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Complexities of sexual health risk management in the 'older' population

Abstract

This paper explores how discourse surrounding sexual health risk can be complicated by 'matters' of fertility and impotence (participants' term).

'Vasectomy' and 'impotence' were unexpectedly prevalent themes when older (age forty-something) participants were interviewed about personal approaches to sexual health risk, in the late 1990s. (One group, four men and eight women, were parents of adolescents at time of interview - most in long term stable relationships/marriages; a second group, four men and five women, were 'dating').

Interwoven with 'known' discourses ('safe sex' as equating 'contraception', a hint of nineteen-sixties 'free love', the notion of sex as natural and spontaneous, …) these new themes illuminate, in surprising ways, some practical difficulties contributing to the low engagement with STI[3]/HIV risk prevention reported by participants.

Such difficulties and disincentives to condom use illustrate complexities of risk management which may contribute to increases in STI rates currently reported in the over-fifty population.

Introduction

This work in progress draws together some of the many strands contributing to 'less than safe' sex in the lives of twenty-one participants aged 'forty-something' interviewed in 1995 and 1997-8. The focus here is some surprising (or perhaps just generally unspoken) potential physical contributors to sexual health / infection risk, and the complex ways they inter-relate with more generally recognised concerns.

The research adopts discourse theory informed qualitative / interpretive approaches but, within that, is somewhat eclectic in the analytic techniques applied to the data (for justification see Kirkland, 2000).

The interpretations presented here are drawn from how people *recount* and *account for* their sexual relationships and (insofar as is possible to ascertain from these data) how they *conduct* their sexual behaviour. Sometimes the content speaks for itself but, where appropriate, it is related to a more interpretative analysis of participants' experiences or is linked to wider

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[3] Sexually transmitted infection (STI) is the currently favoured term in the UK replacing sexually transmitted disease (STD) which was current at the time of the interviews, so is retained elsewhere in this paper.

discourses.

In the course of the analysis, emerging themes tended to relate either to 'ways of talking', or at least thinking, about sex or to various aspects of the physicality of sex including not/using condoms. 'Ways of talking' focuses primarily on the 'discourse', and physicality on the 'material', of any 'material discourse' about safe(r) sex (see Yardley, 1997, Ingham and Kirkland, 1997). So, more specifically, a 'material discourse' theoretical position underpins the analyses presented here – especially as an awareness that our talk is *not* ultimately separable from our material being and doing.

Findings

Ingham et al. (1991) noted from interviews with young women (aged up to 25 years) that '*women older at first intercourse ... are more likely to delay intercourse (within the relationship) ... and to use condoms (at least at first intercourse)*' which they suggest '*could be explained by greater knowledge amongst older women ... or increased assertiveness*' and '*if the partners of older women are themselves older, they may adopt a more responsible approach*' (page 129). Unfortunately, there is little in the present study to bear out any optimistic inference that even *greater* maturity in years might lead to improved efficacy in the context of safe(r) sex.

As with younger people (see, for example, Coleman and Ingham, 1999) some interviewees would 'just put one on' (men) or insist on their use (women) at least with *some* partners. However, many did not consider condom use very important, at least for *themselves* (as opposed to 'for young people', etc.). As Chapman and Hodgson (1988) commented *'Complacency and even antipathy toward condom use seemed often to be quite independent of any conviction that AIDS is a serious disease*' (ibid. page 104).

Overall, the range of concerns and difficulties reported here are not markedly different from those of young people and, though a few will be mentioned in passing, these common concerns are not elaborated here. Instead, two particular themes are introduced that appear to be age-relevant; first, some effects of increased risk arising 'post fertility' and, second, some counter-intuitive effects arising from sexual difficulties.

Age and fertility *(menopause, hysterectomy, vasectomy, 'impotence')*

Unanticipated physical and age-related factors emerged from the data, such as menopause, hysterectomy, vasectomy and impotence.

Within the health professions, though this is changing (especially post Viagra), it was often considered that sexual activity ceased post fertility. The evidence here suggests that, although this may be the case for some, for others it may signal freedom from the need for contraception and consequently lead to increased risk in other regards.

The primacy of concern about pregnancy seems often to confound any other

consideration of condom use. Any concept of 'safe sex' had been dominated by concerns about pregnancy for most of the participants, despite some patchy knowledge of HIV and, to a lesser extent, other STDs. Since many had by now addressed contraception by other means, either unintentionally (eg through menopause or unplanned hysterectomy) or intentionally (eg female sterilisation, vasectomy) they inclined towards celebrating 'risk free' sex, and did not *want* to consider relatively 'novel' sexual risks such as HIV infection.

In particular, several women resisted the notion that, now fertility is no longer an issue, they should have to think about protected intercourse; it seems that 'unprotected sex' is a particular attraction of menopause, and they are somehow cheated if that expectation is not realised.

However, accounts of vasectomy and, in related but distinct ways, impotence surfaced some further complications to sexual health risk management.

Vasectomy

To set the scene - eleven of the total twenty one participants discussed, or referred to, vasectomy (seven from the parent study and four from the dating study). In the parent study, vasectomy was chosen or considered because of dissatisfaction with other forms of contraception, and a sense that the family was complete.

Four people reported that, when they approached their GP about sterilisation, they were advised that it would be better or easier for the male partner. One consultant is reported saying '*What are you going to do about contraception? … You ought to have the old man tom-catted*' (3256ff).

Vasectomy refusal

Two of the men in these cases rejected the proposal. One man responded to his wife that '… *his grandfather had had a child. Yes. His grandfather had had a child at seventy five*' (3754). She was very distressed by the tone of this refusal, given the implications of divorce or dying and her husband remarrying and starting a new family '… *I went to the ladies and cried all day I think huh*' (3761ff). The other of these men said '*I didn't want to take such an irreversible - I know it's not irreversible, but such an irreversible step you know*' (4327).

Vasectomy agreed

One woman who subsequently separated from her husband seemed quite surprised when he agreed to the procedure '*He was very good. I have to say that. Yeah he .. luckily he accepted it*' (4386). She went on to comment that '*it was very painful for him*' (4410).

Vasectomy problems

This last point resonates a little with an interviewee who eventually disclosed loss of libido which he attributed to the vasectomy. Initially the account seemed positive: '*We didn't want to risk having any more children. .. And so .. it was far easier for me to have .. the operation than for em - than for (wife's name). And less stressful.* (DK: yeah) *But it wasn't at the time!* (laughing) *As a - as a long term thing .. It was easy wasn't it?*' (DK: And that's worked out alright has it?) '*Yes.*' (2115ff). This 'yes' was spoken very definitely but through the course of the interview it was gradually revealed that loss of sex drive had effectively ended the couple's sex life.

These accounts are important not least because news of such experiences might discourage others from the approach. However, the picture is not always so bleak. The only other case where a vasectomy proved problematic in itself was for a man who underwent the procedure because of his wife's circumstances. Unfortunately, the marriage failed but he had the vasectomy reversed shortly before settling down in a new relationship with a much younger partner.

Vasectomy so 'no worry'

At least four couples had discussed the decision quite carefully, taking into account the possibilities of their marriage failing, one of them dying, and particularly one of their existing children dying. For another man it was an '*easy decision*' (1992) and though he and his wife did discuss most of the topics already mentioned, for them choice of contraceptive was about '*what's "user friendly"? … At the end - the discussion was about having free sex when, where and whenever .. and .. what inhibited that and what didn't*' (1996). He and the remaining people who reported vasectomy gave a fairly convincing impression that they continued to have an active sex life which they very much enjoyed. As one of the women commented '*I've not had to worry with condoms and all the other things there are ...*' (552ff).

Vasectomy so 'no condoms'

Yet the last two extracts point to the down-side of vasectomy regarding safe(r) sex. As one woman in the dating study commented '*he had had a vasectomy ... and he just did oral sex with partners before me .. and so, you know we didn't take any precautions .. as such. So that was that. But .. there again you don't know 'cos people <u>lie</u> don't they!*' (2742ff). And since her partner was a married man with children there must be some potential risk even if he had no current physical relationship with his wife.

Pregnancy is considered carefully but STDs are not

Amongst the parents who reported vasectomy, the main consideration was to avoid pregnancy and vasectomy sits amongst the lowest contraceptive failure rates. A women in the dating study also did not want children and recalled that '*within a short time he* [previous partner] *decided to have a vasectomy - so that took away - m' 'e th' - the <u>practical</u> problem of unwanted pregnancies*' (2414). She continued '*The issue of AIDS - sort of d' just, didn't come up at*

the time' and later says she '*felt confident enough - about him that I .. I didn't feel there was a .. a health risk from the point of view of AIDS*' (2440).

Complications arising from 'supposed' versus 'actual' monogamy

Although unmarried, the previous participant's account reflects a similar unconsidered confidence to that implicit in accounts above from married women and is resonant with Willig's (1995) finding of '*an association between marriage and safety whereby being married came to signify a state of safety with regard to HIV*' (page 79). Unfortunately for this woman the confidence was misplaced, and she eventually discovered '*he had been having .. at least one other sexual relationship .. towards the end of our relationship ... Which initially I wasn't aware of ..*' (2468). Later she commented '*It was a concern to me. ... He didn't consider the risks .. risky enough to be regarded as - as risks I think really. em Which I thought was quite a poor attitude. ...*' (2586ff). The notion of sexual *health* protection is contradictory in the context of a supposedly 'faithful' relationship.

Vasectomy and condoms

On a more positive note, one of the older women commented ' *... it's amazing how many men have had vasectomies but still .. will .. use contr' - em condom .. which is .. wh' which is Good!*' (3234). This comment was, however, in the context of discussion of sex outside any pretence of a committed monogamous relationship.

Impotence

Interviews were completed by June 1998, shortly before the publicity surrounding Viagra raised awareness of the prevalence of erectile difficulties[4]. I will use the participants' own term 'impotence' here.

Four of the participants (two male, two female) reported some experience of impotence, either for themselves or about one (or two) partner(s). Two further participants (one male, one female) mentioned some related experience.

Impotence is not a straightforward condition. Many men over forty will have at least some transitory experience; in the words of one male in his mid forties '*I mean there've been obviously er .. occasions - when .. "Oops! it's not working very well" but* (slight laugh) *very few and far between*' (3397ff). For this man the experience was clearly just a part of life. For others such an experience can undermine self confidence and can lead to a seemingly (to the person(s) concerned) intractable condition. Others throughout their lives will experience 'situational impotence' similar to the description of another participant: '*Well I ... was able to have sex put it that way but it wasn't a full erection ... I mean ... When I say the impotence ... it's ... on occasions it doesn't work at all, but sometimes it does ... but sometimes it's only ... sort of half there ... at half cock*

[4] Though they were already documented in the medical and psycho-sexual literatures (eg Kaplan, 1974, Bancroft, 1989).

so to speak ...'[5] (7515ff).

No risk?

A crude analysis might conclude that impotence removes sexual health risk since if you 'can't do it' you can neither impregnate a partner, nor pass on an undesirable microbe through penetration. However, as indicated above, the condition is rather more labile than that, so problems may arise in several quite distinct ways.

Deterrents to condom use?

Where an erection is a somewhat 'fragile' experience there may be considerable reluctance to risk 'losing it' during the delay and, for some, the embarrassment of putting on a condom. As one man commented '*I don't mind using contraceptives .. personally I prefer the woman to use it ... because of my problems .. it does take .. certain thi' - you know it takes the spontaneity away ... so I prefer not to use it*' (8020).

Returning to vasectomy, the man who lost his libido had '*heard that it actually .. reduces your .. sex drive a bit*' (2152ff). This discourse may contribute to the antipathy to vasectomy reported above. Further, whilst loss of libido/erection is amenable to therapeutic intervention, this man received none and, since most erectile dysfunction still remains untreated, any difficulties experienced in this regard may lead to increased risk in the same way as impotence generally.

Partner response

The two women who discussed *new* partners who were impotent tended to emphasize how they were '*… very tactile and em very considerate*' (3603) of one, and of the other '*… very caring and quite considerate*' (3417ff) in the context of alternative sexual pleasures.

However, both reported difficulties, first with the delay in any initial intimacy and then with the men's frustrations: '*he was getting more and more frustrated with it* [attempted treatments]' (1383) of one and '*it was very frustrating for him … he was quite angry and upset about it all ..*[deterioration due to diabetes]' (3569) of the other.

Relationship risk?

The woman in the second example felt this contributed to their relationship ending '*because he probably felt that inevitably I would .. look elsewhere*' (3583) – perhaps only for sex, given his other attractions – a further possible route to sexual health risk.

[5] This account was given rather hesitantly and the omission marks here (eg '...') represent only the deletion of such hesitation from the extract (eg '*I, I .. em er .. i I*').

In the other account the interviewee thinks she '*stayed with him longer than - If it had been a normal .. relationship*' (1390).

STD risk

More relevant to safe(r) sex is the variety of strategies they tried for coping with the impotence, including giving '*him the two lolly sticks*' (3395) but these strategies did *not* include the use of condoms. With reference to contraception she said '*.. there was just no question of it at all!* (laughing) *He didn't have one that worked!*' (2887). Aside from this being a rather harsher comment than elsewhere, the vagaries of situational impotence suggest there is always the possibility that something *may* happen (or have happened in another room), increasing health risks and the possibility of unintended pregnancy.

Gender

Although previous literature in this area has emphasised 'conventional femininity' as passive[6] if not helpless, accounts by, and of, men in our study often ran counter to either patriarchal hegemony or to the 'male sex drive' discourse (Hollway, 1984, Wight, 1996) in various ways: men as 'not interested', 'not casual' or 'not demanding'. There were examples of men refusing sex and of men preferring to *let* the woman take the initiative, though hegemonic 'male dominance' is often acknowledged and hedged in these accounts[7].

A woman who was surprised to discover, through the course of the interview, how often she is the 'initiator' was amongst considerable evidence here that women often take control of first intercourse. This was commented on by four of the five women and three of the four men in the dating group. However it was often presented as not quite 'normal' - whereas men taking the initiative went un-remarked and apparently 'taken for granted'.

There seems to be considerable muddle between expectation and practice in this area, but if women are more in control of initiating first intercourse than is generally acknowledged or even ‘realised’ - by women or men - it is perhaps not surprising that 'planning' is either absent or haphazard; everyone believes someone else has responsibility for risk management and, at the same time, no-one is keen to be seen buying or carrying condoms in case they may seem to be 'expecting something' that it is not in their remit to expect. It is perhaps this confusion of expectation, practice, un/awareness, un/control, which

[6] On the whole, previous literature in this area has emphasised 'conventional femininity' as 'passivity, helplessness, and victimisation' (Vance, 1984, cited by Stewart, 1999). However this is not the whole story. Holland et al. (1992) have discussed, albeit few, examples of 'more empowered' women, and Stewart (1999) develops this theme with examples from a large scale study of Australian teenage women.

[7] There were some surprisingly strenuous denials by male participants of ‘planning’ sex, since this might be read as 'seduction', suggesting some complex discursive tensions in this area – as well as presenting a problem for ‘planning’ protection.

makes analysis of sexual risk taking somewhat intractable.

However, if men are seen to 'take control' - to some extent - of when intercourse should happen, one might also link this to the discussion of situational impotence above. In general discourse about sex, there is an assumption that men can get an erection whenever they want, and that the only problem is avoiding this when one is not required or desired. But whilst this is true for some men it is certainly not so for all, and is possibly not even the norm (note the Viagra sales).

Zilbergeld (1980) has commented on the prevalence of myth about male potential but, if men are required to *appear* able to perform at will in order to protect their male identity, and if women are not aware that men may be insecure in this regard, then perhaps taking control of timing and situation at least enables men to 'present' as fulfilling this subjective positioning. Perhaps we should not be surprised at their need to be in control - if a woman is not aroused, intercourse may be uncomfortable, or even painful, but her identity is not (instantly) threatened. This is not to argue to retain these male dominant discourses, but to deconstruct them to everyone's advantage.

It is this penetration of physical responses into patterns of reasoning about risk which raises complex challenges to theorising ‘risk and rationalities’.

Discussion

An inclusive, eclectic approach to text analysis here, informed by some principles of discourse theory, seeks to illustrate something of how it can produce a clearer, perhaps richer, account of concerns relevant to safe(r) sex intervention.

Extracts from interviews were used to illustrate discursive processes which occurred 'naturally' in the interview context, but which would be masked by a more ‘systematic’ approach to data collection such as that typified by social cognition models (SCM). Here we illuminate how some of the missing variance of SCM based studies might be accounted for (and, in so doing, raise some challenging questions as to the relevance of their findings in this kind of applied research?).

We also identify some of the discursive 'themes and fragments' which, along with such discursive processes, underlie the contradictory but rich variance in the lived experiences recounted by the participants in the present research.

Equally telling is the way that more personal details were revealed (impotence, ‘loss of libido’) as confidence developed through the interview – and how participants remarked on things previously ‘un-noticed’ (eg the control *they* had in initiating intercourse).

However a lack of 'talk' about sex emerged cumulatively as a pervasive theme through the analyses here: *material discourse* is as much about *physical* as *spoken* (or *unspoken*) communication.

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