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REPORT

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R E P O R T

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SIECUS POSITION STATEMENT ON "SEXUALITY OF THE AGING"

Sexual feelings, desires, and activities are present throughout the life cycle. Older adults have a right to sexuality education, sexual health care, and opportunities for socializing and for sexual expression. Education concerning the sexual feelings, attitudes, and behaviors of older adults should be available to them, their family, health care providers, and other caregivers.

LET'S DO AWAY WITH THE STEREOTYPE
OF OLDER PEOPLE AS SEXLESS

Mac Edwards

Up until the time I started going to the health club at 6:30 each morning—to keep this 50-plus body in shape—I watched the *Today Show* each morning as I dressed for work. They had a regular segment on “seniors” that had a tag line that said something about “enjoying life after 50.” I always cringed when I heard it and muttered something like, “They don’t know what they’re talking about. People in their fifties aren’t even thinking about being seniors. They’re too busy living their lives.” At least I was. And I still am.

So is my partner, Reggie, with whom I’ve lived for nearly 30 years. In fact, we’re enjoying life more than ever—both personally and professionally—and, we don’t have time to even think about getting old or being “seniors.” I think we’re in the majority.

That’s why I feel like I have to do something to dispel this stereotype that people in their fifties—or older—are over the hill in terms of their sex lives.

**FACTS THAT HELP
MAKE THE POINT**

What better place to start than in the *SIECUS Report* to refute the stereotype that older people are sexless. Every article in this issue helps to make that point. Consider these facts:

- Nearly 62 percent of men in their fifties claimed to be sexually active, and 69.5 percent said they were either “very” or “somewhat” satisfied with their sex lives. A similar pattern prevailed for women. (“*Mature Sexuality: Patient Realities and Provide Challenges*” page 22.)
- “I am 58 and as horny as ever...the sex urge is still with me, not much different from my earlier years,” said one woman. “Maybe I am too physically active and healthy. I can’t seem to get it into my head that I am approaching a different time of life....There is little or no speaking about a situation like mine in books or media.” (“*Women’s Sexuality As They Age: The More Things Change, the More They Stay the Same*,” *SIECUS Annotated Bibliography on “Sexuality and Aging Revisited.”*)
- Late adulthood can be highly rewarding....Sex is an important part of this life stage for many older adults, and considerable evidence suggests that sexual activity continues throughout the life course. (“*HIV and AIDS in People Over 50*,” *SIECUS Annotated Bibliography on “Sexuality and Aging Revisited.”*)

- The research on coping, life satisfaction, and social support refutes the image of the older gay man or lesbian as isolated and depressed. (“*Gay and Lesbian Aging*,” page 16.)
- Many of us have remarked that often it is easier for pre-teens and teens to speak about some important matters (the “breakaway issues”) with someone who is not their own parent—perhaps the parent’s good friend or a relative. A grandparent can be ideally situated to help mediate this delicate transfer of power and responsibility from parent to child. (“*Grandparents As Sexuality Educators: Having Our Say*,” page 30.)

**BOOKS THAT HELP
MAKE THE POINT**

And then there are the many books in the *SIECUS Annotated Bibliography on Sexuality in Middle and Later Life* in this issue of the *SIECUS Report* that help to refute the stereotype that older people are sexless. Consider these:

- *Gay Midlife and Maturity* is a collection of articles that demonstrate—through formal research and personal experience—the diversity of gay men and lesbians. It discusses their aging from a positive perspective.
- *Seasons of the Heart: Men and Women Talk about Love, Sex, and Romance after 60* is a book of personal stories about the sexual, romantic, and platonic joys of relationships after 60. One of the chapters is “Not the End of the Song: Love When the World Says ‘No’ and Elders Say ‘Yes.’”
- *Still Doing It: Women & Men Over 60 Write about Their Sexuality* is a book of personal stories and experiences of women and men over 60 that is a testament to sexuality through the life cycle.

CONCLUSION

I’m proud of this issue of the *SIECUS Report* because I feel it has given us plenty of facts to refute the stereotype that people over 50 are past their prime in terms of sexuality and sexual relationships.

I hope you enjoy reading it and that you will use the information to tell others about the reality of positive sexuality in middle and later life.

A PRIORITY: QUALITY SEXUAL HEALTH
FOR OLDER AMERICANS

Tamara Kreinin, M.H.S.A.

Even though we have compiled an impressive group of articles for this issue, I am amazed by the confounding lack of information about sexual health issues as they relate to older Americans.

Why such a void? Perhaps it's because people assume that adults in their fifties and older are less interested in sex and sexual relationships. Perhaps it's because people think that adults in retirement homes and assisted care facilities are "not sexual."

There is no better testimony for providing people with information about sexual health—and quality sexual health care—throughout their lives than this issue of the *SIECUS Report*. It tells us through surveys and personal anecdotes that older Americans are sexually active. We must use this information to encourage providers to discuss sexual health issues with their older patients.

HELPING HEALTH CARE PROVIDERS

Organizations that represent health care providers are in a logical position to bring these issues to the forefront. They can accomplish this by creating resources and providing professional development opportunities for their members. What are some of the sexual health issues that health care providers need to discuss with their clients?

The negotiation of new relationships. Many widowed or divorced older people find themselves experiencing intimacy under unfamiliar circumstances. They must reconcile the messages they learned about sexuality as young people with current realities. Health care providers must be in a position to help their patients explore these issues and direct them toward appropriate resources.

Learning about sexual health issues. For many older adults, the current sexual health landscape is filled with terms like STDs, HIV, and AIDS to which they do not personally relate. While young people have hopefully learned to protect themselves from sexuality-related viruses and diseases through discussions with their parents or school-based education programs, older adults have not had this opportunity—or felt the need.

Health care professionals need to do a better job of educating older adults about protecting themselves from some of the negative consequences of sexual behavior.

Unfortunately, there is no parallel mechanism to school-based education for reaching adults. Professionals need to find creative ways to bring these messages to their patients.

Coping with the physical effects of aging on intimacy and sexuality. As people's bodies age, they need to educate themselves about the physical (and sexual) effects of such change. They need to understand the impact of erectile dysfunction and menopause on sexual health. They also need to understand how such health issues as heart attacks, strokes, and cancer can affect their sexuality.

Health care providers need to de-stigmatize the discussion of these issues and provide a safe environment where patients can ask questions, discuss options, and move forward. They need to tell their patients that their bodies may be getting older but that sexual intimacy is still possible—even if different. They also need to tell them about current treatments, medications, and counseling. Such knowledge can dramatically impact an older person's sexual functioning.

Becoming "askable" adults. The fabric of today's families is changing. Many older adults are serving as caregivers to their grandchildren. And many others play important roles in the lives of the children of their friends and colleagues. They are all in a unique position to serve as role models to young people. They can talk with them, listen to them, give them advice, and help them grow into sexually healthy young adults.

Health care providers need to encourage their older patients to assume the responsibility of becoming "askable" adults. They can do this by providing them with the information and guidance to take this important step.

CONCLUSION

We must support people their entire lives with ongoing dialogue about sexuality. We must create an environment in which they can learn about sexuality, feel comfortable about their sexual selves, and, when the time comes, communicate what they have learned to others.

This *SIECUS Report* provides testimony to the fact that we need to provide all people—young, middle aged, and older—with this information and help. It's an ongoing process that we look forward to helping make happen.

WOMEN'S SEXUALITY AS THEY AGE: THE MORE THINGS CHANGE, THE MORE THEY STAY THE SAME

Patricia Barthalow Koch, Ph.D.

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With the aging of the baby boomers and the development and hugely successful marketing of Viagra® to treat erectile dysfunction, attention from sexologists, pharmaceutical companies, and the public has become focused on the sexuality of aging women.¹

Some of the burning questions that are currently being pursued are: Does women's sexual functioning (sexual desire, arousal, orgasm, activity, and/or satisfaction) decrease with age and/or menopausal status? And what can be done to enhance aging women's sexual functioning?

As researchers try to provide answers for women, pharmaceutical companies, and other interested parties, what is becoming crystal clear is that we (the scientific community, health care professionals, and society at large) don't understand women's sexuality as they age because we don't understand women's sexuality. Therefore, we may not even be pursuing the right questions. For example, are specific elements of sexual "functioning" the most important aspects of women's sexuality or do we need to shift our focus?

MODELS OF FEMALE SEXUALITY: THE IMPORTANCE OF CONTEXT

Much of the information accumulated about women's sexuality has been generated from theories, research methodologies, and interpretation of data based on male models of sexuality, sexual functioning, and scientific inquiry.

As explained by Ray Rosen, Ph.D., at a recent conference on "Emerging Concepts in Women's Health," sexology has pursued a path of treating male and female functioning as similar, as evidenced by Masters and Johnson's development of the human sexual response cycle.²

What has resulted is a lack of appreciation for and documentation of the unique aspects of women's sexual functioning and expression. There is a growing chorus of sexologists acknowledging that women's sexuality, including their sexual response, merits different models than those developed for men.³

As Leonore Tiefer, Ph.D., has advocated, what is needed is a model of women's sexuality that is more "psychologically-minded, individually variable, interpersonally oriented,

and socioculturally sophisticated."⁴ Such models are beginning to emerge.⁵

The new models of female sexual response have been developed from quantitative and qualitative research findings and clinical practice assessments that more accurately reflect women's actual experiences than previous male-centered models.

A key component of these models is the importance of context to women's sexual expression. Context has been defined as "the whole situation, background, or environment relevant to some happening."⁶ For example, unlike men whose sexual desire often is independent of context, women's sexual desire is often a responsive reaction to the context (her partner's sexual arousal, expressions of love and intimacy) rather than a spontaneous event.⁷ Jordan identified the central dynamic of female adolescent sexuality as the relational context.⁸ She described young women's sexual desire as actually being "desire for the experience of joining toward and joining in something that thereby becomes greater than the separate selves."⁹

So throughout women's development and the transitions in their lives (adolescence, pregnancy, parenthood, menopause) context is a key factor in their sexual expression. Thus, the more things change (their bodies, their relationships, their circumstances), the more they stay the same (the importance of context to their sexual expression).

INSIGHTS FROM THE MIDLIFE WOMEN'S HEALTH SURVEY

Applying the new models of women's sexuality that emphasize the importance of context helps us to better understand women's sexuality as they age. Findings from the Midlife Women's Health Survey (MWHS), a longitudinal study of the menopausal transition that is part of the broader Tremin Trust Research Program on Women's Health, support these new models.¹⁰

The Tremin Trust is a longitudinal, intergenerational study focusing on menstrual health that first enrolled 2,350 university women in 1934 and a second cohort of 1,600 young women between 1961 and 1963. (See the Tremin

Trust Web site at www.pop.psu.edu/tremin/). In 1990, an additional 347 mid-life women were enrolled in order to better study various aspects of the menopausal transition, including sexual changes.

All the participants complete a daily menstrual calendar, recording detailed information about their menstrual health. They also complete a yearly comprehensive survey, assessing biopsychosocial information about their health and aging, life experiences, and sexuality, among other factors. These surveys collect both quantitative and qualitative data. Throughout the years, some of the women have been called upon to participate in special qualitative studies in which they have been interviewed. One hundred of the perimenopausal women who are not taking hormone replacement therapy have also supplied daily morning urine specimens so that hormonal analysis could be conducted.

The Tremin Trust participants are incredibly dedicated to the project. For example, they keep daily records throughout their lives (for some almost 70 years) and enlist participation from their daughters, granddaughters, and great-granddaughters. The study's potential for providing a greater understanding of women's sexuality throughout their lives, and the factors that affect sexual changes, is unparalleled. The greatest limitation is the lack of diversity among the participants, since over 90 percent are well-educated white women. However, data collection has been conducted with additional samples of African-American and Alaskan women as well as lesbians. More diverse cohorts may be enlisted in the future.

Analysis of the sexuality data is ongoing, with more data being collected each year. Interesting findings have emerged regarding midlife women's sexuality (ages 35 through 55 years of age) as they progress through menopausal transition. The average age of menopause is 51, with perimenopause beginning as early as the late thirties. In an open-ended question asking what they enjoyed most about their sexuality, more than two-thirds of the women referred to aspects of their relationships with their partners.¹¹ Most of these responses described some aspect of intimacy, including love, closeness, sharing, companionship, affection, and caring, as described below. About 15 percent of the women noted feeling comfortable and secure in their relationship, emphasizing feelings of mutual trust and honesty.

It is the most healthy relationship I've ever been in. Sex in the context of a respectful, caring, non-exploitative relationship is very wonderful.

Wow! The sexual experience is another heightened way we share the humor that comes from shared experiences such as canoeing, fine music, backyard work, scuba trips. It makes the "union" a joyous and complete one!

Many of the lesbian participants felt that the intimacy they shared in their relationships was even greater than what they had experienced or observed in male-female relationships.

Many straight women in 20-to-25-year marriages are distant and emotionally separate from their husbands. I think this is a time when lesbian women and their partners really come into their own—their best time together. There's much greater emotional intimacy with less emphasis on sex. It's very nurturing and increases the bond between us.

Another very important contextual feature that at least one in ten women enjoyed about their sexuality was a newly-found sexual freedom they experienced as they aged, either from their children leaving home or from being with a new partner.

Freedom and ability to be spontaneous with our sexual desires due to the "empty nest."

The freedom to have sex at his apartment. The growing intimacy and closeness that goes along with sex itself. The sexual playfulness and frivolity that threads itself through regular daily activities (teasing, sexual nuances, private jokes, and touches).

Approximately 20 percent of the women discussed some particular aspect of their sexual interactions, with mutual sexual satisfaction, continuing sexual interest, desire, and attraction, and lessened inhibitions and increased experimentation mentioned most often.

We seem to enjoy sex more and more as the years go by. The orgasms seem even better. We both respond well to each other sexually since we feel safe in our loving monogamous relationship.

One-third of these discussions emphasized that touching, kissing, hugging, and cuddling were the most important aspects of the sexual interactions.

You may not consider it sexual, but sleeping together in a queen-sized bed in the last year and a half. While the kids were growing up, we had twin beds. We enjoy the cuddling this provides daily.

Qualities exhibited by their sexual partners, who are most often the women's husbands, have been found to significantly impact the women's sexual responding.¹² Specifically, the more love, affection, passion, assertiveness, interest, and equality expressed by the sexual partners, the higher the women's sexual desire, arousal, frequency, and enjoyment. Women also expressed appreciation for a non-demanding partner who was responsive to their needs.

My partner is very accepting about how I feel and what I like and what I don't like even though it changes often. I also appreciate that he doesn't expect me to have an orgasm every time we make love.

SEXUAL CHANGES AS WOMEN AGE

Each year the women report many changes in their sexual responding. Some women have reported enjoying sex more (8.7 percent), easier arousal (8.7 percent), desiring sexual relations more (7 percent), easier orgasm (6.7 percent), and engaging in sexual relations more often (4.7 percent).¹³ The women attribute their improved sexuality most often to changes in life circumstances (new partner, more freedom with children leaving home), improved emotional well-being, more positive feelings toward partner, and improved appearance.¹⁴

However, two to three times more women have reported declines in their sexual responding, including: desiring sexual relations less (23.1 percent), engaging in sexual relations less often (20.7 percent), desiring more non-genital touching (19.7 percent), more difficult arousal (19.1 percent), enjoying sexual relations less (15.4 percent), more difficult orgasm (14 percent), and more pain (10 percent).

Women are much more likely to attribute declining sexual response to physical changes of menopause than to other factors.¹⁵ Analysis of the health data has found a statistically significant relationship between having vaginal dryness and decreased sexual desire and enjoyment.¹⁶ However, no statistically significant relationship between menopausal status and decreased sexual desire, enjoyment, or more difficulty with orgasm was found. On the other hand, sexual desire and enjoyment were significantly related to marital status, with decreases associated with being married. The woman's age was also significantly related to her sexual enjoyment, with enjoyment decreasing as the woman became older. Further, a significant relationship has been found between poor body image and decreased sexual satisfaction.¹⁷

Other studies among general populations of aging women have failed to find clear associations between menopausal status and declines in sexual functioning.¹⁸ Similar to the MWHs findings, they found psychosocial factors to be more important determinants of sexual responding among midlife (perimenopausal and menopausal) women than menopausal status.¹⁹ The factors include sexual attitudes and knowledge; previous sexual behavior and enjoyment; length and quality of relationship; physical and mental health; body image and self-esteem; stress; and partner availability, health, and sexual functioning.

SEXUAL SATISFACTION AND THE IMPORTANCE OF SEX FOR WOMEN

Even with many aging women in the MWHs identifying declines in their sexual desire, frequency, or functioning, almost three-quarters of them reported overall sexual satisfaction (71 percent), including being physically and emotionally satisfied (72 percent).

Even though sex is less frequent and it takes much longer to feel turned on, it is still very satisfying.

I have been a very fortunate person. The man I married I still love dearly. We both respect each other and try to keep each other happy. We don't have sex as much as we used to but we kiss and hug and hold each other a lot.

The importance of sexual expression varied in the midlife women's lives and was affected by the circumstances in which they found themselves (married, divorced, widowed, in a same-sex relationship). Once again, women evaluated the importance of sexuality in the overall context of their lives. Some women who had lost their sexual partners to death or divorce reported missing a sexual relationship, mostly because of the lack of intimacy.

I find being a widow at a young age to be very lonely. I find that I miss the desire to have a sexual closeness with a man. I also feel very sad and confused as my husband was the only man I have ever been with. Having lost him, I fear beginning a new relationship.

I have been alone for 18 years after a 14 year marriage and three children. I miss regular sex, but *most* of all I miss touching, cuddling, body-to-body contact, not the sex act.

Yet many women without partners had decided that having sexual relations was not worth the price if the overall relationship was not fulfilling.

I am single by choice (heterosexual) and have never wanted children. I am finding it difficult to meet men as I get older and my relationships are further apart. My sexual response is still very strong, but I am not willing to compromise what I want in a relationship just for sex. My attitude is that if that doesn't happen, I am doing fine, and am happy with my life.

I find myself wishing for a "partner" but only if he's a real friend. My celibacy is comfortable at the moment. It has become apparent to me that our culture has taught most females to sacrifice them-

selves to their partner's desires and not to defend themselves. I hope I don't fall in that trap again. I find that I satisfy my physical sexual desires better than my husband ever did.

On the other hand, sexual interaction is very important to many of the aging women.

I am 58 and as horny as ever....The sex urge is still with me, not much different from my earlier years. Maybe I am too physically active and healthy! I can't seem to get it into my head that I am approaching a different time of life.... There is little or no speaking about a situation like mine in books or media. Yet women my age say the same thing: "Where are the men? Men want only younger women. The 'good men' are married or in relationships.".... My request to you is—listen to the voice of the horny women. When we hear each other and gain our dignity, solutions will come!

CONCLUSION

Results from the MWHS, some of which have been shared in this article, illustrate that women experience their sexuality as complex and holistic. Thus, it is doubtful that a particular drug or other substance or device that could improve physical functioning (increase libido or vasocongestion) would be the "magic bullet" to transform women's sexuality as they age. In order to understand and enhance women's sexuality throughout their lives, we must listen to their voices, learn from their experiences, and appreciate the importance of context to their sexual expression.

(Dr. Mansfield is director of the Tremin Trust Research Program on Women's Health. Dr. Koch is assistant director. Dr. Koch is also adjunct professor of human sexuality at Widener University in West Chester, PA.)

—Editor

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HALF OF AMERICANS OVER 60 HAVE SEXUAL RELATIONS AT LEAST ONCE A MONTH

Nearly half of all Americans over the age of 60 have sexual relations at least once a month, and 40 percent would like to have it more often. In addition, many seniors say their sex lives are more emotionally satisfying now than when they were in their forties.

These findings were part of the latest Roper-Starch Inc. survey of 1,300 men and women over the age of 60 conducted by the National Council on the Aging.

"This study underscores the enduring importance of sex among older men and women—even among those who report infrequent sexual activity," said Neal Cutler, director of survey research for the Council. "When people are not sexually active, it is usually because they lack a partner or because they have a medical condition."

As most people might expect, the survey found that sexual relations taper off with age, with 71 percent of men and 51 percent of women in their sixties having sex once a month or more and 27 percent of men and 18 percent of women in their eighties saying they do. Cutler said women had sex less often in part because women are more likely to be widowed.

Thirty-nine percent of people said they were happy with the amount of sexual relations they currently have—even if it is none—while another 39 percent said they would like to make love more often. Only four percent of the people surveyed said they would like to have sexual relations less frequently. The people who had sex at least once a month said it was important to their relationship.

The survey also found that 74 percent of men and 70 percent of women find their sex lives more emotionally satisfying now that they are older than when they were in their forties. As to whether it is physically better, 43 percent say it is just as good as or better than in their youth, while 43 percent say sex is less satisfying.

"When it comes to knowledge about sex, older people are not necessarily wiser than their children. A third of the respondents believed it was natural to lose interest in sex as they got older," said Cutler.

HIV AND AIDS IN PEOPLE OVER 50

Judith A. Levy, Ph.D

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*Grow old along with me,
The best is yet to be.*

(from Rabbi Ben Ezra by Robert Browning)

Lovers have long appropriated Browning's reflections on the properties of aging to describe the ideal of a romantic, singular relationship that begins in youth and continues through old age until death.

While, undoubtedly, such imagery becomes the prophecy that structures some people's lives, others arrive at late adulthood looking for romantic or sexual partnering for personal reasons outside the boundaries of a marriage or after having been divorced, widowed, or never married.

Such courtship or sexual pairing in late adulthood carries numerous challenges and possible rewards along with certain drawbacks and risks. One threatening aspect of sexual dating and mating at any age lies in the danger of contracting HIV/AIDS. Despite the common belief that HIV is a young person's disease, 10 percent of all cases of AIDS have occurred annually among people over 50 since the inception of the epidemic.¹

THE EPIDEMIOLOGY OF AIDS AMONG OLDER ADULTS

Statistics from the Centers for Disease Control and Prevention compiled by Karin Mack and Marcia Ory show that the actual number of AIDS cases diagnosed in adults over age 50 quintupled from 16,288 in 1990 to 84,044 by the end of the year 2000.²

Approximately 50,000 Americans in this age group currently live with AIDS, and over 49,965 persons 50 years of age or older have died from the complications of HIV since the start of the epidemic. Some unknown number of those infected or dead contracted the virus after age 50. Others represent instances of survival into late adulthood after more youthful infection.

This latter group is expected to grow substantially over the next decade, due to the success of highly active anti-retroviral therapy (HAART) in prolonging the lives of people with HIV. Thus, it can be argued that AIDS is aging both as an epidemic and as a serious health threat affecting older adults.

Transmission routes. People over 50 contract HIV through the same transmission mechanisms as their younger

counterparts, although the proportions of cases attributed to any one means may differ.

Early in the epidemic, older persons were infected with HIV disproportionately through the receipt of contaminated blood or blood products during transfusions.³ This danger has largely disappeared for all age groups since 1985 with the routine screening of blood donations.

Currently, most HIV in people over 50 occurs through male-to-male sexual contact, although this trend is declining somewhat for men of all age groups. Mack and Ory report that men having sex with men accounted for 62 percent of known exposures for males 60 years of age or older in 1994; this percentage dropped to 48.3 percent in 1999.⁴ Meanwhile, heterosexual contact has become the primary exposure route for women irrespective of age. Injection drug use, either directly through using contaminated drug paraphernalia or indirectly through sexual partnering with a drug-injector, accounts for a rising number of cases among older adults each year.

HIV RISK FACTORS AFTER AGE 50

As people grow older, a number of physiological changes occurring as part of the aging process influence their sexual behavior and their HIV risk. Among women, normal physiological changes associated with age and sexual functioning include a general atrophy of vaginal tissue and lessening in the rate and amount of vaginal lubrication produced during sexual relations.⁶ With age, the clitoral, vulvar, and labial tissue shrink; the size of the cervix, uterus, and ovaries decreases; and some loss of elasticity and thinning of the vaginal wall occurs. Due to possible tearing or abrading of vaginal tissue during intercourse, which permits easier penetration of the virus, women's biological vulnerability to HIV infection increases following menopause.

Among men, normal physiological changes associated with age include reductions in penile myotonia (muscle tension) during sexual arousal.⁷ Pronounced reductions in erectile functioning can complicate or thwart using a condom during sexual intercourse. Thus, for some men, fear of inability or the actual inability to sustain a full erection during intercourse can discourage attempts at using a condom to prevent STD or AIDS viral transmission.⁸

Sexual risks. Like all age groups, people over 50 differ in terms of their sexual attitudes, interests, and practices.

Such diversity includes personal variation in sexual orientation, initiation into sexual relations, health, partnering experiences, and the effects of major life decisions that facilitate or restrict opportunities for sexual activity. The additive consequences of these multiple influences create differing profiles of sexual behavior and HIV risk for individuals of any age.

Many misconceptions and stereotypes exist concerning the sexual behavior of people over 50. Such fallacies contribute to an older person's risk for HIV and limit successful prevention efforts. Common stereotypes, for example, hold that sexual behavior becomes infrequent or nonexistent in late adulthood. Popular culture, as expressed through birthday cards, comedy routines, and media imagery, often assumes or plays up old age as a time of sexual dysfunction and lack of libidinal interest.⁹ Scientific evidence does confirm that sexual arousal slows and sexual activity lessens as people grow older.¹⁰ Yet, considerable evidence also shows that sexuality remains an important part of people's lives well into old age,¹¹ as does risk for HIV/AIDS.¹²

Older adults who are not sexually active cite debilitating illness and lack of a partner as two major factors that limit sexual activity in late adulthood.¹³ For those who seek a mate, romantic pairing, or recreational sex, the pursuit of a partner carries some level of HIV risk. For example, today's older adults who are widowed or divorced face a dating scene quite different in terms of sexual culture and permissiveness from that of their youth and young adulthood.¹⁴ As a consequence, the normative framework that shaped decision-making about sexual behavior in their youth may prove outdated or inadequate when navigating contemporary sexual relationships and social environments that carry HIV risk.

Older adults find sexual and romantic partners in the same way and in many of the same settings that younger people do. Besides potential possibilities for partnering with individuals who are older or younger, people over 50 also come into contact with their own age-peers through senior centers, nursing homes, retirement communities, singles' clubs, and neighborhood bars that cater to an older crowd. The Internet also has emerged as an increasingly popular means for adults of all ages to find romantic or sexual partners.¹⁵ Adults over 50 years of age represent the fastest-growing group on the Internet,¹⁶ and undoubtedly some unknown number avail themselves of this matchmaking benefit. Numerous Web sites targeting both younger and older adults offer opportunities for developing personal relationships. Of course, from the standpoint of HIV transmission, social relationships that begin and remain online are free of HIV risk. Yet, mounting evidence shows that romances that start online have a tendency to move offline into face-to-face encounters.¹⁷ How many of these connections carry the potential for HIV risk is unknown. Several recent studies, however, have traced transmission of the virus to contacts first made via the Web.¹⁸

Drug-related risks. As is also true for sexual behavior, numerous myths and misconceptions exist concerning the prevalence and practices of drug use in late adulthood.

For many years, clinicians and researchers assumed that individuals who use illegal drugs mature "out of the life"¹⁹ and away from HIV risk by the time they reach 50 years of age. Findings from more recent studies, however, have severely challenged this belief.

For example, Alan Richard and his colleagues examined risk behavior for a national sample of 22,289 out-of-treatment crack cocaine and injection drug users to determine the effects of aging on HIV risk.²⁰ Multivariate analyses showed that projected risk for the sample increased steadily across age-cohorts from younger to older.

For example, 18 to 20 year olds in the sample had an overall 33 percent 10-year projected risk of becoming infected with HIV if they continued to engage in the same drug-related risk behaviors of the last 30 days. Respondents in the sample 61 years of age or older had a higher overall projected risk of 45 percent.

Using the same national database for analysis, Carol Kwiatkowski and Robert Booth also found that sexually active, older drug users engaged in risky sexual behavior at rates similar to that of their younger counterparts.²¹ Of the two-thirds of the older cohort in the sample who were sexually active, approximately one-third had engaged in sexual relations with two or more partners in the prior month, exchanged sex for drugs or money and/or had sexual relations with a drug injector.

Nonetheless, nearly two-thirds of those who were sexually active reported never using condoms. Perhaps not surprisingly, older users in the sample had an infection rate of nine percent.

LIVING WITH HIV/AIDS IN LATE ADULTHOOD

Successful treatment of AIDS begins with diagnosis. When compared to younger individuals, older adults tend to be diagnosed with AIDS later in their disease trajectory.²² Multiple reasons help to explain this lag.

First, health care professionals appear slow to recommend HIV testing for older patients because they often do not perceive people over 50 to be at risk.²³ When same-sex behavior or drug use is suspected of a patient, providers may avoid discussing HIV out of fear of insulting or angering the person. Also, AIDS in its earlier stages often successfully mimics chronic illnesses and conditions common among older patients.²⁴

Thus it appears that for some older persons, HIV testing only occurs when symptoms of AIDS become so advanced that they are difficult to ignore or mistake for other conditions. As a result, older individuals tend to have a lower CD4 cell

count and a higher plasma viral load than their younger counterparts when their HIV-1 sero-status is first identified.²⁵ Also, they tend to experience shorter survival intervals following diagnosis.

Treatment. As is also true of HIV risk, the biological properties that accompany aging influence older persons' AIDS prognosis, treatment, and illness trajectories.

Unfortunately, from the standpoint of effective medical treatment when clinically managing HIV among older individuals, little is known of how the processes of aging interface with AIDS as a progressive disease. Co-morbid conditions commonly associated with aging are believed, but not proven, to accelerate AIDS disease progression.²⁶

Immune senescence, which occurs through repeated cell replication over the life course, also may contribute to rapid declines and lessened response to antiviral treatment in late adulthood, but the role of cellular deterioration in affecting HIV treatment is not well understood and open to argument.

When compared to younger individuals, older persons with HIV report less energy, more fatigue, lower quality of life, and greater isolation from family and friends and other supportive networks.²⁷ Despite such grim research findings, however, any discussion of living with HIV begs attention to the recent development of HAART and other medications that prolong living and quality of life for persons with HIV at all life stages.

The social stresses and potential for severe to fatal health complications associated with AIDS can be great at any age, but as is true of their younger counterparts, people over 50 infected with the virus report that they can and do live productive and satisfying lives.

PREVENTING HIV/AIDS AMONG OLDER ADULTS

Few AIDS prevention programs currently target people over 50. Perhaps this neglect helps to explain why older persons at HIV risk are less likely than their younger counterparts to have adopted AIDS-prevention strategies.

Many proven HIV-prevention methods likely succeed with individuals at any stage of the life course and can be adopted when designing and offering AIDS programming for older adults. Still, the epidemic does appear to manifest itself differently in critical ways among people 50 years of age and older. A number of age-specific interventions based on these differences appear promising.

Biological strategies. Hormone replacement through oral supplements, genital creams, and natural nutrients offers a logical method for reducing HIV risk among older women who experience age-related vaginal changes that encourage viral transmission.

Meanwhile, although far from the only means for treating

male sexual dysfunction, the prescription drug Viagra® has proven highly successful in increasing erectile function in men,²⁸ an outcome that can enhance the likelihood of successful condom use.

While medical treatment for the biological changes associated with aging in both sexes can increase sexual enjoyment and possibly reduce physiological conditions associated with increased risk for viral infection, these medical measures are not without possible iatrogenic effects that should be thoroughly discussed with a medical provider.²⁹

Educational strategies. Research shows that older people are generally knowledgeable about HIV and its transmission.³⁰ Yet few older people see themselves at risk even when engaging in high-risk behavior.

Programming in senior centers or retirement communities where older people gather for health information rarely addresses sexuality or AIDS, and few opportunities exist for older adults to increase self-awareness of HIV risk through discussion with others.³¹ Thus, mounting successful prevention efforts for people over 50 includes developing and offering age-appropriate educational interventions to increase such awareness.

Most older adults gain their information about sexuality from books or magazines, according to a recent AARP survey.³² These media resources offer an excellent venue for promoting AIDS-prevention messages as they already reach a ready and interested older audience.

Health care providers also serve as a traditional source of health information for older patients. But many providers lack the time, training, or skills to talk about sex or HIV with older patients. Special training in educating and treating older adults with regard to HIV/AIDS is sorely lacking but critically needed for health professionals.³³

It bears repeating that people over 50 are not homogeneous in terms of their sexual attitudes, interests, or practices. To prove successful, AIDS-related programming and messages must acknowledge that aging is experienced among older adults according to such diverse factors and personal characteristics as socio-economic status, sexual orientation, gender, race, ethnicity, and health.

Members of the baby boom generation, for example, grew up in a time when sexual and drug experimentation was more widespread than in earlier decades.³⁴ Their orientation toward HIV risk and prevention in later adulthood likely differs from that of individuals reared during previous eras when sexual relations before marriage and drug experimentation and use was less common across the general population.

Similarly, among men who have sex with men, those who are now in their twenties have personally experienced little of the population devastation that AIDS exerted on the gay community in many urban centers in the 1980s. This age-cohort brings a different perspective to sexual risk

and prevention than those who lived through this period as sexually active adults.³⁵

Identifying and addressing such differences among older adults and age-cohorts is essential when designing and offering AIDS educational and intervention programming.

Safer sex. Sexual behavior includes a wide range of erotic practices that do not require a partner and/or an exchange of body fluids carrying HIV risk.

Enormous sexual gratification can be found in masturbation, sexual fantasies, cuddling, kissing, reading erotic literature, nongenital petting, and caressing. Adults of all ages can enjoy these sensual experiences, and they offer an effective way to avoid the threat of AIDS for those who choose not to engage in penetrative sex. They also can become an important means of interpersonal connection and mutual pleasure when one partner in a sexual relationship or encounter is HIV infected, and the couple chooses not to have intercourse.

Latex condom use during sexual intercourse remains a primary and effective means to avoid and curb transmission of the virus for all age groups. A study on condom use conducted by Durex, however, found that older adults are more resistant to using condoms and modifying sexual behavior than their younger counterparts.³⁶ Similarly, in surveying over two thousand adults aged 50 and over, researchers Ron Stall and Joseph Catania found that only a small percentage with a known behavioral risk for HIV infection reported using condoms during sexual intercourse.³⁷ Among those engaging in some HIV risk behavior without using a condom, more than 63 percent indicated having multiple sex partners.

Successfully promoting safer sex to prevent HIV/AIDS requires some attention to personal sexual history, cohort effects, prior experience, and gender differences.

As noted earlier, adults over 50 years of age differ in terms of their exposure to and life experience with the availability and use of condoms and other contraceptive devices. Baby boomers now entering their fifties typically reached sexual maturity in the wake of the development of “the pill” for contraception. Those who opted in their youth for the convenience and freedom of oral contraceptives may have little first-hand experience with successfully using a barrier method that requires immediate application before intercourse. Meanwhile, for older individuals in their seventies and eighties, having come of sexual age prior to the availability of the pill, condoms constituted one of the more popular contraceptive devices. Given such variation in experience and exposure, older adults likely require different information, skill-building opportunities, and encouragement if they are to practice safer sex.

Due to both male biology and the dictates of power relationships as codified through traditional gender norms, men typically have assumed the rights and responsibility for initiating the use of male condoms in a sexual encounter.³⁸

The recent development of the female condom provides women of all ages with a form of barrier protection against HIV that does not rely on male initiation or cooperation. Inserted into the vagina using a special lubricant developed for this purpose, women typically need some training in how to do this if they are to use them successfully.³⁹ Unfortunately, no research to date appears to have investigated the barriers and facilitators to successful female condom use by older women with disabling disorders or pronounced age-related vaginal changes. Still, the female condom offers a promising alternative to the male sheath for those older women who want greater personal control over reducing their HIV risk.

Safer drug use. Among illicit drug users, outreach strategies that provide AIDS education and promote safer needle behavior have proven successful in reducing HIV transmission related to injecting drug use.⁴⁰

Sexual transmission that occurs within the context of illicit drug use, however, has proven far more difficult to successfully curb through outreach services and bears more research and programmatic evaluation.⁴¹ Syringe exchange programs also show excellent results in reducing AIDS transmission in geographic areas where they are legal.⁴²

Older addicts, however, don't necessarily benefit from these risk reduction offerings. A study of older street addicts, for example, found that outreach services can miss older users, as the latter tend to be less accessible for prevention than their younger counterparts.⁴³ Moreover, ill health and chronic disabilities common to old age can restrict the ability of older persons to travel to syringe exchange sites to obtain needle-hygiene supplies. Fear of victimization in these settings by younger users also inhibits program use.

Such deterrents point to the need for developing and offering age-sensitive services that target older users as an often hidden and difficult to access high-risk group.

CONCLUSIONS

Late adulthood can be highly rewarding, as Robert Browning's poetry contends and much research confirms.

Sex is an important part of this life stage for many older adults, and considerable evidence suggests that sexual activity continues throughout the life course, bringing pleasure, better health, and improved subjective well-being.

HIV/AIDS need not curb sexual enjoyment among older adults nor spoil or shorten this later stage of life. Armed with adequate knowledge about AIDS and motivation for its prevention, people of all ages can avoid infection. New treatment options also offer strong hope for both lengthening and enhancing the quality of life for those already infected with the virus.

Thus the rewards of late adulthood, including sexual and romantic partnering, can indeed live up to Browning's promise of being among life's “best.”

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GAY AND LESBIAN AGING

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Research on the lives and well being of older gay men and lesbians was virtually nonexistent 30 years ago. As such, information was based principally on anecdotal evidence, myth, and stereotype.

Unfortunately, this presumed knowledge was rooted in a culture of homophobia and reflected ideological beliefs that often labeled homosexuality as a form of evil, perversity, immorality, or illness. In fact, the American Psychiatric Association did not remove homosexuality as a form of mental illness from the *Diagnostic and Statistical Manual* until 1973.

Additionally, older gay men or lesbians suffered from another stigma in American society due to ageism. Thus, the persistent image was fostered of older gay men or lesbians as lonely, depressed, isolated, desperate, and sexless.¹ This image, however, does not hold up empirically.

Researchers and service providers are becoming increasingly aware that there exists a large population of older gay men and lesbians. According to Dawson, there were 3.5 million such individuals living within the United States in 1982.² This number has and will continue to grow as the older population as a whole is expected to double by the year 2030.³

INCREASED RESEARCH

Until the early 1970s, research on gay and lesbian aging was largely nonexistent. Only in the past two decades has this population become the focus of programmatic research and services developed to meet their needs.

It is worth noting, however, that those gays and lesbians who have been studied represent a select subpopulation: white, formally educated, urban, and upper middle class. In reality, older gay men and lesbians represent an unseen, highly diverse population found within all socioeconomic, geographic, educational, and ethnic backgrounds.

In addition, minimum age criteria used to define “old” in some research is as low as 40 years of age. Unfortunately, few studies solely examined individuals over 60 and even fewer included the “oldest-old,” those over 85 years of age. This becomes extremely important when considering the differences in culture and historical context experienced by individuals of different ages.⁴

Consider, for example, that those gays and lesbians now in their mid-sixties were in their mid-thirties at the time of

the 1969 Stonewall riots and that the oldest-old were well into middle age. Today’s older gay men and lesbians were either in middle or later adulthood at the start of the AIDS pandemic. In addition, those in their sixties or eighties each experienced different levels of discrimination, including potential psychiatric and religious persecution.

Thus, when evaluating research or providing services to older gay men or lesbians, it is imperative that one take into account the differences resulting from the historic and cultural context within which they developed.

Because of historical context, many very old gay men or lesbians have never self-defined themselves as homosexual.⁵ For example, two women may have coupled and defined their relationship as roommates. Self-identification as gay men or lesbians was inhibited by the strong moral and social injunctions against homosexuality. In addition, the concept of “coming out” did not exist during their youth. Thus, the oldest gays and lesbians remain an extremely hidden population. Researchers will hopefully one day provide us with more information on this group as they undoubtedly have much insight to offer to younger gays and lesbians. It is unfortunate that so little is known about them, as these are the individuals who are today most likely in need of services and assistance.

GAY, NON-GAY AGING SIMILARITIES

There are vast similarities in aging between gay, lesbian, and heterosexual populations. Most factors related to aging, whether physical or societal, are the same for both.

When discussing how older gay men adapt to the aging process, Berger cites two individuals’ responses: “Whether you are gay or straight doesn’t make a difference. It’s your attitude that makes the difference,” and “Any person who hasn’t adjusted well to other aspects of his life won’t adjust well to aging, either. Being gay is just icing on the cake.”⁶

Common concerns for older gay men and lesbians include age stigmatization, finances, health, fear of institutionalization, loneliness, and loss of a loved one.⁷ These concerns also exist for heterosexuals.

While many aspects of aging appear universal, research on gay and lesbian aging has demonstrated specific positive and negative effects. Several are discussed below.

GAY AND LESBIAN AGING

Gays and lesbians have usually experienced the stigma of homosexuality before they experience the stigma of being old. Those who have positively dealt with the former will likely experience the latter with less difficulty. By overcoming the stigma related to homosexuality, they will usually develop greater self-acceptance and the self-confidence necessary to overcome age-related stigmas.⁸

Research on overcoming stigma of homosexuality.

In 1973, Francher and Henkin were the first to hypothesize that successful adaptation to—and coping with—life in a homophobic culture provides useful psychological and interpersonal skills to use later in life.⁹ Other researchers have since expanded this concept.

For example, Kimmel hypothesized that the identity process of “coming out” as a gay or lesbian builds unique ego strengths that are adaptive in life.¹⁰ Similarly, Friend hypothesized the development of a “crisis competence,” and Berger discussed “mastery of crisis.”¹¹ Each postulated that prior successful management of the stress of coming out and self-identification as a gay man or lesbian builds strengths that could be used to adapt to future stresses, including those associated with aging.

Each of these theories operates on the assumption that adapting to a public gay identity and becoming involved in the gay community supports life satisfaction. Indeed, research by both Friend and Berger supports such an hypothesis.¹² Research by Quam and Whitman also argues that gays need quality social support and need to be “out” in the gay community to have life satisfaction.¹³

It is important to note, however, that samples for these studies were drawn primarily from individuals actively involved in the gay community and gay friendships. Thus, the association between life satisfaction and public gay identity/community involvement may in some measure be a sampling artifact.

Other research on life satisfaction. Research conducted by Lee disputes the above conclusions.¹⁴ His research identified three factors closely associated with successful aging—good health, social class advantage (influenced by wealth and education), and an “alliance with a significant other.” He argues that successful adaptation in life and aging is not grounded in learning how to cope with crisis or stress but rather in knowing how to side-step crisis or stressors.

The above factors enable individuals to ameliorate and possibly avoid numerous difficulties in life. For many older homosexuals, the early decision not to publicly identify as a gay man or lesbian was highly functional.¹⁵ It allowed them to avoid the stressors associated with living in the highly homophobic pre-Stonewall culture.

Research by Adelman found five factors associated with life satisfaction in older gay men and lesbians.¹⁶

These include:

- Highly perceived importance of a gay or lesbian identity
- Little disclosure of one’s homosexuality at work
- Low involvement with other gays or lesbians
- Awareness of one’s sexual orientation early in life
- Decreased saliency of one’s homosexuality in later life

These factors appear to support Lee’s work in the sense that while an older person’s gay or lesbian identity is highly salient, it may also be highly private.

Less research on older lesbians. There is less research on older lesbians. Almvig found that most remain very private about their identities. In fact, most reveal their orientation only to a limited number of family and friends. Still, research appears to consistently demonstrate that they have a high degree of life satisfaction.¹⁷

Researchers have identified several factors related to older lesbians’ life satisfaction. Adelman found that the largest determining factor was the degree of homophobia to which they were subjected both by others and within themselves.¹⁸ Kehoe, in two separate studies, found that their greatest difficulties were health problems, finances, isolation and loneliness, and age-related problems.¹⁹ Over half rated their mental health as good to excellent. Life satisfaction was consistently related to being physically and mentally healthy as well as having a positive identity as a lesbian.

General evidence of life satisfaction. Overall, this and other research, such as that conducted by Kelly, has found evidence of high levels of life satisfaction among older gay men and lesbians.²⁰ The factors and underlying rationales associated with this finding vary, which in part may be due to differences in sampling and cohort.

Bell and Weinberg found that lesbians and gay men were more likely than heterosexuals to have a network of close friends.²¹ They postulate that heterosexuals are more likely to have family interactions rather than outside friendships. Krieger describes the lesbian community as a “haven in a hostile world.”²² Similarly, Berger states that “integration into a homosexual community is an important factor in the adaptation of older male homosexuals.”²³

Dorfman and colleagues found that older gay men and lesbians had the same level of social support as heterosexuals but that they received such support from different sources.²⁴ Similar to Bell and Weinberg, Dorfman found that gay men and lesbians primarily derived social support from friends and through alternative “friendship” families. Lesbians often maintained close friendships with former lovers and considered them part of this alternative family. Heterosexuals in the Dorfman study were found to receive social support primarily within traditional family structures.

Other concerns. Physical intimacy with a partner is still important for the majority of older gay men and lesbians.²⁵ Most report a continuing satisfaction with this aspect of their lives. Difficulties associated with sexual functioning and intimate relationships due to physical changes, psychological expectations about “performance,” menopause, or loss of a partner parallel those experienced by older heterosexuals.²⁶

Most older adults find it difficult to communicate with physicians and therapists about sexual matters. However, the older gay or lesbian also has to contend with the additional possibility of negative reactions due to both ageism and homophobia.²⁷

Retirement for the gay man or lesbian may have positive benefits. While in the work force, many constantly face the threat of job loss on the basis of their sexual orientation. Many find that retirement gives them the opportunity to become more socially and politically involved because disclosure of their sexual orientation is unlikely to affect their financial livelihood.

The research on coping, life satisfaction, and social support refutes the image of the older gay man or lesbian as isolated and depressed. It is important to remember, however, the sampling problems associated with this research. Thus, different results and conclusions may apply to ethnic minorities, rural, or poor older gay men and lesbians.

Erwin argues that the research findings paint too rosy a picture of life for older gay men and lesbians.²⁸ He points to differences between gays/lesbians and heterosexuals in suicide rates, depression, and substance abuse throughout the lifespan as evidence of his concerns. Dorfman and colleagues, however, found no differences in instances of clinical depression (approximately 15 percent) between older gay men/lesbians and heterosexuals.²⁹

Many of the negative consequences related to being an aging gay man or lesbian are also related to the negative aspects of being gay or lesbian at any point across the lifespan. For example, those who accept negative stereotypes about gays or lesbians have a more difficult time adjusting to their own sexual orientation.³⁰ This is true for both older gay men and lesbians.

AGING CONCERNS

Many of the concerns experienced by older gays and lesbians, such as finances and health, are similar to those experienced by heterosexuals.³¹ Ageism is also a common concern that has a negative impact on both groups.

Ageism may, however, include two unique issues for older gay men and lesbians. First, Baron and Cramer report that gay men usually experience “accelerated aging” and see themselves as old at an earlier age than heterosexuals.³² Bennett and Thompson asked gay men what age they

thought other gay men perceived as the beginning of middle and old age.³³ The respondents believed that others thought middle age began on average at 39 and that old age began at 54. These are substantially lower than the norms for heterosexuals.

Other researchers found no differences between heterosexuals and gays/lesbians when respondents were asked at what age they saw themselves at the beginning of middle and old age.³⁴ Harry argued that “accelerated aging” may be more indicative of mid-life crisis than self-perception of premature aging.³⁵

The issue of accelerated aging relates to a second concern about gay and lesbian communities. That is the expansion of an orientation toward youth.³⁶ Thus, older adults who may have previously found a role as friend or mentor to younger individuals may find themselves excluded.³⁷ These concerns need more exploration and research.

Health care discrimination. The health care system has proved traditionally unresponsive in recognizing the existence of gays and lesbians in terms of providing quality health care.³⁸

Health care services are aimed at a heterosexual population, and individuals who have disclosed their identity as gay or lesbian have experienced varying levels of discrimination, including both failure to treat an illness and abuse.³⁹ Quam and Whitford describe a woman who was afraid to tell her physician that she was a lesbian because he might decide to provide her with little or no care.⁴⁰ Her inability to communicate honestly with her doctor could only have a negative impact on her treatment. Research has also shown that many lesbians simply avoid seeing a health care professional altogether.⁴¹

Gay and lesbian partnerships are often not recognized, even though individuals may have lived together for many years. Many partners are not allowed to visit their loved ones in the hospital, not allowed to participate in their health care decisions, or not welcome in long-term care facilities.⁴² This can have a tremendously painful effect.

Housing discrimination. Many older gay men and lesbians are concerned about housing. They wish to live in communities that are predominately homosexual, or at least sensitive to the needs of the older gay man or lesbian. A study by White demonstrated that middle-aged lesbians hope for an “Old Dykes Home” when they reach their older years.⁴³

Such options are not, however, currently available. And if such facilities are opened in the future to accommodate the baby boomers, many older gays and lesbians with limited incomes will likely not be able to afford them.

Legal planning. It is imperative that all gays and lesbians engage in active legal planning for their future.⁴⁴ Documents such as personal wills, medical powers of

attorney, and nominations for guardianship/conservatorship need to be in good legal order to avoid assaults by family members, the health care industry, and the government.⁴⁵

As gay and lesbian relationships are not legally sanctioned, the law does not recognize them in terms of health care directives, inheritances, and other related matters. It is important for gays and lesbians to work with an attorney who has experience meeting the unique needs of such clients. For example, an attorney unfamiliar with these needs might not think to include certain funeral specifics in a personal will, and the surviving partner could find himself or herself excluded from funeral arrangements or even barred from the funeral itself.⁴⁶

Therapy. For the most part, older gays and lesbians are thought to be more reluctant to seek therapy than their heterosexual counterparts, even though many of the problems for which both seek assistance are similar. Issues that frequently bring older gays or lesbians to a therapist include relationship difficulties, bereavement issues, work worries, and financial stress.⁴⁷ The fear of discrimination and homophobia does, however, inhibit individuals from seeking help when needed.⁴⁸

It is imperative that therapists be aware of internalized homophobia and provide an environment sensitive to their gay and lesbian clients. Simple things like limited marital status categories on intake forms can send an implicit message to clients about a therapist's acceptance of gays and lesbians before the therapist has even had the opportunity to meet the potential client.⁴⁹

It is also important for therapists to examine their ideological perspectives about gays and lesbians. For example, as noted previously, there are cohort differences—particularly between those cohorts who identified themselves as gay or lesbian prior to the Stonewall riots and those cohorts who came after. These two groups may have very different perspectives related to being “out” and toward involvement in the gay or lesbian community. Therapists should respect these different perspectives.⁵⁰

They should also consider that many gay men prefer to participate in psychotherapy groups that are not mixed in terms of sexual orientation.⁵¹ Groups composed of both gay and heterosexual men may prove problematic due to homophobia.

MEETING NEEDS

To meet the needs of older gays and lesbians, several communities across the country have formed support groups. Senior Action in a Gay Environment (SAGE) (www.sageusa.org), in New York City, was formed to meet the needs of older individuals involved in the gay or lesbian community as well as to serve as an outreach program to others.⁵² Its programs are a model for community efforts

that recognize and provide services to the gay and lesbian population, ranging from socialization to home visits to shut-ins. Gay and Lesbian Outreach to Elders (GLOE), located in San Francisco, has similar programs.⁵³

For many older gay men and lesbians, the Internet has opened the door to numerous opportunities for connection, community, and information. Lesbian and Gay Aging Issues Network (www.asaging.org), a constituent group of the American Society on Aging, and Senior Pride Network (www.pridesenior.org) both have extensive Web sites with resources and links for older gays or lesbians.

The Gay and Lesbian Association of Retiring Persons (GLARP) (www.gaylesbianretiring.org) provides an alternative to other related organizations that may not recognize or work for the needs of older gay men and lesbians.

These programs and Internet resources may not be available to poor and non-urban older gays and lesbians. Thus, programs and services are still needed to reach these and other disenfranchised gay and lesbian populations.

CONCLUSION

Empirical research demonstrates that the image of the older gay or lesbian as lonely, isolated, depressed, and sexless is, indeed, a myth. Most enjoy a high level of satisfaction in their lives, have unique coping skills which can facilitate the aging process, receive good social support from a community of friends (and, to a lesser extent, traditional family), and worry about and have difficulties with issues that impact almost all people who are aging.

The difficulties uniquely experienced by older gays and lesbians are largely the result of living with and facing discrimination.⁵⁴ Therefore, people need to address, in part through policy and legislation, the removal of discriminatory barriers and difficulties. Finally, they need to develop more programs and services across the country to meet the needs of older gays and lesbians.

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MATURE SEXUALITY: PATIENT REALITIES AND PROVIDER CHALLENGES

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Interest in sex is not limited to the young. Yet it is only in recent years that “mature sexuality” has begun to surface as a public issue, one that health care providers find themselves addressing with growing numbers of patients.

Our society's attitudes toward sexuality and patterns of sexual behavior have undergone dramatic changes in the course of a few decades. With the passage of time, those changed attitudes and behaviors are increasingly becoming those of the older generations as well as the young.

Generational differences in those attitudes still exist: a poll conducted by *The New York Times* found that 55 percent of those under 30 think it is “okay” to fantasize about sex with someone other than their partner, compared to only 27 percent of those over 70. Forty-two percent of those under 30 favored legalizing same-sex marriages, but only 13 percent of those over 70 shared this view.¹

If the younger generations have more fully embraced attitudes toward sexuality that stand in marked contrast to those prevailing earlier in the twentieth century, many in the older generations are now openly acknowledging the important role that sexuality continues to play in their lives.

Recent studies refute old notions of aging as a period devoid of sex or sexual urges. Moreover, the entry into middle-age of the post-World War II baby boomers, the generation credited with bringing about the sexual revolution of the 1960s and 70s, can be expected to make the issue of senior sexuality an increasingly prominent one.

As one reporter commented, the “Boomers,” whose mantra was once “Don't trust anybody over 30,” are now discovering that “they don't lose their libido or become instantaneously impotent as they age and that the engine does not automatically shift into neutral and begin idling on a specific birthday.”²

The availability of new therapies to combat problems associated with sexuality and aging will further ensure that increasing numbers of older Americans enjoy an active sex life far longer than was thought possible, or even considered seemly, for earlier generations.

IMPLICATIONS FOR HEALTH PROFESSIONALS

The implications of these developments for health care

providers are substantial. The expectations of growing numbers of older Americans will require providers to focus more attention on issues of mature sexuality. They must be educated about these issues, skilled in performing appropriate clinical assessments, and prepared to manage age-related sexual problems they may identify, including offering appropriate counseling and other services.

The Association of Reproductive Health Professionals (ARHP) has developed a Mature Sexuality Initiative to help prepare health professionals to meet these challenges. The goals of this initiative are consistent with ARHP's mission as an organization committed to educating professionals and patients on the broad spectrum of reproductive health issues.

This article is designed to help raise health professionals' awareness of mature sexuality as an issue they need to address. It will hopefully challenge both individual providers and other professional groups to help ensure that older Americans lead lives that are not only healthier and longer but also sexually rewarding.

SURVEYS

A 1979 *Consumer Reports* survey revealed more than 20 years ago that many older Americans were sexually active and open to discussing their sexuality. Numerous recent surveys have confirmed the importance of sexuality in the lives of many older adults. These surveys include:

- The 2000 Harris Interactive/PRIME PLUS/Red Hot Mamas (HI/PP) surveys of physicians, menopausal women, and partners of menopausal women
- The 1999 ARHP survey of 355 participants 50 years and older who were asked questions related to sexual behavior and attitudes
- The 1999 American Association of Retired Persons (AARP) survey of 1,384 men and women 45 years of age or older
- The 1998 National Council on Aging (NCOA) survey of 1,292 American 60 years of age and older

This article will review some of the findings of these surveys to give health professionals insight into the thoughts that older Americans have about sexuality issues and their own sex lives.

[Please note that the researchers conducting these surveys phrased their questions differently and surveyed varied age groups. Therefore, direct comparison of these studies is not possible. Although most of the research was weighted in order to generalize the results to the overall population in these age groups, some of the research (particularly among the oldest participants) is based on small samples.]

(See the *SIECUS Fact Sheet* on “Sexuality in Middle and Later Life” for more information on these surveys and their findings.)

FREQUENCY OF SEXUAL ACTIVITY

The number of “mature” Americans who consider themselves sexually active declines with age. In addition, those who say they are sexually active also indicate a decline in the frequency of sexual relations.

The ARHP survey found that respondents engaging in any form of sexual activity—from kissing to “a night of passion”—“more than once a week” declined from 52 and 41 percent, respectively, for men and women in their fifties to 27 and 19.5 percent, respectively, for those 70 or older.³

The AARP survey reported that 77.3 percent of men and 71.7 percent of women between the ages of 45 and 59 engaged in kissing or hugging at least once a week compared to 63.3 percent of men 75 or older and 27.7 percent of women 75 or older.

The number of men reporting sexual intercourse at least weekly fell from 54.8 percent of those 45 through 59 years of age to 19.1 percent of those 75 or older. For women, those reporting sexual intercourse at least weekly fell from 49.6 percent (45 through 59 years of age) to 6.6 percent (75 or older).

A third of men between 45 and 59 reported “self stimulation,” but this figure dropped to slightly more than five percent of men 75 and older. Few women of any age claimed to engage in self stimulation.⁴

The Harris Interactive/Prime Plus survey of post-menopausal women under 55 years of age reported that more than half had sexual relations at least once a week. Almost half (47 percent) reported a decrease in sexual activity since entering menopause; seven percent reported an increase in sexual activity, and approximately a third (36 percent) reported no change.⁵

AVAILABILITY OF SEXUAL PARTNERS

The availability of a sexual partner has a predictable effect on the level of a person’s sexual activity.

According to the NCOA survey, among seniors with a sexual partner, the percentage who were sexually active climbed to 82 percent for men and 77 percent for women.⁶

Among married respondents to the *Consumer Reports* survey, 80 percent of wives and 77 percent of husbands reported current marital intercourse.⁷ Unmarried men surveyed by *Consumer Reports* were more likely than their female counterparts to have a sexual partner: 57 percent reported an “ongoing” relationship, compared to only 33 percent of women.⁸

The relative lack of sexual partners among women in older age groups clearly contributes to the lower sexual activity levels they report. In the United States in 1996, the ratio of women to men in the 65-plus age group was 145 women for every 100 men; among those 85 or older, the ratio was 257 women for every 100 men.⁹

Pooled data from General Social Surveys between 1988 and 1991 indicated that, by ages 70 through 74, over 70 percent of women had had no sexual partners in the past year, compared to only 35 percent of men in the same age group.¹⁰

The AARP researchers found that, among those 75 and older, 78.6 percent of the women had no sexual partner, compared to only 42 percent of men. They concluded that “many of the gender differences found in this study appear to be related to the presence or absence of a sexual partner.”¹¹

Men are also more likely than women to have younger sexual partners, a factor that further exacerbates the problem of partner availability for older women.¹² Forty-three percent of men in their sixties who were surveyed by the NCOA reported sexual partners younger than themselves, compared with only 11 percent of women in the same age group.¹³

SEXUAL FUNCTIONING

Impairments in sexual functioning may explain much of the decline in frequency of sexual relations or the end of sexual activity that seems to accompany aging in most people.

The AARP study questioned both men and women regarding frequency of orgasm. The large majority (76.6 percent) of men 45 through 59 years of age said they “always” achieved orgasm. This figure dropped to 57 percent of men 60 through 74 years of age and to 48.1 percent among men 75 years of age or older. The number of women reporting they “always” had an orgasm was far lower than men in all age groups, but the decline with age was not as steep: 31.6 percent of women 45 through 59 claimed to “always” have an orgasm compared to 26 percent of those 60 through 74 years of age and 25 percent of those 75 or older.¹⁴

When asked if they ever suffered from impotence, men responding to the AARP survey provided very different answers depending on their age. Nearly 67 percent of men 45 through 59 described themselves as “not impotent.” For those 60 through 74 years of age, this percentage dropped to

33.1 percent, with 27.6 percent reporting “minimal” impotence and nearly 16 percent reporting they were “completely” impotent. Among men 75 and older, only 18.4 percent said they were “not impotent” and the number reporting “complete” impotence had risen to nearly 38 percent. Another 19.3 percent of men in this oldest age group reported “moderate” impotence.¹⁵

LEVEL OF SEXUAL DESIRE

While sexual desire remains relatively high among both men and women as they age, there is a clear decline in the level of sexual desire that accompanies advancing age.

Among participants in the NCOA survey, nearly half of all men and women with sexual partners, and 55 percent of less active men and women, said they had less physical desire for sexual relations than in the past.¹⁶ More than four in 10 women participating in the HI/PP survey reported a decrease in sexual desire following menopause.¹⁷

The AARP survey asked participants how often they experienced sexual desire; 57 percent of all surveyed men claimed to feel sexual desire at least two to three times per week, compared to 22.2 percent of all surveyed women. Frequency of sexual thoughts in men declined dramatically with increasing age.

The presence of a partner influenced frequency of sexual thoughts. Among men with sexual partners, 70 percent claimed sexual thoughts once a week or more often, compared to 57 percent of men without partners. Only 36 percent of women with partners reported sexual thoughts at least weekly, and even fewer women without partners (12 percent) said they thought about sexual relations at least once a week.

Nearly half of women without partners (47.8 percent) said they never had sexual thoughts, compared to only 10.2 percent of men without partners. The number of respondents reporting sexual thoughts at least weekly declined in both sexes with increasing age.¹⁸

SATISFACTION WITH SEXUAL ACTIVITY

If older Americans tend to engage in sexual activity somewhat less often than younger age groups, this does not necessarily mean they are less satisfied with their sex lives.

The ARHP survey found that the percentage of those declaring themselves “satisfied” with their sex life was in most cases higher than the percentage claiming to be sexually active.

Not quite 62 percent of men in their fifties claimed to be sexually active, but 69.5 percent said they were either “very” or “somewhat” satisfied with their sex lives. In this same age group, 24.5 percent of men said they were not

sexually active, but only 13.6 percent expressed dissatisfaction with their sex life. A similar pattern prevailed for women in their fifties.

The percentage of men who were dissatisfied with their sex life increased with age, while the percentage of women who were dissatisfied declined.

When participants in the ARHP survey were asked to compare their current sex life to that when they were younger, approximately 56 percent of men in their fifties and 51.5 percent of women in the same age group described themselves as currently “more satisfied” or “equally satisfied” with their sex life, compared to when they were younger.

ARHP also asked a related question: “Do you consider yourself to be a better lover than you were in the past?” Most men 50 through 59 years of age (54.3 percent) considered themselves to be better lovers than in the past, compared to only 33.5 percent of men 70 or older. For women 50 through 59 years of age, a minority (37.6 percent) thought themselves better lovers now than in the past, and that number fell to 24.1 percent among women 70 and older.¹⁹

The NCOA survey found that, among seniors with current sex partners, approximately 60 percent of both men and women 60 years of age or older considered their sex life physically “more satisfying” or “unchanged” from when they were in their forties.

Asked about the emotional satisfaction they derived from sexual relations, 74 percent of sexually active men and 70 percent of sexually active women stated that they were “more satisfied” or “as satisfied” as when they were in their forties. Reasons given for greater emotional satisfaction included: a new marriage or different relationship, being more in touch with one's partner, no longer distracted by children, more time to enjoy sexual relations, and less stress.²⁰

When asked if they were satisfied with the frequency of sexual relations in their personal lives, 35 percent of the men and 42 percent of the women in the NCOA survey reported being satisfied. Among those seniors with partners, the number of those satisfied with the frequency of sexual relations increased to 42 percent of all men and 65 percent of all women. In every age group, men were more likely than women to say they would like to have more frequent sexual relations (56 percent of all men versus 25 percent of all women).²¹

AARP's survey, the most comprehensive in the group reviewed, also addressed the issue of sexual satisfaction. It found women more likely than men in all age groups to report being “extremely” satisfied with their sex life, but men and women were equally likely to be either “extremely” or “somewhat” satisfied.

When asked about changes that would increase their

satisfaction, frequent responses by both men and women included better health for themselves or their partner, less stress, and more free time. Men, as they aged, increasingly reported their own health as their main concern, while women were more apt to cite their partner's health rather than their own. Older women were more likely than older men to identify "finding a partner" as a needed change. In the 75 and older age group, approximately one-third of both men and women reported that no change was needed (compared to 17.8 percent of men and 22.2 percent of women in the 45 to 59 age group).

SEXUAL DYSFUNCTION IN LATER YEARS

A growing body of research is exploring the problem of sexual dysfunction—disturbances in sexual desire and in the psychophysiological changes associated with the sexual response cycle in men and women.²²

The physiological effects of aging are thought to result in certain types of sexual dysfunction.²³ A slowing of the process by which sexual arousal and climax are achieved is common in older adults but may sometimes enhance rather than impair sexual relations since "it may permit a better response synchronization between the sexes, compared to that in earlier years when men responded more quickly than women."²⁴

Moreover, certain aspects of mature sexuality, such as declining frequency, may have other explanations than age-related physiological changes. As Laumann and Youm noted in their report to the 1999 Conference on Sexuality in Midlife, "predictability and routinization of sex" may contribute to decreased incidence of sexual activity in a long-term relationship; declining frequencies of sexual activity in older couples "may have as much to do, then, with the length and nature of their interpersonal relationships and other network obligations (to children, aging parents) as they do with the physiological effect of aging per se."²⁵

A variety of medical conditions, ranging from heart disease to arthritis, can affect sexual functioning. The presence of these conditions does not, however, mean that sexual activity is contraindicated. In some cases, sexual activity may actually have therapeutic value.²⁶ Health professionals caring for patients with these conditions must be prepared to counsel and often to reassure them about the advisability or safety of sexual activity.

SEXUAL DYSFUNCTION IN OLDER ADULTS

Identifying the presence of sexual dysfunction involves the application of appropriate assessment guidelines. A number of tools have been developed to facilitate sexual history taking and assessment, ranging from brief to comprehensive,²⁷ and

researchers continue working to improve methods for identifying and evaluating both psychological and physiological indicators of sexual dysfunction.²⁸

If sexual dysfunction is present, the provider must then determine if the cause is, in fact, age-related or reflects other problems, such as earlier sexual patterns and problems, medical conditions, the results of surgery, or side effects of medication.²⁹

The provider must also consider whether identified measures of sexual dysfunction in older patients signal problems requiring treatment. Survey data cited earlier suggest that many older Americans are satisfied with their existing level of sexual activity, even if it is lower than at earlier stages of life. Some men may be content to learn that a perceived problem is considered "normal" for their age and not reflective of an underlying, more serious health problem.³⁰

For those seniors without a partner, lack of sexual desire may serve a very useful purpose, and is perhaps responsible for the high levels of satisfaction with their current sex life claimed by so many adults in the oldest age groups surveyed.

Evaluation of sexual dysfunction in older adults who do have partners should involve both patient and partner. The effect of treatment on the relationship with that partner must be taken into account: will it resolve a problem, or create one?

- The husband who uses a testosterone gel only to discover that his wife does not respond to his newly revived sexual overtures may experience a sexual frustration that undermines a longstanding relationship
- Estrogen-androgen therapy for a woman whose husband regularly experiences impotence may create sexual tension that previously did not exist and necessitate further intervention—with unpredictable results

As a general rule, therapy to increase libido or otherwise enhance sexual desire or performance should be considered only if the patient expresses dissatisfaction with his or her current status, there is sexual incompatibility with a partner which therapy may correct, and the partner understands and supports any proposed intervention.

For many older patients, intervention to improve sexual functioning will certainly be appropriate and welcome. In some cases, patient education or referral for counseling and behavioral strategies may be effective. In others, medication may offer the most effective treatment strategy.

MEDICAL TREATMENT OPTIONS

Hormone replacement therapy (HRT) has become a standard treatment for menopausal symptoms in women, relieving overt symptoms such as "hot flashes" and vaginal dryness, as

well as increasing clitoral blood flow and decreasing vaginal atrophic changes.³¹ The use of combination hormonal therapy (estrogen plus progestin) has increasingly replaced the use of estrogen alone. More recently, testosterone has come into use as a component of HRT for some women experiencing diminished libido, which may be unaffected by estrogen.³²

Testosterone is considered the hormone of sexual drive in women.³³ Its deficiency appears to have multiple negative effects on female sexuality, among them global loss of sexual desire, decreased sensitivity to sexual stimulation in the nipples and clitoris, and decreased arousal and capacity for orgasm.³⁴ The importance of testosterone in maintaining a woman's sexual vitality is a persuasive argument for considering replacement therapy for postmenopausal women, who lose approximately 50 percent of their total androgen production.³⁵

There is no clear consensus on the value of testosterone therapy as a treatment for diminished sexual desire secondary to androgen deficiency in men. A trend toward increased arousal and spontaneous erection during administration of exogenous testosterone did not reach statistical significance in one study, which also found no change in frequency of sexual intercourse, masturbation, kissing and fondling, or satisfaction in sexual relationships.³⁶

A double-blind, placebo-controlled crossover study conducted with healthy men experiencing erectile dysfunction found that ejaculatory frequency increased with testosterone treatment and that there were "marked, although statistically non-significant increases in median frequency of reported sexual desire, masturbation, sexual experiences with partner, and sleep erections." No effects on ratings of penile rigidity or sexual satisfaction were observed.³⁷

Other studies claim effects of testosterone therapy on men's sexual interest, arousal and enjoyment.³⁸ Early this year, the Food and Drug Administration (FDA) approved a testosterone gel (AndroGel[®]) for treatment of hypogonadism in men. Clinical studies conducted by the manufacturer found that once-daily application of the gel to arms, shoulders and/or abdomen raised circulating levels of testosterone into the normal range; increased sex drive, bone density and lean body mass; reduced fatigue, and improved mood.³⁹

The effectiveness of sildenafil (Viagra[®]) has "revolutionized" the treatment of erectile dysfunction (ED) in men, ushering in a new era in which oral medications will likely dominate the management of ED as well as other forms of sexual dysfunction.⁴⁰

Sildenafil acts by inhibiting phosphodiesterase type 5, allowing corpus cavernosum smooth muscle to relax and thus increasing penile response to sexual stimulation.⁴¹ Generally well-tolerated, sildenafil is nonetheless contraindicated in patients receiving nitric oxide donor drugs,

isosorbide mononitrate (ISMN) or glyceryl trinitrate (GTN) for angina, as it potentiates the hypotensive effects of nitrates.⁴²

Alternative oral medications to treat ED are being investigated. Oral phentolamine (Vasomax[®]) is now available and, while results of clinical trials suggest it may not be as effective as sildenafil, its major documented side effect is rhinitis—experienced by 7.7 percent of clinical trial participants.⁴³ It has been noted that the end points of impotence treatment studies are diverse, and no long term comparison studies have been performed.⁴⁴

The use of sildenafil in treating female sexual dysfunction has also been investigated, with varying results. A study involving women with spinal cord injuries suggests that neurogenic sexual dysfunction in women may be partially reversed by treatment with sildenafil.⁴⁵ Both men and women suffering from psychotropic-induced sexual dysfunction reported significant improvements in both sexual functioning and overall sexual satisfaction following treatment with sildenafil, although patients taking selective serotonin re-uptake inhibitors (SSRIs) reported less improvement than others.⁴⁶

A study with estrogenized women experiencing female sexual arousal disorder found no improvement in the sexual response of these women.⁴⁷ A safety and efficacy study in postmenopausal women also found that "overall sexual function did not improve significantly, although there were changes in vaginal lubrication and clitoral sensitivity. The role of sildenafil in treating sexual dysfunction in various cohorts of women remains to be determined."⁴⁸

PATIENT-PROVIDER COMMUNICATION

Open communication between health care provider and patient is essential to identifying and addressing sexual problems effectively. Yet surveys suggest that such communication is the exception rather than the rule.

The Harris Interactive/Prime Plus (HI/PP) physician survey, conducted in January 2000, included 158 obstetrician/gynecologists and 143 primary care physicians. Findings from this survey, as well as those from the parallel survey of menopausal women, suggest that inadequate physician-patient communication may be a substantial barrier to maximizing older women's satisfaction with their sexual lives.⁴⁹

The physicians surveyed estimated that nearly half of their patients will experience sexuality problems as a result of menopause, but only about 50 percent of these physicians reported asking their patients about sexual desire as part of a routine gynecological exam. Even fewer ask about patients' sexual satisfaction and sexual response. The large majority of these physicians said they were "very comfortable" or

“somewhat” comfortable discussing sexual problems with their patients, but believed that only “some” or “relatively few” of their patients were comfortable talking to them about such problems.

Among the women surveyed by HI/PP, approximately 75 percent said they felt “very” or “somewhat” comfortable discussing sexual issues with their physician, and more than half (56 percent) said their physician was the person with whom they would be most likely to discuss a sexual problem.

Yet a majority of postmenopausal women in the survey, all under 55 years of age, claimed that their physician either “never” initiates discussion of sexual health, or does so only when the patient first raises the subject. More than half of the physicians surveyed agreed that, when they discuss a sexual problem with a menopausal patient, it is more likely the patient rather than themselves who initiates it.⁵⁰

Menopausal women are not alone in perceiving problems in communicating with their physician about sexual matters. A poll of a broader group of U.S. adults 25 years of age or older found that 71 percent thought their doctor would dismiss concerns they raised about sexual problems. Even more (85 percent) said they would nonetheless raise the issue with their physician.

The poll results, reported at a 1999 conference on Gender and Human Sexuality, also found that 68 percent of those polled who acknowledged sexual problems said they thought discussing them would embarrass their physician.⁵¹ Physicians themselves recognize personal embarrassment as a barrier for many in taking a patient’s sexual history.⁵² Lack of time or inadequate knowledge may also inhibit provider communication with patients on matters of sexuality.⁵³

Male patients tend to be indirect rather than straightforward in addressing health issues and may be less likely than female patients to discuss sexual problems with their physician or other health care provider. A number of barriers may prevent men from bringing health concerns to their physician:

- Sense of immunity from health problems
- Difficulty in relinquishing control
- Belief that seeking help is unacceptable
- Time and access
- Having to state the reason for their visit to the provider
- Not having a male provider⁵⁴

A first step for providers in breaking down communication barriers with their male patients may be to become thoroughly familiar with conditions and risk factors associated with sexual disorders such as ED.⁵⁵

The intimate nature of sexuality clearly poses special challenges to providers in discussing it with their patients.

The skills required are not routinely included in the training of physicians or other health professionals. Using appropriate sexual history-taking strategies and other techniques for raising issues of sexuality with their patients, providers can increase their level of comfort in discussing these issues and do so in a way that is non-threatening to patients and responds to their needs and concerns.

CONCLUSIONS

There is ample evidence that a great many older adults continue to engage in sexual activity well into old age and derive substantial satisfaction and enjoyment from it.

There is also evidence that many older Americans experience sexual dysfunction of one form or another and are dissatisfied with the resulting impact on their quality of life. A broadening array of treatments is available to address these problems when such treatment seems in the best interest of the patient.

Providers are not always sensitive to the importance that older patients attach to problems of sexuality. They also may not be skilled in eliciting information about such problems or comfortable addressing them. Greater provider awareness of these issues is needed, along with adequate training in their assessment, diagnosis, and treatment.

Educational institutions that train health professionals must be encouraged to place increased emphasis on the care of older adults in general, including their sexuality. Professional organizations can also play a large role in bringing about these improvements in provider understanding and performance, both as advocates for supportive professional policies and standards and as the source of ongoing, continuing education for their members.

Additional research is also needed. We must refine our understanding of sexual functioning and the determinants of sexual satisfaction at older ages and be able to measure them in order to diagnose and treat potential problems accurately and appropriately. Long-term evaluation of recently introduced treatment methods is needed at the same time that even newer treatments are being developed and tested.

An informal poll by ARHP of recognized experts in the field of mature sexuality pinpointed a number of specific research needs:

- Negotiation and execution of sexual interaction among mature adults
- Effects of the relationship with the sexual partner on sexual expression
- Securing access to sexual partners among mature adults
- More exploration of male and female sexual dysfunction
- Changes in sexual functioning with age

- Effects of medications and other interventions on sexual functioning
- Patterns of sexual beliefs and behaviors in older populations, including impact of specific demographic characteristics
- Impact of specific conditions (incontinence, pelvic organ prolapse, heart disease) on sexual function
- AIDS in the elderly

This list is by no means comprehensive, but it suggests the breadth of knowledge yet to be acquired about sexuality in the later decades of life. That knowledge will continue to grow, and with it, our ability to treat problems of sexuality among older adults. The public can be expected to embrace these new treatments in much the same way they have those already available. The education and training of health professionals must also keep pace.

(This article was adapted with permission of the Association of Reproductive Health Professionals from their September 2000 publication ARHP Clinical Proceedings.) —**Editor**

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ARHP'S MATURE SEXUALITY INITIATIVE

The Association of Reproductive Health Professionals (ARHP) has launched a Mature Sexuality Initiative that will include publications and education efforts aimed at older individuals, their medical practitioners, and the public.

The article "Mature Sexuality: Patient Realities and Provider Challenges" in this issue of the *SIECUS Report* is adapted from an issue of ARHP's *Clinical Proceedings* published as part of the Initiative.

The Initiative's goal is to promote a better understanding for health care providers of the unique needs of their older patients.

ARHP welcomes input on its Mature Sexuality Initiative. Please contact author Katherine Lacy, ARHP, 2401 Pennsylvania Avenue, N.W., Suite 350, Washington, DC 20077-6710. Phone: 202/466-3825. Fax: 202/466-3826. E-mail: arhp@arhp.org. Web site: www.arhp.org

GRANDPARENTS AS SEXUALITY EDUCATORS: HAVING OUR SAY

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One of the old canards is that grandchildren and their grandparents are natural allies, since they both have the generation in between them as their natural enemies. We eschew this premise while nonetheless acknowledging that since grandparents are not typically a child's primary caretakers, they can play a unique role for their grandkids.

Some cultural commentators, noting the technophilia of young people and the technophobia of those a generation or two removed, have proposed that the current generation of young people knows more than their parents and grandparents and, in an astonishing turnaround from centuries of family relationships, have little use for their elders. While this may be true for programming VCRs and curing computer viruses, it need not be true in matters pertaining to the critical fields of child rearing and helping children learn about sexuality and human relationships.

We older folks *do* know some things. Even though most of us who are currently grandparents experienced woefully inadequate education about sexuality, we wish to improve this process for our grandchildren. We know that it is ridiculous to wait until children ask whether they should look both ways before crossing a street; and that it is foolhardy to wait for them to ask whether it is safe to touch the burners on a stove. We volunteer important information to our children and grandchildren.

Our own interest in this topic is informed by our roles as (incurably doting—like most) grandparents of our six-year-old grandson (Joshua), his three-and-a-half-year-old sister (Becca), and, to a far lesser extent, a six-month-old grandson (Jacob). We acknowledge right away that ours is probably an easier task than most because our grandchildren have been raised by our own children, whose parents (us!) include one sexuality educator and one library media specialist. What this means is that the messages that both grandparents and parents give and will give to the children are quite similar.

Children, as soon as they can understand the concept that their parents also have parents, can be very impressed by the idea of these super, “grand” parents. This provides a wonderful entrée for openness to hearing from us about important things. We can teach about many things (not just about the proper names for genitals but also about how to make and keep friends, treating other people nicely, and so on). Since we are not primarily responsible for discipline,

our grandchildren see us as providing unconditional love. They trust us.

Parents often ask: “When is the best time to start to talk with children about sexuality?” A good answer is: “Start at age two months, when the baby is in the bath. As you warmly sponge bathe, don't skip from ‘this is your cute little chin, and this is your cute little belly button’ to ‘this, er—is your cute little knee’ but include ‘and this is your cute little penis or cute little labia or vagina.’” While the baby will not understand the meaning of the words until some time in the future, it gives the parent time to rehearse saying the proper words for genitals a few hundred times. The good news is that grandparents may have rehearsed saying those words more than parents, and may be strategically positioned to begin to teach children about how wonderful and remarkable all parts of the body are.

When Joshua regaled us with the intricacies of the digestive system—which he had been taught in pre-school—it was clear that he was open to learning facts about other parts of his body.

It is probably not every mother who would phone her own parents to say, “I knew you'd be happy to know that Joshua just found his penis.” And both parents and grandparents have been able to send the same consistent message: “We know it feels good to touch your penis, but you need to keep your hands out of your pants in public; your penis is private, and it's not polite to do that when you are with other people.”

Upon the birth of Joshua's sister, diaper changing was an opportunity to point out both the genital differences between his body and his sister's and the fact that he and his father and grandfathers had penises while his sister, mother and grandmothers had vaginas. When his parents' friends were pregnant, it was natural for him to be told that there was a baby inside her womb and that it would come out of her vagina. Not long ago, Josh asked us whether, since a girl baby comes out of the vagina, did perhaps, a boy baby come out of the penis. A logical question, answered matter-of-factly, like all of his other questions to his grandparents. When we told him that a special second cousin was pregnant and would have a baby, he volunteered that it would be coming out of her vagina and wanted to know whether it would hurt; he was reassured to hear that doctors had ways to help mothers so that it did not hurt too much.

Becca, age 3: “Grandma, what are these?” “That’s your vagina.” “No, [pulling her labia apart] these!” “Oh, that is called your labia.” “Oh.” If parents and grandparents can be matter-of-fact, so then can children.

Many of us have remarked that often it is easier for pre-teens and teens to speak about some important matters

(school, friends, drugs, sexuality, religion, et cetera: the “breakaway issues”) with someone who is not their own parent—perhaps the parent’s good friend or a relative. A grandparent can be ideally situated to help mediate this delicate transfer of power and responsibility from parent to child.

SUGGESTED ACTIVITIES FOR CONVERSATIONS WITH THE KIDS IN YOUR LIFE

- Taking an adventure to the bookstore or library
- Sharing an ice cream sundae
- Having a picnic in the park
- Enjoying a day in the zoo
- Taking a walk along the beach
- Shopping at the mall
- Riding in the car

- Watching a baseball game
- Seeing a movie
- Walking through an art museum

--SIECUS bookmark, *Suggested Activities for Conversations with the Kids in Your Life* (part of SIECUS’ *Families Are Talking* initiative to help parents, caregivers, and children talk about sexuality-related issues).

**P R E S I D E N T B U S H A N D U . S . C O N G R E S S A G R E E
O N L A B O R , H H S , A N D E D U C A T I O N S P E N D I N G B I L L S**

William Smith

SIECUS Public Policy Director

After much debate, members of the U.S. House of Representatives and the U.S. Senate have agreed on a bill to fund the U.S. Departments of Labor, Health and Human Services (HHS), and Education for fiscal year 2002.

The approval came more than two months after the House approved its version and more than a month after the Senate's vote. President Bush signed Public Law 107-116 on January 12.

It is customary for members of the House of Representatives and Senate to take up this always controversial bill late in the session. The delay caused the passage of no less than seven continuing resolutions to keep the three departments running.

The deliberations were far from free of the ideological wrangling that so often plagues the process. This was particularly noteworthy given that Republican and Democratic leaders in the House had made an agreement that they would attach no controversial amendments to the bill.

C O N T R O V E R S I A L A M E N D M E N T S

That agreement failed to restrain a number of House opponents of reproductive and sexual health, though debate on the Senate side was collegial and limited.

In the House, for example, Rep. Melissa Hart (R-PA) offered and then immediately withdrew her amendment to deny all federal funds to school districts that make emergency contraception available at school-based health centers. She withdrew her amendment only after it was doomed by a procedural move and after she received assurances that she could later offer it as a freestanding bill.

In addition, Rep. Ernest Istook (R-OK) was so upset when he failed to convince his colleagues at the subcommittee and committee levels to provide increased funding for abstinence-only-until-marriage programming through the Special Projects of Regional and National Significance—Community-based Abstinence Education (SPRANS-CBAE) grants that he sought a full floor vote.

The amendment sought to increase the \$40 million already agreed to by Republican and Democratic leaders during subcommittee markup to an unprecedented \$73 million. His proposal would have taken \$16 million from

the Child Development Block Grant and \$17 million from the U.S. Centers for Disease Control and Prevention.

A number of forces came together to prevent Istook's attempt to transfer funds from other programs into SPRANS-CBAE. The final floor vote of 106 to 311 included 114 Republicans.

SIECUS is currently surveying all 311 members to determine why their vote was cast against the Istook amendment.

O T H E R H I G H L I G H T S

Other bill highlights related to sexual and reproductive health include:

- *Social Services Block Grant*, \$1.7 billion (a decrease of \$25 million)
- *Adolescent Family Life Act*, \$28.9 million (an increase of \$3.5 million), with a total of \$10.16 million designated for abstinence-only-until-marriage education
- *Title X Family Planning*, \$265 million (an increase of \$11 million)
- *Maternal and Child Health Block Grant*, \$732 million (an increase of \$18 million)
- *CDC HIV/AIDS, STDs, and TB Prevention*, \$1.136 billion (an increase of \$132 million)
- *Ryan White Care Act*, \$1.911 billion (an increase of \$104 million)
- *Community Health Centers*, \$1.344 billion (an increase of \$175 million)

C O N C L U S I O N

The increased funding for the SPRANS-CBAE program sets the stage for a coming year of battle over federal policy on sexuality education.

SIECUS will continue to work toward a federal policy that supports accurate and responsible comprehensive sexuality education. To become a SIECUS Advocate and join our e-mail-based information alert system, send an e-mail to sbarnes@siecusdc.org

INSTRUCTIONS FOR AUTHORS

Submitting Articles and Book and Audiovisual Reviews for Publication in the *SIECUS Report*

Each issue of the *SIECUS Report* features groundbreaking articles and commentary by leaders and front-line professionals in the field of sexuality and education, along with news, special bibliographies on varied topics, book and audiovisual reviews, recommended resources, and advocacy updates. All of this comes to members and other subscribers six times each year.

Manuscripts are read with the understanding that they are not under consideration elsewhere and have not been published previously. Manuscripts not accepted for publication will not be returned. Upon acceptance, all manuscripts will be edited for grammar, conciseness, organization, and clarity.

To expedite production, submissions should adhere to the following guidelines:

PREPARATION OF MANUSCRIPTS

Feature articles are usually 2,000–4,000 words. Book and audiovisual reviews are typically 200–600 words.

Manuscripts should be submitted on 8½ x 11 inch paper, double-spaced, with paragraphs indented. Authors should also send a computer disk containing their submission.

All disks should be clearly labeled with the title of submission, author's name, type of computer or word processor used, and type of software used.

The following guidelines summarize the information that should appear in all manuscripts. Authors should refer to the current issue of the *SIECUS Report* as a guide to our style for punctuation, capitalization, and reference format.

Articles

The beginning of an article should include the title, subtitle, author's name and professional degrees, and author's title and professional affiliation.

Articles may incorporate sidebars, lists of special resources, and other supplementary information of interest. Charts should be included only if necessary and should be submitted in camera-ready form. References should be numbered consecutively throughout the manuscript and listed at the end.

Book Reviews

The beginning of a book review should include the title of the book, author's or editor's name, place of publication (city and state), publisher's name, copyright date, number of pages, and price for hardcover and paperback editions.

Audiovisual Reviews

The beginning of an audiovisual review should include the title of the work, producer's name, year, running time, name and address of distributor, and price.

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INQUIRIES AND SUBMISSIONS

All questions and submissions should be addressed to the editor, by telephone, at 212/819-9770, by E-mail to medwards@siecus.org, or by mail to *SIECUS Report*, SIECUS, 130 West 42nd Street, Suite 350, New York, NY 10036-7802.

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Mission

SIECUS affirms that sexuality is a natural and healthy part of living. SIECUS develops, collects, and disseminates information; promotes comprehensive education about sexuality; and advocates the right of individuals to make responsible sexual choices.

