrogen replacement therapy may induce a loss of libido as a result of increased sex hormone binding globulin leading to a reduction of free testosterone.²⁰ In a survey of 227 members of the Prime Plus menopause support group comparing HRT users to non-users, estrogen therapy alone did not improve sexual

interest and functioning.²¹ Sixty-one percent of the women surveyed reported a decrease in their level of sexual desire after menopause and tried estrogen replacement therapy to improve menopausal symptoms.

Various studies have suggested that testosterone may be important to women's sexual functioning.²² Androgen deficiency has been associated with loss of libido, lack of energy, decreased well-being, and loss of bone mass. The circulating level of androgens generally declines in the decade preceding menopause.²³ Several studies have demonstrated improvement in sexual functioning in postmenopausal women treated with androgens as part of their hormone replacement therapy.²⁴ The reported benefits include increased sexual desire, interest, and enjoyment. Androgen replacement is a more common component of hormone replacement for women who have been ovariectomized and may be more beneficial for them than for women who have experienced natural menopause. In Australia and the United Kingdom, testosterone containing implants are approved for hormone replacement therapy. In the United States, no form of testosterone replacement has been approved specifically for loss of libido in women.²⁵

Psychological factors. Stress, health problems, menopause, hormone replacement therapy, and lifestyle factors such as exercise have also been related to changes in mood. Cawood and Bancroft found various relationships between mood and attitudes and sexuality variables.²⁶

In a multiethnic sample of 337 women 35 to 55 years of age from the Seattle Midlife Women's Health Study, stressful life context and health status were found to have a direct effect on depressed mood, whereas menopausal status had little relationship. Exercise can have positive effects on somatic and mood effects related to menopause.²⁷ Hormone replacement therapy is associated with reductions in depressed mood.²⁸ There may be complex relationships between the effects of hormone replacement therapy on mood and the duration of menopause.²⁹ These studies demonstrate the importance of looking beyond menopausal status to the larger life context of midlife women in trying to understand variables that may influence sexuality.

Social Factors. Changes that have taken place in sex-role expectations for women contribute to cohort effects in cross-sectional studies of aging and female sexuality. The socialization of women who are now in their 90s with regard to sexuality was substantially different than that for women who now are in their 30s or 40s.³⁰ Caution is warranted in attributing differences in sexuality among different age cohorts to the aging process rather than to birth cohort.

Some people, perhaps more in the older generations, believe that a woman's sexual life should end after menopause

when her reproductive years have passed. That view has, however, been challenged. Still, images of sexual attractiveness tend to be youth-oriented, particularly for women, and this may affect sexual self-esteem in aging women.

MALE SEXUALITY AND AGING

Performance is often the focus of studies on the effects of aging on men's sexuality. Most survey research has assessed frequency of intercourse and masturbation as indicators of sexual drive and erectile dysfunction. The recent advent of Viagra has, in some ways, reinforced a focus on the erection as the measure of male sexuality. There is a need to broaden the concepts of male sexuality and develop a fuller understanding of sexual enjoyment and satisfaction in aging men.

Need for broader views of male sexuality. Decreases in sexual desire, sexual arousal, and sexual activity and increases in sexual dysfunction appear with age in healthy married older men.³¹ Men continue, however, to have satisfying sexual experiences while sexual functioning declines.³² This finding highlights the importance of psychological and relationship factors in understanding the quality of men's sexual lives and suggests that a focus on erectile capacity is insufficient.

Data from men ranging in age from 45 to 75 and their partners were used to examine age-related changes in psychological and marital factors likely associated with the quality of sexual experiences. This study explored relationships among psychosexual, marital, and behavioral factors and sexual satisfaction.³³ Although an age-related decline was found in sexual functioning as measured behaviorally and psychophysiological, sexual satisfaction and enjoyment were not related to age. Regression analyses revealed that accurate sexual information, marital adjustment, and fewer erectile problems were all associated with general sexual satisfaction. (This suggests that sexuality education is likely helpful to older individuals. Accurate sexuality information may lead to greater acceptance of changes that accompany aging as well as more realistic expectations, and/or more effective coping strategies.) Frequency of intercourse, positive affect, subjective arousal, and fewer erectile problems were all related to enjoyment of marital sexuality. Erectile functioning alone predicted men's satisfaction with their own sexual function. The authors Raul Schiavi, John Mandeli, and Patricia Schreiner-Engel suggested that future research on sexual satisfaction and aging might include consideration of life meaning, congruence of mate perceptions, personality traits, sexual communication, and equity considerations.

Biological factors—Male "Menopause" or "Andropause." There is apparently no male equivalent to female menopause in terms of a stage of life with dramatic changes in hormonal status. Although gonadal function in men does

not decline as much as in females who have experienced menopause, there is evidence of gonadal decline with age.³⁴ Age-related sexual changes do occur that require adjustment and adaptation for men.³⁵

A number of studies have examined whether testosterone levels decline with age. Cross-sectional data on a random sample of 1,700 men between 40 and 69 years of age in the Massachusetts Male Aging Study indicate that when sociodemographic, psychosocial, health, and life-style characteristics (such as smoking) were taken into account, age was not related to testosterone levels.³⁶ Other studies have reported a decline in free (not bound) testosterone and changes in other hormones and sex hormone binding globulin. It is possible that any decline in testosterone may be related to illness rather than normal physiological processes.³⁷ In general, variations of testosterone levels within the normal range have not been reliably linked to sexual dysfunction. Bancroft has suggested that androgen receptor sensitivity may change with age so that even normal plasma levels of testosterone may not be adequate to sustain former levels of sexual function.³⁸

Psychological factors. Michael Metz and Michael Miner have summarized the psychological changes related to aging in men.³⁹ Some have referred to these as symptoms of "male menopause" or "andropause." They are: a shift in focus from career and extrafamilial roles to increased focus on family, challenge to the male role as leader and protector of the family, increased need for affirmation and acceptance, irritation and anger with aging (especially the physical changes), increased awareness of death and mortality, concerns about self-improvement and personal accomplishments, decline in memory in midlife, and decline in abstraction and concentration after age 60. The degree to which such factors may influence or be influenced by changes in sexual functioning needs exploration.

Social factors. Men are influenced by many of the social factors that may affect women. Problems with an erection-focused, narrow view of male sexuality were alluded to above. Aging in terms of attractiveness is viewed less negatively for heterosexual men than for heterosexual women. Sexual behavior is also not viewed as negatively for older men as for older women. (Perhaps this is because men retain fertility longer than women.) Older men with younger female partners is also part of the cultural imagery of sexuality. The reverse situation is viewed more negatively. There are many interesting questions that researchers can ask with regard to the impact of such social/cultural factors on male sexuality.

Viagra. Viagra could be discussed in terms of its biological, psychological, and social impact on sexuality and aging—not just for men, but for women as well. The availability of

Viagra has transformed the view of erectile dysfunction and its treatment. Its popularity suggests that erectile dysfunction and the resulting anxiety about it are far more prevalent than previously believed. Viagra is also currently used, at least occasionally, by men who are seeking performance enhancement or wishing to avoid potential erectile difficulties—not just by those with erectile dysfunction. The advertising and media discussions of Viagra are certainly likely to promote an image of older persons as still sexual and will also likely enhance expectations that sexual activity involving erections should continue into older ages.

It is a bit too early to determine the ultimate effects of Viagra on relationships. Some feel that the synchrony in heterosexual couples between female menopausal changes of vaginal dryness and/or atrophy and the declining male erectile function is disrupted by Viagra. Women who were content with the shift in focus from intercourse as they and their partners aged may be unhappy with their male partners' newfound erections. On the other hand, erections are symbolic of sexual arousal and partners of men with erectile difficulties sometimes feel that they are not sufficiently attractive to elicit erection. This can lead to problems with arousal for the partners as well. Will Viagra-assisted erections help people overcome some of these interpersonal dynamics? Will Viagra-assisted erections lead to more positive feelings and arousal in partners? Will some partners feel worse because the erection was drug-induced? Future research may answer these questions.

CONCLUSION

Recognizing individual variation and the distinction between sexual activities and satisfaction is important when educating about sexuality and aging. Although sexual activity and interest may decline with age and sexual dysfunction may increase, sexual satisfaction does not necessarily decrease. There is no age limit on sexuality and sexual activity. People are increasingly expecting to continue sexual activity as they age and are seeking help for sexual problems. Within age groups, variability in sexual frequency and other sexual dimensions is high. What is satisfying for one person is not for another.

Aging involves physical, hormonal, neural, and vascular changes that can affect sexual functioning and behavior. Physical and psychological well-being contribute to maintaining sexual activity and interest. Physical and mental illness and medical treatments, including drugs, can be significant factors in age-related changes in sexuality.

Social expectations and the images we have of sexuality and aging can influence sexual self-concept, sexual expression, and expectations for continued sexual activity as people age. Viagra and new pharmacological interventions for sexual problems are likely to foster expectations of maintaining sexual functioning into older age.

A multidimensional interdisciplinary perspective in research and in education is the key to a fuller understanding of the complex interplay of relevant biological, psychological, and social factors that affect sexuality during midlife and beyond. Having accurate sexual information and an awareness of various factors to consider will help individuals better understand, accept, and cope with the changes in sexuality associated with age.

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WHEN ILLNESS TAKES SEX OUT OF A RELATIONSHIP

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Tampa, FL



What happens when illness takes sex out of a relationship?

The emotional and physical demands of chronic illnesses are well documented. Not so its effects on sexuality. It is not a subject that couples feel comfortable discussing—not with each other, not with close friends, certainly not with grown children, rarely even with a doctor.

No one knows how many couples struggle with a loss of sexual intimacy because one or both of them has Alzheimer's disease, Parkinson's disease, diabetes, heart disease, multiple sclerosis, severe arthritis or has suffered a stroke. Invasive surgical procedures, antidepressants, blood-pressure medications and other prescription drugs also can affect the sex drive. But many people face this problem.

The National Center for Health Statistics reports that nearly 40 million people have illnesses that limit physical activity; about 38 percent of them are older than 65. When chronic illness complicates even simple tasks—dressing, bathing, eating, walking—sexual intimacy may seem out of the question. When a sick spouse relinquishes a job, the car keys, a social life and household responsibilities, self-esteem may also dissipate, further complicating the problem.

But the need to be sexually intimate never goes away. Sexual feelings are normal, from birth through old age, says Dr. Bonnie Saks, an associate professor of psychiatry at the University of South Florida (USF) and a psychiatrist and sexuality therapist in private practice in Tampa.¹

"We all have a need for intimacy and physical touch, and it's a cultural myth that we ever outgrow that need," Saks says. "Sex is a natural function, a way of giving and being given to, and without it you lose a richness in life."

Couples who make the effort to maintain a sexual relationship despite devastating disease are generously rewarded, says Donna Cohen, professor of aging and mental health at USF and co-author of *The Loss of Self: A Family Resource for the Care of Alzheimer's Disease*.

"Sex may be the one experience where a healthy spouse and an ill partner can restore the emotional equilibrium of their relationship, making it less of a nurse-patient model," Cohen says. "Even if the ill spouse can only manage a back rub or neck massage, it has this marvelous restorative

impact on the care-giving spouse because it's a small but symbolic effort to rebalance the relationship."²

For some couples, the obstacles to maintaining a sexual relationship may be too great. Faced with the aging process and a difficult medical diagnosis, many couples end their sex life without ever discussing it. Some find alternative ways to communicate their love—a tender touch, a warm kiss, a gentle hug. They may find their relationship deepens and grows richer because they know their time together is short. They celebrate today and hope for tomorrow.

Other marriages, crumbling under the weight of illness and caregiving burdens, may end in despair and the abandonment of a spouse.

LESS OF A MAN? LESS OF A WOMAN?

Emotional costs may weigh heaviest on the ill spouse, who must contend with daily limitations of a disease, a feeling of becoming defective or unattractive, and a terror of degeneration, pain, and death. "My husband is my rock," says a 43-year-old former waitress from St. Petersburg. "I cling to him in the middle of the night when I'm scared." Two years ago, she had a heart attack and was forced to quit her job and severely limit her physical activities. Her husband is afraid of losing her: His mother died of heart disease at a young age.

"Sex is rare," the former waitress says. "On the few occasions we do manage it, it's frightening for my husband because he's afraid my heart will give out, so he backs off. I'm too tired from the illness, and he is too tired from working seven-day weeks just to support us."

Hand-holding, companionable silences and kisses have taken the place of sex in their marriage. "I feel guilty a lot," she says. "He deserves a wife healthy and able to help him. Had I known I would be so sick, I would never have married him. But I do thank God every day that he is here with me."

The dynamics of the care-giving relationship can interfere with a couple's sexual intimacy. If a caregiver must help a spouse in the bathroom, dress him or cut her meat, the caregiver spouse may feel more like a nurse caring for a child than a loving wife or husband. Women, who have generally been raised as nurturers, may adapt to care-giving more readily than men, who must learn a new set of skills.

*"The need to be
sexually intimate
never goes away."*

Both spouses can succumb to frustration, resentment, anger, self-pity, and mild depression—hardly a recipe for romance.

“The first sign that my husband’s diabetes was advancing was when he began having trouble keeping an erection,” says a 49-year-old registered nurse from St. Petersburg. Because of her medical training, she recognized the symptoms of her husband’s disease, but she was unprepared for the emotional toll the loss of their sexual relationship would have on her.

Her husband had been diagnosed as diabetic as a young man and had struggled with the illness until his death in 1996. She decided to talk about her feelings and their experience to help others in a similar situation. She says she remembers how lonely and confused she felt. For months, tension built in the bedroom, the nurse says. “We didn’t talk about it. He’d just get frustrated and roll over in bed,” she says.

She hesitated to talk about the situation because she thought it was selfish to dwell on her needs when her husband was dealing with his medical problems, long hours at work, and a move into a new house. Looking back, she says, she thinks each of them expected the other to be a mind reader.

Because male diabetics sometimes have erectile dysfunction, she suspected that the disease was the reason her husband turned away from her in bed, but she couldn’t help wondering whether he still desired her.

“Logically, I would say, ‘There’s nothing wrong with you as a woman. You’re probably still attractive, but your husband can’t have sexual intercourse.’ But emotionally I was feeling like maybe it was me. How do I know it really is the disease?” Nearly a year later, her husband told her he had lost all sexual desire. He suggested that they try alternatives to intercourse, but she declined. “He said, ‘Just because I can’t have sex doesn’t mean you can’t,’ but I was having trouble dealing with the fact that he couldn’t perform. Plus, I felt like I was taking and not giving back.”

Her husband had talked to his doctors and knew there was treatment for his impotence, but he was reluctant. Confused and conflicted, the woman thought about seeing a sex therapist. Several times, she nearly called for an appointment. “But I wouldn’t and I never told [my husband]. I guess I was afraid it would hurt him, that he’d feel bad, and if I were just strong enough I could accept what was happening.” She saw a marriage counselor and later joined a women’s therapy group, but the subject of loss of a sexual partner because of chronic illness or death never came up. So she read everything she could about the problem.

By this time, her husband’s diabetes had developed complications, and she finally acknowledged the extent of the disease’s impact on their sexual relationship. “It made it easier for

me to accept it, but not easier to live in a sexless marriage. I didn’t blame him, but I resented what was happening.

“I was never the kind of person to say ‘Why me?’ but I found myself asking, ‘What did I ever do to deserve marrying a man who would get sick like this?’ Then I’d feel guilty about it. It was horrible.”

She was also working full time, running the house, handling the family’s finances, and dealing with her mother’s recent death. Her husband’s health deteriorated rapidly. He had kidney failure and limb amputations. During his health crisis, the couple found that sex became unimportant. Her physical desires disappeared.

“What we went through was hard, sad, and painful, but looking back, our relationship really did get better. It was a different kind of love, a deeper kind, but it was just as strong as when we were younger and physically active.”

Toward the end of his life, her husband would hold her and say, “If there’s anything I could do right now, I’d make love to you and show you how much I love you.”

MILD DEPRESSION COMMON

Mild depression is common among care-givers and spouses in chronic illnesses, and it influences the couple’s sexual activity, says Donna Cohen of the University of South Florida. About 60 percent of female caregivers and about 40 percent of male caregivers show signs of mild depression, she says. It also is a symptom of Parkinson’s and other diseases.³

A 73-year-old man from Odessa remembers a time 30 years ago when he and his wife, now 68, gave parties and went dancing on Saturday nights. Party invitations now go unanswered because his wife, who has Parkinson’s disease, has good days and bad days.

“She’s afraid to say yes because she doesn’t know how she’ll feel,” the man says. “We used to go to Busch Gardens, but we haven’t been in a year. She can’t walk far and she doesn’t want to use a wheelchair.”

Their sexual relationship has waned. “Right now, it doesn’t exist,” he says. “My wife never was wild, but she always went along. When she went through the change of life, she wasn’t interested anymore, but maybe that was the beginning of the Parkinson’s. Now I’m almost in the same boat. Since I got diabetes, it’s hard for me to get an erection.”

Last year, he saw a urologist about his sexual dysfunction. While the doctor offered suggestions for treatment, the man has not pursued them.

“Maybe someday, if we’re both in a good mood.... But mostly, I just feel low, like, ‘What the hell, I don’t give a damn.’ I don’t sleep well, I’m always tired, and I never catch up with the things I need to do.”

If another woman were to come into his life, he would be interested. “But it’s like thinking you’ll win the lottery: It’s just wishful dreaming. I’m a man without a future.”

Donna Cohen finds that many older couples abstain from sexual relations when faced with chronic illness. She says the quality of the marriage and their previous frequency of sexual intimacy influence their behavior. Couples in good marriages with a high frequency of intercourse before the illness usually try to continue sexual relations, she says; couples in unhappy marriages or in marriages in which sexual activity is waning often end up abstaining. Prediagnosis fear and postdiagnosis grief also can add to marital conflict and tension, Cohen says.

"If communications aren't good, the couple will fight; then it's more difficult to have sex. After the diagnosis, the integrity of the marriage determines how well they'll cope with the expression of sexual needs."⁴

As a support-group facilitator, Cohen finds that many older women say they don't miss sexual relations because of postmenopausal symptoms of dryness, discomfort, and the inability to achieve orgasm. These symptoms are treatable, Cohen says, and she faults medical professionals for failing to discuss such subjects. "Older people have not gotten good information from their doctors about how to make the sexual encounter more enjoyable," Cohen says.

THE TOLL OF ALZHEIMER'S

Although all chronic illnesses test the fabric of a couple's relationship, perhaps Alzheimer's poses the harshest challenge.

Linda, 52, talks openly about her husband's Alzheimer's disease and how it has affected their marriage. She is on the board of the Alzheimer's Association of Tampa Bay and often speaks about the illness and related issues of sexuality to caregivers and nursing home staffs.

Dick, a 67-year-old retired Navy captain, showed signs of the illness more than a decade ago. Now he is bedridden, incontinent, and has little intelligible speech. Linda cares for him at home, with help from her 23-year-old son and a nurse's aide.

Before Dick became ill, the couple enjoyed a fulfilling sexual relationship, but Linda was not prepared for the way the disease affected her husband.

"Alzheimer's forces a regression, and I think Dick decided that 18 wasn't a bad place to stop," she says, making light of the problem. "He couldn't keep his hands off me. He wanted to make love morning, noon and night, and at least twice in between."

Nobody had told her that hypersexuality can be part of the early and middle stages of Alzheimer's, although the opposite problem—loss of libido—also occurs. At first Linda was happy to continue their physical relationship. But as the disease progressed, her husband's awareness of her satisfaction decreased.

"It was always rather bittersweet. This caring, sensitive lover who always made sure my needs were met no longer

seemed to be aware of my needs," she says.

Caregiver spouses of Alzheimer's patients report other changes in the sexual relationship: the ill spouse may demand frequent sex but may not recognize his or her partner; the encounter may be emotionless and mechanical or marred by inappropriate behavior, such as childish giggling. Such behavior can be off-putting, even frightening, for the healthy spouse. Male caregivers sometimes report that their wives are no longer interested in sex, and they are afraid to initiate sexual relations because it feels like rape.

"The problem for me came with the quick changing of roles," Linda says. "As Dick became more diminished in his ability to function, one minute I was helping him go to the bathroom and wiping his tush, and the next minute he wanted to make love.

"That was emotionally very difficult. Besides, by then there was much less physical release for me, but I felt compelled to go along because there was so little that brought him pleasure. I'd end up crying a lot. I was mourning what had been and what no longer was. I was an object of his sexual desire rather than his wife and lover."

As inhibitions disappear in a person with Alzheimer's, inappropriate behavior is common. Linda warned her women friends that Dick was less discriminating about where and how he touched people.

"I told them please don't stop hugging him, but if he touches you on your breast or bottom, just put your hand on his and say, 'That really does feel good, Dick,' and then move his hand. Don't make a big deal out of it and embarrass yourself or him."

Linda has a part-time job, a house filled with the comings and goings of adult children and a wide circle of friends. Consequently, she doesn't face the social isolation that many caregivers do. Some caregivers of severely ill people turn outside the marriage for companionship.

"Most of the men I've known who are caring for a spouse have sought out other contacts," she says. "I have no problem with that; I think that's fine. My children have all said, 'You know, Mom, if you wanted to date someone...,' and I said, 'Yeah, right, thanks very much, but I don't remember asking if I need your permission.' The reality is it's not necessary for me. I meant it when I said, 'Til death do us part.'"

Other caregivers make different choices. One gerontologist recalls talking with a husband who had brought his wife, an Alzheimer's patient, to be examined because she was so agitated. Under the doctor's questioning, the man acknowledged that one reason for his wife's behavior might be that he had entertained a girlfriend at their home, thinking that his wife would not notice or understand. The doctor intervened, lecturing the husband about appropriate behavior.⁵

Most caregivers who need conversation and compan-

ionship try to find them in outside activities, the church, or synagogue, or support groups. But, as one social worker observes, "There are a lot of lonely spouses walking the halls of nursing homes."

"WHEN SEX GOES, I'M GOING WITH IT"

The bond of love in a good marriage transcends sexuality. When the diagnosis is terminal and time is limited, a special quality can come to a couple's affection.

Sex was always a "top priority" for a Madeira Beach homemaker, 73, and her husband, a retired police officer. They shared a ribald sense of humor. "I used to joke with (him) and tell him, 'When sex goes, I'm going with it,'" she says.

Thirteen years ago, her husband learned he had prostate cancer. "I didn't expect him to live long, so every day was like a blessing," the woman says. They were able to maintain a sexual relationship until surgery left him with no stamina for sex.

"I missed sex, but I put my feelings behind what was happening to him. His health was more important than my sexual needs," she says.

In the last year of his life, her husband, then 79, was bedridden, and the couple occupied their time with chess, books, word games, backgammon, movies, and music. "And I cooked for him. I cooked round the clock," she says. "He ate six meals a day. That was the one thing that kept me going. I was so busy cooking and so happy he was eating."

She and her son cared for her husband until he died at home in October. The fact that she was able to do so much for him has given her great inner peace, she says.

David, 83, of Dunedin, also knows what it is like to lose a loving partner to illness. One year after he married his second wife, she was diagnosed with breast cancer and

underwent a mastectomy, radiation, and chemotherapy. She recovered well and they were able to resume their active travel and social schedule. But several months later she returned to the doctor because of a sharp pain in her back. Tests showed the cancer had spread to her spine. The doctor told her the tumor was unlikely to respond to treatment.

The night after they learned of the prognosis, he put his arms around his wife when they went to bed and held her close, David says. "I told her that I didn't want sex. Instead, I told her I wanted her to know how much I loved her and wanted her to be with me forever. She bravely said that we were both scared because we didn't know what was going to happen. I could not reply to that and just hugged her closer."

Three weeks later, his wife died. She was 65.

"The last words she ever spoke were, 'I love you.'"

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CALL FOR SUBMISSIONS

The *SIECUS Report* welcomes articles, reviews, or critical analyses from interested individuals. Detailed instructions for authors appear on the inside back cover of this issue. Upcoming issues of the *SIECUS Report* will have the following themes:

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August/September 1999 issue.

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"The Construction of Gender"

October/November 1999 issue.

Deadline for final copy: July 1, 1999.

SEX HAPPENS AFTER 50, AND SO DO SEXUALLY TRANSMITTED DISEASES

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When Barbara Barnett answers the phone at the CDC National STD Hotline operated by the American Social Health Association (ASHA), chances are the person at the other end will be 14 to 24 years old, not a senior citizen.

But the statistics tell a different story about sexually transmitted diseases (STDs) and older people. The U.S. Centers for Disease Control and Prevention (CDC) reports that people 50 and older make up more than 10 percent of total AIDS cases in the United States and that HIV rates are increasing among people in their 60s and 70s.

MYTH ABOUT SEX AFTER 50

"There's this myth that once you're past 50, your sex life ends," says Barnett, 66, who is a supervisor for the STD Hotline. "But it doesn't."

On the hotline, Barnett says, she has often talked with seniors who believe they do not have any risk of contracting an STD. "Many are widowed and meeting other people," she says. "They don't know who this new person's partners were."

Barnett has worked at the STD hotline for three years and formerly served on the staff of the CDC National AIDS Hotline, also operated by ASHA, for five years. About once a month, she volunteers to speak about STDs to adult groups including business women, senior centers, and local chapters of the American Association of Retired Persons (AARP). She also has addressed the national AARP group in Washington, DC.

Barnett tells older people that they face similar risks as younger people do for contracting STDs. She says some seniors may feel ashamed to talk about sexuality with their health care provider. But providers share the blame, too, whenever they fail to screen older patients who may be at risk for an STD. And no matter what people believe, seniors are having sex.

A recent survey conducted by Wyeth-Aerst Laboratories found that more than 90 percent of post-menopausal women remain sexually active. But the "safer sex" message is rarely aimed at older adults.

STD/HIV PROBLEM WITH SENIORS

According to the CDC, between June 1, 1996, and April 30, 1997, AIDS cases among those 65 and older rose almost 13

percent, from 1,030 to 1,160. Of those, almost half were infected through unprotected sexual intercourse.

Seniors who are considered at highest risk include those with multiple partners, a partner with a known risk factor, or a history of blood transfusions between 1977 and 1984.

Among people over 50, about 10 percent had one or more risk factors for HIV/AIDS in a nationwide survey by the Center for AIDS Prevention Studies at the University of California, San Francisco, in late 1992. In the at-risk group, 85 percent of those who were sexually active had never used condoms, the study found. Fewer than 7 percent had been tested for HIV, about one-fifth that of a comparison group of at-risk individuals ages 20 to 29.

One explanation may be that seniors are not used to talking about sexuality. "Our current seniors, 65 years old and over, grew up long before the sexual revolution," says Dr. Harold Silberman of the Senior Health Center in Durham, NC. "When they came along, sex was still taboo. You didn't do it much outside of a monogamous relationship."

Barnett said some of the seniors with whom she talks express shame. "They don't even want a prescription filled because certain prescriptions are associated with STDs," she says. "We live in a society that does not encourage older people to talk about sex." Barnett says she finds that especially troubling because many grandparents are rearing teenagers who are starting to learn about sexuality.

Silberman, who cares only for patients receiving Medicare, says he holds both seniors and their healthcare providers responsible for better sexual health. "Most doctors don't routinely screen geriatric patients for STDs because they don't think they're at risk or in danger," he says.

SENIOR PROFILE CHANGING

Meanwhile, the number of seniors is growing. Between 1980 and 1991, the total population increased 11 percent. According to the National Center for Health Statistics, during the same time, the 85-and-over group grew by 41 percent, to 3.2 million people, while the 75-to-84-year-old group climbed 33 percent, to 10.3 million people.

"I think the number of AIDS cases for older people will get larger as the baby boomers get older," says Dr. Steve

Marson, director of the social work program at the University of North Carolina at Pembroke. "Elderly people of tomorrow are not going to behave like elderly people today. Because they are healthier, they are going to have more sex."

Marson, who has done research on seniors and sexuality, says health care providers face a difficult challenge as they plan a strategy for older generations of STDs. Education intervention, he says, will be most effective for seniors. Although baby boomers will be among the highest educated seniors ever, they may not be any smarter about sex. "Baby boomers are more apt to be risk takers," Marson says.

FLORIDA TAKES ACTION

Like Barnett, health department officials in Broward County, FL, saw a need to reach out to seniors. At Barnes & Noble bookstores, condominium clubhouses, and poolside verandas, volunteers from the Senior HIV Intervention Program (SHIP) make the rounds educating seniors about their risks for contracting sexually transmitted diseases or HIV. Started by the state Department of Elder Affairs, SHIP got under way a year ago with funds from the Older Americans Act.

"Prevention is the key," says SHIP coordinator John Gargotta. "This segment of the population has been ignored. They don't even think they can get AIDS."

Broward County's program relies on 30 trained volunteers, all of whom are at least 50 years old, to educate their peers. "Seniors talking to seniors. That's how we do it," says Gargotta. "It works much better when you have older people, instead of younger people, talking to them about AIDS."

Lisa Agate, HIV/AIDS program director for the Broward County Health Department, says SHIP has proven successful.

"Seniors want their own turf," she says. "They don't want to be joined with support groups for young people."

Not all seniors are unwilling to talk about sexuality, Agate says. "At this age, it's either no holds barred—you find seniors talking about everything from vibrators to condoms, no problem—or you have to be careful what you say, especially if they don't want to talk about their sexuality."

Agate says she knows the program has the potential to make a difference. "A lot of the money CDC puts into prevention goes to the highest incidence of AIDS cases. This is a case where you can do the most with prevention because the numbers are relatively low."

RISKS BEYOND AIDS

But AIDS is just the highest profile STD for which seniors may be at risk. Dr. Peter Leone, medical director of the Wake County, NC, STD Clinic, says that part of the reason numbers are climbing may be that seniors do not view themselves as being at risk.

"Women who are past menopause often think they can't get an STD," he says. "People link pregnancy and STD risk. But methods to prevent pregnancy aren't the best ones for preventing STDs. On the other hand, some people think, 'Why should I use a condom? I can't get pregnant.'"

However, Leone says that for the most common viral STD, human papilloma virus (HPV), infection actually drops in older women. A study of 439 sexually active inner-city women 18 to 50 years of age in Brooklyn, NY, suggested a lower prevalence of genital HPV infection in older subjects. Leone notes that multiple factors may play a role in lower HPV prevalence as we age, including a more mature immune system, physiological changes in the cervix of older women, and changes in behavioral risk factors. But Leone quickly points out that immunity to one HPV type does not cross over to other HPV types, of which there are about 20 that infect the genital area.

"Some diseases are more age-related, like chlamydia, which affects younger women more often than older women," Leone says. "But chlamydia affects men no matter what age. So you have to focus on sexual behavior."

CONCLUSION

Barnett remembers a 79-year-old woman who called the STD Hotline for information about syphilis. Barnett says the woman had recently been diagnosed with the disease.

"Her husband had infected her," Barnett says. "But she did not find out until after he died. Not only was she concerned about the disease, she was concerned because her husband had never told her."

"She asked if I was an older person, as I am, which was an advantage in this case," Barnett says. "Some days you feel like one grain of sand in the desert. But if I can help one person change her life, it makes it all worthwhile."

Editor's Note: This article was adapted from an article in the *STD News* newsletter, volume 5, number 4, of the American Social Health Association (ASHA). For background information on the article as well as ASHA resources, contact Allison Kallou, director of public relations, at ASHA, P.O. Box 13807, Research Triangle Park, NC 27709. ASHA's CDC National STD Hotline is 800/227-8922.

GAY AND LESBIAN SENIORS: UNIQUE CHALLENGES OF COMING OUT IN LATER LIFE

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Senior Action in a Gay Environment (SAGE) is a place for elder gay men and lesbians—those who are just coming out and as well as those who have been out for many years.

Over the past 20 years, SAGE has embraced and celebrated the lives and the challenges of these elder gays and lesbians by helping them in a variety of ways that include serving as a substitute relative, as a place to form new relationships, as a senior center, as a rap group, as a therapy group, and even as a friendly place to help people recertify for food stamps.

Through social activities, volunteerism, activism, education, outreach, and clinical and case management services, SAGE strives to insure that gays and lesbians can age with an enhanced quality of life and a dignified sense of themselves.

In some circumstances, gay and lesbian seniors who come to SAGE are reaching out to a gay-identified organization for the first time in their lives. This first contact is often necessary because they are facing a major crisis: a couple seeks support because one of them is losing the battle with breast cancer; a lover has died and the surviving partner needs bereavement counseling, home care, or help applying for benefits; an older gay man has had HIV for many years and finds himself isolated because his community of friends has died; a couple that has been together for 40 years comes in for couples therapy because retirement and health problems have had a negative impact on their relationship; a local hospital social worker calls because an 85-year-old man whom she suspects is gay is going to be institutionalized because he reports no family support system.

CLOSETED AND ISOLATED

Many SAGE members and clients are not “out” to many people in their lives. They report keeping their gay identity to themselves, not feeling safe opening up, and having health care and social work providers assume they are heterosexual.

SAGE realizes that the divulging of a person’s sexual identity to others is a life-long process that does not stop when family and friends are told. All gays and lesbians daily face the question of whether to come out to people. But

elder gays and lesbians face particular crises relating to health care and health care benefits that require them to make difficult decisions about coming out.

For those who came of age before the Stonewall uprising that was the cornerstone of the gay liberation movement, coming out and living openly as a gay or lesbian was an extremely risky and dangerous proposition. They risked losing their stature, employment, social and economic standing, housing, friends, and family, as well as their dignity. Organized religion, government, and law enforcement were both condemning and brutal. Their social life was creatively disguised. They risked intense scrutiny, if not arrest, when they went to a gay establishment. Witch hunts, police raids, and undercover sting operations were always a possibility.

Support groups were not available and political organizations were not marching for gay rights during the 1930s, 1940s, and 1950s. During those decades, families often severed their support and ties when a family member came out. Even today, the issue of a family member’s sexual identity often remains untouched, not discussed, and not embraced. As a result, those gay and lesbian seniors fortunate enough to have family involved in their lives often maintain such family relationships at a distance.

To quote a SAGE member, “merely speaking the word *homosexual* implied you *were* homosexual and, therefore, sick, mentally deranged, immoral and dangerous.”¹ In the 1940s, this member explained, he was so influenced by homophobic society, that he often denounced gay men even though “all the time I knew I was one.” He hid his sexual orientation so that he could serve in the military during World War II. His partner explained that at the age of 19, he himself was found unfit for military service after he told an army physician that his older sister had sent him to a doctor to *cure* him of his homosexuality. He said, “I was given sex hormones and told to cultivate the friendship of girls.” He quit this “therapy” after eight visits.² Ken Dawson, the first executive director of SAGE, expressed the following in regard to the damaging effects of societal homophobia on pre-Stonewall gays and lesbians: “The need for secrecy caused isolation which imperiled their most inti-

*“Their invisibility
compounds the
isolation that can
accompany old age
and loss.”*

mate relationships. And the greatest damage was done to those gay people who *believed* what society said about them, and thus lived in corrosive shame and self-loathing.”³

“COMING OUT” GROUPS

Phillip Piro, SAGE’s supervisor of group services, has conducted many “coming out” groups during his 11-year tenure. The composition of such groups has varied, with participants ranging from 40 to 80 years of age. Many of the men had had loving marriages with women. Their decision to come out involved the potential for major loss, including the loss of their wives, their children, and their families. Some came out soon after a divorce or the death of a spouse. Some came out after retirement when they no longer feared losing their livelihood. Others are struggling to come out while living at home with a parent for whom they are caretakers. Most have not had the opportunity to meet or see positive gay role models in their lives. Some mistrust other gay people. The groups help people form a community, work through the shame and the mourning that often accompanies the coming out process, break through negative, internalized gay stereotypes, and make meaningful gay friendships.

Mary Jeanne Sanford, SAGE’s coordinator of women’s support services, has found in her discussion groups that many women express their greatest regret as not having children. Some relate that they married for the express purpose of having children. The women she encounters are varied: one aristocratic Southern woman is just starting to come out at the age of 80; another woman, who defines herself as *heterosexual*, has had two-long term lesbian relationships. Some lesbian-identified women want nothing to do with the gay community; others, once they come out, want as little as possible to do with the heterosexual world.

THREE AGING TYPES

A meaningful difference among elder gays and lesbians is found in the diversity of their sexual identity formation. R. A. Friend writes in the book *Gay and Grey: The Older Homosexual Man* that there are three possible styles: *stereotypic* (living in the closet), *passing* (as a heterosexual), and *affirmative* (leading an open, positive gay life).⁴

Some seniors have been closeted for most of their lives and have internalized a great deal of societal homophobia. Friend refers to these individuals as fitting the *stereotypic* style, tending to believe the negative images of gays and lesbians promoted by society.⁵ Their homosexuality remains a secret, and they consider their aging as punishment for their immoral life, resulting in fear, ignorance, and sometimes self-hatred as well as a distancing from family.⁶

Others have lived a heterosexual lifestyle, have had children, and have, in midlife, realized their need to come out.

Friend describes this *passing* as another adaptational style. He describes some old lesbian and gay adults who still spend a great deal of energy trying to appear heterosexual even though they are in long-term same-gender relationships. They lived their lives passing as heterosexual because they saw no other option, because they needed to please others, or because they felt that heterosexuality was superior.⁷ Some repressed their desires for members of the same sex and remained in complete denial until they came to a realization that they were gay or secretly acted on their same-sex desires during their marriages until they were able to come out (if ever).

Still others have acquired what Friend called an *affirmative* adaptational style, describing those who have managed to attain a high level of self-acceptance. This includes individuals who have a positive, affirmative gay sexual identity, who are comfortably out to themselves and others, and who are active in the gay and lesbian communities.⁸

VARIED LIFE COURSES

Several studies of old gays and lesbians indicate that there is not one single normative life course to which they ascribe and that the positive gains of the gay rights movement have had different impacts depending on their ages and experiences.

In her book *Lesbians Over 60 Speak for Themselves*, M. Kehoe points out that many old lesbians are still careful about their coming out in today’s more accepting environment because they have become accustomed to hiding their identities. She talks about the common practice among gays, and especially gay women, in the first part of the twentieth century of keeping a low profile regarding sexual identities.⁹

An article, “Life Course Diversity Among Older Lesbian and Gay Men: A Study in Chicago,” by G. Herdt, J. Beeler and T. W. Rawls in the *Journal of Gay, Lesbian, and Bisexual Identity* indicates that differences in individuals’ subjective self-concepts and their sexual identities are influenced by variations in their life-course as well as by the timing of key historical events. This includes influence by their gender, by their cohort group, by their marital status, by their coming-out histories, and by their friendship networks.¹⁰

INVISIBLE AND ISOLATED

Regardless of their comfort with their sexual identity, gay and lesbian seniors also must, like everyone else, face the struggles that come with aging. For even the most self-actualized person, aging is accompanied by multiple losses that include the death of partners, siblings, friends, neighbors, and, sometimes, children as well as the loss of work, mobility, and health. This social isolation is often compounded for older gay men and lesbians and can become extremely debilitating.

For some reason, the general population does not think of gays and lesbians as getting old. When I first joined SAGE, my partner's colleague questioned the size of the gay and lesbian old population. "How many of them are there?" she asked. Startled by the question, my partner answered, "Well, we get old too!"

The problem is that closeted gay and lesbian seniors are not a very visible population, even to service providers. This invisibility compounds the isolation that can accompany old age and loss. Years of internalized homophobia—due to first-hand experiences and historical factors—as well as societal ageism, where the aging process is feared and seniors are very often dismissed, contribute to this population's experience of isolation.

In his article "Adult Development and Aging" in the *Journal of Social Issues*, D. C. Kimmel explains that those who affirm their sexual identities as gays and lesbians often develop coping mechanisms and tools to assist them with adjusting to growing old and coping with the stigmatized status that accompanies old age.¹¹ In her article "Lesbianism and Later Life in An Australian Sample: How Does Development of One Affect Anticipation of the Other?" in the *Journal of Gay, Lesbian, and Bisexual Identity*, C. E. Sharp also concludes that the process of becoming a lesbian is both creative and empowering, and, therefore, promotes strengths to help a person deal with marginalization and develop a positive identity despite the negative impact of societal stigmatization. She explains that the process of coming out may assist women in the transitions to, and positive experiences of, later life.¹²

A RETREAT INTO THE CLOSET

Unfortunately, home care and housekeeping services specifically for gay seniors are not regularly available. As a result, many retreat back into the closet when they are faced with dependency on agencies and services. Even those who had open relationships, who were active in the community, and who were comfortable with their identity are often unwilling to open themselves up to the additional vulnerabilities that accompany coming out.

Old gays and lesbians may decide to keep their sexual identity to themselves in regard to new doctors, home attendants, social workers, hospital staff, and visiting nurses. They may not feel safe opening up and may rationalize that retaining a gay identity is not important. They may fear that they will receive biased or inferior service if their sexual identity is exposed.

A few months ago, one of my clients was transferred from a hospital to a nursing home for temporary rehabilitation. At my first visit to this Brooklyn nursing home, I asked to meet with the social worker who would set up a discharge plan for my client, Lydia. I ended up meeting with

the director of social services who was covering for the social worker that week. I introduced myself as Lydia's social worker from SAGE. "What is SAGE?" he asked. As I felt my anxiety surge at the thought of outing Lydia, I answered obliquely that SAGE was an agency in the city that assists senior citizens. "What does SAGE stand for?" he continued. "Senior Action in a Gay Environment," I answered as I handed him my card while attempting to mask my anxiety with a smooth transaction. "Why is Lydia involved with your agency?" he responded. "Because she's a lesbian and she needs social work assistance," I heard myself answer.

Panic struck as I reflected that Lydia had not come out to her home attendant for fear that the attendant would be uncomfortable, and, in turn, might not treat her well. I quickly explained to the director of the nursing home that I could not hide my identity in terms of my credibility in advocating for Lydia but that I was uncomfortable with the fact that I had outed her as a result of our conversation. I requested that he be sensitive about disclosing this information in the nursing home. The director said he appreciated my providing him with this information and that it would help in conducting an intake interview with Lydia in preparing her treatment plan. He said he would be sensitive in terms of disclosure to other staff, understanding that not everyone is gay affirming. Fortunately, in this instance, I found that each staff person was more helpful than the next. I do not always encounter this in under-funded and understaffed facilities.

Lydia was eventually discharged in an extremely timely manner and received increased home care, which she had badly needed even before her hospitalization. As much as I can think it best for everyone to be out to all their providers, I know it is clearly frightening for people to be in a vulnerable position when they are sick, healing, dependent, and uncertain about the provider's treatment if the provider knew they were gay or lesbian.

CONCLUSION

When old gay men or lesbians do not disclose their sexual identity, they prevent themselves and others from sharing in a comprehensive understanding of their lives.

Service providers can help by opening themselves to alternative interpretations of people's lives and identities. They can help by being sensitive and alert to obvious and hidden clues in intake processes, assessments, treatments, and services that will help them identify gay and lesbian seniors.

Subsequent sensitive and affirming services to elder gays and lesbians can include connecting them to a gay and lesbian peer group, arranging for people to provide them with friendship through visits or phone calls, helping them consider positive interpretations of their lives, and helping them hold onto, embrace, or find a sense of their contribution to the world.

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RECOMMENDED BOOKS ON OLDER GAY AND LESBIAN SEXUAL HEALTH

SIECUS' Mary S. Calderone Library recommends these books for individuals interested in knowing more about aging gays and lesbians and their sexual health.

Gay and Gray: The Older Homosexual Man

Raymond M. Berger

This book, now in its second edition, examines the depth and complexity of aging among gay men. Consisting of interviews and questionnaires, it breaks the stereotype that older gay men do not adjust well to aging. Chapters include: "The Older Homosexual Man in Perspective" and "Sexual Attitudes and Behavior in Mid-life and Aging Homosexual Males."

1996; \$14.95; ISBN 1-56023-875-5; *The Haworth Press, Inc., 10 Alice Street, Binghamton, NY 13904-1580; Phone: 800/342-9678; Fax: 800/895-0582; Web site: www.haworthpressinc.com*

Gay Mid-Life and Maturity

John Alan Lee, Ph.D., Editor

This book is a collection of articles that demonstrate—through formal research reports and personal experiences—the diversity of gay men and lesbians. It discusses aging from a positive perspective.

1991; \$39.95; ISBN 1-56024-028-8; *The Haworth Press, Inc., 10 Alice Street, Binghamton, NY 13904-1580; Phone: 800/342-9678; Fax: 800/895-0582; Web site: www.haworthpressinc.com*

Gay Widowers:

Life After the Death of a Partner

Michael Shernoff, M.S.W., Editor

This anthology reflects the diversity of experiences of men who are about to lose or who have already lost their partners. Essays include: "Surviving a Partner's Death Deeply in the Closet"; "Do You Have a Partner?"; and "Mental Health Considerations of Gay Widowers."

1994; \$14.95; ISBN 1-56023-105-X; *The Haworth Press, Inc., 10 Alice Street, Binghamton, NY 13904-1580; Phone: 800/342-9678; Fax: 800/895-0582; Web site: www.haworthpressinc.com*

The Lesbian Family Life Cycle

Suzanne Slater

This book identifies the stages of lesbian relationships throughout life and provides a developmental model for lesbian families. It is divided into two parts: "Enduring Realities of Lesbian Family Life" and "Stages of the Lesbian Family Life Cycle." Chapters include: "The Middle Years" and "Lesbian Couples Over 65."

1995; \$25.00; ISBN 0-02-920895-5; *Simon & Schuster, 200 Old Tappan Road, Old Tappan, NJ 07675; Phone: 800/223-2348; Web site: www.simonsays.com*

VIAGRA 1999

Domeena C. Renshaw, M.D.
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Viagra has—for better or for worse—affected American marriages and relationships forever.

Consider the wife who welcomes home her 65-year-old husband who has just picked up a prescription of Viagra, has a smile on his face, and asks to resume sexual intercourse after 15 years of abstinence. How will they deal with this new challenge? Enthusiasm? Some couples will enjoy the positive outcome. Anger? Some will have trouble picking up where they left off a decade or more ago. Will she refuse? Maybe. But she may then risk the possibility that he will seek someone else. And from that point forward, she will carefully count his Viagra pills and check his phone messages.

Consider the wife who asks her physician to phone in a Viagra prescription so she can slip it into her aging husband's bedtime hot chocolate. She may soon find that it is not the aphrodisiac that she had expected. Physicians will have to educate wives like her to the fact that Viagra is not a magic love potion that can rekindle a loving relationship with one small dose.

Consider the wife who eventually reaches the point where she asks, "Is it Viagra or is it me?" She is one of many who will become upset because they feel left out.

Physicians who prescribe Viagra must educate both the patients and their partners about its use. They must remind them that foreplay, tenderness, and romance are essential elements that should not be forgotten after taking the pill.

THE DOCTOR'S ROLE

Does Viagra raise ethical issues for the physician? Yes. Most certainly. The issue is the same as when a husband asks his doctor to prescribe penile injections and vacuum pumps so he can have a better erection for his mistress. The doctor needs to educate the patient about medical risks such as sexually transmitted diseases (STDs), HIV, and unintended pregnancy as well as the destructive marital consequences of discovery.

The physician will have a true values challenge in deciding whether or not to comply with the patient's request. As an ethical alternative, he could request that the patient return with his wife for a joint session to discuss the joy of renewed coitus with Viagra, to discuss the strengths of their long-standing relationship, their children, her health, her lubrication needs, and their cooperation.

The physician could also use this opportunity to

emphasize the difference between mechanical sexual relations and a renewed courtship that might lead the way for both partners to resume love making. Finally, he could schedule a return visit in five weeks for questions and a checkup, thus becoming a family ally and, possibly, a marriage saver.

The physician could also conduct a full physical examination prior to prescribing Viagra. Since many of the 30 million men over 50 years of age with an erectile dysfunction (ED) rarely have medical checkups, the physician could check the patient's blood sugar, blood pressure, prostate, hormones, testosterone, and thyroid. He could also check for ejaculatory problems; visual problems; for the use of specific medications such as digoxin, nitrates, tranquilizers, and sedatives; for the use of over-the-counter medicines, alcohol, and tobacco; to determine his morning, sleep, and masturbatory erections, and to determine his use of erotic fantasy, books, movies, and the Internet to achieve sexual orgasm.

VIAGRA DEATHS

From April to July 1998, over 3.6 million outpatient prescriptions were written for Viagra. They resulted in 123 reported deaths. Some Viagra deaths were outside the United States. Sixty-nine U.S. patients were verified as having died after taking Viagra. The cause of death was unknown or unmentioned in 21 of those cases. Two of the remaining 48 had a stroke, 46 had cardiovascular events (21 had a myocardial infarction, 17 had cardiac arrest; three of these had prior coronary artery disease, and one had severe hypertension). For 55 of the 69 patients, the average age was 64 (with ranges from 29 to 87). Most of them took only 50 milligram tablets. Only three used 100 milligrams. Twelve of the patients self-medicated before or after Viagra with nitroglycerine. This is a fatal intake. Nitrates are contraindicated. The time from use of Viagra to death in 25 of the 69 cases was within four to six hours. Of these, 18 deaths were immediately after intercourse. In 41 percent of the 69 deaths, the cause was unknown. One 55-year-old took 800 milligrams and allegedly died of a heart attack.¹

QUESTIONS AND ANSWERS

The following are a series of questions that I have received about Viagra along with my answers.

What Viagra dosage is usual?

It comes in 25, 50, and 100 milligram units. They are equally priced in Illinois at \$10 a pill on a card of five. Some discount pharmacies charge \$8 a pill. I start my patients on one 50 milligram pill a day. If they show no response, I prescribe 100 milligrams on the third day. I have not yet needed to prescribe 150 milligrams.

What are the risk factors of Viagra?

Serious risk factors of patients are cardiovascular disease; a previous coronary; hypertension, or hypotension; a history of smoking; and diabetes. These factors were present in 74 percent (51) of the men who died. Five of those who died had no risk factors. A brief headache or dyspepsia are possible but not dangerous.

Will patients pretend impotence to get the pill?

Yes. Some get the pill and then sell it on the black market.

Is there possible abuse of Viagra?

Yes. Of course. This is true whenever a physician prescribes Viagra without taking a medical history and giving a physical checkup.

Is Viagra an aphrodisiac?

Viagra is *not* an aphrodisiac. It may, however, magically restore the sexual interest of men with a sexual dysfunction because it causes the fear of failure to evaporate. This renewed confidence may enhance the frequency of sexual relations.

Do doctors self-prescribe Viagra?

Some have.

Is Viagra addictive?

There is no evidence that Viagra is addictive.

Should men who take tranquilizers use Viagra?

Viagra has been used successfully with the same instructions to use one hour pre-coitus, plenty of foreplay and penile stimulation preferably *before* taking the needed evening or morning dose of psychotropics.

Does alcohol use affect Viagra?

Alcohol delays the absorption of Viagra.

Does a heavy, fatty meal affect Viagra?

It also delays absorption.

Can a delayed erection occur with Viagra?

Yes. It can occur up to five hours later with both 50 and 100 milligram doses.

Can Viagra cause a continuous erection of the penis?

This is not a reported side-effect in the original studies of over 3,000 men. Some men report persistent partial erec-

tions after ejaculation. This is not priapism. Some men have used Viagra experimentally. Others have used penile injections or pellets as well as Viagra, which led to priapism. These were avoidable risks.

Does Digoxin cause erection problems?

Yes, recent studies have verified this. In fact, digoxin is now used to treat the priapism of men with sickle cell anemia.

Does Viagra enhance erections of young men who have no sexual problems?

Not usually. A placebo effect is always possible. Penile injections or alprostadil urethral inserts (sex shots) will provide a mechanical erection in most men with no foreplay, fantasy, or partner. Sildenafil or Viagra is unique as a "love pill" because love play is required for the erectile response. Seniors who take Viagra and forget they took it will simply fall asleep. An expensive nap!

What about impregnation by Viagra patients?

A man can impregnate a woman into late age. So a physician must discuss contraception with all Viagra patients.

Are some women taking their husband's pills.

Yes. Some have. "Me, too" is strong pressure.

What about women taking Viagra?

Some women envy the sexual restoration and youthfulness Viagra has brought to men over 50 years of age. From the hundreds of calls I received from women when Viagra was first introduced, I feel that women misperceive Viagra as an aphrodisiac or an orgasm pill, which it is not. Some have taken a pill from their husband's bottle and reported ecstasy. Is that a placebo effect? Probably. Their calls demonstrate there is a huge market of women who have unwillingly lost sexual desire. Irving Goldstein, a urologist at Boston University, is using Viagra off label with menopausal women patients. So is John Mulhall, M.D., a urologist at Loyola.

Are imports of Viagra banned anywhere?

Israel banned imports of Viagra in May 1998 after six U.S. deaths were reported.

Is there a black market for Viagra?

Yes. There are apparently sites on the Internet that sell Viagra at double or triple the price.

Is bogus Viagra sold on the streets?

Yes. Huge profits have been made in the Middle East where Viagra is sold on the streets for \$30 a pill. Unfortunately, the contents of these pills are unknown.

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"ASK DR. HELEN" OFFERS HELP TO AGING ADULTS ON BUILDING HEALTHY, PRODUCTIVE RELATIONSHIPS

Mac Edwards
SIECUS Report Editor

Dr. Helen Greenblatt was 71 years old when she was approached seven years ago to write an advice column for the biweekly newsletter for the 19,000 residents of Leisure World in Laguna Hills, CA, where she and her husband are residents.

She recently spoke to SIECUS from her home about her mission to make her Leisure World neighbors—whose average age is 72—realize that they are “the entrepreneurs of their lives” and that they *can* develop a passion for life even when they are old.

She credits the success of her *Leisure World Voice* column not to her editorial skills but to the fact that older Americans are realizing “what a wonderful time it is to be a senior,” she said. “There’s an awakening going on out there. I wouldn’t call it a sexual revolution, but stuff is stirring. Things are brewing.”

She explained that she is regularly stopped while walking her dog, after her bridge club, or at other community mixers to talk about dating, love letters, safe sex, and other topics related to reaching out and building solid relationships. She uses these talks and other correspondence as themes for her column.

NEW ENERGY FOR LIFE

Recent research indicates that the number of seniors enjoying or wanting to enjoy intimate relationships has doubled in the past decade. Many credit this new vitality to the results of health and fitness research as well as to recent pharmaceutical breakthroughs such as Viagra.¹

A survey released this fall by the National Council on the Aging found that of the nearly half of all Americans 60 years old or older who engage in sexual relations at least once a month, three-fourths are finding it as good as or better than it was when they were in their 40s. And more than half of those respondents said they would like to have sex more often.²

The number of senior Americans having or wanting regular sexual relations was less than 25 percent of all those polled when the Council started conducting its survey in 1990. These figures “underscore the growing importance of sex among older men and women,” said Neal Cutler, a research director at the Council. “When older people are not sexually active, it is usually because they are widowed, lack a partner, or because they have a medical condition,” he

said. “But every year we see it become more of an issue for them. It’s an important and vital part of their lives.”³

In a recent national study of Americans 60 to 90 years old, the Lifespan clinic found that an overwhelming majority said they were more satisfied with the quality of their lives than ever before. The clinic attributes this to medical breakthroughs that have enabled older Americans to feel better and live longer.⁴

DR. GREENBLATT IS READY

When seniors at Leisure World approach Dr. Greenblatt with questions about enjoying their remaining years she is ready with candid comments. Some of her advice:

She told a senior woman to protect her private parts from lustful seniors and not to “relinquish it without getting a receipt” (in other words, don’t fool around without some type of commitment).

She told a single senior male that it was healthy to masturbate but that he should do it when “no one is around to watch who doesn’t want to be.”

She advised a senior woman who was worried about viewing a sexually explicit video with her 75-year-old boyfriend even though the experience had intensified their sexual relations. “Be grateful that you have found an elderly gentleman still interested in exploring the sensual mysteries of life with a woman who has a similar interest,” she said.

She candidly told a 69-year-old woman that she shouldn’t worry that neighbors would see her boyfriend’s car in the driveway when he spent the night. She said: “It’s too late to worry about your neighbors. You’re a big girl now. Have fun and enjoy love.”

Her advice is a very popular part of the newsletter, and her positive feelings about sexual relations in later life are spreading throughout the community.

DR. GREENBLATT’S OWN STORY

Dr. Greenblatt’s own personal story is proof that a busy, full life leads to health and happiness in old age.

She has been happily married for 25 years (they wed

when she was 53) to her second husband, 83, who is a retired truancy officer. He proposed six months after they met. "He's a doll," she said.

She also has a thriving practice in Laguna Hills as a marriage counselor and sexuality therapist. (She calls herself "a physician for the heart.") She received her credentials after retiring from a career in education where she was a guidance counselor, teacher, and vice principal. She completed studies for her doctorate in psychology at the age of 70.

She says that most of her patients are too young to live in Leisure World. (You must be at least 55 years old.) "They think I have wisdom," she said of the couples she counsels. "But what I have is plain old experience. And my experience tells me that today's seniors are a lot like today's youth."

And Dr. Greenblatt is there for both her young and old followers to provide them with guidance and help as they reach out and build meaningful relationships in their lives.

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3. Ibid.
4. B. Harris Hayes, "Giving Advice," p. A28.

RECOMMENDED BOOKS ON AGING AND SEXUAL HEALTH

SIECUS' Mary S. Calderone Library recommends these books for individuals interested in knowing more about aging and sexual health.

The Family Guide to Sex and Relationships

Richard Walker, Ph.D.

Complete with over 300 color photos, illustrations, and diagrams, this book provides information on the entire sexuality spectrum.

1996; \$34.95; ISBN 0-02-861433-X; Macmillan USA; Phone: 800/428-5331; Web site: www.superlibrary.com

The New Ourselves Growing Older: Women Aging with Knowledge and Power

Paula B. Doress-Worters and Diana Laskin Siegal

This book provides comprehensive information on leading a fulfilling life after the age of 40. Topics include:

sexuality in the second half of life; birth control in mid-life; and relationships in middle and later life.

1994; \$18.00; ISBN 0-671-87297-4; Simon & Schuster, 200 Old Tappan Road, Old Tappan, NJ 07675; Phone: 800/223-2348; Web site: www.simonsays.com

Questions and Answers About Sex in Later Life

Margot Tallmer, Ph.D.

This book addresses the most commonly asked questions about sexuality in later life. Written in a question-and-answer format, it discusses such issues as dating, nudity, and sexual desire. It also looks at sexuality in the nursing home environment.

1996; \$15.95; ISBN 0-914783-75-0; The Charles Press Publishers, P.O. Box 15715, Philadelphia, PA 19103; Phone: 215/545-8933; Fax: 215/545-8937; Web site: www.charlespresspub.com.

**OFF THE STRAIGHT & NARROW:
LESBIANS, GAYS,
BISEXUALS AND TELEVISION**

The Media Education Foundation
26 Center Street, Northampton, MA 01060
Phone 800/897-0089 or 413/584-8500
Web site: www.mediaed.org
\$225/\$125, high schools

Growing up straight in the 1960s and in Middle America, I don't remember knowing or meeting anyone who was openly gay. Today, the gay community is no longer "invisible." Lesbians, gays, and bisexuals have organized a successful movement, prodding people to recognize them as significant members of our society. In the process, they have also put pressure on the media—both television and movies—to portray them honestly and fairly. Both media have made significant strides. But it is television, more than movies, that still seems afraid to show gays and lesbians in a realistic light—even to the point of not wanting them to touch each other.

Off the Straight & Narrow: Lesbians, Gays, Bisexuals and Television, a new educational video from the Media Education Foundation (MEF), is the first in-depth documentary to cast a critical eye on the growth of gay images on television since the 1960s. The video, which provides a brief history of lesbians, gays, and bisexuals on the small screen, challenges viewers to consider the limits of gay images, with a hard look at who is represented, what they say, and how people respond.

Unusually accessible, yet sophisticated,

Off the Straight & Narrow features interviews with media scholars who offer both historical and cultural contexts for exploring the social implications of these representations. Presented to viewers in "chapters" such as "Saints, Singles," "Gay Power," and "Race & Sexuality," the video discussion is documented with an array of television news, drama series, and sitcom clips from the past 30 years.

When television dared to air its first gay documentary in 1967 (showing no women, no pictures, and no references), the media was on the threshold of becoming a battleground for gay opinion. Three decades later, television remains a war zone for controversy over issues of gender and sexuality due to "network anxiety." Just a year ago, it cancelled *Ellen*, the sitcom featuring openly gay actress/comedienne, Ellen DeGeneres.

Although television gives us a "rich panoply" of characters to maximize advertising revenues, what images does it really offer? Exactly how are gays, lesbians, and bisexuals written into a straight television world? While the mass media is becoming more accepting of our diverse culture, and viewers are seeing a larger number of gay images on television, the number of those images still represents a small portion of all images seen on television in music videos, cartoons, and sports programming.

The video's scholars all agree that daytime "soaps" have been more adventurous than prime-time television. However, it is the daytime talk show, a television format pioneered by Phil Donohue in the 1970s, that has been more hospitable to the gay community at large. It's more than likely that viewers will encounter an openly les-

bian or gay person on daytime talk television shows than anywhere else.

Off the Straight & Narrow shows us that lesbian and gay characters continue to be portrayed on television in the least threatening way. They exist in the straight world and, more to the point, in the straight television world, simply to validate the heterosexuality of the main character, or as a foil for anxiety or humor and sympathy. The video chapter "Betwixt & Between" shows us that bisexuals are not on the television screen at all. It seems television insists its characters be straight or gay—but not in between.

Off the Straight & Narrow clearly suggests that television needs to expand its range of who it validates as truly human and that new program strategies should be tried and old messages should be challenged. As the gay community continues to make room for itself in society, the scholars point out that lesbians, gays, and bisexuals should also make room for themselves in the media through greater involvement in the writing, directing, and producing processes.

An invaluable tool for educators interested in introducing students to issues of representation and diversity in the media, *Off the Straight & Narrow* shows how gay culture has made its way into the view of mainstream America. In so doing, the video both asks and answers the question: "How are we to make sense of the transformation in gay representation, from virtual invisibility before 1970 to the 'gay chic' of the 1990s?"

Reviewed by Lisa Hanock-Jasie, SIECUS' director of public relations.

HALF OF OLDER AMERICANS SEXUALLY ACTIVE, SURVEY SAYS

Nearly half of all Americans 60 or older engage in sexual relations at least once a month, according to a survey released by The National Council on the Aging (NCOA) in September 1998. It also found that 4 in 10 want to have sexual relations more frequently than they currently do. The random survey of 1,300 older Americans was conducted by Roper Starch Worldwide.

"This study underscores the enduring importance of sex among older men and women—even among those who report infrequent sexual activity," said Dr. Neal E. Cutler, NCOA director of survey research.

"Our study debunks the prevailing myths about sexuality in older years," said James Firman, Ph.D., president and CEO of NCOA. "For many older Americans, sex remains an important and vital part of their lives."

More information: NCOA, 409 Third Street, S.W., Washington, DC 20024; Phone: 202/479-1200; E-mail: info@ncoa.org.

A SIECUS Annotated Bibliography



All people have the right to information, education, and health care services that will help them promote, maintain, or restore their sexual health.

This "Sexuality and Health" bibliography contains resources for those who want to improve aspects of their sexual lives, for those who want to overcome mental and physical obstacles, and for those who want to protect themselves from sexually transmitted diseases and HIV.

SIECUS does not sell or distribute the books mentioned in this bibliography. They are however, available for use in the Mary S. Calderone Library. For those interested in purchasing any of the books, they will find annotations with contact and price information.

This and other SIECUS bibliographies are available free of charge on the SIECUS Web site or for \$2 per copy by contacting the SIECUS Publications Department, 130 West 42nd Street, Suite 350, New York, NY 10036-7802; Phone: 212/819-9770; Fax: 212/819-9776; E-mail: siecus@siecus.org; Web site: www.siecus.org.

This bibliography was compiled by Amy Levine, M.A., SIECUS librarian, Lissette Marrero, SIECUS information assistant, and Christine Ramos, SIECUS intern.

GENERAL

Contraceptive Technology Seventeenth Revised Edition

Robert A. Hatcher, M.D., M.P.H., et al

This book is for the general public as well as professionals. It is a practical guide to planning a safer sexual lifestyle, preventing unplanned pregnancy, and protecting against HIV and other sexually transmitted diseases.

1998; \$39.95; ISBN 0-9664902-0-7; Ardent Media, Inc., Box 286, Cooper Station P.O., New York, NY 10276-0286; Phone: 800/218-1535; Fax: 212/861-0998.

Enabling Romance: A Guide to Love, Sex and Relationships for the Disabled

Ken Kroll and Erica Levy Klein

This is an illustrated guide to intimacy and sexual expression for individuals with physical disabilities. Debunking popular myths and stereotypes, this guide includes chapters on living and loving with specific disabilities, sexual variations and alternatives, safer sex and family planning, building self-esteem, and dealing with attendants. It also lists referrals and suggested readings.

1995; \$15.95; ISBN 0-933149-78-6; Woodbine House, 6510 Bells Mill Road,

Bethesda, MD 20817; Phone: 800/843-7323;
Fax: 301/897-5838; Web site: www.woodbinehouse.com.

The Practical Encyclopedia of Sex and Health

Stefan Bechtel and
the Editors of Men's Health
and Prevention magazines

Written in simple language, this book is a practical reference on sexuality and health. Topics are presented in alphabetical order. 1993; \$27.95; ISBN 0-87596-163-0; Publishers Book & Audio, P.O. Box 070059, Staten Island, NY 10307; Phone: 800/288-2131; Fax: 800/818-9907.

The Sensuous Heart: Guidelines for Sex After a Heart Attack or Heart Surgery

Susanne Cambre, R.N., B.S.H.A.

This cartoon-style booklet discusses the emotional and physical needs of people who have had a heart attack or heart surgery. It answers questions about sexual intercourse and discusses the effects of alcohol, prescribed drugs, stimulants, and illegal drugs. 1990; \$5.75; ISBN 0-939838-28-1; Pritchett & Hull Associates, Inc., 34440 Oakcliff Road N.E., Suite 110, Atlanta, GA 30340; Phone: 800/241-4925; FAX: 800/752-0510; Web site: www.p-h.com.

Sex and Back Pain: Advice on Restoring Comfortable Sex Lost to Back Pain

Lauren Andrew Herbert, P.T.

The author, who is a physical therapist, describes types of back pain and suggests comfortable sexual positions for those with such physical problems. Drawings and photographs illustrate exercises and positions. 1992; \$12.95; ISBN 1-879864-00-2; IMPACC, Inc., P.O. Box 1247, Greenville, ME 04441; 800/762-7720; FAX: 207/695-2330; E-mail: order@IMPACCUSA.com; Web site: www.impaccusa.com.

The Sexual Desire Disorders: Dysfunctional Regulation of Sexual Motivation

Helen Singer Kaplan, M.D., Ph.D.

The author applies her psychodynamically orientated approach to determine individualized treatment for patients. Through case studies, she examines psychiatric disorders, organic problems, medical conditions, drugs, and age-related disorders that can lead to loss of sexual desire.

1995; \$44.95; ISBN 0-87630-784-5; Taylor and Francis, Inc., 47 Runway Road, Suite G, Levittown, PA 19057; Phone: 800/825-3089; Fax 215/269-0363.

**Sexual Dysfunction:
A Guide for Assessment
and Treatment**

*John P. Wincze and
Michael P. Carey*

This book, which is for professionals, provides an overview of the most common sexual dysfunctions. Chapters include "Sexual Desire Disorders," "Sexual Arousal Disorders," "Orgasm Disorders," "Sexual Pain Disorders," "Psycho-social Approaches to Treatment," and "Integrating Psycho-social with Medical Approaches." 1991; \$19.95; ISBN 0-89862-218-2; The Guilford Publications, 72 Spring Street, New York, NY 10012; Phone: 212/431-9800; Fax: 212/966-6708; Web site: www.guilford.com.

**Sexual Function
In People with Disability
and Chronic Illness:
A Health Professional's Guide**

*Marca L. Sipski and
Craig J. Alexander*

This book consists of 29 chapters written by over 30 contributors. It addresses general sexual function, specific disabilities and illnesses, and treatment concerns. 1997; \$57; ISBN 0-8342-0886-5; Aspen Publication, Ordering Department, 7201 McKinney Circle, Fredrick, MD 21704; Phone: Fax: 800/901-9075; Web site: www.aspenpub.com.

**Sexual Pharmacology:
Drugs That Affect
Sexual Functioning**

*Theresa L. Crenshaw, M.D.,
and James P. Goldberg, Ph.D.*

Intended for medical professionals, this book is a user-friendly reference source on the positive and negative effects of drugs on sexual function. It also helps consumers learn about the drugs they take. 1996; \$75; ISBN 0-393-70144-1; W. W. Norton & Company, Professional Book Orders, 800 Keystone Industrial Park, Scranton, PA 18512; Phone: 800/233-4830; Fax: 800/458-6515; Web site: www.wwnorton.com.

Sexuality Across the Life Course

Alice S. Rossi, Editor

This book is a collection of 14 essays on sexual behavior throughout life. They include "Sexuality, Marriage, and Well-Being: The Middle Years," "Sex and Sexuality in Later Life Stages," and "The Effect of Chronic Disease and Medication on Sexual Functioning." 1994; \$34.95; 418pp.; ISBN 0-226-72833-1; The University of Chicago Press, 11030 South Langley Avenue, Chicago, IL 60628; Phone: 800/621-2736; FAX: 800/621-8476; E-mail: kh@press.uchicago.edu; Web site: www.press.uchicago.edu.

**Who Cares?
Institutional Barriers
to Health Care
for Lesbian, Gay,
and Bisexual Persons**

Michele J. Eliason, Ph.D., R.N.

This book addresses the prejudice and stereotyping that gay, lesbian, and bisexual persons may encounter in health care. Chapters include "Lesbian, Gay, and Bisexual Issues," "The Damage Done by Negative Stereotypes," "Lesbian, Gay, and Bisexual Family Issues," "Health Care Provider Attitudes," "Sexual Identity and Developmental Transitions," "Lesbian and Bisexual Women's Health," "Gay and Bisexual Men's Health," and "Making Health Care Safe and Inclusive." 1996; \$25; ISBN 0-88737-676-2; Jones and Bartlett Publishers, Inc.; 40 Tall Pine Drive, Sudbury, MA 01776; Phone: 800/832-0034; Fax: 978/443-8000; Web site: www.jbpub.com.

MEN

**The Complete
Prostate Book:
Every Man's Guide**

Lee Belshin, M.S.

Addressing both benign prostatic hyperplasia (BPH) and prostate cancer, this guide offers advice to men with such problems.

Topics include diet, exercise, stress management, and treatment options. Its includes a resource list of organizations and a glossary. 1997; \$14.95; 226pp.; ISBN 0-7615-0447-8; Prima Publishing, P.O. Box 1260-BK, Rocklin, CA 95677-1260; Phone: 800/632-8676; FAX: 916/632-1232; Web site: www.primapublishing.com.

**The Gay Men's
Wellness Guide**

*The National Lesbian
and Gay Health Association
Robert E. Penn*

This manual was written with the help of 24 health care providers who specialize in gay health concerns. It addresses physical and psychological well-being, body image, aging, substance abuse, HIV/AIDS, safer sex, domestic abuse, coming out, and much more. It also provides a comprehensive list of gay-affirming clinics and hospitals, a glossary of medical terms, referrals, and suggested readings. 1997; \$19.95; ISBN 0-8050-4772-7; Publishers Book & Audio, P. O. Box 070059, Staten Island, NY 10307; Phone: 800/288-2131; Fax: 800/818-9907.

**A Lifetime of Sex:
The Ultimate Manual
on Sex, Women, and
Relationships
for Every Stage
of a Man's Life**

*Stephen C. George,
K. Winston Caine,
and the Editors
of Men's Health Books*

This book incorporates humor with comprehensive information on a variety of topics such as relationships, sexuality, and health, as well as other diverse issues that affect different stages of life. 1998; \$31.95; ISBN 0-87596-424-9; Publishers Book & Audio, P.O. Box 070059, Staten Island, NY 10307; Phone: 800/288-2131; Fax: 800/818-9907.

Male Sexual Awareness

Barry and Emily McCarthy

This book provides information on male sexuality and sexual functioning. It is designed to help men integrate their sexuality into their lives in a way that enhances awareness and satisfaction.

1998; \$12.95; ISBN 0-7867-0473; Publishers Group West, 1700 Fourth Street, Berkeley, CA 94710; Phone: 800/788-3123; Fax: 510/528-3444; Website: www.pgw.com.

Male Sexual Vitality

Michael T. Murray, M.D.

This guide presents both conventional and holistic approaches to improving male sexual health. Subjects include the male reproductive system, erectile dysfunction, infertility, prostate health, genitourinary tract infections, and eating habits.

1994; \$10.95; 150pp.; ISBN 1-55958-428-9; Prima Publishing, P.O. Box 1260-K, Rocklin CA 95677; Phone: 800/632-8676; FAX: 916/632-1232; Web site: www.prima-publishing.com.

New Male Sexuality

Bernie Zilbergeld, Ph.D.

This self-help book is about the sexual development, thoughts, feelings, and behaviors of men—from young adulthood through old age. It discusses male sexuality, relationships, and resolutions to sexual problems.

1992; \$7.99; ISBN 0-553562-59-2; Bantam Doubleday Dell, Distribution Services, 2451 South Wolf Road, Des Plaines, IL 60018; Phone: 800/323-9872; Web site: www.bdd.com.

Overcoming Impotence

Steven Morganstern, M.D.
and Allen Abrahams, Ph.D.

Written for men and their partners, this book emphasizes self-help as a means to identifying dysfunction and also provides information on finding help and choosing treatment. Chapters include "Understanding

the Male Mechanism," "What Causes Impotence," and "Treating Other Male Sexual Dysfunction Problems."

1994; \$15.95; ISBN 0-13-146978-9; Simon & Schuster Order Dept., 200 Old Tappan Road, Old Tappan, NJ 07675; Phone: 800/223-2348; Website: www.simonsays.com.

Sex: A Man's Guide

Stefan Bechtel and
Laurence Roy Stains

A contemporary reference of more than 130 topics, this book offers advice as well as facts. Chapters include "The Male Body," "The Female Body," and "Better Sex Techniques."

1996; \$17.95; ISBN 0-87596-458-3; Publishers Book & Audio, P.O. Box 070059, Staten Island, NY 10307; Phone: 800/288-2131; Fax: 800/818-9907.

Solving Prostate Problems: Answers and Advice From a Leading Expert

Martin Gelbard, M.D.,
and William Bentley

This book is intended to dispel the fear and anxiety resulting from prostate problems. Chapters include "The Prostate Gland," "Symptoms of Prostate Problems," and "Prostate Cancer," as well as others. A glossary is included.

1995; \$17; ISBN 0-671-88465-4; Simon & Schuster, 200 Old Tappan Road, Old Tappan, NY 07675; Phone: 800/223-2336. Web site: www.simonandschuster.com.

WOMEN

Dr. Susan Love's Breast Book

Susan M. Love, M.D.

The second edition of this book provides a detailed look at the breast and health implications for women of all ages. Chapters include "Diagnosis of Breast Problems" and "The Courses of Breast Cancer."

1995; \$17; 627pp.; ISBN 0-201-40835-X; Addison-Wesley Publishing Company; Corporate and Professional Order Department, 1 Jacob Way, Reading, MA 01867; Phone: 800/822-6339; FAX: 800/367-7198; Web site: www.aw.com.

Dr. Susan Love's Hormone Book

Susan M. Love, M.D.

This book provides detailed information on menopause. Chapters include "What Is Menopause" and "Hormones: The Menu of Options."

1997; \$24.50; 362pp.; ISBN 0-679-44970-1; Random House, Inc., 400 Hahn Road, Westminister, MD 21157; Phone: 800/733-3000; FAX: 800/659-2436; Web site: www.randomhouse.com.

Gateways to Improving Lesbian Health and Health Care Opening Doors

Christy M. Ponticelli, Editor

This interdisciplinary book is designed to show health care providers how they can sensitize their care while meeting the needs of lesbian clients. Topics include: lesbian health and health care, surviving childhood sexual abuse, domestic violence, coming out, and communication between lesbians and primary care providers.

1998; \$14.95; ISBN 1-56023-103-3; The Haworth Press, 10 Alice Street, Binghamton, NY 13904; Phone: 800/429-6784; Fax: 800/895-0582; Web site: www.haworthpress-inc.com.

The Lesbian Health Book: Caring for Ourselves

Jocelyn White, M.D.,
and Marissa C. Martinez, Editors

This book is an important resource for health care providers as well as an empowering resource for lesbians who are negotiating their way through the health care system. It brings together a wide range of voices to highlight personal and community efforts to make health care accessible

and responsive to lesbians. Sections include "Past Tense, Present Challenge," "Through Health and Illness," "Life's Cycle," "Living True," and "Looking Forward." 1997; \$18.95; ISBN 1-878067-31-1; Seal Press, 3131 Western Avenue, Suite 410, Seattle, WA 98121; Phone: 800/754-0271; Fax: 206/285-9410; Web site: www.sealpress.com.

Our Bodies, Ourselves for the New Century

*The Boston Women's
Health Book Collective*

This book is an easy-to-use resource that addresses all aspects of a woman and her body. This updated version covers topics including the female condom, the abortion pill, and mastectomy issues, among other female health concerns. It addresses issues regarding heterosexual, lesbian, and bisexual women. 1998; \$24; ISBN 0-684842-31-9; Simon & Schuster Order Dept., 200 Old Tappan Road, Old Tappan, NJ 07675; Phone: 800/223-2348; Web site: www.simonsays.com.

The Pause: Positive Approaches to Menopause

Lonnie Barbach, Ph.D.

From the same author who revolutionized thinking about female sexuality with *For Yourself and For Each Other*, this book offers practical information to women who are managing difficult symptoms during menopause. 1995; \$13.95; ISBN 0-525-93702-1; Penguin Putnam Consumer Sales Department, P.O. Box 12289, Newark, NJ 07101-5289; Phone: 800/253-6476; Fax: 201/896-8569; Web site: www.penguinputnam.com.

The Planned Parenthood Women's Health Encyclopedia

*Planned Parenthood
Federation of America, Inc.*

This easy-to-use book addresses more than 120 topics on women's health. Each topic is concise and often includes resources for more information. Glossaries of "Medical Language" and "Medical Testing" are

included as well as an index and suggested readings. 1996; \$22; ISBN 0-517-88823-8; Random House Inc., Order Dept., 400 Hahn Road, Westminster, MD 21157; Phone: 800/726-0600; Fax: 800/659-2436; Web Site: www.randomhouse.com.

What Every Woman Needs to Know About Menopause

*Mary Jane Minkin, M.D.,
and Carol V. Wright, Ph.D.*

Written in a question-and-answer format, this book includes chapters on "The Physiology of Menopause," "Perimenopause and PMS," "Menopause and Your Mind," and "Menopause and Sexuality." 1996; \$25; 351pp.; ISBN 0-300-06573-6; Yale University Press, P.O. Box 209041, New Haven, CT 06520, Phone: 800/987-7323; FAX: 800/777-9253; E-mail: custservices.press@yale.edu.

The Woman's Guide to Hysterectomy: Expectations and Options

*Adelaide Haas, Ph.D.,
and Susan L. Poretz, Ed.D.*

This book provides information about hysterectomy. It addresses common fears and expectations as well as questions about diagnosis, surgery, postoperative care, and sexual relations and sexuality after surgery. 1995; \$14.95; 294pp.; ISBN 0-89087-743-2; Celestial Arts, P.O. Box 7123, Berkeley, CA 94707; Phone: 800/841-2665; FAX: 510/559-1629; E-mail: orders@tenspeed.com; Web site: www.tenspeed.com.

A Women's Guide to Overcoming Sexual Fear and Pain

*Aurelie Jones Goodwin, Ed.D.,
and Marc E. Agronin, M.D.*

This workbook is a guide to help women overcome sexual difficulties. It provides a series of exercises to help women restore healthy sexual functioning. It includes suggested readings, resources, and referrals. 1997; \$14.95; ISBN 1-57224-089-X; New

Harbinger Publications, 5674 Shattuck Avenue, Oakland, CA 94609; Phone: 800/748-6273; Fax: 510/652-5472; E-mail: newharbpub@aol.com; Web site: www.newharbinger.com

Women's Sexual Health

*Ruth Steinberg, M.D.,
and Linda Robinson, R.N., C.N.M.*

This book provides an overview of many aspects of a woman's sexual well-being. It provides current information on issues pertaining to contraception, fertility, cancer, and sexually transmitted diseases, among other topics. Chapters include "Psychological and Emotional Issues," "Common Infections," and "Common Physical Problems and Solutions." 1995; \$12.95; ISBN 1-55611-471-0; Penguin Putnam, 405 Murray Hill Parkway, East Rutherford, NJ 07073; Phone: 800/526-0275; Fax: 800/227-9604.

ORGANIZATIONS

American Association of Sex Educators, Counselors, and Therapists (AASECT)

This is a not-for-profit organization that certifies sexuality educators, counselors, and therapists. Upon request, AASECT will provide a list of certified sexuality therapists in a specific area. Send a self-addressed, stamped envelope to the above address. P. O. Box 238, Mt. Vernon, IA 52314; Web site: www.aasect.org.

American Cancer Society, Inc. (ACS)

This not-for-profit organization is dedicated to eliminating cancer as a major health problem through research, education, advocacy, and service. They provide pamphlets on the following topics: prostate, breast, cervical, vaginal, labial, ovarian, endometrial, uterine, and testicular cancer as well as a publication on sexuality and cancer for men and one for woman. 1599 Clifton Road, N.E., Atlanta, GA 30329-4251; Phone: 800/ACS-2345; Web site: www.cancer.org.

American Diabetes Association

This organization's mission is to prevent or cure diabetes and to improve the lives of people affected by it. They provide two information sheets *Diabetes Day-by-Day: Women's Sexual Health and Diabetes Day-by-Day: Men's Sexual Health*.
1660 Duke Street, Alexandria, VA 22314;
Phone: 703/549-1500; Fax: 703/836-7439;
Web site: www.diabetes.org.

American Foundation for Urologic Disease, Inc. (AFUD)

This organization is dedicated to supporting research, education, and patient support services for those who are or may be at risk or affected by a urologic disease or disorder. They provide a pamphlet entitled *How to Treat: A Couple's Guide to Erectile Dysfunction*.
1128 North Charles Street, Baltimore, MD 21201; Phone: 800/242-2383; Fax: 410/468-1808; Web site: www.afud.org.

American Heart Association

This organization's mission is to reduce disability and death from cardiovascular diseases and stroke. They provide a brochure entitled *Sex and Heart Disease and Sex After Stroke*.
National Center, 7272 Greenville Avenue, Dallas, TX 75231-4596; Phone: 800/242-8721; Web site: www.americanheart.org.

American Menopause Association

This organization is dedicated to providing support and assistance in all issues concerning menopause.
350 Fifth Avenue, Suite 2822, New York, NY 10118; Phone: 212/714-2398.

American Social Health Association (ASHA)

This not-for-profit organization publishes a variety of educational materials. It also operates the National STD Hotline, a toll-free information and referral service listed below.
P. O. Box 13827, Research Triangle Park, NC 27709-3827; Phone: 919/361-8400; Fax: 919-361-8425; Web site: www.ashastd.org.

Impotence World Association, Inc. (IWS)

This not-for-profit organization is dedicated to impotence education.
P. O. Box 410, Bowie, MD 20718-2400;
Phone: 800/669-1603; Fax: 301/262-6825;
Web site: www.impotnceworld.org.

National AIDS Hotline

This is a hotline sponsored by the U.S. Centers for Disease Control and Prevention (CDC).
800/342-AIDS, English; 800/344-7432, Spanish; 800/243-7889, TTY.

National Alliance of Breast Cancer Organizations (NABCO)

This is a network of breast cancer organizations that provides information, assistance and referral to anyone with questions about breast cancer. It acts as a voice for the interests and concerns of breast cancer survivors and women at risk.
9 East 37th Street, 10th Floor, New York, NY 10016; Phone: 212/719-0154, 800/719-9154; Web site: www.nabco.org

National Lesbian and Gay Health Association (NLGHA)

This organization is dedicated to enhancing the quality of health for lesbians and gays through education, policy development, advocacy, and the facilitation of health care delivery.
1407 S Street, N.W., Washington, DC 20009;
Phone: 202/939-7880; Web site: www.nlgha.org.

National STD Hotline

This is a hotline sponsored by the U.S. Centers for Disease Control and Prevention (CDC).
800/227-8922

Planned Parenthood Federation of America (PPFA)

This not-for-profit organization provides health care services, advocacy, and educational programs on sexuality issues.

810 Seventh Avenue, New York, NY 10019;
Phone: 800/829-PPFA. Contact your local Planned Parenthood: 800/230-PLAN; Fax: 212/245-1845; Web site: www.plannedparenthood.org.

Sexual Health Network

This Web site is dedicated to providing easy access to sexuality information, education, counseling, therapy, medical attention, and other sexuality resources for people with disability, illness, or other health-related problems.
Web site: www.sexualhealth.com.

Sexuality Information and Education Council of the United States (SIECUS)

SIECUS' mission is to affirm that sexuality is a natural and health part of living; to develop, collect, and disseminate information; to promote comprehensive education about sexuality; and to advocate the right of individuals to make responsible sexual choices.
130 West 42nd Street, Suite 350, New York, NY 10036-7802; Phone: 212/819-9770; Fax: 212/819-9776; E-mail: siecus@siecus.org; Web site: www.siecus.org.

The Society for the Scientific Study of Sexuality (SSSS)

SSSS is an international organization dedicated to the advancement of knowledge about sexuality. It brings together an interdisciplinary group of professionals who believe in the importance of both the production of quality research and the clinical, educational, and social applications of research related to all aspects of sexuality.
P. O. Box 208, Mt. Vernon, IA 42314; Phone: 319/895-8407; Fax: 319/895-6203; Web site: www.ssc.wisc.edu/ssss.