Midlife safer sex challenges for heterosexual New Zealand women re-partnering or in casual relationships

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ABSTRACT

INTRODUCTION: The rate of sexually transmitted infections (STIs) amongst midlife and older heterosexual women in New Zealand is rising. Popular culture celebrates a heightened sexuality for this population group. However, depictions of sexually savvy 'cougars' are at odds with reality for many women. International literature highlights that these women are often ill-equipped to negotiate safer sex and condom use, instead focusing on pleasing men and attributing their silence to spontaneity. The study aimed to explore barriers to safer heterosexual sex as perceived by midlife and older New Zealand women who are re-partnering or in casual relationships.

METHODS: This qualitative study utilised Interpretive Phenomenology Analysis, supported by the theory of gender and power, to examine the gender-normative assumptions and behaviours in women's accounts of unprotected sex. Eight single women aged 40–69 participated in individual, in-depth interviews. This exploration included eliciting women's accounts of potential information resources, such as clinical consultations.

FINDINGS: Analysis indicated that these women held misconceptions about STI transmission but had not sought educational material, nor discussed their sexual health with health professionals. Results highlighted women's ambivalence about prioritising safer sex, preferring to comply with partners' wishes, particularly when under the influence of alcohol. Women described valuing their own pleasure and their distaste for condom use, but data emphasised that women predominantly aligned their choices with men's preferences.

CONCLUSION: This study highlights that the women were both ill-informed and vulnerable with regards to sexual health. General practitioners are well placed to provide education and sexual health advice.

KEYWORDS: Condoms; heterosexual; middle aged; sexual behaviour; sexual health; women

Introduction

New Zealand's rising rates of sexually transmitted infections (STIs) among middle-aged people, particularly women, is concerning, yet this population receives little health promotional attention. Literature indicates that the majority of health professionals do not broach safer sex conversations with midlife and older women, even when women present general practitioners (GPs) with ready opportunities, such as requesting a cervical smear or contraception.[1–3] Although international and national research emphasises sexual health in under 25s, New Zealand statistics show a steady rise in STIs in older age groups.[4,5] In New Zealand, between 2001 and 2010, the proportion of people over 40 contracting an STI rose from 7.4% to 9.5%.[4,5] The Sexual Health Surveillance Report 2010 indicates that in New Zealand in 2010 the greatest burden for syphilis was in the over 39 years age group and 45 years was the average age for HIV contraction.[5]

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Local data reflect trends in developed countries. Rising rates of STIs among middle-aged and older people are documented in Britain,[6] Canada[7] and Australia.[8] Nahmias and Nahmias, in their international review of the determinants of STIs,[9] suggest certain behaviours that are more prominent in younger people increase young people's risk of STI contraction: an increased number of non-monogamous sexual partners, accessing wider social and sexual networks, and sexual behaviour that is influenced by alcohol or substance use. Current literature indicates that such behaviours are now occurring in older people.

Pertinent to this research, New Zealand sexual health surveillance reports demonstrate increasing rates of STIs among women, relative to men. In 2001, women comprised 45.5% of people who contracted one STI, rising to 47.7% by 2010.[4,5]

Over recent decades, contemporary Western societies have seen a major cultural reframing of midlife for women. Popular culture normalises, even celebrates, sexual desire for older women, in a manner unseen in previous generations. Divorce and widowhood mean there are more single people looking for relationships. The range of internet social networking sites provide easy access to multiple potential partners.[10–12] The sexual revolution of the 1960s and '70s brought about changes in attitudes to sexuality, making casual forms of sexuality more socially acceptable for those whose youth was in that era.[10,13,14] Older people, however, are less likely to use barrier protection when engaging in sexual activity.[13,15,16] Literature reviewed highlights three factors influencing older women's decisions: reduced perception of risk, difficulties negotiating safer sex behaviours, and choosing to not take measures to reduce risk.

Priorities within New Zealand health settings may add to reduced risk awareness among older women. Sexual health promotion activities do not target this group. Limited GP-initiated discussion around safer sex issues also impacts on women's STI risk awareness. A New Zealand study identified that safer sex discussion was not initiated by GPs, even when women had an STI diagnosis; the onus of raising the topic fell to patients.[1] Factors in GP reticence to discuss this issue include not wanting to cause embarrassment[2] or offence,[3] time constraints,[3] or presumptions that women are already informed.[17]

Women's awareness of STIs does not correspond with insistence on condom use. Perceived gender roles may make it difficult for women to negotiate safer sex behaviours. A recent New Zealand study[1] highlighted persistent difficulties for women in raising the topic of condom use because of their association with casual sex and promiscuity. Assertiveness through requesting condom use is believed by some women and men to be inappropriate feminine behaviour.[1,16,18] Power imbalances in relationships also present barriers for some women to negotiating safer sex behaviours. Gavey et al.[18] argue that health education messages within New Zealand aimed at persuading women to be assertive about condom use ignore the complex interactions existing within sexual relationships that constrain women from unilaterally deciding male partners will use condoms.

Concern about women as sexual victims means less research has focused on women's pleasure-motivated preference for unprotected sex. Beliefs about romance or commitment are disrupted when sexual histories are discussed and women may choose not to ask their male partner(s) to use barrier methods in order to 'keep the magic'[19] of a new relationship. Some women prefer that their partners do not use condoms because they perceive that condoms impair pleasure. Such negative perceptions relate to loss of spontaneity,[18] interruptions to the sexual encounter,[20] and a loss of arousal.[21,22]

Societal factors within New Zealand also influence safer sex decision-making. Research highlights a generalised tolerance of excessive alcohol use.[23] Alcohol consumption is associated with less-safe sexual activity.[22,24,25] Burgeoning media representations of carefree sexuality for midlife and older women[26] neglect sexual health realities. The purpose of this paper is to contribute to knowledge about barriers to safer sex behaviours for midlife women living in New Zealand.

Methods

This study utilised Interpretive Phenomenology Analysis (IPA),[27] a qualitative approach exploring individuals' perceptions of situations. IPA uses semi-structured interviews with a small, relatively homogeneous group and an idiographic, iterative process of analysis.

Given the significance of gender roles and related power imbalances, analysis was informed by Connell's theory of gender and power (TGP).[28] This theory posits that gender-power imbalances create gender norms for 'appropriate' feminine behaviour and position women subordinately to men.

Ethical approval for the study was obtained from the Massey University Human Ethics Committee, and included consultation with Māori.

Participants

Recruitment processes involved purposive sampling and snowballing. The latter approach is useful for recruiting participants for 'sensitive' research interviews.[29] Women were recruited through local media advertising and via local women's groups. Inclusion criteria for participants were as follows: heterosexual women over 40 years of age; in relationships of less than three months, or in casual relationships. These criteria encompassed extramarital and non-monogamous relationships, 'one night stands', and variations of 'swinging' (group sexual encounters). Eight women (aged 40–69 years) participated, a number in keeping with IPA methodology. The women were residing in a semi-rural region close to a main city in New Zealand's North Island. This region was selected for feasibility purposes for a small, in-depth study. As is common with research involving sensitive topics, where recruitment of ethnic minorities is challenging,[29] all the women identified as New Zealand Europeans. Small sample sizes are typical of the IPA model and of in-depth interviewing about sensitive topics. A small feasibility study nevertheless provides ample rich data from which to make recommendations for future research.

WHAT GAP THIS FILLS

What we already know: Societal changes have led to more liberal attitudes to sexuality amongst midlife and older women. Heavy alcohol use is normalised in New Zealand and associated disinhibition contributes to women's decisions to forgo negotiating condom use.

What this study adds: The study identifies situations where midlife and older women are more vulnerable to risk behaviour for sexually transmitted infections, such as the period subsequent to a separation or when in the context of a perceived romantic love relationship. The women in this study did not know how to raise the topic of sexual health with general practitioners and would like them to initiate discussion of sexual health opportunistically.

Data collection and interview design

Data were collected using face-to-face, semi-structured interviews. Open-ended questions addressed participants' relationship histories, views and experiences of safer sex behaviours, and experiences of negotiating condom use in current or recent relationships. Interviews were audio-recorded, transcribed verbatim and verified for authenticity by each participant.

Data analysis

Analysis involved the following iterative process: one researcher elicited points that were coded and clustered into themes; a second researcher undertook a procedure of confirmation or amendment. Transcripts were analysed consecutively and, where new themes were identified, earlier transcripts were reviewed for these themes. Guided by the TGP, particular attention was given to women's accounts of power dynamics impacting on the negotiation of safer sex behaviours.

Findings

Results indicate that midlife women's sexual health risk is not targeted by health promotion activity or by GP-initiated discussions. Themes also highlight women's ambivalence about prioritising safer sex; it was perceived to be more 'risky' not to comply with partners' wishes than to protect health. Although women described the significance of their own pleasure and

distaste at condom use, data highlighted women predominantly aligned their choices with men's preferences.

Theme one: silent GPs

All participants reported a lack of discussion initiated by health professionals around safer sex issues, even when there were clinical reasons to do so. One woman in her mid-40s presented her GP with an opportunity to begin safer sex discussions when she requested hormonal contraceptive implants for the first time.

> When you went to see a health professional about the implant did they ever talk to you about STIs? (Researcher)

> No not at that stage they didn't... They [the medical practice] gave me a pamphlet on how it [the implant] worked but that was it really. (#5, 49 years)

Five of the women asserted it would be easier to raise concerns about safer sex at a sexual health clinic rather than with their own GPs. No participants recalled seeing sexual health promotion material designed for people in midlife or older.

Theme two: health belief versus health behaviour

Participants believed women in general should be more concerned about STIs, but this belief was not reflected in accounts of their experiences. All participants acknowledged engaging in unprotected sexual activity in new or casual relationships. One woman's response, when asked if new or casual partners always used condoms, indicated inconsistent use:

> Yeah, maybe I slipped once or twice and then I 'got caught' [contracted an STI] again. (#3, 47 years)

Participants appeared to have an accurate intellectual assessment of risk but considered that particular circumstances put them outside this 'high risk' group. For example, one woman who had unprotected casual sex with several men believed that she was not at risk of an STI because she didn't 'sleep with that sort of a man' (#7, 65 years). Assumptions persist that sexual risk is linked to personality type and women believe they can judge risk.

Theme three: alcohol and sexual health

Participants attributed unsafe sex to alcohol intoxication. Seven women asserted that alcohol was a causal factor in their unsafe sexual activity.

> So what was the difference between the ones you used condoms with and the ones you didn't? (Researcher)

> Depending how... [drunk] I was and that was the [key] thing. (#4, 47 years)

> Well it's more about being in a state of inebriation and crossing a line where you don't care. (#8, 69 years)

Of note, the majority of women were ambivalent about alcohol consumption. Alcohol acted as a 'social lubricant', easing re-entry into dating. Participants' accounts indicated that they normalised the link between intoxication and unsafe sexual practices.

Theme four: barriers to use of barrier methods

All women had, even when sober, accepted a risk in preference to using a condom. Six women spoke of condom characteristics as reasons for preferring unprotected sex: the smell, taste or feel of condoms, or a dislike of lubricants and spermicides. Participants also suggested that protected sex is less pleasurable. They considered that condoms interrupted the 'flow', reducing sensation and pleasure.

> I think what you do is spoil the flow or the rhythm and all of a sudden you have this clinical aspect coming into it. (#7, 65 years)

There was a consensus amongst participants that interrupting the perceived flow of the activity was particularly difficult with first sexual encounters with new partners:

> Hell yes, it would be revolting to have to have that conversation with someone in that moment... it would be dreadful. (#6, 55 years)

The above quote highlights the gulf between concepts of sexual pleasure and sexual health. As well as having reservations about the physical and aesthetic challenges of condom use, sexual health talk was anathema to assumptions about idealised, spontaneous sex.

Theme five: 'rose-tinted lenses'

Participants' accounts indicate that notions of romance reduce the likelihood of condom use. Romantic love refers to situations where women wanted a long-term, monogamous relationship. This aspiration was not necessarily reciprocated and women appeared to avoid clarifying conversations. Romance impacted on women's perception of risk and reduced condom use. Several women described unprotected sex with men they believed to be monogamous but later learned were not.

> I had no reason to think it wasn't [a monogamous relationship]... even when the signs are there, you don't want to believe them. (#2, 45 years)

Romantic love also increased the women's desire for more intimate sexual connection and more enjoyable sex for her male partner, which was believed to be more likely without condoms

> If you care for someone you want them to enjoy it. (#6, 55 years)

In the context of romance, three women gave examples of situations where they believed condoms should have been used but were not, because they did not want to create tension in the relationship. By implication, requesting condom use was not considered normal.

Theme six: separation and vulnerability

Five women discussed a period of heightened sexual activity following the break-up of their long-term (marriage or de facto) relationship; during this time sexual health was a low priority. Comments below suggest that increased numbers of sexual partners were a grief reaction, not expressions of new-found sexual freedom.

> In the last three years there has been not much emotion involved. It's just purely for the sex. There were just no feelings... I was just a bit hurt after my separation and I just went nuts to start off with. (#3, 47 years)

> I have been talking to my friends... I think we go a bit wild because we are sort of looking for a bit of fun because we got hurt.... It's like we are grieving or something. (#4, 47 years)

Three women suggested that the desire to re-partner placed them in a position of increased vulnerability to STI risk behaviour.

> So I was always [following the break up] not in a good space, in a sexual, emotional, well not emotional, well you know, oh who needs [man A] now that I have [man B]..... Even though [man B] turned out to be an... [had many partners]. (#1, 42 years)

In women's accounts, emotional vulnerability and desire to re-partner reduced their confidence in discussing safer sex—for the most part this topic was 'off-limits'.

Theme seven: empowered talk versus action

Contextual or relational factors impact on the women's ability to negotiate safer sex behaviours. Seven women believed that they and other women in their midlife or older years would not find the negotiation of safer sex difficult. However, five women contradicted this assertion later in their interviews.

> We are getting on with it and then I suddenly thought, oh no, and I said, 'stop', and he didn't and we carried on. (#2, 45 years)

> This guy last night... I did say it [suggested condom use]...I did suggest it but he just ignored me. (#5, 49)

One woman asserted that gender role perceptions might make it difficult for some women to negotiate safer sex behaviours.

> Well it depends on the women... if she was a forthcoming strong woman. But there are women out there that are very meek and mild... They enjoy sex but, well we are still quite Victorian in some

> areas... We expect the males to carry the condom. (#8, 69 years)

Women, in their accounts of partner non-compliance with requests for condom use, did not indicate that there was anything particularly problematic about being disregarded in this way; as if it were to be expected.

Theme eight: midlife context

Five women believed the era they grew up in impacted on the importance placed on STI prevention. Typical comments included the following statements:

> I think it is a generation thing as well. It wasn't rammed home quite as much as it is now... I guess in our younger days we were more worried about getting pregnant and not STIs. (#5, 49 years)

Seven women reported that they, and men they had sexual encounters with, had been in long-term relationships where neither had been concerned about STIs. Ongoing or permanent contraception meant they had not considered using condoms:

> When you have been married for so long, it's not something you think about. Then you are out in the crowd, it's not something you necessarily have in the back of your mind. (#1, 42 years)

> They think 'I've been with my wife', they were quite gob-smacked I brought it up. (#2, 45 years)

Data repeatedly highlighted the apparent naivety of midlife and older women in relation to sexual health and the absence of life experience in discussing sexuality and sexual health, despite being sexually active. Of note, none of the women mentioned HIV or AIDS.

Discussion

The purpose of the study was to develop a greater understanding of barriers to safer sex for midlife women. Consistent with literature reviewed, barriers to condom use related to the following: limited risk awareness; difficulties in negotiating; and blurring between partner pressure and personal preferences.

For participants, reduced perception of risk may have been fostered by sexual health promotion activities that are predominantly focused on youth, combined with a lack of GP-initiated sexual health discussion. Women had inaccurate beliefs that they were not alerted to risks because risks were insignificant. Participants held erroneous beliefs that negated how STI risk pertained to them and rationalised their unsafe sexual behaviour with men they perceived to be of low STI risk. Findings reflect other studies' results that older women hold misconceptions about STI transmission and are interested in GPs discussing sexual health issues.[30,31]

'Silent GPs' was an important theme across the transcripts. Women believed they would welcome safer sex discussions if raised during sexual health–related consultations, with the GPs' focus on educating women about STI realities in older age-groups. The authors recommend further research to examine GP reticence in alerting older women to STI risk. The 'Update Me' pamphlet[32] published by New Zealand Family Planning is a resource that may be useful in the general practice setting.

Participants considered that age-related contextual factors lead to reduced concern about STIs for those over 40. People who experienced youth prior to the advent of HIV/AIDS were alert to pregnancy, not STIs, as the 'danger.' Lengthy monogamous relationships render women naive to sexual risk.

Risk perception is skewed in the context of perceived romantic love. Idealisation and temporary suspension of rational judgment during the initial stages of romance is a well-documented phenomenon more commonly associated with adolescent relationships.[33] The findings from the current study, however, suggest that the 'rose-tinted glasses' appeared to be an important factor in risk perception for older women in new relationships.

Relational factors made it difficult for some of the women to initiate safer sex discussions.

These included perceptions of what is appropriate feminine behaviour within a relationship and gender power imbalances. This study supports Gavey and McPhillips'[34] assertion that gender role constructs exert a powerful influence just prior to a sexual encounter with someone new. To have a condom available and to suggest its use when sex is still uncertain may be perceived as presumptuous and unfeminine. Within relationships, the concern that requesting condom use will create tension presents a formidable barrier that has women deferring to men. Such concerns are particularly relevant within the context of romantic love. This contradicts a view held by the women that they or other women their age should be able to insist on condom use.

The women in the current study disliked condoms. They stated that certain physical characteristics of condoms, such as their taste, smell or texture restricted certain aspects of sexual foreplay, such as partner masturbation and oral sex. Rich[19] highlighted the loss of extemporaneity associated with condom use initiation as another factor in women choosing not to use condoms. Empowering women with methods to incorporate condom use into foreplay in a way that avoids loss of spontaneity or feminine identity is suggested.

Popular media emphasises recreational aspects of sexuality for older women, with little mention of safer sex behaviour. In the current study, participants considered that casual sexual encounters are common among newly separated midlife women. However, they rejected the notion that women, at this time, enjoy an uncomplicated, new-found sexual freedom. Participants identified that they were experiencing an emotionally difficult time and indicated that, in hindsight, sexual risk-taking had been unwise. This finding emphasises the importance of sexual health discussion if a GP becomes aware of an older female patient's change of relationship status.

Participants reported that sexual risk taking was more likely when intoxicated, but because alcohol eased casual partnering, women were ambivalent about the extent to which their drinking was hazardous. This finding has important implications for future general practice and public health promotion initiatives.

Limitations

This was a small study, from one geographical area of New Zealand, of women who identified as being of New Zealand European descent. The study of homogeneous populations is characteristic of IPA methodology but has implications for making future research recommendations. Participation was through self-selection and the sensitivity of the topic led to the involvement of women who were possibly more comfortable with sexual health discussion than older women in the general population.

Final comments

This study highlights the extent to which midlife heterosexual women may be both ill-informed and vulnerable in relation to sexual health. Earlier life experiences, including extended periods of monogamy and gender 'training' in femininity rendered women unskilled to act on behalf of their health. Of note, women minimised and 'smoothed over' the significance of experiences where men overrode requests for condom use. Findings indicated that although midlife women are stereotyped as 'cougars' on the hunt, this apparent sexual assertiveness may be alcohol-fuelled, not underpinned by self-confidence. Although women were interested in their own pleasure, pleasing men took precedence. Given these issues, it is concerning that none of these women had experienced health professionals initiating discussions about any sexual health topics, even when there were opportunities to do so. Although this finding concurs with international research and some small New Zealand studies, further research is needed locally to investigate GPs' reluctance to discuss sexual health with this population.

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COMPETING INTERESTS
None declared.