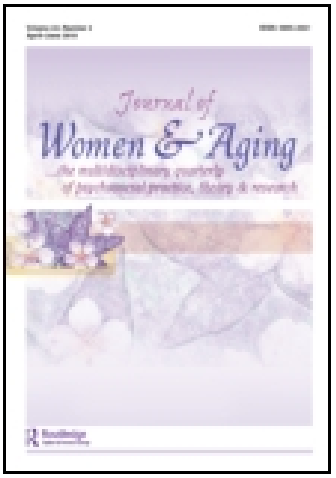

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Attitudes and Stereotypes Regarding Older Women and HIV Risk

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Persons aged 50 years and over will soon disproportionately represent the future of the HIV/AIDS epidemic. It is estimated that by 2015 older adults will represent 50% of persons living with HIV in the United States. Despite the HIV/AIDS growing population among older adults, attitudes, beliefs, and stereotypes toward older adults that exist in general society have affected HIV prevention, education, and care. Specifically, ageist attitudes about the sexuality of older adults in general and older women in particular, low clinical HIV suspicion among healthcare providers, lack of knowledge about risk among older women, and differentials in power related to negotiating sexual practices all lead to heightened concerns for the prevention, identification, and treatment of HIV disease in mature women. This article examines common attitudes, beliefs, and stereotypes that exist within general society as well as health and social service providers that place older women at a disadvantage when it comes to HIV prevention, education, and treatment.

KEYWORDS HIV/AIDS, women, sexuality, risk, stereotypes

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INTRODUCTION

Early in the HIV/AIDS epidemic, midlife and older women were seen as invisible (Zablotsky, 2008). In fact, they were invisible within a population already unseen and unheard (Emlet & Poindexter, 2004). Many older women who become HIV positive, have acquired the virus through sexual contact. However, attitudes and stereotypes about the sexuality of older women may negatively affect our ability to accurately prevent, diagnose, and treat HIV/AIDS in older women. Ageist attitudes about the sexuality of older adults in general and older women in particular, low expectations about the likelihood of HIV in older clients among healthcare providers, a lack of knowledge about risk among older women, and differentials in power related to negotiating sexual practices all lead to heightened concerns for the prevention, identification, and treatment of HIV disease in mature women (DeHertogh, 1994; Lindau et al., 2007; Paul, Martin, Lu, & Lin, 2007).

The purpose of this article is to identify common attitudes, beliefs, and stereotypes that exist within general society as well as health and social service providers that place older women at a disadvantage in regard to HIV prevention, education, and treatment. Second, we will present some strategies that can and should be utilized by providers, researchers, and policymakers to enlighten the public as well as the academic community about the impact of HIV disease on midlife and older women.

Historically, HIV/AIDS has been viewed as impacting those in young adulthood and early middle age. HIV disease and even sexuality have been seen as primarily relevant to younger people. Genke (2000) referred to the "invisible ten percent," as the approximately 10%–12% of newly reported cases of AIDS were in adults age 50 and over. Nevertheless, the largest cohorts of people living with HIV and AIDS are increasingly older. According to the Centers for Disease Control (CDC), in 2009 the largest percentage of people living with HIV and living with AIDS were in the 45–49 age range (CDC, 2010a). In 2009, women in the age range of 45–55 had the highest rate of all women living with AIDS, the second-highest diagnosis rate of AIDS, and the highest rates of both HIV and AIDS death. Moreover, the prevalence of women diagnosed with AIDS over age 55 increased steadily from 2000 to 2010 (CDC, 2010b). The success of antiretroviral therapy has created a group of adults who are aging into their later years with HIV/AIDS, in addition to those being diagnosed in later life. This emerging population consists of individuals, sometimes referred to as long-term survivors, who may have lived with HIV disease for several decades. Presently, 31% of persons living with HIV are over the age of 50 (Administration on Aging, 2012). Between 2015 and 2020, more than 50% of persons living with HIV will represent persons aged 50 years or older (Brooks, Buchacz, Gebo, & Mermin, 2012; Administration on Aging, 2012; Vance, McGuinness, Musgrove, Orel, & Fazeli, 2011). Considering the current survival time from first HIV diagnosis

to be nearly 25 years (Schackman et al., 2006), these numbers foretell the pattern of aging among those living with HIV/AIDS. Clearly, there is a rapidly growing population of people 50 years and older people who are living with HIV/AIDS, and many who do not have HIV/AIDS but are at risk (CDC, 2009; Brooks et al., 2012). Despite these trends, beliefs and stereotypes toward older adults that exist in general society have affected HIV prevention, education, and treatment. The vast majority of older women who become HIV positive acquire the virus through sexual contact. Attitudes and stereotypes about the sexuality of older women may have a deleterious effect on our ability to accurately prevent, diagnose, and treat HIV/AIDS in older women. To disentangle myths from facts, the following is an exploration of common perceptions about older women and their sexuality.

OLDER PEOPLE ARE NOT SEXUAL

Past generations might have considered older people to be nonsexual in much the same way that children are considered nonsexual (Simon & Gagnon, 1999). Although there are frequent references in the literature to pervasive ageist attitudes with regard to the appropriateness and frequency of sex and sexuality of older people (J. M. Campbell & Huff, 1995; Crose & Drake, 1993; J. L. Hillman, 2000; Kaye, 1993; Mack & Bland, 1999), there is also mounting countervailing evidence that attitudes are changing (Emmers-Sommer & Allen, 2005). Popular press, popular media, and advertising have brought older adult sexuality to the forefront. While older men have often been cast as romantic leads in film and television, this has more recently been extended to older women in films such as *Something's Gotta Give*, staring 57-year-old Diane Keaton, which grossed over a quarter of a billion dollars. Although romantic leading roles are still far more common for younger women, there an increasing number of older women in romantic leading roles in television, film, and even popular music. It is advertising, however, that has provided virtually ubiquitous romantic representations of older people. Kingsberg (2002) coined the phrase "Viagratization of America" to characterize the marketing and other attention to sexuality of older populations that has resulted from the pharmaceutical industry's efforts to promote its products (p. 431). Large pharmaceutical companies also contributed to the academic interest in this topic. One of the largest studies of sexuality in older people was funded by Pfizer (National Council on Aging [NCOA], 1998). It is not merely medical and pharmaceutical corporations who see sexuality as a component of the market with older people. In February of 2013 alone, *AARP Magazine* published three stories on sex and romance. It seems clear that American cultural attitudes about the likelihood, appropriateness, and frequency with which older people engage in sexual encounters is shifting,

although it is less clear that the academic and professional communities are keeping pace (Emmers-Sommer & Allen, 2005). For example, there have been no large-scale studies of health professionals; however, several authors have suggested that many are reluctant to discuss sex and sexuality with older patients (Beaulaurier et al., 2009; Brown & Sankar, 1998; DeHertogh, 1994; J. L. Hillman, 2000; Paul et al., 2007). This may, in part, relate to the relative dearth of literature on sexual risk in older people. Most literature on sex and sexuality in older people focuses on health benefits rather than risks (Beaulaurier et al., 2009; Gelfand, 2000; Kaye, 1993; Kingsberg, 2002; Matthias, Lubben, Atchison, & Schweitzer, 1997; Walker & Ephross, 1999). On the positive side, the sexuality literature consistently challenges the stereotypes that health professionals may have about the sexuality of older people. There is obvious danger, however, in pointing out the health benefits of sex and sexuality—as well as interventions and procedures designed to enhance or facilitate sexual experiences of older people—without also discussing risks of HIV and other STIs. This is particularly true with regard to populations who are not likely to be aware of risks or how to avoid them, as is often the case with older people (Topolski, Gotham, Klinkenberg, O'Neill, & Brooks, 2002).

OLDER WOMEN DON'T HAVE SEX

The common notion that sexuality declines with age appears to have some empirical basis. Both women and men report fewer sexual partners, and some report no partners, due to biological and social factors related to aging. Carpenter, Nathanson, and Kim (2006) found that the prevalence of sexual activity declined with age: 73% among respondents who were 57 to 64 years of age were having sex, a slightly less percentage (53%) among respondents who were 65 to 74 years of age, and 26% among respondents who were 75 to 85 years of age (Carpenter et al., 2006; Lindau et al., 2007). Not all of this is due to waning desire; rather, physical ability and the ability to locate a suitable location for sexual activity were found to be limiting factors (Carpenter et al., 2006; Levy, 1994). In addition, cultural norms equating sexual expression with youth may make middle-aged and older people ashamed of their sexual desires. This may discourage people from acting on sexual desires when they exist (Burnside, 1975, cited in Levy, 1994; Luria & Meade, 1984). Moreover, women may internalize the belief that they are physically attractive only in their youth (Calasanti & Slevin, 2001; Dinnerstein & Weitz, 1994; Gibson, 1993; Luria & Meade, 1984). This may result in self-limiting of sexual activity even when desire is present (Carpenter et al., 2006; Starr & Weiner, 1981). Many people believe that older persons reduce their sexual activity because they no longer have a libido (Kennedy, Martínez, & Garo, 2010); however, the main predictor of sexual activity in older age is a

person's pattern of sexual activity in their early life (Kennedy et al., 2010). Seventy percent of older adults with regular partners reported having sex at least once or twice a month (Jacoby, 1999). Many older adults remain sexually active into their 80s (Addis et al., 2006; Lindau et al., 2007; Schick et al., 2010). Further, a substantial number of men and women engage in vaginal intercourse, oral sex, and masturbation even in the eighth and ninth decades of life (Addis et al., 2006; Lindau et al., 2007; Schick et al., 2010). Older adult couples did engage less often in sexual intercourse, self-stimulation, and oral sex than middle-aged adults did; however, more than 30% of those over age 70 reported having intercourse at least once a week (Zeiss & Kasl-Godleym, 2001). A smaller study by Ginsberg, Pomerantz, and Kramer-Feeley (2005) has also expanded knowledge of sexual behavior by focusing on lower-income older adults living in subsidized housing. The majority of this sample who lived alone reported that they had wanted to engage in more sexual activity over the past year. For those living with a partner, approximately 60% reported engaging in touching or holding hands, embracing or hugging, and kissing on a daily basis. In addition, 50% reported having engaged at least once in the past year in mutual stroking, and approximately 40% reported having engaged in intercourse. The study found that the most important barrier to having more sexual experiences was lack of a partner (Zeiss & Kasl-Godleym, 2001). Like their younger counterparts, many older people have multiple sex partners (Foster, Clark, Holstad, & Burgess, 2012; Lindau et al., 2007; Schick et al., 2010).

Clearly, a large number of older adults report sexual activity and interest. AARP's survey indicated that a majority of respondents over the age of 70 felt that sex was important to their quality of life and disagreed with the notion that sex was only for young people (Skultety, 2007). Given these factors, and that the baby boom generation is currently entering older age, it seems likely that the notion of older adult sexuality will become normalized as physical barriers are reduced and social barriers decline.

OLDER WOMEN ARE NOT INTERESTED IN SEX

In large population studies, women have consistently been found less likely than men to report sexual activity at all ages, including as older women (Jacoby, 1999; Lindau et al., 2007). Of men and women with an intimate partner, men report being more sexually active than women. Women were more likely than men to report lack of interest as a reason for sexual inactivity (Lindau et al., 2007). Women also report that sex is less important to their life satisfaction than do men on both national and international surveys (Jacoby, 1999; Laumann et al., 2006; Lindau et al., 2007). Carpenter et al. (2006) assert, however, that although frequency may decline somewhat, sexual desire remains fairly stable throughout adulthood. Although

women tend to report that sex is less important to them than do men, this does not indicate that women tend to find sex unimportant. Sexual interest remained moderate to high for the majority of women and men in their 70s: 54% of men and 21% of women ages 70 to 80 reported having had sexual intercourse within the past year, and one quarter reported having had intercourse more than once per week (DeLamater & Sill, 2005; J. Hillman, 2008). Further, 9% of women in their 40s and 50s indicated they would be "quite happy" not to have sex again. At age 75, 35% of women indicated that this was true for them (Jacoby, 1999; Loe, 2004). While this suggests that desire may wane for some women, it also suggests that a predominant number of women retain sexual desire well into old age. Some authors have questioned the stability of these findings, noting that many studies do not tap into differing variations of sexuality in older adults. These authors argue that activity may vary greatly over the course of an older person's lifetime, by cohort, marital status, and a variety of other factors (Levy, 1994; Zeiss & Kasl-Godleym, 2001). Culture may play a major role in the responses of women to questions regarding their sexuality. It is common to assert that the demands of work and family may diminish time, energy, and desire for sex (Carpenter et al., 2006; Levy, 1994). Cultural norms tend to associate sexuality and youth (Carpenter, 1998; Carpenter et al., 2006; Emmers-Sommer & Allen, 2005). Conversely, traditional roles for older people have not included sexuality, which may be viewed as perverse or pathological (Butler, 1988; Levy, 1994; Simon & Gagnon, 1999). This may manifest as shame or as diminished desire (Carpenter et al., 2006; Levy, 1994). Women may be particularly vulnerable to such societal attitudes, due to associations related to sexual desirability and youth (Carpenter et al., 2006; Levy, 1994). It is important to consider that some women may actually have more time and energy for sexual and other activity once they are not occupied with career and family obligations. Moreover, retirement itself may give women as well as men time and access to partners that was not available to them during their childbearing years. While it is unclear whether and how societal norms may affect desire, such norms may affect how older women talk about sex—even to researchers. Levy (1994) observed that virtually all research on the sexuality of older people is based on self-reports. This is problematic in an area where there is a clear gender and generational bias against appearing promiscuous or even sexual. An older woman who represents herself as sexual may feel vulnerable to ridicule, embarrassment, and shame (Herron & Herron, 1999). It is important to separate general trends from individual behavior. Older women are extremely diverse in their attitudes and behavior, and there is evidence that for at least some women more liberal societal attitudes toward sex in combination with freedom from reproductive concerns may lead to increased sexual activity (Herron & Herron, 1999; Loe, 2004; Zeiss & Kasl-Godleym, 2001). Cohort effects may also be important. It is common to suggest that the baby boom generation was socialized to

more open attitudes about sex and sexuality than earlier generations (Loe, 2004). Adults who lived in the 1960s during the era of the sexual revolution, the social movement that challenged traditional behaviors related to sexuality (Allyn, 2000), are old enough to qualify for AARP membership. Women born in the 1940s came to sexual maturity at the same time birth control pills became widely available. It is reasonable to expect that they will retain more liberal attitudes toward sex and sexuality than women born earlier. A number of authors have suggested that older adults of this generation may participate in the same risky sexual behaviors that were acceptable during the sexual revolution (Adekeye, Heiman, Onyeabor, & Hyacinth, 2012). Whether related to cohort or other effects, Loe found that some of the women in her study were consistently the initiators in their sexual relationships. Moreover, there are an increasing number of older women who have been unattached and dating due to divorce and other factors. It is likely they will expect to continue dating, and they will continue having sexual relationships, including multiple partners as they age (Emmers-Sommer & Allen, 2005; Simon & Gagnon, 1999). The cultural belief that age diminishes sexual attractiveness applies earlier and with greater force to women than to men, such that older women are perceived as less attractive sexual partners than similarly aged men. Although ageism reduces women and men's sexual prospects, women's are further restricted by sexism (Carpenter et al., 2006). In spite of that, Winn and Newton (1982) found that many women continued sexual activity into old age, often through sexual activity with younger men. Some authors have speculated that this may be due to the unavailability of older partners and the strength of older women's sexual drives (Zeiss & Kasl-Godleym, 2001).

OLDER WOMEN HAVE PHYSICAL AND HEALTH BARRIERS THAT PREVENT SEX

About half of both men and women report having experienced a physical problem during sex. Due to advertising and the popular press, male erectile dysfunction problems are by far the most familiar to most people (Kingsberg, 2002; Lindau et al., 2007; Loe, 2004). However, women have also expressed sexual difficulties. The most prevalent include low desire, difficulty with vaginal lubrication, and inability to climax (Lindau et al., 2007; Zeiss & Kasl-Godleym, 2001). Through the aging process, there is a tendency for natural vaginal lubrication to decrease (Brooks et al., 2012; Sherman, Stevens, Jones, Horsfield, & Stevens, 2005; Whipple & Scura, 1996). This may partially account for another common complaint of older women, painful intercourse (Zeiss & Kasl-Godleym, 2001). These physical conditions, once known to health professionals, are relatively easily treated with over-the-counter products (J. Hillman, 2008). The etiology of diminished interest is less clear. It is possible there is a relationship to

biological causes related to postmenopausal hormone changes, but evidence of this is inconsistent. As previously noted, many women find increased enjoyment in sex postmenopause (J. Hillman, 2008; Loe, 2004). Decrease in sexual interest could be related to lifestyle changes or an internalization of the societal norm that they *should not* be interested in sex (Butler, 1988; J. Hillman, 2008; Levy, 1994; Simon & Gagnon, 1999). Winterich (2003) asserts that we simply do not yet know whether changes related to menopause are an important determinant of sex in older women. She found in a series of interviews with postmenopausal women that other factors, such as status, quality of relationship, sexual history, health, and other social factors were more important determinants.

For heterosexual women, the partner's health and ability may be as important as her own. In Jennifer Hillman's (2008) study, the most commonly reported reason for sexual inactivity was the male partner's physical health. This is consistent with the National Health and Social Life Survey, which found that while the prevalence of sexual dysfunction is higher in young and middle-aged women than in men, prevalence actually decreases in women as they age (Laumann, Paik, & Rosen, 1999). This prompted Kingsberg (2002) to observe that health problems and lack of a partner probably account for most of the abstinence among older adults. Other authors suggest that perceived sexual desirability and value, perceptions that it is unacceptable to have a new relationship after the death of a spouse or divorce, or the attitude that it is abnormal to be interested in sexual activity may also be important factors (J. M. Campbell &Huff, 1995; Zeiss & Kasl-Godleym, 2001). It is notable that none of these factors is biological or inevitable.

IF OLDER WOMEN HAVE SEX, IT IS WITH THEIR HUSBANDS

While it is common for attitudes to be inconsistent with behavior, there are few areas of behavior where this is truer than in relation to marital infidelity. As many as 97% of Americans consider marital infidelity to be unacceptable behavior (K. Campbell & Wright, 2010). Reports from the General Social Survey suggested that 23% of men and 12% of women have engaged in extramarital sex (Wiederman, 1997). There is also evidence that such reports are increasing. Recent estimates suggested that between 20% and 40% of couples experience infidelity, and as many as 25% of women report extramarital sexual activity (K. Campbell & Wright, 2010; Whisman & Snyder, 2007). While these rates are high, there is reason to suspect they are conservative (Blow & Hartnett, 2005; Glass & Wright, 1992; Whisman & Snyder, 2007). Reports in the popular press as well as some peer-reviewed publications suggested that rates could be as high as 60% for men and 50% women (Buss & Shackelford, 1997). This would be roughly consistent with the national divorce rate (K. Campbell & Wright, 2010). It is likely that most of the people who asked to

respond to questions about their marital infidelity disapprove of that behavior. This alone suggests that some of the variation between self-reports may relate to socially desirable response bias.

Undercounts of women's extramarital activity may be particularly likely (Glass & Wright, 1992). Most studies of infidelity do not include older married women. However, middle-aged women tend to report lower levels of extramarital sexual activity than their male and younger female counterparts. The same stigma and potential for bias that may affect the reports of younger women could affect the reports by older women even more profoundly. Thus, understanding of older women's extramarital sexual activity is based largely on self-reports, extrapolation, and anecdote.

OLDER WIDOWED, DIVORCED, AND SINGLE WOMEN ARE NOT SEXUALLY ACTIVE

Middle-aged heterosexual women, whatever their marital status, are less likely than their male counterparts to be sexually active, and when they are sexually active they have fewer partners. However, postmenopausal women who were asked about why they ceased sexual activity indicated that relationship factors, poor health, past abuse, or the absence of a partner were more often than reason than physical factors (Carpenter et al., 2006). Correspondingly, heterosexual women's options for sexual partners diminish more with age than do men's, due to higher mortality among men, social norms pairing men with younger women, and higher rates of remarriage among divorced and widowed men (Carpenter et al., 2006).

It is notable that most studies examining sexual activity in middle-aged and older adults focused on *married* people. Yet substantial (and increasing) numbers of women and men in these age groups are not married, nor are they cohabiting (Cooney & Dunne, 2001). By focusing on married and cohabiting sexuality, researchers not only fail to discover how the sex lives of sexually active middle-aged and older "singles" may differ from their "partnered" counterparts but also fail to consider the factors that determine sexual partnering in the first place. Some barriers for older women are likely to be related to internalized stereotypes. Older unattached women may be less likely than their male counterparts to have sex outside of marriage or with "casual" partners due to societal norms. Women who feel they are growing less attractive with age may not offer themselves as partners (Carpenter et al., 2006).

OLDER MARRIED WOMEN DON'T HAVE MULTIPLE PARTNERS

Although there is little empirical research on monogamy after age 50, there are indications that some older women do engage in sex with multiple

partners. Greeley (1994) reported that the prevalence rate of infidelity among women under 50 was about 15%, and about 5% for women over age 50 in the General Social Survey (GSS) of 1991. Weiderman (1997) using GSS data from 1994 reported marital infidelity for women was highest between ages 40 and 49 at 19%, dropping to 11% from ages 50–59, and 7.6% by ages 60–69. These studies do not indicate whether the greater fidelity reported by older women was related to generation or age. However, it is interesting to note that the age cohort that reported the highest infidelity would be 60 or more in age now. Although the National Survey of Family Growth (NSFG) does not include older women in its sample, in 2002 a total of 8.5% of women surveyed indicated that they had concurrent male sexual partners within the past year (Adimora et al., 2011) and 11% indicated having had multiple partners in the past year. This was almost double the amount who indicated having multiple partners in the NSFG in 1995 (Whisman & Snyder, 2007). This suggests that over time the number of women who report multiple partners may be increasing.

As with most data on sexuality in older women, what data exist are based on self-report. Most authors note that socially desirable response bias could be a factor in responses. How questions are asked may also be a factor. Whisman and Snyder (2007) indicate that responses on the NSFG varied by 5 percentage points, depending on whether the question was asked in face-to-face interviews or computer-assisted self-interviews, with the later producing more self-report of multiple partners, supporting the notion that social desirability of responses plays a role in self-reports. The stigma associated with sexuality is higher for older women, which may also be a factor in responses on studies that included older women. It is possible to speculate that due to decreased sex drive, lack of available partners, physical issues, or other reasons, older women may engage in less extramarital sex than they did as younger women.

Conversely, it is also possible to speculate that older women whose children have left home, who have more time due to retirement, or who have more access to partners due to changes in living arrangements (e.g., moving to a senior living community), may actually have more opportunities for extramarital sex than they did as younger women. Unfortunately, the literature currently offers little guidance as to what may actually be contributing to extramarital sex, or the lack thereof, in older women. What is clearer is that the idea that it is principally older men who are sexually active with multiple partners stigmatizes men as promiscuous and women as passive.

Older male Viagra users are seen as the disease carriers and are thus blamed for rendering senior communities at risk when STIs appear (Loe, 2004). Men are more likely than women to report having partners outside monogamous relationships. Nevertheless, *most* sexually active men report that their relationships are monogamous (Carpenter et al., 2006).

IF YOU ARE NOT AT RISK OF PREGNANCY, YOU ARE NOT AT RISK

Many older women do not perceive themselves to be at risk for HIV/AIDS (Henderson et al., 2004; Lindau et al., 2007; Schick et al., 2010). For example, women who are postmenopausal and who no longer require birth control to prevent pregnancy may not believe they need condoms (Kirk & Goetz, 2009; Lindau, Leitsch, Lundberg, & Jerome, 2006; Williams & Donnelly, 2002). In fact, despite sexual activity and risk for HIV infection, few older adults use condoms to protect themselves from infection during sexual intercourse (Emlet & Farkas, 2001; Onen, Shacham, Stamm, & Overton, 2010; Schick et al., 2010). These beliefs appear to translate into risky sexual behavior. According to the 2008 National Survey of Sexual Health and Behavior, persons aged 50 years or older did not use condoms during their most recent sexual intercourse with 91.5% of casual partners, 76% of friends, 69.6% of new acquaintances, and 33.3% of transactional sexual partners (Schick et al., 2010). The lack of knowledge about risk and a bias against condom use may be based on ageist stereotypes (Kingsberg, 2002). In fact, sexual transmission of HIV is at least 2 to 4 times more efficient in women than in men (Türmen, 2003). Among postmenopausal women, vaginal tissue tends to become dryer and more prone to tearing, increasing risk of viral transmission (Mack & Bland, 1999; Savasta, 2004). Due to age-related weakening of the immune system, and the emergence of other chronic health conditions with age, HIV tends to progress and convert more rapidly to AIDS in seniors (Coleman, 2003; Emlet & Farkas, 2002; Nokes et al., 2000; Strombeck & Levy, 1998). Clinicians often do not expect HIV/AIDS in older women, so symptoms can be ignored, misdiagnosed, or diagnosed late (Emlet & Farkas, 2001, 2002; J. L. Hillman, 2000; Wooten-Bielski, 1999). Older male partners may contribute to the problem, since condom use may make it harder to maintain an erection. Erectile dysfunction drugs may increase the frequency of unprotected sex, and thus increase risk since older people tend not to see themselves at risk of pregnancy or HIV/STIs (Falvo & Norman, 2004; Henderson, et al., 2004; Rogers-Farmer, 1999; Savasta, 2004; Theall, Elifson, Sterk, & Klein, 2003; Topolski et al., 2002).

OLDER PEOPLE ARE NOT GAY OR LESBIAN

Although some estimates are higher, the CDC reports that gay, bisexual, and other men who have sex with men (MSM) make up about 2% of the population (CDC, 2012). Gallup reports that 3.4% of U.S. adults self-identify as LGBT. They report rates that are as low as 1.9% for people ages 65 and older, and 2.6% for people ages 50–64. However, they acknowledge that these rates may be affected by a greater reluctance of older people to self-identify as LGBT (Gates & Newport, 2012). There is also some evidence to

suggest that older gay and lesbian people express their sexuality less often (Doress-Worters & Siegal, 1994). What is clear, however, is that there are people at every adult age who identify as gay and lesbian. The most prevalent transmission route for HIV is men who have sex with men. This holds true at all adult ages (CDC, 2010b). However, stigma about MSM is more prevalent among older people, which may lead to nondisclosure of risk behaviors. Men who conceal their sexual behavior with men from their current female sexual partner have reported higher rates of sexual risk behaviors with their male and female partners (CDC, 2003; Kalichman, Roffman, Piccianao, & Bolan, 1998; Siegel, Schrimshaw, Lekas, & Parsons, 2008).

OLDER WOMEN DO NOT NEED TO KNOW MUCH ABOUT HIV/AIDS

Many older people have dated or incomplete understanding of how HIV/AIDS is transmitted and generally do not know their own HIV status (Topolski et al., 2002). Knowledge relevant to older women (e.g., their sexuality, risk behaviors, appropriate HIV prevention strategies, and the interventions that facilitate them effectively) is severely lacking (Chiao, Ries, & Sande, 1999; Foster et al., 2012; Kingsberg, 2002; Strombeck & Levy, 1998). Moreover, the risk factors for persons aged 50 years and older have changed since the outbreak of the epidemic in the 1980s. Prior to screening the blood supply for HIV/AIDS, blood transfusion was the primary mode of transmission for this age group (Ammann et al., 1983; Curran et al., 1984; Peterman et al., 1985). However, the most prevalent routes of transmission for women over age 50 is now heterosexual contact (49%) or "unknown" (42%; CDC, 2004). Lindau et al. (2007) found that women were reluctant to talk about sexual problems, and that negative societal attitudes about women's sexuality may discourage discussion. Emlet and Farkas (2001) found that most sexually active seniors engaged in behaviors that put them at risk. Educational outreach to older adults about sexual risk is uncommon (Beaulaurier et al., 2009). The combination of factors suggests that more targeted efforts need to be made to educate older women about HIV/AIDS and other STIs.

CONCLUSION

Sexual activity is complex at every age, including old age. The literature suggests that many older women are interested and actively engaged in sexual activity. As societal attitudes change and baby boomers enter older age, it is likely that both sexual interest and activity will continue to increase. Older people are likely to carry with them the stereotypes of their generation

as well as those of the society at large. This may depress sexual activity in the overall population of older women. However, all studies of sexuality and older women have indicated that there is a large number of older women who remain interested and engaged in sexual activity. The literature more compellingly makes the case that stereotypes inhibit discussion about sexual activity, may inhibit some expression of sexuality, and contribute to a lack of knowledge about risky sexual behavior on the part of older women. This is particularly important in light of what Poindexter and Keigher (2004) have called the "graying" of HIV. In fact, older women are increasingly at higher risk of HIV and AIDS, due to biological risk factors and risky sexual behaviors in combination with the growing number of HIV-positive people in their age group.

Stereotypes hinder older women's access and engagement in HIV prevention, education, and treatment. Health and social service providers need to engage their clients in educational outreach activities that focus on HIV prevention that encourage open conversations about HIV risk behaviors. To develop targeted educational outreach activities, there is a need for research that investigates the sexuality and sexual risk of older women in more depth. Current studies have taken a major positive step by identifying interest and self-reported sexual activity. However, there is very little information on how, when, and where older people engage in these activities or on how to intervene effectively to help them develop safer sexual practices.

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