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Older women and sexuality – are we still just talking lube?

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There is little practical information for older women about their changing sexuality. As they age, women are likely to continue to seek ways of expressing their sexuality, but there are issues to consider that both their family doctors and therapists may overlook. Physical conditions or disabilities may hamper their ability to enjoy sex. Pharmaceutical interventions only attempt to improve desire and sexual response. If an older woman begins a new sexual relationship, ignorance of sexually transmitted infections (STIs) puts her at risk. There is good evidence that the incidence of STIs is rising amongst older people. Older women's lack of knowledge about safer sex and poor communication skills may increase their risk of developing sexually acquired infection. Older women who live in long-term care facilities face additional challenges. Their right to be sexually active, along with their right to privacy, may not be realised. Such problems also present challenges for caregivers. In addition, comprehensive assessment criteria are needed to ensure that women in long-term care facilities have the capacity and knowledge to give informed consent to sexual activity and to avoid sexual exploitation. Older gay women may find themselves dealing with an additional problem: Do they feel obliged to conceal their sexual orientation? Older transgender people, who have "passed" for years and find themselves in the physical care of untrained staff, may risk prejudice and humiliation. More evidence is required to determine ways that older women may be helped to live a healthy sexual life and to augment both their knowledge and skills. Professionals working with older women would benefit from more training.

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You have been seeing an older female client over the past few months. She had separated from her long-term partner a few months earlier, ostensibly because of low desire, which had a devastating effect on the relationship. One day, she appears radiant, eyes sparkling, with a girlish laugh you have never heard from her before. She tells you that she has met someone. She compares the sex to riding a bicycle. Her body remembered exactly what it was supposed to do. She did not even need lubricant. After congratulating her on this new development in her life, you consider asking her if they have been using condoms or getting tested for sexually transmitted infections (STIs). Or do you even consider asking these questions?

When a version of this article first appeared online in the Canadian Women's Health Network Magazine (Spring, 2012), it received more hits than any article they had ever published. The thirst for information about older women's sexuality was very apparent.

Over the past few decades, with women's sexual pleasure front and centre (in women's magazines at least), where do older women fit into the equation? Typing "older women and sex" into a Google search yielded 139,000,000 results in 0.22 seconds, most being links to porn sites. Clearly, older women maintain an interest in sexual activity, yet

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there is little information available to them about how to adjust to their changing bodies and situations beyond "communicate with your partner" and "use lube".

We cannot assume that older women have regular sex partners, or that single older women even want to find partners. The search "dating sites for seniors Canada" gives us 1,890,000 results in 0.32 seconds, suggesting that older women, newly single, separated, divorced or bereaved, have the same needs for intimacy, emotional connection, physical affection and sensual pleasure as other women. While dating sites are not the forum of choice for all, single, older women figure prominently on these sites, including those exclusively designed for older people.

There is a body of research stretching from Masters and Johnson up until the present day which supports evidence that sexual activity continues well into the later years. As early as 1966, Masters and Johnson investigated 34 women and 39 men over the age of 50 for a period of four years. In view of the small sample size, they said that they were only able to "suggest clinical impression rather than to establish biological fact" (Masters & Johnson, 1966). But perhaps the most important clinical impression they offer is that physiological ageing processes do not preclude sexual activity in later life, and that ageing may even bring potential benefits to sexual response – an idea as radical today as it was at the time.

Desire in women is maintained until quite late in the aging process. Thompson et al. (2011) reported that "self-rated successful aging, quality of life and sexual satisfaction appear to be stable in the face of declines in physical health, some cognitive abilities, and sexual activity and function [. . ...] from age 60 – 89". Many other studies in older women have corroborated these findings (e.g., Heiman et al., 2011; Trompeter, Bettencourt, & Barrett-Connor, 2012).

What do practitioners have to offer their older female clients beyond the above-mentioned advice to use lube? Unfortunately, advice that does not generally include disabilities associated with ageing, for example, arthritis and body image concerns similar to those experienced following mastectomy. Certainly, lubricant can be helpful to the postmenopausal woman. However, in addition to vaginal dryness, some postmenopausal women may have thinning or even atrophy of the vaginal walls. Bachmann and Nevadunsky (2000) found that up to 40% of postmenopausal women have symptoms of atrophic vaginitis.

Postmenopausal women are also at greater risk of developing a condition called lichen sclerosis. The condition usually presents as white, itchy, sore patches on the skin of the genital area and sometimes around the anus. Treatment is required to reduce symptoms and prevent complications such as persistent symptomatic labial adhesions.

Although the treatment of conditions such as lichen sclerosis is not lucrative, pharmaceutical companies have developed an interest in "sexier" conditions experienced by this group of women. The pharmaceutical industry has identified potential markets for the medical treatment of diminished desire, reduced frequency of orgasm and vaginal dryness. Kuzmarov and Bain (2008) discussed female sexual arousal and response, but moved quickly to recommend hormone therapy to correct low levels of desire. After devoting a few pages to testosterone therapy, they allow two short paragraphs to an alternative vision: there might be psychosocial issues that play a larger role in defining the female sexual response; and secondly, that serum and androgen levels do not necessarily correlate with the degree of sexual interest or arousal.

In keeping with the medicalisation of female sexual dysfunction, pharmaceutical companies have been seeking the elusive magic treatment equivalent to those little blue pills for men. Given Tiefer's analysis which served as the basis of the New View Campaign, Challenging the Medicalisation of Sex, one wonders if they have missed something crucial, namely those psychosexual issues (Tiefer, 2001).

Those fortunate newly single, older women who find a new partner may be pleasantly surprised at their physical response. A woman who was in a loveless relationship, with the lack of desire (and lubrication) that went along with it, may find herself feeling like a teenager, lubricating effortlessly with the right new partner. She may throw away the lube and the Replens, but forget to reach for the condom, if her new partner is male.

Here is the "rub": Fang, Oliver, Jayaraman, and Wong (2010) reported that between 1997 and 2007, rates of STIs in Canada had increased with higher rates reported amongst 40−59 year olds compared with those aged 15−29. This suggests that women entering new sexual relationships may be at a greater risk of developing STIs because they lack sufficient awareness about safer sex or are unable to assert themselves in the relationship. As a result, older women may fail to ask a male partner to use a condom.

Looking at the older cohort, Von Simson and Kulasegaram (2012) cite studies showing an increase in the cases of syphilis, chlamydia and gonorrhea in the UK, USA and Canada in 45−64 year olds. They reported (Von Simson & Kulasegaram, 2012, p. e688), "there has also been an increase in cases of HIV with those aged 50 and over accounting for 20% of adults accessing HIV care, an 82% increase in figures from 2001…" and "new diagnoses of HIV in the over 50s have doubled between 2000 and 2009". Similarly, Bodley-Tickell et al.'s (2008) study found that in less than 10 years, the rate of STIs in those over the age of 45 will be doubled.

Researchers at the Center for Sexual Health Promotion, National Survey of Sexual Health and Behavior Indiana University found that (Reece et al., 2010, pp. 266−276) "one in five sexually active singles reported using a condom regularly and only 12 percent of the men and 32 percent of women said they used one every time". Those over the age of 45 had the lowest rate of condom use (Reece et al., 2010). In the same year Jena, Goldman, Kamdar, Lakdawalla, and Yang (2010) revealed that men using phosphodiesterase type 5 (PDE5 inhibitors such as Viagra) had higher rates of STIs in the years before and after they used these drugs.

It is not surprising that older, single people are not using barrier methods of protection. When these women were younger and they were sexually active, human immunodeficiency virus/acquired immuno deficiency syndrome (HIV/AIDS) and barrier protection to prevent STIs were not widely promoted by health professionals. The combined oral contraceptive was the method of choice for most women at that time with some using an intrauterine device or the diaphragm. Older women may establish sexual relationships with men who have also been in long-term relationships. It would be erroneous to assume that their previous relationships had been monogamous. But how many partners have they each had since then? Have they been getting tested and using STI protection with each new partner?

What is the likelihood of older patients getting tested for the common STIs, let alone HIV? Physicians and therapists may make assumptions about their patients in the same way that patients make assumptions about their partners. Practitioners may be reluctant to raise sexual health issues with older people or encourage routine testing for STIs. Women who continue to have their Pap tests until the age of 70 are not likely to be tested for Chlamydia, which is generally considered a young person's STI. Women in the age group of 15−24 years, who are at the highest risk for chlamydia and gonorrhea may assume that their physicians are checking them for "everything" when they are having their annual internal exams. They may just have a Pap test without getting any STI swabs. For that reason, they should be asking their physicians to check for STIs if they have been engaging in risk-taking sexual behaviours. Women who request STI testing will get a swab during an internal examination, which may reveal gonorrhea or chlamydia. A vaginal smear can

detect trichomonas, yeast or bacterial vaginosis. Depending on her history and clinical relevance, a doctor may also order a blood test for syphilis, Hepatitis B, C or HIV.

Regardless of their age, women find it difficult to raise issues of protection and to negotiate safer sexual practices and STI screening with their new partners. It is difficult for some people to tell a new partner what pleases them. Imagine the scenario when it comes to safer sex:

> Did you use protection with all of your partners until you got tested? How often did you get tested? When was the last time you got tested and for which STIs? Of course I trust you. No I don't think you're promiscuous. . .

Take the example of Canadian "snowbirds". At an HIV conference in 2009, gerontology researcher, Kathleen Mairs, reported that she had surveyed 299 Canadians over the age of 50, who took vacations during the winter months in Florida, USA (Mairs, 2009). She found most were sexually active, and almost half had dated at least one Floridian. New cases of STIs amongst this age group are growing faster than in people under 40. But only 47 of those surveyed – 17.7% – had ever been tested for HIV. Less than a quarter of men and almost none of the women used condoms. According to the "Senior HIV Intervention Project" in Fort Lauderdale, FL, women over the age of 60 are one of the fastest growing risk groups (Agate, Mullins, Prudent, & Liberti, 2003).

The US Centres for Disease Control and Prevention track the age of first HIV diagnosis. In 2003, they reported 865 new diagnoses of HIV in people aged between 60 and 64 years. By 2007, this figure had increased to 980 new HIV diagnoses in the same age group (available at: http://www.cdc.gov/hiv/topics/surveillance/resources/reports/2007report/pdf/2007surveillancereport.pdf).

Vaginal dryness increases the risk of acquiring STIs. A case in point is HIV, which attacks white blood cells. With increased white blood cells at the site of infection, a woman's irritated, inflamed vagina facilitates direct access of the virus to her bloodstream.

Try to imagine a conversation about safer sex between older adults who have met online, or even through friends. People make assumptions about their own health, but "I feel fine" is not a medical diagnosis. Most people are unaware when they have an infection. For example, 75% of the women with chlamydial infection are asymptomatic. This suggests that asking prospective partners if they are "clean" or "have anything" is unhelpful. Those who are asked about their own sexual health may be suspicious about their partner's sexual history.

The difficulties faced by older women living independently are significant, but such problems are compounded when individuals live in long-term care facilities. Caregivers often receive insufficient or inadequate training about older people's sexual health. Requests for training are often motivated by the caregivers' fear that, although following "routine practice" (also known as "universal precautions") to control the spread of infection, they remain at the risk of infection from residents' body fluids. As the population ages, increasing numbers of older people with Hepatitis B and HIV/AIDS will enter long-term care facilities. This suggests that the need for education and training of caregivers about sexual health will also increase. Initial training should focus on health and safety issues. Training should then concentrate on developing caregivers' communication skills to enable them to feel comfortable when discussing sexuality with older clients.

Training professional caregivers raises a number of issues. Caregivers have to appreciate that residents and their partners will expect their need for privacy to be respected.

It may also be difficult to establish whether a woman with cognitive impairment has the capacity to give informed consent to sexual activity with her partner. It is important for caregivers to understand that consent must be voluntary. There must be no coercion so that unwanted advances can be effectively rejected. If someone is unable to recognise potentially abusive situations, she does not have the capacity to give informed consent. Where mental capacity is in doubt, caregivers should be clear about who has the authority to determine capacity.

Older peoples' advocates have reported that attitudes to sexuality and capacity to consent in some long-term care facilities are laissez-faire. Advocates report that caregivers believe that as residents are adults, they are autonomous. This attitude results in failure to acknowledge and report abuse. The Advocacy Centre for the Elderly in Canada has uncovered more than one cases where women with dementia were being sexually assaulted, including assault by a spouse.

Some facilities medicate older people to eradicate their sexual drives. Such a practice is, *prima facie*, unlawful because it fails to adhere to the doctrine of informed consent to medical intervention. Is there a role for staff in assisting seniors in practising safer sex, for example, putting on a condom in the face of a disability? There are also equity issues. Does a woman who was an "out" lesbian in her entire adult life feel that she needs to go back for the closet? What about someone assigned as a male at birth who transitioned to a female as an adult? What she had chosen not to undergo genital reconstructive surgery? There are little caregivers who do not know about one's body. What was private is no longer so. Thankfully, a lesbian, gay, bisexual, transgender (LGBT) toolkit was created in Toronto, Canada to assist care providers in these situations (available at: http://www.toronto.ca/ltc/lgbt_toolkit.htm).

So, although a little lube may go a long way, it is clear that the needs of older women require a good deal more study – and a great big reality check.

Notes on contributor

Lyba Spring has been a sexual health educator for 32 years, of which 30 years she spent working for Toronto Public Health in English, French and Spanish. Post retirement, she works independently, writing curriculum, speaking at conferences, workshops, writing articles as well as a regular blog for the Canadian Women's Health Network. Lyba's interest in reproductive health and broader sexual health issues evolved from her first encounter with feminism in 1968. As a collective member of the first women's studies programme at the University of Toronto, she became familiar with the "Boston Women's Health Book Collective". Living in France in the 1970s, she was one of the translators of their book "Our Bodies Ourselves" into French. As a sexual health educator, Lyba has responded to scores of media requests. For five years, she was a regular guest on a television program for francophone youth. She continues to consult with television producers on documentary programs. Lyba is a passionate health advocate, in particular, regarding women's health issues. She is concerned with a broad range of issues from publicly funded programmes for human papillomavirus (HPV) vaccine (which she opposes) to the underpinnings of rape culture.

References

Agate, L.L., Mullins, J.M., Prudent, E.S., & Liberti, T.M. (2003). Strategies for reaching retirement communities and aging social networks: HIV/AIDS prevention activities among seniors in South Florida. *Journal of Acquired Immunodeficiency Syndrome, 33*(Suppl. 2), 238–242.

Bachmann, G., & Nevadunsky, N.S. (2000). Diagnosis and treatment of atrophic vaginitis. *American Family Physician, 61*(10), 3090–3096.

Bodley-Tickell, A.T., Olowokure, B., Bhaduri, S., White, D.J., Ward, D., Ross, J.D.C., . . . Goold, P. (2008). Trends in sexually transmitted infections (other than HIV) in older people: Analysis of data from an enhanced surveillance system. *Sexually Transmitted Infections, 84*, 312−317.

Fang, L., Oliver, A., Jayaraman, G.C., & Wong, T. (2010). Trends in age disparities between younger and middle-age adults among reported rates of chlamydia, gonorrhea, and infectious syphilis infections in Canada: Findings from 1997 to 2007. *Sexually Transmitted Diseases, 37*(1), 18−25.

Heiman, J.R., Scott Long, J., Smith, S.N., Fisher, W.A., Sand, M.S., & Rosen, R.C. (2011). Sexual satisfaction and relationship happiness in midlife and older couples in five countries. *Archives of Sexual Behavior, 40*, 741−753.

Jena, A.B., Goldman D.P., Kamdar A., Lakdawalla, D.N., & Yang L. (2010). Sexually transmitted diseases among users of erectile dysfunction drugs: Analysis of claims data. *Annals of Internal Medicine, 153*(1), 1−7.

Kuzmarov, I.W., & Bain, J. (2008). Sexuality in the aging couple, part 1: The aging woman. *Geriatrics & Aging, 11*(10), 589−594.

Mairs, K. (2009). *The lifestyles and Sexual Health of Canadian Snowbirds* (Unpublished master's thesis). University of Waterloo, Waterloo, Ontario, Canada. Retrieved from https://uwspace.uwaterloo.ca/bitstream/handle/10012/4922/Mairs_Kathleen.pdf?sequence=1

Masters, W.H., & Johnson, V.E. (1966). *Human sexual response*. Boston, MA: Little, Brown.

Reece, M., Herbenick, D., Schick, V., Sanders, S.A., Dodge, B., & Fortenberry, J.D. (2010). Condom use rates in a national probability sample of males and females ages 14 to 94 in the United States. *Journal of Sexual Medicine,* 7 (suppl 5), 266−276.

Spring, L. (2012, July 17). Older women and sexuality . . . are we still just talking lube? *Canadian Women's Health Network Magazine*. Retrieved from http://www.cwhn.ca/en/networkmagazine/olderwomenandsexuality.

Thompson, W.K., Charo, L., Vahia, I.V., Depp, C., Allison, M., & Jeste, D.V. (2011). Association between higher levels of sexual function, activity, and satisfaction and self-Rated successful aging in older postmenopausal women. *Journal American Geriatric Research Society, 58*(8), 1503−1508.

Tiefer, L. (2001). A new view of women's sexual problems: Why new? Why now? *Journal of Sex Research, 38*, 89−96.

Trompeter, S.E., Bettencourt, R., & Barrett-Connor, E. (2012). Sexual activity and satisfaction in healthy community-dwelling older women. *American Journal of Medicine, 125*(1), 37−43.

Von Simson, R., & Kulasegaram, R. (2012). Sexual health and the older adult. *Student British Medical Journal, 20*, e688.