Review

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Women's sexual health in later life: Gaps and opportunities in research and practice

Alexandra CH Nowakowski[1] and JE Sumerau[2]

Abstract

This article complements emerging reviews and summaries of the recent expansion of sexuality studies within and beyond geriatrics and associated fields. To this end, we synthesize important insights and discussions taking place throughout geriatrics and other fields at present, and situate these conversations in broader discussions concerning sexualities, health, and aging. In so doing, we outline some gaps in existing work as well as opportunities for not only filling these gaps in our understandings of women's sexual health in later life but also in order to demonstrate the usefulness of expanding prior approaches to analyses concerning womanhood, aging, sexualities, and health over the life course. In conclusion, we outline some specific pathways for future research concerning women's sexual health in later life.

Keywords

aging, gender, review, sexual health, sexualities

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Throughout the social, physical, and medical sciences, research concerning sexualities has expanded dramatically in the past three decades.[1] At present, for example, interdisciplinary social scientists are celebrating the twentieth anniversary of the first journal focused specifically on sexualities in societies,[2] and the *Journal of the American Geriatrics Society* has initiated debates about the role of sexualities in adults' later lives in contrast to historical assumptions about sexless aging among many medical and social scientists.[3] Similarly, recent years have witnessed review articles concerning relationships between sexualities and a host of medical and aging phenomena including but not limited to managing romantic relationships in later life,[4] reactions to and management of sexual functioning issues,[5] and life course effects and resonance of experiencing sexual violence.[6] Overall, we are witnessing a growing consensus concerning the importance of sexualities in later life.

As such, this review article serves as a compliment to these emerging conversations across scientific fields. Specifically, we utilize our experiences working and publishing in such fields as well as our standpoints as sexual and gender minorities to highlight some ways these endeavors can be further expanded in the case of women's health in later life. Especially, as more and more review pieces continue to emerge, which can provide resources for scholars coming to these topics in a wide variety of ways, here we focus less on summarizing existing literature and more so on providing pathways to understanding and beginning study of areas missing in such reviews and fields more broadly. Specifically, we focus on observations of the literature as practitioners in this field rather than an attempt to replicate prior summaries focused on specific parts of these emerging literature works, and direct readers to these other works, cited throughout, for such

[1]Department of Geriatrics/Department of Behavioral Sciences and Social Medicine, College of Medicine, Florida State University, Orlando, FL, USA
[2]Department of Sociology, College of Social Sciences and Public Health, The University of Tampa, Tampa, FL, USA

Corresponding author:
Alexandra CH Nowakowski, Department of Geriatrics/Department of Behavioral Sciences and Social Medicine, College of Medicine, Florida State University Orlando Regional Campus, 250 E Colonial Drive, Suite 200, Orlando, FL 32801, USA.
Email: xnowakowski@fsu.edu

summaries. In so doing, as suggested by Granville and Pregler,[7] we focus on potential gaps in the field in hopes of both broadening these emergent areas and directing attention to the wide variety of ways sexualities influence women's health and experience as they age and occupy varied socio-cultural locations.

To this end, however, we do not focus on gender more broadly, but rather focus specifically on women's sexual health in later life. In so doing, we create a set of possibilities for other studies focused on women in later life and for comparison to both men and nonbinary people in aging, health, and sexual studies. Although such studies are rare in the case of nonbinary people, but see Sumerau and Mathers' newly released work on the subject,[8] scholars in masculinities fields have begun to outline the state of the literature concerning men's health,[9,10] and gender scholars have initiated comparative works of women and men over the life course.[11,12] We direct scholars interested in such comparisons to these works while focusing here specifically on gaps and possibilities in work concerning women's sexual health in later life throughout this piece.

In fact, our work here can be seen as a direct extension or addition to the important recent work from Granville and colleagues.[3,7] Whereas, Granville and Pregler[7] importantly utilize clinical cases to demonstrate the importance of greater recognition of sexualities in treatment and response to later-life populations, here we expand this recognition to discuss other areas of sexualities that may become relevant in a wide variety of clinical settings over time. Put simply, we expand upon their usage of clinical cases to call for attention to other areas of clinical care in need of more study, and situate this call in relation to common issues and concerns that may emerge over the life course for women aging physically, socially, and psychologically in varied ways and as part of varied groups. In so doing, we highlight the ways that clinical attention, like that suggested in Granville and Pregler's work, to various aspects of sexual health and aging may be especially useful and important in a wide variety of contexts and settings over time.

Biographical standpoints

As is often the case across the sciences, we come to the insights shared throughout this review as a result of our own personal and professional biographies.[13] Specifically, the first author of this article is a bisexual, agender person who was assigned female at birth. They are also a medical science and medical sociology researcher and teacher as well as someone raised by two medical scientists. Furthermore, the first author has cystic fibrosis (CF), which was misdiagnosed throughout most of their life, and has spent the bulk of their life managing symptomology and reactions concerning this chronic condition, medical and other treatment for this condition, and the management of this condition throughout their interactions with others. Although they experience society as White and as someone from the upper to upper-middle class, such experience has been complicated by their experience as someone managing a chronic health condition, a sexual and gender minority, and a researcher and advocate for these populations.

Alongside the first author, the second author also engages in their work as a medical sociologist and sexualities researcher from standpoints historically missing in the sciences more broadly. Specifically, the second author is a nonbinary transwoman, and a bisexual first-generation college attendee and graduate. She is also a survivor of varied forms of violence, and a person managing chronic mental and physical health conditions (at least to some degree) as a result of these experiences. At the same time, the second author is a product of being orphaned and adopted who was assigned and typically experiences the world as White, but grew up and came out of the lower working class with no knowledge about her biological origins until she was in her mid-twenties. Furthermore, the second author had little to no access to medical care or insurance until near the end of her twenties. As with the first author, these social locations influence the way the second author views the existing literature works.

Especially, as researchers have noted the importance of culture, biographical standpoints, and context for making sense of aging, health, gender, and sexualities,[14] our own experiences noted above situate our reading of the existing literature in context and culture. This both explains how we may read the literature differently than others who possess varied biographies, and directs attention to the importance of multiple discussions and reviews concerning any literature. Put simply, the role of social context in this type of work suggests it should be added to over time by others operating from and within different cultural, contextual, and biographical social locations to capture the multitude of ways one may interpret or otherwise meet discussions of women's sexual health in later life from different vantage points. In this article, we thus utilize our own standpoints alongside our expansive work in areas where health, gender, sexualities, and other social factors meet to provide potential future research and clinical pathways for the continued expansion of work on women's sexual health. In so doing, we first outline some important insights and gaps in existing studies concerning older women's sexual health.

Expanding existing studies

As Granville and colleagues[3,7] note, the experiences of women in later life concerning sexualities have received more attention in recent years. Despite many gaps remaining in this area of scholarship, researchers have begun to systematically focus on some aspects of women's later life sexual health in relation to both aging and medical conditions. In this section, we outline some of the important

aspects of these studies while discussing some ways such study could be expanded for greater scholarly understanding and clinical use. In so doing, we seek to demonstrate how broadening this area of focus can deliver more systematic understanding of women's health over the life course and the clinical responses to sexual health issues women may face as they age.

Sexual functioning in later life

To this end, we begin with important studies focused on sexual functioning in later life. Researchers have explored, for example, the quality of sexual experience after and in relation to menopause,[15] experience managing chronic health conditions and sexual function in later life,[16] biosocial relationships between age, womanhood, and sexual function,[17] and relationships between mental conditions and sexual function in later life[18] among women in the Unites States. In all such cases, researchers find both that aging impacts the meaning and function of sexualities, and that sexualities remain important and significant at later ages.

What these studies suggest, however, is that there also needs to be work outlining what sexual functioning means to people in varied social and physical and age locations? What does it mean to have proper sexual functioning, for example, for a cisgender woman (i.e. her gender and sex identification match or are on the same side; she was assigned female and developed a gender identity as a woman) in her sixties in a monogamous, heterosexual marriage? Does this meaning differ for similar cisgender women in different social classes, different racial groups, different countries and cultural traditions, or in relation to different chronic health conditions that may develop over time? These are simply a couple questions that could add more weight, clinically and in the literature, to our understanding of sexual functioning in women's sexual and health-related experiences over time.

What is sexual?

At the same time, such studies also create questions about what exactly counts as sexual in a given woman's life. Examining questions about oral sex, for example, researchers found that definitions of this sexual behavior as central to partners significantly related to perceptions of sexual quality, but that such definitions—and thus relationships to health and functioning based on them—could vary between people of different sexes, genders, ages, or in different types of relationships.[19] Incorporating diverse sexual behaviors also raises questions about prior foci in research. For example, studies have often focused on male sexual dysfunction as predominantly related to erection and/or sterilization,[20] but would these experiences represent dysfunction to men for whom oral or manual or other types of sexual behaviors were equally or more valued in their relationships?

While this is only one example, to understand this and other complexities, we would need to expand our questions—in clinical settings and in studies—beyond assumptions about what "sex" means, what sexual "functioning" refers to for different people, and what counts as "quality" sex in a given relationship. Especially, as each of these terms can have different meanings in different cultures and settings, such disambiguation is important for both scholarship and practice. As Liuet al.[19] notethat such an expansion could create better tools for clinicians and better understanding for researchers about the sexual health of patients and subjects by defining "sexual health" in relation to the meanings respondents themselves desire instead of based on one or another given hypothesized definition held by practitioners.

Relationships

As suggested in the prior paragraphs, this type of expansion requires paying attention to the lessons researchers and clinicians are learning about relationships, and how such collaborative experience may shape notions of health, sexualities, and later life itself.[4,13,21] However, the examination of relationship dynamics in later life has itself already become a growing field with insights about, for example, the negotiation of time and quality of life within couples experiencing later life together,[22] negotiations of caregiving,[23] grief,[24] and a wide variety of other areas.[13] As noted in many cases, relationships in later life are dynamic and negotiable much the same way they are in earlier periods of the life course.

As a result, understanding women's later life sexual health relies, at least partially, on understanding their experiences within and negotiations about relationships, partnership terms, and romantic and instrumental relationship needs. Furthermore, clinicians can seek to ascertain communication patterns in relationships as well as the ways relationship partners respond to a given illness condition, diagnosis, sexual behavior, or other factor related to overall sexual experience, desire, practice, and/or health.[7,13]

Instrumental health issues

As part of understanding functioning, meanings, and relationships, however, we must also pay attention to instrumental health issues, like illness status and sexually transmitted infections (STIs) as well as the role of disabilities in relationships, functioning, and preferences.[7,13,25] How, for example, do disabilities influence what relationships look like, how sexual behaviors are defined and given meaning within relationships, and what counts as functioning in sexual, health, and/or sexual health terms?[26] What role do concerns about and experiences of STIs play

in later life, within relationships, and especially in the management of such conditions in relation to other health concerns older women may face in their lives?[7]

Furthermore, what role does a chronic health condition play in these dynamics or multiple chronic conditions between partners in a relationship, and how might such dynamics shape the entire negotiation process between partners related to sexual health, behavior, and functioning?[13] Each of these and many other questions could be explored both in clinical settings seeking to care for and make sense of women's later life sexuality and in broader scale research about the ways women, men, and nonbinary people experience biological, psychological, and social life over time and throughout the life course.[8]

Scratching the surface

As the above examples suggest, Granville and colleagues[3,7] are correct when they note that our existing work on women's later life sexual health is only scratching the surface. Although we could continue with many examples of potential expansion of the field, another important one that shows up at least implicitly in many of the reviews and studies cited above concerns the relationship of all these dynamics to women's experiences feeling and/or managing pain—physically and emotionally—over time.[6,27] At the same time, understanding women's sexual health requires greater attention to the experience and desire for pleasure voiced by women in many studies as well.[7,13] To tease out these sides of the coin, we offer the above suggestions as early steps in expanding research and clinical exploration of the variability, complexity, and importance of sexual health among women in later life and in varied social, psychological, and biological contexts, settings, and standpoints.

Missing pieces in the existing literature

As noted in another recent review of sexual–romantic–health interactions in later life[16] and echoed by Granville and Pregler,[7] another important frontier for researchers and clinicians moving forward concerns demographic variability in women's later life sexual health. For example, researchers have already noted the importance of better incorporating racial minority populations, voices, and experiences into such studies as well as the need for understanding racialized pathways in the ways racial minority women experience both health and aging in later life and across time.[28,29] Similar attention has begun to be granted to the many ways socioeconomic status and other social class variations impact aging, health, relationships, and overall quality of life.[30] In this section, we join these emerging studies by directing attention to sexual and gender variation often missing from discussions of women's health overall and women's later life sexual health more specifically.

Lesbian, gay, bisexual, queer, and asexual women

As noted in recent review pieces focused on relationships,[13,21] an important area in need of significant research and clinical work concerns the sexual, romantic, and health experiences of lesbian, gay, bisexual, queer, and asexual (LGBQA) women. Although, we are beginning to see more targeted policy and research work related to the later life care and experiences of LGBQA populations more broadly, the sexual and romantic aspects of such work remain scant, and many aspects of care that clinicians may face more and more in future years remain understudied and even often absent from existing protocols. In fact, studies of LGBQA later life, though rare, suggest that one of the major issues such populations face is a partial or even complete lack of understanding about their healthcare needs, romantic relationship types, and sexual behaviors on the part of doctors, nurses, and other clinical personnel.[21] Considering this is also a problem for younger LGBQA people and that larger numbers of these populations are coming out and living openly, this could be a massive need facing the overall and geriatric medical systems over the next few years.

This is also a tricky area in need of study because LGBQA women represent both a commonly grouped together population and also separate and sometimes distinct populations in terms of sexual and health needs, experiences, and issues. Although there is overlap in some cases, there are also many ways that, for example, lesbian and bisexual women experience very different sexual experiences and healthcare needs. This is also true for some women who utilize gay and lesbian interchangeably and others for who these terms mean very different things due to generational or other socio-demographic aspects of their own lives. Likewise, clinicians may well face both romantic and aromantic asexual women, as well as asexual women who are sometimes or have been at times sexual in practice, but in each case, the details and important clinical factors for helping asexual women in later life with their health may be varied and very specific to a given population or even patient. Although, these are only a few of the complexities that may emerge in relation to women's sexual health in later life where such women are also sexual minorities, they demonstrate the pressing need for expanding our, at present fairly limited, information about the later life sexual health and needs of LGBQA women.

Transgender people

At the same time, however, even more recent increasing academic and social recognition of transgender people

presents another set of unanswered questions throughout our current literature works[21] (see also Sumerau and Mathers[8] or the public glossary at www.glaad.org for transgender-related definitions and terminology within and beyond medical settings). Especially, considering that transgender people often experience much more negative experiences with medical providers than most social groups,[31,32] the absence of literature on transgender people throughout life, as well as in later life, presents a significant challenge to clinicians, researchers, and practitioners working from models based on cisgender-only populations. In fact, one may suspect similar issues arising as more and more people openly identify as nonbinary or gender fluid (i.e. as neither men or women in terms of gender identity, but somewhere between or beyond these labels)[8] whether or not they identify as transgender.[33] In such cases, the limitations in our existing frameworks, models, and protocols have wide ranging consequences while creating important needs for clinicians and practitioners more and more likely to work with these, increasingly visible, populations within our society.

Incorporating transgender people into gerontological and geriatric care also may speak to needs within populations as well.[8] Transmen, for example, may experience issues related to their bodies and/or physiology later in life regardless of transition in earlier life (i.e. whether or not they are able to access and/or choose to engage in gender-affirming surgical or hormonal treatments to biologically change their secondary sex characteristics).[8] Nonbinary people assigned female at birth often view sex, sexual, and gender-related health in different terms than cisgender women, men of varied kinds, or nonbinary people assigned male at birth. Of course, alongside these potential populations, there are also issues—with transition or more broadly—transwomen experience throughout life that can dramatically impact stress levels, potential for chronic conditions, and experiences with violence. All of these factors can make transwomen's later life sexual health a complicated and important aspect of care. At the same time, with each of these populations, clinicians will need the tools and the languages to approach bodies, identities, and lived experiences in productive and effective ways. In all such situations, at present, the literature works available are, at best, limited and often have little to say about sexual health, later life health, or the combination of these factors.[8]

Relationship diversity

Furthermore, these discussions emerging—and importantly resonating—in broader medical circles concerning relationships may need to be expanded to different forms of relationships. People in polyamorous unions, for example, may or may not have the same needs as people in monogamous unions, but at present, the focus is almost entirely on monogamous unions, divorces resulting from monogamous unions, and widowhood resulting from monogamous unions. Similarly, people in mixed sexuality relationships (i.e. one partner is heterosexual or gay or another sexual identity, but the other partner(s) are not) may run into different issues in later life than those is same sexuality relationships (i.e. one partner is gay or bisexual or another sexual identity and the other partner(s) is the same). As these types of relationships, despite their long-term existence, are only currently beginning to enter the overall social and medical scientific literature works, we know almost nothing about what they look like, and what people in them might need, in later life.[33] How might women's later life sexual health be similar or different in poly, mixed orientation, or other types of relationships less often focused on in traditional medical education?

Sexual violence

Finally, recent reviews and discussions in geriatric and broader medical fields have begun to note the absence of discussions of sexual violence in the existing literature works.[34] Considering that the experience of sexual violence significantly impacts short-term and long-term health over the life course,[34] this is another area where our existing literature works have little to say, but where researchers and practitioners are likely to need to have answers in practical care settings. Even as researchers and clinicians begin to incorporate information on sexual violence into our work, many questions will need to be addressed in the literature. For example, how do people who have experienced sexual violence make sense of, manage, or relate to sex and sexualities over the life course? In what ways might such experiences impact later life views or experiences of sexual behavior or desire? Similarly, in what ways might such experiences be related to later life experiences of illness conditions, pain, or other phenomena that influence later life sexuality? These are only a few of the questions that require consideration, and demonstrate the importance of incorporating consideration of sexual violence into our existing literature works.[34,35]

Conclusion

Each of the aforementioned areas offer steps in pathways for expanding the existing literature works and clinical understanding of the wide diversity of older women's sexual health. Whether we look to areas in this literature or populations not often captured in such literature, we see a broad landscape of women's later life sexual health experiences in need of attention, consideration, and illumination. Especially, as researchers and practitioners seek to, as Granville and Pregler[7] note, take seriously the importance of sexual health in the broader health and quality of life of diverse populations of women in later life, these and other

emerging avenues provide research trajectories that can provide more depth and breadth to our existing scholarly and clinical understandings and approaches.

To this end, we close this article with a call for the recognition of the dynamic complexity of women's later life sexual lives. At the heart of each of the above examples and the continuously emerging reviews and discussions of this topic lies an increasing understanding of the importance of taking seriously the emotions, meanings, preferences, desires, and difficulties reported and experienced by women in various social demographic groups and at various times in the passage of life. As noted in many studies beginning to systematically focus on the emotional and sexual relationships between older adults,[13] the ways women manage and negotiate their sexualities, emotions, partnerships, and overall health in later life all come together in their lived experiences, their understandings of themselves, and their communications with their partners. Simply put, it is these agentic considerations clinicians require to understand and best serve the women who they meet in different care settings where sexualities and relationships become relevant to broader medical care over the life course.

As such, here we join the growing chorus of voices calling for systematic attention to and care for women's later life sexual health. Especially, as research increasingly recognizes that women's later lives are anything but sexless regardless of how much or how little sexualities are practiced in a given case[7] and that women in later life are by no means a uniform group of only one type or one set of factors,[16] researchers and clinicians seeking to understand and serve such populations must utilize our existing skills to illuminate such complexity and develop protocols for speaking to the variety of women's later life sexual health. To accomplish this, we must recognize this agency and diversity, and build from it to better understand the meanings and practices of sexualities within and between varied groups of women in a wide variety of settings. With this in mind, throughout this article we have provided potential pathways for this important work, and alongside our fellow scholars, we continue to work toward more complete and quality care for all women as they navigate the intersections of sexualities, health, and sexual health over the life course and in relation to their broader health experiences.

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ORCID iD

Alexandra C.H. Nowakowski https://orcid.org/0000-0002-9072-2482

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