

Older Women's Attitudes, Behavior, and Communication about Sex and HIV: A Community-Based Study

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ABSTRACT

Objectives: To examine the effects of race and marriage on the sexual attitudes, behavior, and patient-physician communication about sexuality and HIV/AIDS among older women.

Methods: This was a cross-sectional survey of 55 community-residing women aged 58–93.

Results: 57% of respondents had engaged in sexual activity since the 60th birthday. Nearly 60% of single women who had been sexually active in the previous 10 years reported that they had not used a condom; 21% of women with a current sexual partner agreed that condom use is not necessary “if you can no longer get pregnant.” African American women were significantly more likely to report making changes in their sexual behavior due to HIV (53% vs. 19% white, $p = 0.02$). Married and African American women were more likely to discuss sex with a physician (80% vs. 47%; $p = 0.03$ and 75% vs. 46%, $p = 0.05$, respectively). African Americans were more likely to have had a physician initiate such a discussion (69% vs. 38%, $p = 0.04$).

Conclusions: Older women in this sample were sexually active, engaged in potentially risky sexual behavior, and believed that physicians should address issues of sexuality. Older African American women were significantly more likely than white women to report HIV-related changes in their behavior and to discuss sex with a physician. This community-based study corroborates clinical research and suggests both a gap and a disparity in older women's dialogue with physicians. It also indicates the need for more broadly generalizable data on issues pertinent to older women's sexual health.

INTRODUCTION

THE NUMBER OF CASES OF HIV/AIDS among older women in the United States is increasing. In 2002, 7.1% of Americans living with

HIV/AIDS had been diagnosed after the age of 55, compared with 5.9% in 1999. Women comprised 25% of these cases. Approximately 6% of HIV/AIDS diagnoses among women occurred after age 55; 73% of these occurred in black wo-

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men, 15% in whites, and 12% in Hispanics.¹ The disproportionate burden of HIV disease in older African American women reflects that seen in younger age groups. Most older women are believed to contract HIV/AIDS via heterosexual transmission.² Although data on sexual behavior of older women are scarce, estimates indicate that many older women remain sexually active (or desire to do so but are limited by lack of a partner) through the ninth decade.³⁻⁶

Biological, psychological, and social factors likely interact to contribute to the growing incidence of HIV/AIDS among older women. Biological changes increase the susceptibility of postmenopausal women to sexually transmitted infection (STI) because of hypoestrogenism and the resulting atrophy of the vaginal mucosa that occurs with aging.⁷ Older women with chronic illness may be more immunologically vulnerable to infection. Symptoms of HIV/AIDS, such as cognitive changes, fatigue, weight loss, and frailty, may be mistakenly attributed to older age or a comorbid illness, resulting in a missed diagnosis.^{7,8} Psychologically, older women may be more reluctant to use condoms because they do not require contraception. Additionally, condom use can be difficult for their older male partners who may not achieve a full erection until after the initiation of coitus.

Social factors may exert an important influence on the prevention, transmission, and detection of HIV/AIDS among older adults in the United States.⁷ Because of the use of highly active antiretroviral therapy (HAART), people diagnosed with HIV/AIDS are living longer and healthier, with the capacity to remain sexually active.⁸ Concurrently, widespread use of sildenafil and other products marketed to treat male erectile dysfunction has liberated or revitalized the sexual lives of many older couples, possibly increasing older women's exposure to HIV and other STIs.⁹ Despite the fact that older women represent a growing risk group for HIV and other STIs, public health campaigns designed to prevent STIs, including HIV/AIDS, rarely portray or speak to this population, and widespread ignorance about older adults' sexuality persists.⁷ Furthermore, recent studies demonstrate poor knowledge among older women about HIV/AIDS and sexual risk.^{10,11}

In order to improve the care of older women in this domain, this study begins to explore sexual attitudes, behavior, and patient-physician

communication about HIV/AIDS among a diverse sample of older women. From a community-based study designed to test the feasibility of a population-based study of older women's sexuality, this analysis aims to add new knowledge about older women's sexuality and explore the validity of existing data about older women's sexuality derived almost entirely from clinical populations of women seeking medical care.

MATERIALS AND METHODS

Community-residing women aged ≥ 58 were recruited from several neighborhoods in the Chicago metropolitan area, selected, using Census tract data, for racial, ethnic, and socioeconomic diversity. Flyers asking women to participate in an interview about social and personal life, health, and aging were posted in at least 20 retail, recreational, residential, healthcare, and public community locations in each neighborhood. Using a purposive sampling method that aims to represent the key characteristics of a population and facilitate subgroup analysis,^{12,13} the study aimed to recruit 10 women in each of four age groups (60-64, 65-69, 70-74, 80+), four marital status categories (never married, married, divorced, widowed), and across three racial/ethnic groups (Hispanic, non-Hispanic African American, and non-Hispanic white). At least one respondent in each of the marital status categories was recruited within each ethnic group and within each age group. Within each racial/ethnic group, women were recruited from a range of educational and socioeconomic backgrounds (the latter determined by residence in one of the preselected neighborhoods).

Between August and October 2001, nearly 100 women volunteered to participate by phoning the University of Chicago Survey Laboratory. Fifty-five women, meeting the predefined age, race, partner status, and neighborhood sampling characteristics, aged 58-93, were enrolled to complete each quota cell. Each participant was paid \$50 in consideration of her time.

The University of Chicago Institutional Review Board approved the study protocol, and all participants gave written consent. Experienced female interviewers conducted the 2-hour face-to-face interviews using an in-depth close-coded questionnaire. The questionnaire contained items

in the following major domains: sociodemographics; social history, including sexual relationships; current sexual behavior; health and illness; and attitudes about (1) sexuality and STIs, including HIV/AIDS, and (2) patient-physician communication regarding sexuality, STIs, and HIV. Items used to assess sexuality and sexual attitudes were modified from the 1992 National Health and Social Life Survey (NHSLS)¹⁴ to incorporate issues of particular concern to older adults (the NHSLS surveyed adults aged 18–59 years).

SPSS 12.0 (Chicago, IL) was used for the analysis. Statistically significant differences in bivariate relationships were determined using analysis of variance (ANOVA) and chi-square tests. Two-tailed Fisher’s exact tests (FET) were applied in contingency tables with expected frequencies of ≤5 in 20% or more of the cells.

RESULTS

As seen in Table 1, 68.5% of the 55 respondents were white (including Hispanic whites), and 31.5% were African American. Median age was 71 years (range 58–93). Thirty-two percent of women were currently married, and 75% were at least high school graduates. Census tract data were available for 44 of 55 participants. Participants came from 33 census tracts, ranging in median household income from \$9,853 to \$75,241 (median \$39,221, SD \$15,271). As expected, because of the sampling strategy that required enrollment of approximately equal numbers of African American, Hispanic, and white women in each of the predefined strata, there were no

racial differences in age, marital status, or education. Hispanic women comprised 28% of the sample, all of whom also identified as white. Racial analyses dichotomously compare African Americans and whites. Although the sample size was too small to assess ethnic differences, Hispanic and non-Hispanic respondents were equally likely to answer questions pertaining to sexuality. Thirty-eight percent of the women had at least one sexual partner in the past year. African American women were more likely than whites to have had a sexual partner in the past year (59% vs. 27%, $p = 0.03$). Overall, item non-response was low.

Sexual attitudes and behavior

Almost all the women in this sample perceived a positive link between sexuality and general health; 98% of women agreed that an active sex life is good for health, and 89% agreed that sexual satisfaction is an important part of feeling fulfilled in life (Table 2). Almost a third of the women reported having a sexual partner in the last month (27%), 38% had at least one sexual partner in the past year, and more than half (57%) had at least one sexual partner since their 60th birthday. Married women were significantly more likely than unmarried women to have had a sexual partner in the past year (67% vs. 25%, $p = 0.01$). African American women were more likely than whites to have had a sexual partner in the past year (59% vs. 27%, $p = 0.03$).

Awareness of HIV/AIDS and sexual risk

As seen in Table 3, only 29% of the sample reported having made a change in their sexual be-

TABLE 1. SAMPLE CHARACTERISTICS (N = 55)

	White ^a 68.5%	African American/black 31.5%	Total
Current age			
Mean, years	72.5	68.4	71.2
SD	9.2	6.4	8.6
Married, %	29.0	33.3	30.4
Sexually active, ^{b*} %	27.0	58.8	37.0
Education, %			
<High school graduate	29.7	17.6	25.9
High school graduate/GED	21.6	29.4	24.1
Postsecondary	48.6	52.9	50.0

^aIncludes Hispanic respondents, all of whom self-identified as white.

^bRespondent indicated at least one sexual partner in the past year.

* $p < 0.05$.

TABLE 2. SEXUAL ACTIVITY AND ATTITUDES

	<i>Marital status</i>		<i>Race</i>		<i>Total %</i>
	<i>Married (%)</i>	<i>Unmarried %</i>	<i>White %</i>	<i>African American %</i>	
Had at least one sexual partner . . .					
In the past month	40.0	21.9	21.6	41.2	27.3
In the past year	66.7	25.0*	27.0	58.8*	38.2
Since age 60	66.7	53.3	47.2	75.0	56.6
Agree that an active sex life is good for your health	92.9	100.0	96.8	100.0	98.0
Agree that sexual satisfaction is an important part of feeling fulfilled in life	86.7	87.1	88.9	88.2	88.9

* $p < 0.05$.

havior because of HIV/AIDS, with no significant difference between married and unmarried women ($p = 0.72$). African Americans were significantly more likely to have made such a change (53.3% vs. 19.4%, $p = 0.02$). Of women who were sexually active in the past 10 years, only 28% used a condom at their last sexual event. No married respondents reported using a condom. African American women were more likely than white women to report condom use, although the difference had borderline statistical significance (55.6% vs. 13.3%, $p = 0.06$). Despite relatively low condom use, 81% of women believed that condoms should be used even "if you can no longer get pregnant."

Patient-physician communication about sexuality and HIV

Most women thought that doctors should ask about sex (75%), yet only 55% reported a doctor

discussing sex with them since they turned 60 (Table 4). Married women were more likely to report a discussion with their doctor about sex (80.0% vs. 46.9% single, $p = 0.03$). African Americans were more likely to report a discussion with their doctor about sex (75.0% vs. 45.9% white, $p = 0.05$) and that a physician had initiated such discussion (68.8% vs. 37.8%, $p = 0.04$). At the last routine medical visit, only 2 women reported having been offered an HIV test, only 1 woman was offered any other STI test, and only 6 women reported they had received STI or HIV information from their physician.

DISCUSSION

Little is known about sexuality and HIV/AIDS risk behavior among older women,¹⁰ and even less is known about how older women communicate with their physicians about these issues.

TABLE 3. HIV/AIDS RELEVANT BEHAVIORS AND ATTITUDES (% AGREEMENT)

	<i>Marital status</i>		<i>Race</i>		<i>Sexually active in past year^a</i>		
	<i>Married</i>	<i>Unmarried</i>	<i>White</i>	<i>African American</i>	<i>Yes</i>	<i>No</i>	<i>Total</i>
Reported no change in sexual behavior because of AIDS	78.6	67.7	80.6	46.7*	70.0	71.9	71.2
You don't need to use a condom if you can no longer get pregnant	41.7	15.6	25.0	6.7	21.1	18.2	19.2
You don't need a condom if you know your partner well	66.7	37.9	45.5	46.7	72.2	32.3*	46.9
Did not use a condom at last sexual intercourse event ^b	100.0	58.8	86.7	44.4	66.7	75.0	72.0

^aRespondent indicated at least one sexual partner in the past year.

^bQuestion asked only of women whose last sexual event occurred in the past 10 years.

* $p < 0.05$.

TABLE 4. PATIENT-PHYSICIAN COMMUNICATION BY MARITAL STATUS AND RACE

	Marital status		Race		Sexually active in past year ^a		Total (%)
	Married (%)	Unmarried (%)	White (%)	African American (%)	Yes (%)	No (%)	
Agreed that physicians should ask about sex life	92.3	72.4	72.7	80.0	88.9	66.7	75.0
Since turned 60, had conversation with doctor about sex	80.0	46.9*	45.9	75.0*	71.4	45.5*	54.5
MD brought up subject, asked about sex	66.7	41.9	37.8	68.8*	52.4	42.4	45.5
Respondent brought up subject	40.0	16.1	21.6	23.5	42.9	12.1*	23.6
At last routine MD visit							
Offered HIV test	7.1	3.2	2.8	5.9	5.0	3.0	3.7
Offered other STI test	6.7	0.0	2.7	0.0	0.0	3.0	1.8
Given HIV/STI information	6.5	20.0	10.8	5.9	9.5	12.1	10.9

^aRespondent indicated at least one sexual partner in the past year.

**p* < 0.05.

Previous research derives primarily from clinic-based samples of women seeking healthcare (thus, may not generalize to women seeking care in another setting, to women who do not seek healthcare, or to women without health problems) or large population-based samples of much younger women (thus, questionably generalizable to older women). Although community-based, in-home, interviewer-administered research is costly, it expands the generalizability of clinic-based findings. Typically, clinic-based samples are also purposive, enrolling a convenience sample of patients willing to participate during their clinic visit.

To expand and explore the validity of knowledge based on findings from clinic-derived samples, this study begins to examine sexual attitudes and behavior, awareness of HIV/AIDS and sexual risk, and patient-physician communication about HIV/AIDS in a diverse community-based sample of older women. We found that Hispanic women were equally likely to answer interviewer-administered questions pertaining to sexuality, but further analyses based on ethnicity were limited because of the sample size. Although socioeconomic diversity was attained through neighborhood sampling, the study is limited by the absence of individual-level income data.

Consistent with other recent research, this study finds that sexuality remains an important aspect of life for women at older ages.¹⁵⁻¹⁷ In our cohort, nearly all the women (even those not currently sexually active) displayed positive attitudes toward sexuality and agreed that sexuality

comprises a positive component of overall health and fulfillment in life.

A large majority of the women agreed that physicians should ask patients about their sex life, but nearly half reported they had not talked with a doctor about sex. This finding corroborates the reports of general practitioners' reluctance to discuss sex with older patients¹⁸ and the attitudes of older women studied in clinical settings. In a clinic-based study of 514 women aged ≥50, Henderson et al.¹¹ found that although information from health providers was significantly associated with older women's knowledge about HIV/AIDS, only 38% reported receiving such information. Nusbaum et al.¹⁷ studied 163 women aged ≥65 seeking gynecological care, of whom 97% thought that sex is important to a relationship and that physicians ought to initiate discussion of the topic, yet 52% of women reported that a doctor had ever done so.

Married women, regardless of whether they were sexually active, were more likely to report having discussed sexuality with a physician, although one in five had not done so. The majority of unmarried women, even those who were sexually active, reported they had not had a conversation with their physician about sexuality. When a conversation about sexuality did occur in the clinical setting, women largely relied on physicians to initiate it rather than raise the subject themselves. Again, this finding agrees with that of Nusbaum et al.,¹⁷ who reported that 79% of female patients aged ≥65 would have discussed sexuality if the physician had brought up the topic; 81% said they

would return for an appointment specifically to address sexual concerns. To the degree that sexual activity outside a marital relationship raises the risk of exposure to HIV or other STIs in this population, the women who may have been at highest risk were least likely to report communication about such issues. Additional work is needed to determine if marriage is, in fact, protective against HIV and other STI transmission for older women and how marital and partner status influence physician and patient behavior regarding discussion about sexuality.

In contrast to earlier studies in younger female populations,¹⁹⁻²² this study suggests that older African American women's awareness about HIV and sexual risks may be higher than that of their white counterparts. For example, in this cohort, African American women were significantly more likely to report change in behavior due to HIV/AIDS and more frequently reported condom use. African American women were also half as likely to agree with the statement that condoms are unnecessary "if you can no longer get pregnant." Better awareness may reflect the higher prevalence of HIV/AIDS and STIs among African Americans and greater access to information targeted to children or grandchildren of these women or a higher degree of sexual activity, as seen in this sample. Future studies of sexual attitudes and behavior among older women should carefully examine the relative effects of educational attainment, socioeconomic status, social network effects, partner status, and sexual activity vs. race on awareness of and behaviors pertinent to HIV/AIDS.

The findings also suggest that physicians may preferentially engage older African American women about issues of sexuality. African American women more often reported a physician-initiated discussion about sexuality. Do physicians appropriately target African American women for counseling, given the higher prevalence of sexual activity, HIV/AIDS, and other STIs in this population? In this study, physicians were more likely to initiate discussion about sex with African American women but no more likely to provide HIV information or testing. Whether dialogues about sexuality more broadly caused the behavioral or attitudinal change seen among older African American women cannot be discerned in the cross-section. However, other studies indicate that race substantially influences patient-physician communication,^{23,24} and one study of adolescent females found that African Americans are

more likely than whites to have had a physician initiate a sexual history.²⁵ Understanding these interesting communication disparities calls for deeper investigation and may translate to a broader understanding of racial differences in physician communication with older patients.

CONCLUSIONS

Although older women in this community-based purposive sample were sexually active, engaged in potentially risky sexual behavior (i.e., the majority did not use condoms), and believed that physicians should address issues of sexuality, insufficient attention was paid to their sexual health. Some older women in our sample, particularly African Americans, report having made changes in their sexual behavior in response to HIV/AIDS, even despite poor communication with physicians about these issues. This community-based study corroborates findings from the clinical setting and begins to address the lack of knowledge about older women's sexual behavior, attitudes, and interaction with physicians about sex and sexual risks. Although the limitations in generalizability due to the small sample size and limited information on socioeconomic status can best be addressed with a nationally representative population-based sample, this study suggests both a gap and a disparity in older women's dialogue with physicians. It also indicates the feasibility of and need for a large, population-based study on issues pertinent to older women's sexual health.

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