Although it is widely believed that sex no longer matters after middle age, the opposite is true, and sex often becomes more and not less important as a person grows older. Because sex is among the last pleasure-giving biological processes to deteriorate, it is potentially an enduring source of gratification at a time when these are becoming fewer and fewer, and a link to the joys of youth. These are important ingredients in the [older] person’s emotional well-being.

Helen Singer Kaplan

Young love is from earth, while late love is from heaven.

Turkish proverb, cited in Hillerman (2000, p. 8)

OBJECTIVES

By the end of this chapter, readers will be able to:
1. Identify three cultural myths about sex and older adults.
2. Determine demographic factors affecting sexuality among older adults.
3. Identify the nature of the relationship between sexual activity and sexual satisfaction reported by older adults.
4. Understand how health status and health care affect the sexual activity and sexual satisfaction of older adults.
5. List common conditions and illnesses of older adults that can negatively affect sexuality.
6. Identify common prescription medications with potential sexual side effects.
7. Determine how to respond to patients’ concerns about sexual issues.
clearly enjoys each other’s company. Indeed, many Americans categorize all sexual behaviors between partners prior to penile insertion as “foreplay,” a prelude to “real” sex. Many even agree that fellatio is not “having sex.” Despite the distinction that is often made between caressing and fondling as “foreplay” and coitus as the “main event,” many individuals find non-coital sex play pleasurable and rewarding as an end in itself—even when it does not lead to penile insertion or orgasm. This may be especially true for elderly persons or those with physical conditions that make some types of sexual activities uncomfortable, painful, difficult, or impossible.

Thus, in any discussion of sexuality in late adulthood, we need to maintain a broad definition of sexuality that will allow us to perceive existing sexual behaviors more accurately and to provide appropriate professional assistance.

### Demographic Factors

Americans are now living longer than they did even a generation ago, and this trend is likely to continue (Mohan & Bhugra, 2005). There will be an increasing number of individuals who live into their 80s and beyond. Moreover, social definitions of aging are changing. In his 20s, Mick Jagger said he could not imagine performing rock and roll at age 50, but later found that it was possible to be part of both the AARP and

### Sex and the Elderly Population

#### Defining Sexuality

Sexuality includes the way we think about ourselves as sexual beings and the corresponding gender roles and behaviors, the need for intimacy, ideas about reproduction, and the feelings of excitement and pleasure that are associated with sex (Mohan & Bhugra, 2005). Sexuality also includes the entire range of sexual behaviors as well as the decision to be celibate and is an important aspect of activity and participation.

Too often, when we think of sex we think of a specific sexual act, such as coitus, oral sex, anal sex, or masturbation. Often, we tend to trivialize the sensuality of such intimate behaviors as kissing, holding hands, or looking into a loved one’s eyes. The couple in Figure 16-1 clearly enjoys each other’s company. Indeed, many Americans categorize all sexual behaviors between partners prior to penile insertion as “foreplay,” a prelude to “real” sex. Many even agree that fellatio is not “having sex.” Despite the distinction that is often made between caressing and fondling as “foreplay” and coitus as the “main event,” many individuals find non-coital sex play pleasurable and rewarding as an end in itself—even when it does not lead to penile insertion or orgasm. This may be especially true for elderly persons or those with physical conditions that make some types of sexual activities uncomfortable, painful, difficult, or impossible.

Thus, in any discussion of sexuality in late adulthood, we need to maintain a broad definition of sexuality that will allow us to perceive existing sexual behaviors more accurately and to provide appropriate professional assistance.

**Figure 16-1** Couples who have been together for a long time can find pleasure in a variety of close or intimate activities. (Photo from Jeffrey M. Levine, MD. Copyright, 2007.)
MTV generations. Our ideas about how a 70-year-old should look, feel, or behave are likely to be very different when we are 20 years old than at age 40 or 60.

Unfortunately, the opportunity to develop or maintain intimate relationships is a problem for many older Americans. The groundbreaking 1994 Sex in America survey (Laumann, Gagnon, Michael, & Michaels, 1994) reported that for noninstitutionalized men and women, access to a sexual partner becomes increasingly problematic as we age. For men aged 60 to 64, the survey found that approximately 85% had a sexual partner in the past 12 months; this decreased to 45% for men 80 to 84 years old (U.S. Bureau of the Census, 1998a). The change was even more precipitous for women, who, by their very late years are very unlikely to have a sexual partner (Gott, 2005).

The demographic reality is that in the United States there are more women than men in every age category beginning at age 30 (U.S. Bureau of the Census, 1998b). Two factors help explain this situation. First, although there are more males born than females, males die naturally at a higher rate in infancy, and adult males tend to be more susceptible to certain age-related diseases, such as cardiovascular disease. Second, to a greater degree than women, men in our society traditionally have been socialized to take physical risks, fight wars, and take employment in dangerous occupations, such as mining and commercial fishing. These behaviors further decrease the number of men in society. Whatever the reasons, a woman’s life expectancy exceeds a man’s by as much as 6 years (U.S. Bureau of the Census, 1996). Marriage patterns in the United States also contribute to the difficulty older women have finding a spouse or partner. Despite highly publicized relationships like that of Demi Moore and Ashton Kutcher, women commonly marry men older than themselves and are more likely to survive a husband by several years.

This demographic imbalance, especially in late adulthood, makes it difficult for older heterosexual women to find a sexual partner. For those aged 75 or older, there are 1.3 women for every man in the population (U.S. Bureau of the Census, 1996). The situation for widowed women is made worse by the fact that many elderly men are married and thus not available to widowed women. Of those aged 75 or older, 66.7% of men, but only 28.8% of women, are married (U.S. Bureau of the Census, 1998b). Only half of older African Americans report having a regular sexual partner as compared to roughly two-thirds of other racial/ethnic groups.

Another demographic factor is affecting current perceptions of old age. Because baby boomers make up such a large segment of the population, they continue to have a great deal of influence on the rest of society. The “sex, drugs, and rock and roll” generation is redefining what is “old.” The sexual revolutionaries of the 1960s and 1970s were exposed to the ideal of free love, and they were the first generation on “the pill.” Now they are unwilling to concede that sex might end after middle age.

It should be noted that although there is relatively less research on sexuality outside the United States, existing evidence from China (Guan, 2004) and the United Kingdom (Gott, 2005) suggests that many issues with regard to sexuality in later life are universal.

**Life Stage Effects**

For most individuals in our society, late adulthood is a distinct life stage (Sharpe, 2004). Parents are usually deceased, and any children are adults. Given today’s mobility, family members may live at some distance from one another. For many, full-time employment will have ended. Those who are employed full time may find that their responsibilities have shifted and their work is less satisfying. Many turn to hobbies and volunteer or become involved in other social activities to provide enjoyable and meaningful occupation.

Many older people find themselves alone after the death of a long-time spouse or companion. This means that the opportunities for sex, other than self-stimulation, may be decreased. Nevertheless, “late life is a sexual stage of development like any other across the life span” (Sharpe, 2004, p. 199). The situation is made difficult, however, by the fact that those with whom one may be interested in exploring a sexual relationship may themselves be prisoners of the prevalent cultural stereotype.

Some contemporary retirement communities provide insight into the changing climate regarding older adults and sexuality. From Florida to California, communities where the average age is in the 70s reflect the demographics of late...
adulthood—increasing numbers, an imbalance of men and women, and better health and more vigor than might have been expected a decade or two ago. With their singles clubs, dance groups, social mixers, and newsletter advice columns, these communities also mirror the sexual interests and needs of their residents. They provide opportunities for meeting other people and developing relationships as part of a larger set of programs and opportunities for occupational engagement more generally.

The situation in nursing homes contrasts sharply with that in retirement communities. Adults in nursing homes tend to be treated as sexless beings by staff, and sexual activities may be actively discouraged (Sharpe, 2004). Although they may recognize the residents’ rights to sexual expression, those in the nursing home industry have pragmatic concerns that often take precedence. These include a concern that patients might physically hurt themselves, a concern for what is acceptable to patients’ families, as well as concerns about the possibilities of litigation. When dementia is a factor, there also is a concern about mutual consent (Ward, Vass, Aggarwal, Garfield, & Cybyk, 2005). Privacy issues are a significant concern for those wishing to sustain sexual relationships while in a nursing home. And there are significant ethical dilemmas about individuals with cognitive decline who may or may not be able to understand consent. Nursing homes have an obligation to protect those who cannot consent, but it may not always be easy to determine the wishes of the individual.

Declining health with associated decrements in performance skills can be a significant barrier to sexual fulfillment for older people. If health begins to fail, there is a resulting loss of independence that can take a heavy emotional toll. Moreover, if you are no longer able to drive, afraid to go out at night, and living on a fixed budget, you may become socially isolated. Finding and enjoying sex under such circumstances can be difficult. In addition, a decline in general health can affect sexual physiology. It may be that studies showing a decrease in sexual activity by elderly individuals are actually measuring a decline in their overall health.

In fact, older men and women report that better health for themselves and their partners is among the most important factors for improving their sexual satisfaction. Moreover, those who have a health problem that negatively affects their sexual relationships do not necessarily seek professional treatment. It is often believed that new drugs have greatly enhanced the sex lives of older adults. In reality, only a small percentage of those needing help (10% of men and 7% of women) have ever taken any medicine, hormone, or treatment to enhance sexual satisfaction. However, a majority of both men (62%) and women (59%) who have used such medications or treatments report enhanced satisfaction with their sex life, as well as improved relationships with their partners (AARP, 1999).

Gays and Lesbians in Older Adulthood

Aging can be stressful and problematic for all individuals in Western societies; however, there are no scientific data to suggest that homosexuals and heterosexuals differ in response to older adulthood. The reality is that the data on elderly homosexuals are scant. The most recent AARP sexuality study reported that only 4% of males and 1% of females reported having a same-sex partner (AARP, 2005). However, the report did not look at those who previously had a same-sex sexual relationship. Moreover, given the social changes of the past three decades, there is no reason to believe that the way current older homosexuals experience their situation will remain the same for those who are growing older during a period when attitudes toward gays and lesbians are significantly different.

What is known about the current generation of elderly gays and lesbians is summarized in this section. For those who would like additional information, Rosenfeld’s (2003) volume on issues relevant to lesbian and gay elders is a good place to start. A recent study by MetLife (2006) provides insights into the views and wishes of aging gay and lesbian individuals. Many of these individuals have close partner relationships in later life, but like other elders, they worry about the prospect of outliving their partner. They also worry that health professionals will discriminate against them and will not treat their health and sexual concerns with respect. Thirty-two percent of gay men and 26% of lesbians indicated that this fear was their greatest concern about growing old. In addition, 19% reported little or no confidence that medical personnel would treat them with dignity and
respect as lesbian, gay, bisexual, or transgender (LGBT) people as they age.

At the same time, there is contrast between the stereotype of unhappy old homosexuals and findings reported in the literature. For example, older gay men maintain both their interest in sex as well as their ability to function sexually (Pope & Schulz, 1991), and gay and lesbian individuals struggle with the same issues about sustaining sexual orientations later in life that characterize other populations (MetLife, 2006). It is important to remember that elders, including the transvestite shown in Figure 16-2, have as many ways of engaging in demonstrations of their personal sexual choices as do younger individuals. An attitude of acceptance is essential in working with elders, as is true in any clinical situation.

Adelman (1991) has examined the relationships of stigma, gay lifestyles, and adjustment to aging, finding that there is a significant relationship between adjustment to later life and the sequence of early gay development events. Specifically, there is a significant relationship between adjustment to later life and satisfaction with being gay; that is, high life satisfaction, low self-criticism, and few psychosomatic complaints constitute patterns of adjustment related to being “very satisfied with being gay.” Those who were “less than very satisfied with being gay” attributed a perceived failing in life with respect to careers, friendships, or intimate relationships to their homosexuality. Stigma was frequently referred to as a reason for being less than very satisfied with being gay.

Sexual Attitudes and Behaviors of Older Adults

The Baby-Boom generation feels strongly that sex is for every age, not just the young. And a large majority of both men and women in their 40s and 50s see no reason that sex should not be enjoyed by singles, the divorced, and widows and widowers (National Council on Aging, 1998). Although older Americans believe that sex is emphasized too much in our society, a vast majority show a positive attitude toward sex (Table 16-1). Most adults, regardless of their age, are interested in sex, find sex satisfying, and consider sex to be an important part of their lives.

Although as we age our bodies change and we respond more slowly or differently, sex remains an important and enjoyable aspect of life for older adults. Years of sexual experience may more than compensate for any decrease in physical responsiveness. The physical changes that occur with age can provide an opportunity to revitalize lovemaking. Many older adults seize the chance to slow down and focus on intimacy, not solely on the act of coitus. They spend more time hugging and cuddling, fondling, and caressing to express their affection. In one study of adults aged 60 to 91, nearly three quarters of those who remained sexually active reported that lovemaking had become more rewarding over the years (AARP, 2005).

The cultural myth that we become less attractive and sexually appealing as we age probably goes hand in hand with the myth, too often presented in the media, that older adults are less sexual (Hilt & Lipschultz, 2005). The study conducted for the AARP and Modern Maturity magazine in 1999 reported that the number of people who view their partners as romantic or find them physically attractive does not decrease with age. The study found that 59% of men aged 45 to 59 gave their partners the highest possible rating for being “physically attractive.” Of those men aged 75 or older, this rose to 63%. Of women aged 45 to 59 years, 52% gave their partners the highest possible rating for being “physically attractive,” as did 57% of those aged 75 and older. For the same age categories, 37% of the younger men said...
The NCOA (1998) study found that 39% of respondents 60 years or older wanted to have sex more frequently than they currently do. Across all age segments (60s, 70s, and 80 years and older), older men are twice as likely as women to report wanting more-frequent sex (NCOA, 1998). Another study found that the main predictors of sexual activity for one elderly population (mean age 77.3 years) were being married, having more education, being younger, being male, and having good social networks (Matthias, Lubben, Atchison, & Schweitzer, 1997). The main predictors of sexual satisfaction for the older adult population were being sexually active, having good mental health, and having a better functional health status. About half of the respondents to the 2004 AARP study reported they were satisfied with their sex lives. According to an earlier AARP survey (1999), factors that respondents indicated might improve their sexual satisfaction included better health for themselves or their partner, less stress, and more sexual initiative from their partners.

### Age-Related Physical Changes and Sexual Functioning

Certainly, older adults are more susceptible to many disabling medical conditions such as cardiac problems and arthritis, as well as normal aging changes that may make the expression of

<table>
<thead>
<tr>
<th>Attitudes Toward Sex After 50</th>
<th>Strongly Agree/Agree</th>
<th>Neutral</th>
<th>Strongly Disagree/Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>There is too much emphasis on sex in our society</td>
<td>73</td>
<td>19</td>
<td>8</td>
</tr>
<tr>
<td>Sexual activity is a critical part of a good relationship</td>
<td>60</td>
<td>28</td>
<td>12</td>
</tr>
<tr>
<td>Sexual activity is a pleasurable but necessary part of a good relationship</td>
<td>48</td>
<td>26</td>
<td>25</td>
</tr>
<tr>
<td>Sexual activity is critical to my overall quality of life</td>
<td>49</td>
<td>28</td>
<td>23</td>
</tr>
<tr>
<td>Sex becomes less important to people as they age</td>
<td>42</td>
<td>26</td>
<td>32</td>
</tr>
<tr>
<td>Sexuality is a duty to one’s spouse or partner</td>
<td>30</td>
<td>35</td>
<td>35</td>
</tr>
<tr>
<td>I would be quite happy never having sex again</td>
<td>12</td>
<td>18</td>
<td>70</td>
</tr>
<tr>
<td>I do not particularly enjoy sex</td>
<td>10</td>
<td>19</td>
<td>71</td>
</tr>
<tr>
<td>Sex is only for young people</td>
<td>4</td>
<td>12</td>
<td>84</td>
</tr>
</tbody>
</table>

sexuality difficult as a result of changes in performance skills as well as body structures and body functions. As is shown in Table 16-2, sexual activity may diminish in frequency. In addition, the treatments used for medical conditions may hinder the older adult’s sexual response. Those in late adulthood may experience a decrease in physical energy, along with increases in physical discomfort, which may affect the desire and capacity for sexual activities. One study has found that for women, age also is associated with less sexual daydreaming and more negative sexual attitudes (Purifoy, Grodsky, & Giambra, 1992). However, the need for intimacy, excitement, and pleasure continues throughout the life span, and there is nothing in the normal biology of aging that would preclude the ability for sexual activity.

Physical Changes in Men

There are several sexual changes that occur as men age, including a decrease in the production of testosterone. Consequently, the size and firmness of the testicles may decrease. There also is a reduction in sperm as men age, although unlike women, who once past menopause can no longer become pregnant, men can father children into very late life. Another common change is an increase in the size and condition of the prostate.

Men in late adulthood may notice that it takes longer to get an erection than when they were younger, and many older men need more manual or oral stimulation of the penis to produce an erection. Moreover, the erection may not be as firm or as large as it was when the man was younger (I. Goldstein, 2004). A man also may experience a longer time before ejaculating. In addition, the feeling that ejaculation is imminent may be shorter, and there is a reduction in seminal fluid. The loss of tumescence (swelling due to engorgement of blood vessels in the penis) may occur more quickly in older men. Finally, the refractory period, the amount of time it takes to achieve a subsequent erection, tends to increase with age.

As men get older, they are more likely to experience erectile dysfunction (i.e., the inability to have and maintain an erection). Traditionally, erectile dysfunction was commonly termed impotence. However, because the word “impotence” is imprecise and implies personal failure or not being “manly,” the term “erectile dysfunction” is now preferred. Evidence suggests that minimal erectile dysfunction can be found in 17% of men aged 40 to 70, 25% experience moderate dysfunction, and 10%, complete dysfunction (I. Goldstein, 2004). The rate of dysfunction triples from age 40 to age 70.

The magnitude of the problem is unknown because it often goes unreported. Many men associate the inability to have an erection with loss of manhood and are embarrassed to admit they have a problem. However, in one survey, 26% of men (aged 45 and older) acknowledged having either moderate or complete erectile dysfunction (AARP, 1999).

An erection results when an aroused man’s brain signals nerve cells in the penis to release nitric oxide. In turn, this produces the release of cyclic guanosine monophosphate, or cGMP, which is key to having an erection. The cGMP enlarges blood vessels in the penis, allowing blood to engorge the penis, thus producing an

<table>
<thead>
<tr>
<th>Gender</th>
<th>Sexual Activity Engaged in at Least Once a Week in the Past Six Months</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male</td>
</tr>
<tr>
<td>Kissing or hugging</td>
<td>83</td>
</tr>
<tr>
<td>Sexual touching/caressing</td>
<td>68</td>
</tr>
<tr>
<td>Sexual intercourse</td>
<td>49</td>
</tr>
<tr>
<td>Self-stimulation</td>
<td>36</td>
</tr>
<tr>
<td>Oral Sex</td>
<td>26</td>
</tr>
</tbody>
</table>

erection. A man will continue to produce cGMP as long as he is sexually stimulated (Kolata, 1998). At the same time, however, he will produce phosphodiesterase 5, or PDE5, which destroys cGMP. The result is an appropriate level of engorgement. After orgasm, or when sexual stimulation ends, cGMP production ceases, PDE5 destroys any remaining cGMP, and the erection resolves.

The proportion of men who have tried potency-enhancing medicines, hormones, or other treatments has doubled since 1999. Viagra and similar medicines work by blocking the effect of PDE5 (Kolata, 1998). A man with erectile dysfunction who takes the medication may increase the effects of cGMP by slowing the impact of PDE5. The result can be an erection for a man who otherwise would not have one.

**Physical Changes in Women**

The common physical changes that affect women’s sexuality result from lowered levels of estrogen hormones after menopause. Postmenopausal women usually experience a decrease in vaginal lubrication—which may make coitus uncomfortable—and a decrease in vaginal expansion during arousal. Nonprescription vaginal lubricants are readily available and effective for this problem.

Older women also may notice changes in the shape and flexibility of the vagina. However, these changes should not affect one’s ability to enjoy sexual activity. Moreover, sensitivity of the clitoris and nipples remains unchanged with age. The sexual tension that occurs just before orgasm may be less dramatic in older women, but the constriction in the vagina and withdrawal of the clitoris under the hood is the same as in younger women. A somewhat surprising result of more men using medication for erectile dysfunction is the increased pleasure the men’s use of these treatments is giving their female partners, no matter what their age—a finding that challenges the widely held belief that older women are not all that welcoming of their partner’s newfound ardor (AARP, 2005).

**Hormonal Changes and Sexual Response**

As we age, there are accompanying changes in the levels of sex hormones, although it is not clear whether or how these may impact our sexuality. Sexual dysfunction may occur at any point of the sexual response cycle but most typically involves difficulties related to sexual arousal or to orgasm. A model proposed by Masters and Johnson (1966) consists of four phases: excitement, plateau, orgasm, and resolution. Examination of these phases in elders suggests that aging has the greatest impact on arousal (Sharpe, 2004), particularly because of changes in hormone levels. Orgasm, on the other hand, is least affected, and the refractory period is more affected in men than in women. Table 16-3 summarizes the changes described in this section.

Androgens, from the Greek word andros for male, circulate at the highest levels in men. The most important androgen is testosterone, which is present in both men and women. On average, men have at least 10 times more testosterone than women (Worthman, 1999). Men produce testosterone primarily in their testes, with a small additional amount produced by the adrenal glands. Testosterone levels are not constant; they fluctuate on a daily cycle and according to daily events. Research has shown that testosterone is responsive to physical, emotional, and intellectual challenges. On average, testosterone levels of U.S. males tend to go into a steady decline after age 20, and the hormone’s concentration in the blood decreases by about 30% by the time a man reaches the age of 80 years (Worthman, 1999). This pattern of hormone decline with aging, however, is not universal. For example, one cross-cultural study indicates that male subjects in Bolivia have a modest decrease in testosterone levels after age 30, with hormone levels remaining relatively stable after that time (Leary, 1992). On the other hand, testosterone in Tibetan males does not peak until the late 50s and then falls precipitously during the 60s and 70s (Worthman, Beall, & Stallings, 1997a). A study of dihydroepiandrosterone sulfate (DHEAS), an androgen produced by the adrenal glands, also showed dramatic variations in level by age when U.S. males were compared with Bolivians and Tibetans (Worthman, Beall, & Stallings, 1997b). Neither the cause nor possible significance of this variation is known at present; however, the lack of a universal pattern suggests that environmental factors, such as nutrition and other cultural factors, may play a significant role in the regulation of these hormones.
Sexual desire and satisfaction may be less affected by age than arousal and ejaculation (Sharpe, 2004). That is, decreasing erectile capacity in aging men may be related to decreasing sensorineural and autonomic function; however, factors other than the frequency of and potency for sexual response are important to the overall rating of sex life. Many factors apparently contribute to this situation, including decreased health and mobility, increased incidence of disease, partner considerations, and increasing neurological dysfunction.

Women produce lesser amounts of testosterone in their ovaries and adrenal glands than men do in their testes and adrenal glands. The brain can convert testosterone into estradiol, so that the “male hormone” becomes the “female hormone.” Scientists are uncertain whether testosterone has any separate effect in women other than to increase the available estrogen reaching the center of the brain that controls sexual motivation and drive.

Like testosterone, estrogens are a part of a shared male and female biology, although estrogens circulate at higher levels in women than in men. There are actually three estrogens—estrone, estradiol, and estriol—forming a closely related family. In both men and women, estrogens appear more directly necessary to staying alive than androgens. There is a great deal of controversy about the connection between blood levels of testosterone and measures of sexual desire, or libido. Moreover, some researchers have suggested measuring bioavailable testosterone rather than serum testosterone (Rowland, Greenleaf, Dorfman, & Davidson, 1993). However, the relationship of testosterone to sexuality is intriguing.

At the onset of menopause, a woman’s ovaries and adrenal glands produce less testosterone and other androgens. As a result, the amount of testosterone circulating in the body is reduced by at least half. Although some women may react to this change by experiencing a noticeable drop in sexual desire, others do not. Some researchers believe women who find their sex drive diminished during menopause may respond to testosterone therapy. However, caution is suggested. There is more to libido than hormones, and a lack of sexual desire may result from any of several causes (Mohan & Bhugra, 2005).

Estrogens are produced by the testes in males and by the ovaries in females. Men make estradiol, and women make all three estrogens. Each is concentrated in a different part of the body and has its own place in the life cycle. In women, estrogens serve to maintain the condition of the vaginal lining and to produce vaginal lubrication. There is no known function for estrogen in men. However, estrogen therapy may be helpful to men as well as women. For example, researchers at Johns Hopkins University have found that a form of estrogen increased the blood flow to the heart by nearly a third in men with coronary artery disease (Blumenthal et al., 1997).

The use of hormones or other medicines (including those for erectile dysfunction) has grown tremendously. About half of former or current users of medication for a sexual problem who have a regular sex partner report that the medicine had a positive effect on their relationship with their partner. There is a lack of clear research about the benefits and risks of hormone replacement therapy, whether estrogen for women or testosterone for men or women. Therapists should encourage their clients to discuss these issues carefully with their physicians and to weigh potential advantages and disadvantages.
if blood pressure is normal. In general, if a patient can walk about 300 yards on flat surfaces or climb two flights of stairs briskly without getting chest pain or feeling breathless, sexual activity is probably safe. Those who have had a heart attack should check with their physician prior to resuming sexual activity. Use of Viagra and similar medications may be dangerous, and taking nitroglycerine with these medications is not recommended.

Cerebrovascular Accident

Cerebrovascular accident (CVA, or stroke) is the third leading cause of death in North America, yet little is known regarding sexual problems and adjustment following CVA. Several studies (Korpelainen, Nieminen, & Myllalä, 1999; Monga, 1993) suggest that cerebrovascular diseases may commonly result in sexual dysfunction, leading to a marked decrease in sexual activity. However, a Finnish study (Sjögren, Damberg, & Liliequist, 1983) found the number of patients who completely stopped having sexual intercourse after the stroke was markedly lower (33% of patients, 27% of spouses) than previously reported.

Psychological and social factors seem to exert a strong impact on sexual functioning and the quality of sexual life after stroke (Nadler, 1997). Common physical problems of those who have sustained a stroke are decreased libido and arousal, decreased vaginal lubrication, decreased incidence of orgasm, premature ejaculation or inability to ejaculate, pain, lack of satisfaction, and hypersexuality. In addition, CVA may result in sensory, motor, or cognitive deficits, spasticity, contractures, aphasia, or incontinence. Psychological changes may result in anxiety, depression, and changes in self-image or

**BOX 16-1 Some Illnesses that May Affect Sexual Arousal or Desire**

- Testosterone deficiency caused by aging, disease of the testicles, surgery or injury to the testicles, diseases of the pituitary gland, surgical removal of adrenals or ovaries
- Cardiac disease, including coronary artery disease, postcoronary recovery, high blood pressure
- Liver problems including hepatitis, cirrhosis
- Kidney problems including nephritis, renal failure, dialysis
- Pulmonary diseases
- Degenerative diseases
- Thyroid diseases
- Head injuries
- Psychomotor epilepsy
- Hypothalamic lesions
- Pituitary gland tumors
- Chronic obstructive pulmonary disease
communication. Aphasia can interfere with communication about sexuality. The site where the brain damage occurred also may affect sexuality. Kinsella and Duffy (1979) found that psychosocial factors play a crucial role in determining sexual drive, activity, and satisfaction after stroke, and their influence is even stronger than that of medical factors.

**Arthritis**

The pain, stiffness, fatigue, and limited ability associated with joint inflammation may interfere with sexual activity (Nadler, 1997). Several small clinical studies have shown that approximately half of arthritic men and women experience sexual problems, including fatigue, weakness, pain, and limited movement. Pain and stiffness of the hip joints were the main causes of sexual difficulty, and approximately one out of five patients reported a loss of libido or sex drive. Some arthritis drugs, especially corticosteroids, have been shown to reduce sex drive.

Sexual dysfunction in arthritic patients may be difficult to manage for several reasons. The nature of the problem may be difficult to diagnose because it often is complicated by the underlying medical condition. In addition, chronic illness places a great deal of stress on patients and their relationships. For those suffering from arthritis, it is important to find positions that avoid or reduce pain and pressure on the affected joints.

Pain management is a particular concern for individuals with arthritis, and use of appropriate pain medications may be warranted. As is true with other physical conditions, clients should be encouraged to discuss this issue with their physician to ensure that appropriate interventions are provided. Positioning and relaxation strategies can also help, and therapists will want to explore these nonmedical methods with their clients.

**Chronic Obstructive Pulmonary Disease**

Pulmonary diseases are not uncommon in later life. Individuals who have smoked are particularly at risk, but others may develop chronic obstructive pulmonary disease (COPD) as well. Individuals with COPD are likely to tire easily, so that sexual activity may result in excessive stress or fatigue. Someone tethered to supplemental oxygen may find that with the oxygen, activity is limited by the device, and that without it, fatigue is too great to allow for activity. Therapists can help clients explore alternatives that may reduce energy expenditure and thereby allow for sexual expression.

**Other Factors Affecting Sexuality**

**Alcohol and Other Drugs**

Alcohol and other drugs interact with the cerebral cortex, autonomic nervous system, and the neural structure of the limbic system. Drugs that affect the cerebral cortex and the limbic system interfere with motivation, judgment, and emotionality. The Massachusetts Male Aging Study (Bremner & McKinlay, 2003) found that lower amounts of alcohol intake, not smoking, and increased physical activity were related to lower rates of sexual dysfunction among men in their study. These results were also found in a study by Bacon et al. (2003), who found that physical activity greater than or equal to 2.7 hours/week was associated with lower risk for erectile dysfunction, but alcohol consumption and smoking resulted in increased risk for erectile dysfunction in men. Decreased sexual performance may provide motivation to alter these health risk behaviors.

Any substance that interferes with vasocongestion or myotonia can produce sexual problems by interfering with erection and orgasm. This can occur in men or women because the neurophysiology of orgasm is similar for both.

Excessive alcohol consumption may adversely affect sexual arousal and sexual performance at any age. However, there may be a cumulative effect on long-time heavy drinkers. Although some people report that the use of drugs and alcohol make them feel less inhibited and freer to enjoy sex, acute or chronic use of alcohol and drugs can inhibit sexual desire, performance, and satisfaction in men and women. Abuse of alcohol and drugs almost inevitably contributes to sexual problems not only directly, but also by affecting emotions and straining relationships.
for erection and orgasm after a prostatectomy should most often return to the presurgery level.

**Emotional Concerns**

Psychiatric illnesses, especially major depression and dementia, are frequently associated with sexual dysfunction in late life. Decreased libido is a cardinal symptom of depression. In one study it was found that more than 70% of depressed patients had a loss of sexual interest when not taking medication, and they reported that the severity of this loss of interest was worse than the other symptoms of depression (Casper et al., 1985). Depression itself can impair sexual performance, and certain antidepressants trigger sexual dysfunction. However, sexual dysfunction is a common side effect seen in patients taking antidepressants, particularly selective serotonin reuptake inhibitors (SSRIs) (Beers & Berkow, 2000). Modifications to therapy including reducing drug dosages, altering timing of drug dosages, taking drug holidays, adding an adjunctive drug, and switching to alternative antidepressants can be employed to eliminate undesirable side effects.

Alzheimer's and other dementias can have a profound effect on sexuality (Ward et al., 2005). Sometimes sexual desire increases and can result in unreasonable and exhausting demands, often at odd times or in inappropriate places. Occasionally, aggression may be shown if those needs are not met. Other individuals may lose interest in a physical relationship and may become very withdrawn. Sometimes there is a loss of inhibitions and there may be sexual advances to strangers, or other inappropriate sexual behavior such as undressing or fondling in public. Sexual advances are sometimes made because the person with dementia mistakes another person for their partner. Sometimes, an action which appears sexual (e.g., a woman lifting her skirt) may be an indication of something else, such as the need to go to the toilet.

**TABLE 16-4 Some Prescription Medications with Possible Sexual Side Effects**

<table>
<thead>
<tr>
<th>Type of Drug</th>
<th>Trade Names</th>
<th>Potential Problems</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tranquilizer; antianxiety</td>
<td>Valium, Xanax, Ativan</td>
<td>Changes in libido; erection problems; delayed orgasm/ejaculation</td>
</tr>
<tr>
<td>Antidepressant</td>
<td>Prozac, Zoloft, Paxil, Effexor</td>
<td>Changes in libido, delayed orgasm/ejaculation</td>
</tr>
<tr>
<td>Antihypertensive</td>
<td>Clonidine, beta blockers</td>
<td>Erectile dysfunction, decreased libido</td>
</tr>
<tr>
<td>Ulcer medication</td>
<td>Tagamet</td>
<td>Decreased libido, erectile dysfunction</td>
</tr>
</tbody>
</table>
Psychosocial stresses such as the loss of a partner due to disability or death, fears of self-injury or death due to medical conditions (e.g., history of myocardial infarction, shortness of breath), or sensitivity to loss of personal appearance or control of hygiene (e.g., due to incontinence or the presence of a colostomy) can sometimes spell the end of an individual’s desire for sexual activity.

Older individuals living in social isolation, suffering the threat of health problems, and coping with adjustments to physical changes associated with aging may be at especially high risk for emotional problems with consequent sexual implications. Sexuality involves a balance of emotional and physical factors: How we feel affects what we are able to do. A man who fears he may not have an erection may experience sufficient stress to prevent an erection. In fact, many aging men suffer from performance anxiety and may avoid sex rather than risk “failure” in front of a partner. On the other hand, a woman who has always associated coitus with reproduction may feel little need for sex after menopause.

Sexually Transmitted Diseases and the Elderly Population

Older men and women are at significant risk for HIV/AIDS and other sexually transmitted diseases. Not only are many older individuals sexually active, especially in retirement communities where social opportunities abound, but they may be at risk because of a lack of information. Whether you are 18 or 80, unprotected sex with a partner with an unknown sexual history carries risks. At an age when pregnancy is not a concern, many never think of using protection; the safe-sex message aimed at the younger generations is often lost on the sexually active older adult. In fact, the elderly are one sixth as likely to use condoms during intercourse as compared to those in their 20s (Gott, 2005; Goodroad, 2003).

Syphilis, genital herpes, and chlamydial infections do not appear to present any differently or to be more severe in older persons. However, elders are clearly not immune from HIV infection, and these infections appear to progress more rapidly to AIDS and death in elders as seen in Table 16-5. A report from the Centers for Disease Control (www.cdc.gov/hiv/topics/surveillance/resources/slides/epidemiology/slides/EPI-AIDS.ppt, 2005) indicates that more than 50,000 cases of AIDS have been reported among individuals older than 55. The normal aging changes in older women, such as a decrease in vaginal lubrication and thinning vaginal tissue, can put them at higher risk during unprotected sexual intercourse.

Typically, older people with HIV/AIDS are diagnosed later, experience more rapid progression of the disease, and survive a shorter period of time than those who are younger, although the observed shorter survival time may result from a delay in diagnosis, because health care professionals may not suspect HIV/AIDS among older patients (Goodroad, 2003). Symptoms of HIV infection are often nonspecific, including anorexia, weight loss, and decreased physical and cognitive function. The most common opportunistic infections in older HIV-infected patients are Pneumocystis carinii pneumonia, tuberculosis, Mycobacterium avium complex, herpes zoster, and cytomegalovirus. HIV-related dementia may be confused with Alzheimer’s disease.

Summary

Culture and Society

There appear to be at least three cultural myths about the sexuality of older adults that are not true: that older adults do not have sex, that new drugs have greatly enhanced the sex lives of older adults, and that people find each other less physically attractive over time.

Fewer North Americans live in generationally integrated neighborhoods. Since the birth of suburbia after World War II, there has been an increasing tendency toward age-segregated residential patterns. The popularity of retirement communities is only the most recent example of this trend, and one effect of

<table>
<thead>
<tr>
<th>TABLE 16-5 AIDS Cases by Age</th>
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</thead>
<tbody>
<tr>
<td><strong>Age</strong></td>
</tr>
<tr>
<td>50 to 54</td>
</tr>
<tr>
<td>55 to 59</td>
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<tr>
<td>60 to 64</td>
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<tr>
<td>65 and older</td>
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</table>

Implications for Health Care Providers

The preservation and enhancement of sexual activity in geriatric patients requires an understanding and sensitivity to the fact that many individuals want and intend to continue sexual activity, despite changes in physical and sexual function.

Clearly, there is a role for health professionals as advocates to represent the right of those in late adulthood to pursue sexual pleasure with other consenting adults. Providing for privacy, supporting relationships, and addressing cultural stereotypes would have positive effects on the health, self-esteem, and dignity of many elderly individuals. Medical and other health care professionals have tended to subscribe to cultural stereotypes as much as society in general. There is a need for health professionals to initiate education for change with regard to sexuality in late adulthood. After all, even young adults have a vested interest in this change, because they may expect to become older adults at some point in the future.

Despite its importance to the quality of life, when it comes to sexuality, “don’t ask, don’t tell” seems to be the preferred approach of most health care professionals. Although about one-fourth of older adults report seeking treatment from a medical professional for a problem related to sexual function (AARP, 2005), sexuality is typically ignored during the medical assessment of clients of any age. Cultural stereotypes about aging make it even less likely that sexuality will be discussed with older patients. If patients do bring up the subject of sex, at best they may be handed a generic informational brochure or at worst be shamed for bringing up such an “inappropriate” topic. This anxiety may be fueled by a lack of training, because few health care professionals have had formal instruction in human sexuality through the life cycle. In addition, our own sexual attitudes, values, and beliefs affect our professional responsibility to address sexuality as a legitimate health care issue. Open-minded, non-judgmental individuals who are comfortable with their own sexuality are likely to approach the topic differently than those who believe that sexuality is limited to genital contact between married heterosexuals under a certain age.

Sexuality probably is not discussed with clients for many reasons. Health care professionals may believe that it is someone else’s responsibility (H. Goldstein & Runyon, 1993). They may lack education on the subject, believe
that other “more important” issues take precedence, think their clients would be embarrassed, or, more likely, would themselves feel uncomfortable. Communication with older adults and families is critical to the fulfillment of sexual health. For older couples in new relationships, it is often difficult for families to appreciate that their older relative may have a new relationship. Family meetings may help to open up communication with the couple and their loved ones.

Assessing sexual concerns can be done in the context of addressing limitations or changes in the patient’s lifestyle and general health care issues. The evaluation of sexuality concerns may be done in the form of a simple checklist or as open-ended questions such as “what concerns you about your sexuality?” Another technique is to make a general statement indicating that other patients have expressed concerns about how a disability or illness affects sexuality, and to ask whether this is something that the client would like to discuss. This gives patients the opportunity to discuss any sexual concerns or to decline if they do not have any problems or do not choose to discuss them at that time or with that caregiver. Among the important considerations are the following:

- Look for possible barriers to sexuality—for example, lack of knowledge and understanding about sexuality, loss of partners, and family influence on sexual practice often present substantial barriers to sexual health among older adults.
- Privacy issues may present a substantial barrier to sexual health among older residents of long-term-care facilities. Consequently, arrangements for privacy must be made among consenting adults. These arrangements may include a resident’s room or an appropriate and private common room. Patient safety while maintaining privacy should be considered by ensuring access to call lights and adaptive equipment as necessary.
- Determine the presence of any physiological changes through a health history, review of systems, and physical examination for the presence of normal and aging changes that impact sexual health.
- Address concomitant factors such as fatigue, incontinence, fear of incontinence, spasticity, pain, and hormonal issues.
- Review medications, as many of those commonly used to treat depression and hypertension among the elderly impact sexual desire and response. Potential medications should be identified by reviewing the client’s medication bottles, and the client should be questioned about the potential impact of these medications on sexual health. If the medication is found to impact sexual health, alternative medications should be considered.
- The older adult should also be questioned regarding the use of alcohol, as this substance has a potential impact on sexual response. Also consider if depression may be affecting sexual health.
- Cognitively impaired older adults continue to have sexual needs and desires but may lack the capacity to make appropriate decisions regarding sexual relationships. Accurate assessment and documentation of the ability to make informed decisions regarding sexual relationships must be conducted by an interdisciplinary team. Limits must be placed on any inappropriate sexual behavior, such as public masturbation, disrobing, or making sexually explicit remarks that may be a result of dementia or other neurological conditions.
- Sexual problems resulting from chronic illnesses are prevalent among the older adult population. In many cases, these problems are treatable. For example, erectile dysfunction/impotence in older men with chronic medical illnesses is often effectively treated with new erectile agents. Physician referral for these needs should be made without hesitation.
- Occupational therapists should be aware of, and ask about, specific performance skills or body functions and body structures that contribute to sexual dysfunction. For example, an individual with arthritis might need to discuss positions that reduce pain and conserve energy.
- Should a patient present a sexual concern, the health care professional needs to assess whether it is a problem of sexual desire (e.g., decreased or hypoactive sexual desire), a problem of sexual function (e.g., erectile dysfunction), or a problem of sexual satisfaction (e.g., anorgasmia, premature ejaculation). Other concerns might be related to sexual self-image if the client’s body, which was once a source of pleasure, is now a source of discomfort or disfigurement. In addition, there may be a relationship issue with a partner or spouse, or concerns about the loss or lack of a sexual partner.

Many professionals find the PLISSIT intervention model a helpful guide in working
with sexual issues (Annon, 1976). The acronym PLISSIT stands for Permission • Limited Information • Specific Suggestions • Intensive Therapy. Health care professionals should be able to provide the first two levels (PLI) of intervention, because most people simply need permission to talk about their sexual concerns in a supportive, confidential environment and be assured that their feelings are normal and acceptable. Some patients may need limited information about their specific problem and for the professional to provide accurate answers to their questions. Others, however, may require specific suggestions about how to deal with a particular problem or intensive therapy to resolve their concerns (SSIT). In such cases, the appropriate course for the health care professional may be to refer the patient to a qualified professional who is better prepared to meet the patient’s needs.

Dealing with the sensitive area of sexuality also may bring up ethical considerations. Health care providers must be aware of the limits of their own comfort, knowledge, and skills, and be prepared to refer to someone better qualified to help a patient with a sexual problem.

Most codes of ethical behavior for health care professionals explicitly forbid sexual contact between a health care provider and a client for very good reasons. Research has found that the inherent power imbalance makes a client vulnerable to exploitation and leads to negative effects for most clients who have had a sexual relationship with a health care professional (Friedman, 1997; Gabbard & Nadelson, 1995). It is imperative that professionals maintain appropriate boundaries to protect their clients from harm and protect themselves from professional or legal liability.

Boundaries are equally important if the professional is faced with a patient who makes inappropriate sexual remarks or sexual advances. Flirtatious behavior or sexual joking may be the patient’s way of coping with his or her own anxiety, expressing an interest in the topic of sexuality if the topic has not been addressed directly, or “trying out” his or her sexuality (Friedman, 1997). In a firm but friendly manner, the professional can acknowledge and redirect the patient’s expression of his or her needs. If a patient exhibits abusive or threatening verbal or physical sexual behavior, it should be documented and reported to a supervisor. Depending on the circumstances, psychiatric or neurological consultation may be indicated.

Health care professionals must recognize their limits and deficiencies in the area of sexuality and maintain balance and respect in what they do. Ignoring the sexual dimension may adversely affect the patient’s well-being, whereas attention to this area may improve the patient’s quality of life (Goldstein-Lohman & Aitken, 1995).

**Case Study**

Mr. Smith is a 67-year-old male who was diagnosed with Alzheimer’s disease 4 years ago. Although he still lives at home with his wife, he recognizes her only intermittently. He needs help with all his self-care activities except feeding himself, and his wife feels an obligation to assist. An occupational therapist has been asked to review the home for safety, and to recommend environmental modifications to assist Mrs. Smith in providing care for Mr. Smith.

At the end of the visit, Mrs. Smith pulls the occupational therapist aside. In a somewhat halting fashion, Mrs. Smith tells the OT that her husband has recently been “bad.” When the therapist inquires about what this means, it develops that Mr. Smith has been attempting to disrobe in public, and has repeatedly fondled Mrs. Smith in public. She is embarrassed and unsure how to handle this.

**Questions**

1. What might the occupational therapist do to respond to Mrs. Smith’s concerns?
2. Given that Mr. Smith appears to want continued sexual activity with his wife, what suggestions might you make to help deal with his socially unacceptable expression of this wish?
3. How can Mrs. Smith’s concerns be taken into account?
Review Questions

1. What are the major demographic factors affecting sexuality in late adulthood?
2. What is the general level of sexual activity for older men and women? How does it change through late adulthood?
3. What is the general level of sexual satisfaction for men and women in late adulthood?
4. How do health status and health care affect the sexual activity and satisfaction of older adults?
5. What are some of the diseases that can lead to erectile dysfunction? What is the primary physiological cause of erectile dysfunction?
6. How do cardiovascular diseases, stroke, and arthritis affect sexuality?
7. How does depression affect sexuality?
8. Name four prescription medications that can adversely affect sexuality, and indicate the nature of those potential side effects.
9. What are three cultural myths about sex and older adults?
10. What is the PLISSIT model?

Web-Based Resource

For helpful information about the experience of sexuality in late adulthood visit:


www.aarp.org/health/, AARP (The Health Site), date connected May 23, 2007. This site includes survey and research, as well as health care tips and information.


REFERENCES


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