CYNTHIA R. MORTON, HYOJIN KIM, AND DEBBIE TREISE

Safe Sex After 50 and Mature Women's Beliefs of Sexual Health

This study explores sexual health risk attitudes among women aged 50 and older. Focus group research found that women 50+ are aware of the risk for sexually transmitted diseases (STDs), but are uncomfortable about seeking health information from their regular physician who may erroneously believe that they already possess the knowledge. Although they know the importance of condom use in avoiding STDs, they may avoid negotiating condom use with their partners in an effort to avoid conflict or rejection. The results highlight a need for greater focus on women 50+ who continue to pursue active sex lives.

Health communication campaigns designed to reduce or prevent sexually transmitted diseases (STDs), including HIV and AIDS, have largely been directed at those populations most susceptible to them. Generally, segments of the population identified as most at risk for contracting STDs are in the age categories from teens to middle adults. Therefore, it is not unusual to see STD awareness campaigns directed to these specific audiences. Although ongoing efforts to educate these age groups about sexual health vigilance are not misplaced, the exclusive focus on them may artificially reinforce a perception among health care providers and information specialists that sexual health is an issue which comes with an expiration date designated by age or stage in one's life.

In 2006, the Centers for Disease Control and Prevention (CDC) reported that 25% (280,000 persons) of the population living with HIV was aged 50 or older, and diagnosed cases among this age group are predicted to rise (CDC 2008). Yet despite this trend, research that emphasizes this group's perceptions of their own sexual health risks as they age is lacking, thereby setting up the potential for a "senior

Cynthia R. Morton (cmorton@jou.ufl.edu) is an Associate Professor of Advertising and Hyojin Kim (hkim@jou.ufl.edu) is an Assistant Professor of Advertising, both at the University of Florida. Debbie Treise (dtreise@jou.ufl.edu) is a Professor of Advertising and Associate Dean for Graduate Studies for the College of Journalism and Communications at the University of Florida. This research was support in part by seed funding from the University of Florida College of Journalism and Communications.

The Journal of Consumer Affairs, Fall 2011: 372–390
ISSN 0022-0078

epidemic" of STDs. Equally important is the fact that the medical community has been slow to recognize and diagnose STDs among older consumers in the past due, in part, to the stereotypes associated with sexual interest at older ages and the presumption that years lived is an accurate predictor of one's sexual health knowledge (Fletcher 1995; Schuerman 1994; Talashek, Tichy, and Epping 1990).

Although descriptors such as *aged*, *old*, *mature* and *elderly* are relative terms that have been used interchangeably, the focus of this investigation is the age group 50 and older. This study explores the risk perceptions and sexual health knowledge among sexually active women aged 50+. In doing so, the researchers hope to shed light on the issues identified by members of this group in an effort to identify sexual health information gaps that need to be addressed. This information will better serve the interests of the oft-overlooked mature population segments who continue to pursue active sex lives into their senior years. The paper proceeds with a profile of the "new" elderly as defined by the Baby Boomer generation (those born between 1946 and 1964) and a discussion of the STD risk for older adults. From this, the research questions are derived, and themes that guide the study are defined. Following a report of the research method and findings, implications for health communication specialists and health care providers are discussed.

SHIFTING PERCEPTIONS OF THE NEW AGED

Stereotypic connotations of the aged in western culture conjure images of people suffering from senility, frailty, financial distress and loneliness (Blankenborough 2008; Robinson and Umphrey 2006). However, research on aging recognizes that elder status is more than a function of one's chronological age. Featherstone and Hepworth (1995) suggested "the idea of the elderly is not a sufficient label for all purposes. . .and thus this group [should be] bifurcated into *young old* and *old old*." Similarly, Long (1998) proposed that the elderly be segmented into three discrete age bands that account for one's stage of elderliness: "young old" (aged 55 to 64), the "mature old" (aged 65 to 74) and the "old old" (aged 75 and older). Still other researchers appreciated the impact that nonage-specific variables have on labels that describe the aged. Moschis (1996) went as far as to suggest that biophysical, physiological, psychological and social circumstances should be acknowledged as components that contribute to one's age profile rather than only years lived. His research advanced a life-stage model (e.g., healthy indulgers, healthy hermits, ailing outgoers and frail recluses) founded on an idea that

movement from one stage to another is age-irrelevant and can begin and end abruptly at various points in life (Moschis, Lee, and Mathur 1997).

Common perceptions of aging will shift more in a direction that depicts the gray population as vibrant, energetic, financially stable and youthful as the generation of aging baby boomers (a.k.a. "Abbies") move into their senior years (Fry 2003; MacNeil 2001). This "new aged" group of people 50+ is cited as being the fastest-growing segment for Internet dating services (Ballal 2006; Juarez 2006), thus defying most stereotypes that persist about people in their age group. Prior research also supports the fact that intimacy and sex remain important aspects for a healthy life as one gets older (Calvert 2003; Koch and Mansfield 2001), with prescription pharmaceuticals such as Viagra and over-the-counter sexual enhancement products making the possibility for continued sexual experiences real. It is not uncommon then that many aging consumers find themselves back in the dating scene after divorce, a failed long-term relationship or spousal death. Yet, the dating scene to which they return may put them at risk for any number of STDs, including HIV and AIDs, if their risk awareness is low or if practical strategies for sexual health are lacking (Levy 2001).

STDs AND OLDER ADULTS

The incidence of STDs, including HIV/AIDS, is growing faster among people over the age of 50 than any other age group (Winningham et al. 2004). This age group accounts for approximately 10% of new AIDS cases (CDC 2007); heterosexual AIDS transmission is increasingly becoming a main cause of AIDS among older adults (Karlovsky, Lebed, and Mydlo 2004; Schable, Chu, and Diaz 1996; Stall and Catania 1994; Williams and Donnelly 2002). Several biological, behavioral, psychosocial and relationship factors increase susceptibility to STDs and HIV/AIDS among women 50+. Included among the biological factors are issues associated with the normal aging process (Corneille, Zyzniewski, and Belgrave 2008; Sherman, Harvey, and Noell 2005; Letvak and Schoder 1996; Whipple and Scura 1996), age-related declines in immune response (Letvak and Schoder 1996) and prescription medications that compromise one's natural defenses (Fletcher 1995; Gott 1999).

However, sexual health knowledge and risk perception seem to be the greatest obstacles to changing risky behavior among older women. Infrequent or nonuse of condoms is commonly observed in this age group that considers condoms mainly as a means of contraception (Calvet 2003; Corneille, Zyzniewski, and Belgrave 2008; Gott 1999; Sormanti, Wu, and El-Bassel 2004; Williams and Donnelly 2002). Studies have found

that older adults in particular hold a low level of risk perceptions and knowledge about STD transmission and HIV infection, which in turn is linked with high-risk sexual behaviors, low likelihood of HIV testing and low intentions to adopt HIV/AIDS preventive strategies (Akers et al. 2008; Bergin et al. 1995; Karlovsky, Lebed, and Mydlo 2004; Maves et al. 2008; Rose 1995, 1996; Stall and Catania 1994; Winningham et al. 2004). In a national study, 90% of high-risk women sampled between the ages of 40 to 75 did not consider themselves at risk of contracting HIV, and 23% of these women did not know if their partner had any risk factors for HIV (Binson and Pollack 1997).

The low level of risk perceptions is attributable in part to the stigma attached to STDs and HIV/AIDS and older adults' inability to recall their risky sexual practices (Karlovsky, Lebed, and Mydlo 2004; Lichtenstein 2008). More important is the fact that older adults tend to misjudge their susceptibility to HIV/AIDS due to misconceptions and erroneous heuristic constructions about HIV transmission (Paniagua 1999; Ward et al. 2004). Stall and Catania (1994) found that individuals over 50 at risk of HIV are one-sixth as likely to use condoms during sex and one-fifth as likely to have been tested for HIV when compared to those at risk in their twenties. In fact, women over 50 with heterosexually acquired AIDS are more likely to have never used a condom before HIV diagnosis compared to their younger counterparts (Schable, Chu, and Diaz 1996).

In a study of the effects of demographic, sociobehavioral and contextual factors on predicting HIV/AIDS risk perceptions, Ward et al. (2004) found that objective knowledge about HIV/AIDS and high-risk sexual behaviors did not significantly contribute to an individual's perceptions about risks of contracting these sexually transmitted infections. These researchers concluded that sociodemographic characteristics and environmental factors not only influence heuristic decision making regarding HIV/AIDS risk, but also mask or misrepresent a person's actual probability of infection. Similarly, Winningham et al.'s (2004) research showed that engaging in high-risk sexual behaviors has little or no negative impact on perceptions of personal susceptibility to HIV infection. Furthermore, they found that high-risk behavior was associated with less education, less self-efficacy for condom use, more exposure to peers who discussed HIV-related risk behavior and less comfort when communicating with partners about sex.

A few other studies have noted the significant influence of partners' attitudes toward condom use and relationship characteristics on sexual behaviors. Many women over the age of 50 experience changes in relationship status while initiating or engaging in new sexual relationships

(Kreider and Fields 2001; Rich 2001). Traditional gender role beliefs encourage women to prioritize relationships and place others' needs before their own (Corneille, Zyzniewski, and Belgrave 2008). Studies indicate that factors such as relationship duration, relationship characteristics, gender role beliefs and gender-based power dynamics influence sexual risk behaviors in women generally and in older women particularly (Corneille, Zyzniewski, and Belgrave 2008; Sherman, Harvey, and Noell 2005). Many women in long-term, monogamous relationships believe their partners to be safe and uninfected with STDs; therefore, they are less likely to use condoms (Reisen and Poppen 1999). Considering the unique attitudes toward sex and aging, multiple risk factors of STDs are particularly relevant for women over 50.

THEORETICAL GROUNDING

Research that seeks to understand individual motivations to pursue safe sex practices often introduces the concept of self-efficacy. Bandura (1986) defined self-efficacy as the individual's belief in his ability to perform a particular behavior in a given situation. Moreover, self-efficacy mediates the interaction between the individual's knowledge and his actual performance of the behavior (Rostosky et al. 2008, Bandura 2001). Not only does low self-efficacy minimize the likelihood of condom use, but age (older), length of the relationship (longer) and partner status (having a main partner) are variables negatively correlated with current condom use and future condom use intentions (Corneille, Zyzniewski, and Belgrave 2008). Feelings of love, trust and commitment are also associated with less frequent use of condoms (Clark et al. 1996; Wendt and Solomon 1995). Thus, women may choose not to use condoms in order to avoid potential conflict or loss of a relationship (Corneille, Zyzniewski, and Belgrave 2008; Sormanti, Wu, and El-Bassel 2004). From this, it follows that women who let their partner decide are also less likely to use condoms compared to women who share decision making with their partners regarding condom use (Harvey et al. 2002). So, while older women may have knowledge about STDs, they may choose to acquiesce to the wishes of their partners to avoid discord.

Certainly self-efficacy is inextricably tied to older adults' receptiveness to behavior change and ownership over their sexual health. However, Protection Motivation Theory (PMT) (Rogers 1975, 1983) and the Extended Parallel Process Model (EPPM) (Witte 1992) present researchers with options for redirecting entrenched notions about one's own capabilities to negotiate compliance with a sexual partner. PMT predicts that motivation

to adopt a recommended coping response, such as the regular use of condoms, will be contingent on an individual's assessment of the severity of the threat and his perceived vulnerability (Prentice-Dunn, Mcmath, and Cramer 2009). Health researchers have used the model to develop messages and behavior change strategies that speak directly to the existing salient beliefs of the audience. The present investigation is informed by the application of PMT in that mature women must not only understand their risk for contracting STDs (threat susceptibility) and the consequences of having STDs at an advanced age (threat severity), but also must feel capable of discussing these concerns openly with their partners (self-efficacy) for the purpose of negotiating safe sexual health behaviors.

The EPPM suggests that as threat awareness increases, the level of self-efficacy can determine the course of action taken to mitigate the threat (Witte 1992). If the fear of STD risk is high, the individual may turn away from the message. Witte (1992) notes that a high-perceived threat (severity + susceptibility) accompanied by low self-efficacy can result in the unintended consequence of a maladaptive response; targets might avoid the message altogether because the points raised are too frightening and thus overwhelming, thereby putting themselves at risk for engaging in the very behavior that the health message was meant to address. Response efficacy, or the degree to which a proposed response to a problem will be effective, both influences and is influenced by self-efficacy (Witte and Allen 2000). The EPPM is particularly pertinent to guiding the research study's objective to better understand what communication challenges exist among sexually active mature-aged women.

The current study examines specific topics associated with women's sexual attitudes and behaviors toward sex health practices in order to gain a better understanding of opportunities that exist for better serving the needs of this group. Four research questions are proposed for investigation.

RQ1: What are 50+ women's attitudes toward self at this stage of their lives?

RQ2: What are their attitudes toward sex, dating and partner selection?

RQ3: What is their sexual health knowledge and how does this knowledge inform their behaviors?

RQ4: What are their sources of health information?

RESEARCH METHOD

Focus groups were conducted among women aged 50 and older to explore the research questions. In his meta-analysis on the use of focus

groups in the social sciences, Morgan (1996, p. 133) notes that an important rationale for using of focus group is that this technique "gives a voice to marginalized groups." Another advantage associated with using focus groups over other methods is that the format empowers and gives participants a degree of control over their own interactions as participants can "both query each other and explain themselves to each other" (Morgan 1996, p. 139). In addition, it allows for greater collaboration between researcher and participant because the latter is allowed to raise important issues that the researcher did not foresee (Balch 1998). Although the use of a group format as a viable technique for addressing sensitive topics may be questioned, prior research on similarly sensitive topics (i.e., issues related to HIV/AIDS among gay males) have been successfully used in applied settings to gain insights (Joseph et al. 1984). In this study, participants were informed of the study topic (e.g., sexual health) when they were recruited for focus groups. As such, they appeared to exhibit no reticence about discussing the topics presented; rather, the researchers observed that participants would extend the opportunity for interaction with one another after the group had been formally adjourned.

Participants were recruited from the local and surrounding areas of a large southeastern university community. The recruiting criteria stipulated that the participants: (1) be 50 years of age or older, (2) be single and unmarried, (3) be actively dating and (4) have been sexually active in the previous 12 months. Although no specific definition was placed on the criterion of "actively dating," the researchers did seek to qualify women in heterosexual relationships only. The age distribution included the core target of Baby Boomers, although older volunteers were not discouraged from participating in the study.

Participants were identified using self-selection and snowball sampling. Flyers were posted on public notice boards at retail establishments in the local area, and a classified ad was placed in the local newspaper to extend the reach of the recruiting information to multiple surrounding counties outside the immediate recruiting area. Recruitment messages listed the general topic of discussion as "dating over 50," specified the cash incentive for participation, and provided contact information for interested individuals to get more information about participation. Women contacted the research team by telephone and were screened extensively to ensure their qualification status. Those who met the qualifications for participation were invited to join one of the focus group discussions. Participants who agreed to participate in the study were informed of the topic for discussion prior to the focus group and had an

opportunity to opt out at any time. Each recruit was also encouraged to tell her network of friends about the study so that they too might contact the researchers about participation.

Participant recruiting was ongoing until enough groups were administered to reach saturation, or the point at which no new information emerged on the discussion topics (Lindlof 1995). Given the sensitivity of the topic, the researchers believed that friendship referrals would be effective in building incremental participant numbers because it would mitigate reticence and build interest among other women who might be qualified to participate in the study. A $25 cash incentive and dinner were given to each woman for her participation in the study.

A discussion guide was developed to address the specific topics related to the study's guiding research questions. The complete discussion guide contained a total of twenty questions.

The discussion moderator was a member of the research team who is similar in age and gender as the recruited participant demographic. The two other members of the research team assisted in administering the focus groups and were present to observe the discussions. Each group discussion lasted approximately one hour and was recorded for later reference. Transcripts were made from the audiotapes and then analyzed for relevant themes.

A total of twenty-seven volunteers were recruited into four focus groups between March and July 2008. The groups ranged in size from four to seven participants, and their ages ranged from 50 to early 70s, with most of the participants between 50 or 60 years of age. Only one participant reported being in her 70s. In terms of Long's (1998) typology, the group participants were representative of the "young old" and "mature old." The diverse composition of the group included women who were still employed full time, women supporting teenage children who live at home, and women who were retired and independent of children or others. A majority of the women had attained single status either through divorce or the death of a spouse. Only one participant reported to have never married. Of the 27 participants, one was African American and all others were Caucasian. Each participant indicated that she had dated actively in the six to 12 months prior to her participation in the discussion. Two participants reported being in a long-term monogamous relationship with a single partner.

The researchers uncovered relevant themes tied to various topic areas. A comprehensive examination of the major findings and illustrative quotes are presented verbatim in the sections that follow.

FINDINGS

Self-Actualization and Its Consequences

The discussion began with questions that explored participants' perceptions of themselves at their current stage of life and at earlier stages in life. Even though they recognized the limitations their age imposed on their ability to be as physically active as when they were younger, generally they felt happy about their present station in life relative to when they were younger.

The participants were aware of the positive (e.g., hot-to-trot "cougars") and negative (e.g., physically unfit, overweight, depressed, incontinent and "dried up") stereotypes attributed to mature women, but regarded their life experiences as something that made them more confident in relationships and as sexual partners than when they were younger. This confidence not only helped them negotiate the negative stereotypes targeted to their age group, but also to prioritize where and how sex and dating fit into their lives. For example, one participant suggested that giving more priority to her own satisfaction rather than only her partner's gave her greater confidence in sexual situations.

> I think I also used sex as a way to gain company. . .and to not be alone. Um, now it's a lot better than it was then—a lot more satisfying and I think that's partly because. . .I think men finally figured out that it's not just about them.

Although a few participants viewed their stage of life as reason why they should be less interested in sex and the prospect of a committed relationship, their age was empowering to them. To these women, confidence meant dating without the burden of negotiating the terms of a long-term commitment. These perspectives tended to come from the "mature old" participants of the discussion groups who were aged over 65 than the younger group participants.

> What works for me at this point is knowing I'm too old to probably ever have a real committed relationship sexually again because the people that I date. . .they're not. . .they're either younger or they are not. . .I don't know. . .something about the times today, I don't see men being committed like I thought they were back in the '50s or '60s or '70s. I don't see that.

> I tell people I don't have that sex monkey on my back anymore and it's very freeing. I feel as innocent. . .as a 14-year-old girl. . .I don't miss it. . .I've really kind of lost that drive and I just don't miss it. The requirements and things too, why would I waste my time? I've wasted like pretty much of my life with hits and misses.

Despite the confidence expressed, participants also acknowledged that they are more cautious about dating relationships due to the threat of

venereal diseases. Threat severity and threat susceptibility were salient to the groups, which pointed to HIV/AIDS as particularly high on their list of concerns. One participant compared her age group's sexual health risk with that of 20-something women in terms of how each must approach relationships in order to avoid HIV.

> It was only maybe four or five years ago that I realized how long it takes for it to show up. . . . it's amazing. It really is. It's funny because we're seniors, and it's not like we're in our 20s or teens, and here we are with the same questions as they [have], the only difference is that the impact on us would get us real fast. Then we'd be in big time trouble.

The participants representative of the young olds (aged 50 to 64) had reached adulthood during a time of sexual freedom and sexual liberation. Some participants confessed to having relationships with multiple partners without using protection when they were much younger and expressed regret for past risky behaviors that could have resulted in long-term health consequences.

> I think back in my youth, probably before 25, there was this freedom to have sex without fear. Now, in this age, I'm fearful of HIV because it's out there and there's a lot of it. So, we have that dynamic to deal with, and how do you negotiate safer sex and how do you talk about that. And coming from a history of not really talking deeply about sex and sexual behaviors, this is a new arena.

CRITERIA FOR CHOOSING SEXUAL PARTNERS AND SUBSEQUENT PERCEIVED RISK

Although the participants could easily itemize those qualities they believed to be important in a dating prospect (i.e., physically attractive, generous, intelligent, caring, etc.), their concerns about the risk of contracting an STD influenced whom they dated and the stipulations they placed on choosing potential partners. When asked about the qualities they looked for in a man they wanted to be sexual with, several participants mentioned the importance of having a commitment of monogamy from their partner. Some participants also required that potential partners get tested for HIV and AIDS as a precursor to having sex. They believed the willingness to be tested was a step toward building trust in the relationship. For example, one participant elaborated on this idea.

> . . .I ask them I say after I've been dating them a couple months and they passed all their tests and all that stuff, and I've gotten to know their family and their friends, I ask them, "At a certain point, could you see living with me the rest of your life?" And, I won't go any further with that until they can say, "Yes, 100%,

> I can see myself living with you." I don't have a different standard for somebody I'm sexually active with.

Concerns about STD seemed to depend on the perceived risk associated with a potential partner, and participants had various approaches for assessing sexual health risk. For example, one participant indicated that she bypassed the discussion about sexual health history altogether because her partner was a long-time acquaintance before they became sexually involved and she therefore perceived the threat risk to be low.

> I had been with same partner for 12 years then left him and went with a different partner about six years ago and this was somebody that hadn't had sex in the last year, had been tested, I was past menopause, it was somebody I'd known, you know, for 25 years, so no, I didn't.

Negotiating the Condom Use and Responsibility

Although there was a consensus among the majority participants about the importance of knowing a potential sex partner's history, a few women admitted to being unsure about specifically when and how to begin the discussion. At one point in the conversation, the moderator paused the discussion guide to observe the open exchange between participants about what the script for discussing HIV and AIDS testing should include. One participant asked the group about when it would be appropriate to open the conversation, and another participant offered advice for negotiating the use of protection with a partner.

> I've got a great opener's line. My single cousin, who pretty much was a wild child. . .taught me a lot. Anyway the opening line for the condom is, "If you don't have a condom on you, I always carry a few in my purse."

An alternate approach suggested from a different participant was, "I just pass it off on somebody else and say, 'All my friends are afraid I'm jumping into sex without adequate protection, so I need to ask you these questions.'" The researchers noted much discussion among the group at this stage in the conversation.

The majority of women indicated that they assumed responsibility for supplying condoms. In general, concerns about contracting an STD and the fear and uncertainty associated with how STDs are transmitted seemed to be primary reasons that participants believed they should supply them. For example, one participant talked about her lack of confidence in being aware of and knowledgeable about STDs and how they may affect her.

> I'm naïve and I don't even know what all of them are. I just know what I've read and what I've heard from friends, but I don't know how. . .I can't keep up

> with that. At my age, I've had too many problems. I've had surgery, I've had Caesarian injury, and I've had some other things that got my attention, and I don't feel confident to keep up with that kind of thing right now. Maybe that'll ease up on me, but right now I feel very in the dark from what I'm supposed to fear other than the main transmutable ones.

Past experience made them leery about the idea that their partner might not be concerned about safe sex practices or that they would not be appropriately prepared with protection when it was needed. One participant said, "I'm telling you, the men I've met in my age group have an 80-year-old condom in their wallet and it just really sends my mind reeling."

Participants were asked to elaborate on how they actually discussed protection with their partner. Some women were resolute in their rationale for using protection because they strongly believed that condoms reduced the risk of STDs and were willing to end a relationship with a partner if he did not use protection.

> Like I said, if he says no, then that means he's gone. You know, there is no discussion beyond that. If he tells me that we can't use protection, then you don't have time to be together, so you can go on and find somebody else that will be with you, but it won't be me. I'm trying to take the risk factor away by using a condom, but I can't control any of the stuff that happened before me. You know? And even if I did know, it wouldn't do anything for me, except make me scared-er. . .you know, so I don't journey on that path. Just let's deal with what's happening right now, cover it up, and then we can go from there, but I have no control over what happened before me.

Interestingly, although the majority felt strongly about protection, only a few of them were confident in their ability to negotiate that conversation, and were unsure of how to deal with resistance from potential partners. One participant referred to this resistance as a "power struggle" that cause strife in the relationship.

> I found a great deal of resistance from the men I have been dating. . .regarding protection. He does what he wants. . .[Men] just don't want to be bothered. They don't want to be bothered and they get very annoyed and make a big deal out of nothing. And it became, at times, a power struggle.

Conversely, only one participant sought to assuage partner resistance with an alternative that placed responsibility back on the woman to manage the issue of protection.

> Not to be the devil's advocate, but if I were a guy I probably would buck too. So I try to put myself in their shoes and look at alternatives and I recommend a female condom—which most of them haven't seen or heard of their lives—and find a great deal of fun. So that kind of breaks the ice, the female condom. It puts the responsibility on me.

Obstacles to and Opportunities for Sexual Health Information

When asked where they obtain sexual health information, participants focused on their doctor not as a resource for information as one would expect, but rather as a barrier to gaining information about sexual health. They cited several reasons for this. Several women said that their comfort level talking to their doctor was very low; therefore, they did not tend to open a dialogue with their physician to obtain sexual health information. This discomfort arose from embarrassment and perceptions that their physicians were out of tune with their needs. One participant explained that despite being a long-term patient, she felt embarrassed about discussing sexual health concerns with her doctor because she and her ex-husband were patients of his before their divorce. To this participant, overcoming feelings that her physician might pass judgment—whether spoken or unspoken—about her behavior was enough to make her avoid asking the doctor questions.

> I see a male physician. I think they're just so busy. My physician knows that I'm split up with my husband.... In fact I had to go see him because I had a "problem" (laughs)...I got some kind of infection, I guess it was a yeast infection or something...and I was kind of embarrassed, I didn't want to talk about it, you know, because my husband also sees him and we're going through the divorce process...and I kind of got that silly feeling like, "Well I don't want to discuss it. It's not really hurting in any way. Just treat me for it." That's probably my feeling more than anything to do with him.

Both the young old and the mature old participants agreed that their doctor simply did not ask them about sexual health, and if they did, inquiries were presented more as a courtesy (i.e., "Do you have any questions?") than a real attempt to open a conversation about sexual health. When asked why they believed their doctors did not talk to them about sex health issues more, participants attributed it to the doctor's discomfort with talking to older women about these issues, especially if the doctor was male and also over 50. One participant said, "They almost act uncomfortable that you brought up something you're not supposed to." Another participant attributed this lack of discussion to the doctor's assumption that their patients' knowledge and life experiences about the issues surrounding sexual health were greater because of her age.

> I think they associate us with knowing. I mean, I'm older than my physician. I don't know if he's—well I doubt that he's embarrassed—but I think they just assume that we know about it.

A participant who is a mother of a teenage daughter also echoed this sentiment. She related that she and her daughter see the same gynecologist. She noted that although the doctor pays careful attention to opening a conversation with her teenage daughter about sexual health, he regularly neglected to give similar consideration to her (the mom). Moreover, based on this participant's account of the interaction, it was clear that she never raised this concern to her physician in order to change the pattern of interaction.

Of note is that the physicians these women discussed were primarily male, which may contribute to mature women's discomfort in using the physicians as an information source. Whether due to comfort, convenience or access, the individuals in the group tended to have a long history with one male doctor who may serve as either general practitioner or gynecologist or both. It is also possible that this generation of women, who grew up with strict social mores dictating what was appropriate behavior for "nice girls," may have difficulty confiding in their physicians. The cross-gender interaction, then, might compound the perceived barrier to communication for this age group.

A majority of the participants cited the Internet, women's magazines and television personalities as their primary source of information for sexual health. Dr. Oz, the medical doctor from the Oprah show, and Dr. Sue Johanson, the host of the late night show *Talk Sex with Sue Johanson*, were two resources from whom participants reported having learned a great deal. Participants also confided that media personalities were more "approachable" than their doctors because of their candor in discussing various topics associated with sexual health.

> She's [Sue Johanson] on late at night though, and I was watching last night and much to my embarrassment, I could see that my son could see what I was watching from the kitchen. He walked in on me, and then later on I think he went to check it out in his bedroom. But, that's an interesting program. It's on so late you know that she discusses. . .nothing is too strange or too weird. She gives you a real straight up answer and she's awfully glib on it. If you get creeped out then don't listen. . .She's very open minded, to say the least, and I learn a lot from that program. I forgot to mention it earlier. It's really informative. Of course, there are probably a lot of things I'm never going to do, but never mind. Never say never!

DISCUSSION

The purpose of this research was to explore knowledge and behaviors of sexual health risk among women 50 years and older. Focus group research explored dating women's perceptions of self, attitudes toward

sex and dating, sexual health knowledge and sources they consulted to gain health information. Several of the findings from the study reinforced prior research on the over 50 demographic. Women who participated in this study generally had a positive sense of self and were unfazed by the labels directed toward their age group. They understood that the aging process imposed some physical limitations on what they could do, but still reported being more confident and comfortable with themselves compared to when they were younger. Although they were aware of the negative characterizations of older women in the media, they chose to focus on positive portrayals of mature women and older female celebrities who display a lifestyle that contradicts the elderly woman stereotype.

Evidence from this study suggests that women over 50 are not oblivious to sexual health risks. Within the framework of the PMT and the EPPM, participants knew the risks of contracting an STD and the severity of the consequences as they negotiated the dating landscape. Many of the participants still viewed themselves as sexual beings despite the fact that the pool of male partners for monogamous relationships is reduced as they get older. However, low self-efficacy seemed evident among a majority of participants who were reticent to raise the issue of condom use with their partners for fear it could result in a power struggle or rejection. Consistent with previous research (Corneille, Zyzniewski, and Belgrave 2008; Harvey et al. 2002; Sormanti, Wu, and El-Bassel 2004), this reticence resulted in women acquiescing to their partners' preference not to use condoms. However, participants seemed interested in understanding how other women maneuvered partner negotiations, which suggests that they continued to process the potential consequences of their behavior, and might be interested in learning new strategies for negotiating condom use. Health communication messages directed at low self-efficacy women should present them with a script for negotiation that not only helps increase self-efficacy but also reinforces the benefits of lowering their susceptibility to STDs.

Among the most intriguing findings is the hesitation women felt about using their primary care physician as a source of sexual health information. A consensus expressed across the participant pool was that, although they wanted answers to sexual health questions, they did not feel comfortable asking their doctors about sex or sexual health practices, even though some women admitted to having the same family physician for many years. They also lamented the fact that the doctor never explored questions they might have about sex, presuming that women over 50 are already informed or not interested in knowing. Helping women gain confidence in talking with primary care physicians and making those

physicians aware of their need is critical to serve this segment of the population.

Indeed, the search for sexual health information seemed limited to Internet access, television doctors and popular programming alternatives (e.g., Dr. Oz, *Talk Sex With Sue*). This reinforces previous research findings that expectations about who should initiate the conversation about sexual health—patients or doctors—can be a barrier to communication and can result in neither one initiating conversation (Fletcher 1995; Schuerman 1994; Talashek et al. 1990). This also suggests that health communication strategies should focus on building women's self-efficacy for talking with their physicians.

The findings of this study show a critical need for improving communication between women over 50 and their physicians. That is, sexual health messages aimed at mature women should educate them about the importance of regularly consulting with their physicians during the semi-annual visits. Communications aimed at this audience could provide a menu of health concerns that women could use to begin the conversation with their physician. Conversely, an opportunity exists to recruit medical doctors, who serve patients aged 50+, to be the frontline watchdogs to ensure that aging consumers have the opportunity to discuss sexual health concerns without embarrassment. This may mean training physicians to rethink their expectations about the sexual behavior of aging consumers and to make sexual health a regular component of all patients' medical exams.

This research highlights the need for social marketing campaigns to address sexual health behaviors for older adults, because health campaigns targeted to them seem to focus on reactive strategies post-STD infection rather than proactive strategies for maintaining good health. Although some of the prevalent findings from this exploration corroborate previous research, other findings uncover new opportunities for raising awareness about the risk of STDs and HIV/AIDs among an otherwise underserved target on these issues. Messages that educate older women about their sexual health risk and encourage them to take greater ownership in the negotiation of sexual health behaviors with their partners will serve to foster individual behavior change—and perhaps curb the trend of STD prevalence—among older adults over the long term.

REFERENCES

Akers, Aletha Y., Lisa Bernstein, Joyce Doyle, and Giselle Corbie-Smith. 2008. Older Women and HIV Testing: Examining the Relationship between HIV Testing History, Age, and Lifetime HIV Risk Behaviors. *Sexually Transmitted Diseases*, 35 (4): 420–423.

Balch, George I. 1998. Exploring Perceptions of Smoking Cessation among High School Smokers: Input and Feedback from Focus Groups. *Preventive Medicine*, 27: A55–A63.

Ballal, Smitha. 2006. Who Says E-Romance Is Dead? *Business Week*, July 17, 12.

Bandura, Albert. 1986. *Social Foundations of Thought and Action: A Social Cognitive Theory*. Englewood Cliffs, NJ: Prentice Hall.

———. 2001. Social Cognitive Theory: An Agentic Perspective. *Annual Review of Psychology*, 52: 1–26.

Bergin, C., M. O'Reilly, J. Goha, D. O'Neill, and F. Mulcahy. 1995. Incidence of Sexually Transmitted Disease amongst an Elderly Cohort Attending a Genitor-Urinary Medicine (GUM) Clinic. *Journal of the European Academy of Dermatology and Venereology*, 5 (3): 218–221.

Binson, Diane, and Lance Pollack. 1997. AIDS-related Risk Behaviors and Safer Sex Practices of Women in Midlife and Older in the United States: 1990 to 1992. *Health Care for Women International*, 18: 343–354.

Blankenborough, Darren. 2008. "Old People Are Useless": Representations on Aging on the Simpsons. *Canadian Journal on Aging*, 27 (1): 57–67.

Calvert, Helene M. 2003. Sexually Transmitted Diseases Other than Human Immunodeficiency Virus Infection in Older Adults. *Clinical Infectious Diseases*, 36 (5): 609–614.

CDC. 2007. *HIV/AIDS surveillance report, 2005*, Revised edition, vol. 17. Atlanta, GA: US Department of Health and Human Services, Centers for Disease Control and Prevention.

———. 2008. New Estimates of U.S. HIV Prevalence, 2006. http://www.cdc.gov/hiv/topics/surveillance/resources/factsheets/pdf/prevalence.pdf.

Clark, Leslie F., Kim S. Miller, Janet S. Harrison, Kay L. Kelly, and Janet Moore. 1996. The Role of Attraction in Partner Assessment and Heterosexual Risk for HIV. In *Understanding and Preventing HIV Risk Behavior: Safer Sex and Drug Use,* edited by Stuart Oskamp and Suzanne C. Thompson (80–99). Thousand Oaks, CA: Sage.

Corneille, Maya A., Linda E. Zyzniewski, and Faye Z. Belgrave. 2008. Age and HIV Risk and Protective Behaviors among African American Women. *Journal of Black Psychology*, 34 (2): 217–233.

Featherstone, Mike and Mike Hepworth. 1995. Images of Positive Aging: A Case Study of *Retirement Choice Magazine*. In *Images of Aging: Cultural Representations of Later Life,* edited by Mike Featherstone and Andrew Wernick (29–47). New York: Routledge.

Fletcher, Courtney V. 1995. Sexually Transmitted Viral Diseases in the Elderly. *Journal of Geriatric Drug Therapy*, 10 (2): 53–79.

Fry, Patricia. 2003. Retirement, Baby Boomer Style. *World and I,* June, 18.

Gott, C. Merryn. 1999. Sexual Risk-Taking in Later Life. *Reviews in Clinical Gerontology*, 9 (2): 139–150.

Harvey, S. Marie, Sheryl T. Bird, Christine Galavotti, Emestine A. Duncan, and Donna Greenberg. 2002. Relationship Power, Sexual Decision Making and Condom Use among Women at Risk for HIV/STDS. *Women and Health*, 36 (4): 69–84.

Joseph, Jill G., Carol-Ann Emmons, Ronald C. Kessler, Camille B. Wortman, Kerth O'Brien, William T. Hocker, and Catherine Schaefer 1984. Coping with the Threat of AIDS: An Approach to Psychosocial Assessment. *American Psychologist*, 39 (11): 1297–1302.

Juarez, Vanessa. 2006. In the Internet Dating World, Boomers Are a Hot Commodity. *Newsweek*, February 20, 60.

Karlovsky, Matthew, Brett Lebed, and Jack H. Mydlo. 2004. Increasing Incidence and Importance of HIV/AIDS and Gonorrhea Among Men Aged Over 50 Years in the US in the Era of Erectile Dysfunction Therapy. *Scandinavian Journal of Urology and Nephrology*, 38 (3): 247–252.

Koch, Patricia Barthalow and Phyllis Kernoff Mansfield. 2001. Women's Sexuality as They Age: The More Things Change, the More They Stay the Same. *SEIUS Report*, 30 (5): 5.

Kreider, Rose M. and Jason M. Fields. 2002. Number, Timing, and Duration of Marriages and Divorces: 1996. U.S. Department of Commerce, Economics and Statics Administration, U.S. Census Bureau. http://www.census.gov/prod/2002pubs/p70-80.pdf.

Letvak, Susan and Dianne Schoder. 1996. Sexually Transmitted Diseases in the Elderly: What You Need to Know. *Geriatric Nursing*, 17 (4): 156–160.

Levy, Judith. 2001. HIV and AIDS in People Over 50. *SIECUS Report*, 30 (2): 10–16.

Lindlof, Thomas R. 1995. *Qualitative Research Methods.* Thousand Oaks, CA: Sage.

Long, Nick. 1998. Broken Down by Age and Sex—Exploring Ways We Approach the Elderly Consumer. *Journal of the Market Research Society*, 40 (2): 73–92.

MacNeil, Richard D. 2001. Bob Dylan and the Baby Boom Generation: The Times They Are A-Changin'–Again. *Activities, Adaptation, and Aging*, 25 (3/4): 45–58.

Maves, Ryan C., Edward R. Cachay, Maile Ann Young, and Fierer Joshua. 2008. Secondary Syphilis with Ocular Manifestations in Older Adults. *Clinical Infectious Diseases*, 46 (12): e142–e145.

Morgan, David L. 1996. Focus Groups. *Annual Review of Sociology*, 22: 129–152.

Moschis, George P. 1996. *Gerontographics: Life Stage Segmentation for Marketing Strategy Development*. Westport, CT: Quorum.

Moschis, George P., Euehun Lee, and Anil Mathur. 2007. Targeting the Mature Market: Opportunities and Challenges. *Journal of Consumer Marketing*, 14 (4): 292–293.

Paniagua, Freddy A. 1999. Commentary on the Possibility that Viagra May Contribute to Transmission of HIV and Other Sexual Diseases Among Older Adults. *Psychological Reports*, 85 (3): 942–944.

Prentice-Dunn, Steven, Ben F. Mcmath, and Robert J. Cramer. 2009. Protection Motivation Theory and Stages of Change in Sun Protective Behavior. *Journal of Health Psychology*, 14: 297–305.

Reisen, Carol A. and Paul J. Poppen. 1999. Partner-Specific Risk Perception: A New Conceptualization of Perceived Vulnerability to STDs. *Journal of Applied Social Psychology*, 29 (4): 667–684.

Rich, Ellen R. 2001. Negotiation of HIV Preventive Behaviors in Divorced and Separated Women Reentering the Sexual Arena. *Journal of the Association of Nurses in AIDS Care*, 12 (4): 25–35.

Robinson, Tom and Don Umphrey. 2006. First- and Third-Person Perceptions of Images of Older People in Advertising: An Intergeneration Evaluation. *International Journal of Aging and Human Development*, 62 (2): 159–173.

Rogers, Ronald W. 1975. A Protection Motivation Theory of Fear Appeals and Attitude Change. *Journal of Psychology*, 91 (1): 93–114.

———. 1983. Cognitive and Physiological Processes in Fear Appeals and Attitude Change: A Revised Theory of Protection Motivation. In *Social Psychophysiology,* edited by John Cacioppo and Richard Petty (153–176). New York: Guilford.

Rose, Molly A. 1995. HIV/AIDS Knowledge, Perceptions of Risk, and Behaviors of Older Adults. *Holistic Nursing Practice*, 10 (1): 10–17.

Rostosky, Sharon Scales, Olga Dekhtyar, Pamela K. Cupp, and Eric M. Anderman. 2008. Sexual Self-Concept and Sexual Self-Efficacy in Adolescents: A Possible Clue to Promoting Sexual Health? *Journal of Sex Research*, 45 (3): 277–286.

Schable, Barbara, Susan Y. Chu, and Teresa Diaz. 1996. Characteristics of Women 50 Years of Age or Older With Heterosexually Acquired AIDS. *American Journal of Public Health*, 86 (11): 1616–1618.

Schuerman, Debra A. 1994. Clinical Concerns: AIDS in the Elderly. *Journal of Gerontological Nursing*, 20 (7): 11–17.

Sherman, Cristy A., S. Marie Harvey, and John Noell. 2005. "Are 'They' Still Having Sex?" STIs and Unintended Pregnancy among Mid-Life Women. *Journal of Women and Aging*, 17 (3): 41–55.

Sormanti, Mary, Elwin Wu, and Nabila El-Bassel. 2004. Considering HIV Risk and Intimate Partner Violence among Older Women Of Color: A Descriptive Analysis. *Women and Health*, 39 (1): 45–63.

Stall, Ron D. and Joe Catania. 1994. AIDS Risk Behaviors Among Late Middle-Aged and Elderly Americans: The National AIDS Behavioral Surveys. *Archives of Internal Medicine*, 154: 57–63.

Talashek, Marie L., Anna M. Tichy, and Hugh Epping. 1990. Sexually Transmitted Diseases in the Elderly: Issues and Recommendations. *Journal of Gerontological Nursing*, 16 (4): 33–40.

Ward, Elijah G., William B. Disch, Judith A. Levy, and Jean J. Schensul. 2004. Perception of HIV/AIDS Risk among Urban, Low-Income Senior-Housing Residents. *AIDS Education and Prevention*, 16 (6): 571–588.

Wendt, Sally J. and Laura J. Solomon. 1995. Barriers to Condom Use Among Heterosexual Male and Female College Students. *Journal of American College Health*, 44 (3): 105–110.

Whipple, Beverly and Kathleen W. Scura. 1996. The Overlooked Epidemic: HIV in Older Adults. *American Journal of Nursing*, 96: 123–126.

Williams, Edith and Jerre Donnelly. 2002. Older Americans and AIDS: Some Guidelines for Prevention. *Social Work*, 47 (2): 105–111.

Winningham, April, Sara Corwin, Charity Moore, Donna Richter, Roger Sargent, and Cheryl Gore-Felton. 2004. The Changing Age of HIV: Sexual Risk among Older African American Women Living in Rural Communities. *Preventive Medicine*, 39 (4): 809–814.

Witte, Kim. 1992. Putting the Fear Back into Fear Appeals: The Extended Parallel Process Model. *Communication Monographs*, 59: 329–349.

Witte, Kim and M. Allen. 2000. A Meta-Analysis of Fear Appeals: Implications for Effective Health Campaigns. *Health Education & Behavior*, 27: 591–615.