

Chapter 2

Knowledge of Sexuality and Aging

Many men and women engage in vaginal sex, oral sex, and masturbation well into their 80s and 90s. Significant gender differences appear as older women are more likely to be limited by the availability of a partner and older men are more likely to be limited by physical health and erectile dysfunction.

Gathering information about an older client's sex life is challenging, rewarding, and a requisite part of an intake interview. In order to make this practice more effective and efficient, clinicians themselves can become more informed about basic aspects of elderly sexuality. Various large-scale national and international research studies indicate that older adults report being sexually active well into their 80s and beyond. Predictors of middle-aged and older adults' sexual activity include their prior level of sexual activity and satisfaction, the availability of a partner, and physical health. Knowledge of sexuality has also expanded, in which new empirical findings from large-scale studies suggest that aging adults engage in a wider variety of sexual behaviors, including masturbation, anal sex, and being sexually active with multiple partners, than previously believed. However, significant gaps in the literature regarding minority group and LGBT members' sexuality and aging remain.

Many adults appear uninformed about the physiological changes typically associated with aging and sexuality; many do not know that erectile dysfunction may be treatable or that masturbation can promote improved vaginal lubrication in women. Many aging adults, as well as their health care providers, are unaware that commonly prescribed medications and over-the-counter drugs can significantly impair sexual function. Gathering information about a patient's past and current sex life can reveal important information about close relationships, body image, knowledge of sexuality and aging, trauma, medical history, gender roles, and self-esteem. As informed clinicians, the chance to discuss issues of sexuality with both middle-aged and older patients presents unique opportunities and benefits.

Frequency and Types of Sexual Behaviors

Early Research Findings

The first empirical studies to provide information about the sexual practices of older adults were conducted in the 1950s by Kinsey and his colleagues (Kinsey et al. 1948, 1953). It is notable that before this time, the sexual life of older adults was virtually unexplored in any scientific way. Societal prohibitions against the discussion of such topics certainly influenced the overall lack of research prior to this time, and led to an uproar among some segments of the public when these landmark studies' results were released.

What Kinsey and his colleagues revealed was that among their sample of community-living older adults, men over the age of 60 engaged in intercourse slightly more than once a week on average, with no sudden decline in sexual activity related to aging. Women over the age of 60 were found to engage in intercourse less frequently than their male counterparts, but with similar patterns of sexual behavior to those reported in their late teenage years. In the mid-1960s, Masters and Johnson (1966) also pronounced that men and women were biologically capable of engaging in sexual intercourse at any age.

Another series of researchers presented more detailed information regarding older adults' sexual behaviors during the mid-1970s and 1980s. George and Weiler (1981) recruited more than 340 elderly husbands and wives in a longitudinal study of sexual behavior. Excluding the effect of losing a partner by widowhood, the frequency of sexual activity among these older men and women remained remarkably stable over the 6-year study period. These spouses reported that they engaged in sexual intercourse between one and two times a week on average. Pfeiffer and Davis (1972) found that elderly women were more likely to engage in sexual relations if they were married.

Specifically, an older woman's marital status, particularly whether she was divorced or single, was a better predictor of a decrease in her reported frequency of sexual intercourse than was her age itself. Although this finding appears remarkably obvious, it marked a drastic and important change in the way in which sex researchers began to interpret their basic frequency reports of sexual intercourse among older adults. Researchers, like clinicians, began to focus on some of the individual aspects of older adults that made them more or less likely to engage in specific types of sexual behavior. In other words, understanding the context in which an older person's sexual expression takes place began to take precedence over the acquisition of absolute numbers or base rates.

Other investigators also began to explore sexuality and aging beyond the singular act of intercourse. Butler and Lewis (1976) indicated that the sexual behaviors engaged in by elderly persons often encompassed more than intercourse, and that older adults often placed greater emphasis on cuddling, fondling, and mutual manual stimulation. Botwinick (1984) also expressed the importance of examining sexual gratification in regard to a variety of sexual behaviors, including masturbation.

However, empirical findings regarding the percentage of older adults who engage in masturbation have varied greatly. For example, Starr and Weiner (1981) revealed that approximately one-half of the older participants in their study engaged in masturbation on a regular basis. In contrast, the majority of older participants in a study conducted by Waslow and Loeb (1979) reported that they refrained from self-stimulation, primarily out of religious concerns and an overall lack of privacy in an institutional setting. In sum, the few studies that did examine the extent to which older adults engaged in masturbation varied widely in their selection of participants and the extent to which they addressed contextual issues (e.g., availability of a partner, religious beliefs, and prohibitions), and their subsequent findings appear just as varied.

US Population Data

Despite the necessity of evaluating older adults' sexual behavior on an individual basis, a number of recent research studies do provide valuable information about general trends in sexual relations across the life span, and about some of the factors that are predictive of sexual activity with age. Again, emphasis should be placed on the fact that these research studies only highlight general trends, and that they do not indicate absolute ideals or expectations for midlife and older adults. What the findings of these studies do offer, however, is a wealth of information that contradicts the commonly held stereotype that older adults are asexual beings who do not participate in or desire sexual relations.

Within the last decade, findings from a number of large, nationally representative surveys now allow for an examination of middle-aged and older adults' reported participation in a variety of sexual behaviors. (Previous studies provided valuable insight into older adults' frequency of sexual intercourse and other behaviors, but those studies typically were smaller, non-representative community-based or convenience samples). Two of the largest studies that provide a representative cross-section of the US population are the National Social Life, Health, and Aging Project (NSHAP; Lindau et al. 2007; Waite et al. 2009), including responses from 3,005 men and women aged 57–85, and the 2010 American Association of Retired Persons (AARP) Survey of Midlife and Older Adults (Fisher 2010), derived from responses from 1,670 men and women between the ages of 45 and 90.

The NSHAP included in-home interviews and oversampled Black, Hispanic, male, and 75–85 year-old participants; whereas the AARP study represents the first online research study of its kind to provide a representative US sample, including an oversampling of Hispanic participants. This oversampling allowed for greater numbers of underrepresented groups to be included in the surveys, and provided enough responses to provide statistically meaningful analyses. (Individuals recruited for the AARP survey also were provided with Internet access if they did not already have it). Although the two studies differ in the ways in which the age ranges of participants were broken down for analysis, with the NSHAP reporting data for men and

Table 2.1 Participation in sexual behaviors by age and gender

National Social Life, Health, and Aging Project (NSHAP) 2007 US survey				
		Age range		
		Percentage agreement within previous year		
		57–64	65–74	75–85
Men	Behavior			
	Any kind of sex	84	67	38
	Vaginal sex ^a	40	31	23
	Oral sex ^a	62	48	23
	Anal sex ^b	–	–	–
	Foreplay ^{a,c}	94	90	92
Women	Masturbation	63	53	28
	Any kind of sex	61	40	17
	Vaginal sex ^a	34	31	24
	Oral sex ^a	53	46	36
	Anal sex ^b	–	–	–
	Foreplay ^{a,c}	89	88	89
	Masturbation	32	22	16

American Association of Retired Persons (AARP) 2010 national survey					
		Percentage agreement within the last 6 months			
		45–49	50–59	60–69	70+
Men	Vaginal sex	69	72	60	40
	Oral sex	63	56	30	17
	Anal sex	19	23	3	1
	Foreplay ^c	82	85	84	73
	Masturbation	66	72	50	47
Women	Vaginal sex	58	51	45	13
	Oral sex	49	38	25	9
	Anal sex	8	4	5	1
	Foreplay ^c	74	69	61	41
	Masturbation	50	48	37	18

European Male Ageing Study (EMAS) European, cross-national 2010 survey					
		Percentage agreement within the last month			
		40–49	50–59	60–69	70+
Men	Vaginal sex ^a	96	93	81	60
	Foreplay ^c	93	92	81	73
	Masturbation	57	46	36	26

^aSample limited to those participants with an available partner^bNot assessed^cIncluded kissing, hugging, sexual touching, petting, and caressing

women aged 57–64, 65–74, and 75–85, and the AARP study reporting data for men and women aged 45–49, 50–59, 60–69, and 70 and older, a number of age and gender differences emerge along a variety of dimensions. Please refer to Table 2.1 for selected findings.

To provide an overview of relevant findings from these US population-based studies:

- Both older women and older men report participation in vaginal sex, oral sex, and masturbation well into their 80s and 90s.
- Older men and women are significantly less likely to participate in vaginal, oral, and anal sex and masturbation than middle-aged men and women.
- Men, whether they are middle-aged or older, are more likely to have vaginal, oral, and anal sex, and to masturbate than women.
- Older adults appear unlikely to “substitute” oral sex or masturbation for vaginal sex, when it is unavailable, although rates of participation in foreplay remain consistent across age.
- Approximately 10% of aging men and women report a sexual orientation other than heterosexual.
- Six percent of men and one percent of women indicate that they have multiple sex partners, while less than 5% report usually or always using condoms.
- Significantly, more Hispanic men report participation in weekly vaginal sex than non-Hispanic men.

More specific findings reveal that older adult men and women in America, including those with and without an available partner, are less likely to report that they have any kind of sex than their middle-aged counterparts. To provide some base rates, findings suggest that at least 85% of middle-aged men in the USA have sex at least once annually, whereas 67% of the young-old men (aged 65–74) and only less than half or 38% of the middle-old men (aged 75–85) have sex at least once each year. Women in the USA report having sex significantly less than men, with at least 61% of middle-aged women, nearly half (40%) of the young-old women (aged 65–74), and only 17% of the middle-old women (aged 75–85) having sex at least once a year. It also is important to note that these reported “base rates” for participation in sexual activity may be skewed due to differences across gender and age regarding the availability of a partner. Among those in the AARP (Fisher 2010) survey, men aged 70 and older were twice as likely to report having a recent or currently available sexual partner (63%) than women aged 70 and older (34%). A number of factors may contribute to this significant gender difference, including the longevity of women compared to men and the propensity of men to select younger female partners. Even into the eighth and ninth decade of life, however, older men and women report participation in vaginal and oral sex, as well as masturbation.

Fortunately, both the NSHAP (Lindau et al. 2007; Waite et al. 2009) and AARP (Fisher 2010) surveys provide information about the sexual behavior of aging men and women with available partners. Partnered middle-aged and older women and men’s reported participation in vaginal, oral, and anal sex also can be compared to their reported use of foreplay and masturbation, allowing for some important conclusions. For example, as women age, their participation in vaginal sex does not decrease significantly as long as they have an available sexual partner. In contrast, among men with an available sexual partner, their participation in vaginal sex declines significantly with increasing age, suggesting that some aspect of male

sexuality, likely impaired health or ED, is responsible for a decline in participation. It also is important to note that aging adults do not appear to substitute oral sex for vaginal sex; no increases in the use of oral sex coincide with decreases in vaginal sex. Similarly, rates of participation in masturbation do not increase (as a substitute) as declines in vaginal sex occur. It appears that masturbation is an activity separate from partnered sexual activity. It also is important to note, however, that this finding may be due to cohort effects; the average, aging baby boomer may consider the use of other forms of sexual behavior, such as oral sex, or self- or mutual masturbation, when vaginal sex is not part of their repertoire.

Additional findings from the NSHAP (Lindeau et al. 2007; Waite et al. 2009) and AARP (Fisher 2010) surveys are notable. While 92% of the AARP participants identified their sexual orientation as heterosexual, 3% reported that they were gay, 1% reported lesbian, 1% indicated bisexual, and the remaining reported "other" which included "bicurious" and gay individuals who were married. Among those respondents who were Hispanic, they were significantly more likely to report having vaginal sex at least once a week (39%) when compared to all other respondents (28%). This difference remained consistent when examining participants who had an available partner. In this case, 54% of Hispanic respondents with a partner reported having vaginal sex at least once a week when compared to 41% of all other respondents with an available partner. In addition, of the respondents aged 70 and older, 53% of male Hispanics reported having sex at least once in the past six months compared to 40% of all other respondents. Among respondents aged 70 and older, rates of participation in sex in the last six months were similar for women (approximately 13%) whether they were Hispanic or not. Although the relatively small number of respondents did not allow for a meaningful statistical analysis of these apparent differences by age and gender, it appears that both Hispanic and non-Hispanic men are more likely to engage in vaginal sex in older adulthood than their female counterparts.

General information also could be determined about middle-aged and older adults regarding the presence of multiple partners and condom use. Among all AARP participants, 4% report that they have been sexually active with more than one partner at a time. By gender, 6% of men and 1% of the women respondents indicated that they had simultaneous, multiple partners. Findings from the NSHAP (Lindau et al. 2007; Waite et al. 2009) indicate that less than 5% of older men and 4% of older women "usually or always" use a condom when having sex. Unfortunately, it is not possible to determine from the published survey data what proportion of adults with multiple sex partners use condoms, nor is it possible to identify specific characteristics of those respondents (beyond gender) who were more likely to report having multiple sex partners.

Although these two studies provide vital information about US citizens' participation in various sexual activities across the life span, a number of significant limitations exist. For example, a variety of ethnic minorities (e.g., Asian, Black, and Native American), LGBT individuals, and the oldest-old (individuals aged 85 and older) were not oversampled in order to provide meaningful frequency data for

sexual behaviors. Certainly, these two studies represent cutting edge work in the field, and require significant amounts of funding, but the lack of attention to these underrepresented groups is suggestive of Western culture's predominant acceptance of sexuality among younger, Caucasian, heterosexuals. Future work is needed to establish base rates for sexual activity among other US subpopulations.

Cross-national Findings

Although caution must be taken when comparing the base rates observed in the aforementioned US surveys, a variety of cross-national European studies provide additional information regarding the frequency with which older adults engage in sexual activity. The European Male Ageing Study (EMAS; Corona et al. 2010) obtained information from more than 3,300 community-living middle-aged and older men (aged 40–79 years) from eight different European nations including Italy, Belgium, Sweden, the U.K., Poland, and Hungary. (A number of findings from the EMAS are presented in Table 2.1.)

What is notable from the EMAS study is that European middle-aged and older men with available partners report that they engage in sexual intercourse more frequently than their American counterparts. However, the age-related declines in reports of vaginal sex into older adulthood revealed among American males also appeared among European males. Both American and European males report similar, high levels of participation in foreplay appear to hold continued value above and beyond that associated with a simple precursor to vaginal intercourse.

In relation to masturbation, the European middle-aged and older men's reported participation in masturbation was lower than American men's reports. However, this lower likelihood of participation in masturbation among European men was reported for the previous month versus the past six months in the AARP (Fisher 2010) study and in the past year for the NSHAP. Because European men showed a similar, slight decline in participation in masturbation with increased age, it appears unlikely that they compensated for a lack of participation in partnered or vaginal sex with masturbation. Overall, European and American middle-aged and older men report some differences in their likelihood of participation in various sexual behaviors, but general declines in sexuality activity into older adulthood appear consistent between both groups. Also similar to the American population-based studies, virtually no information is available regarding European middle-aged and older adults who identify themselves as non-heterosexual, as a member of a minority group, or who are among the oldest-old (over 85 years of age.)

In terms of additional cross-national differences, findings from Laumann and colleagues' (Laumann et al. 2006) global study reveal significant discrepancies in sexual behavior and satisfaction between Western and Asian participants. For example, although women's ratings were lower than men's (also see Youn 2009), both women and men from China, Japan, and Thailand reported significantly lower rates

of sexual satisfaction and placed significantly less importance upon sex than their Western counterparts. Additional analyses of the survey data indicate, consistent with smaller cohort studies (Cain et al. 2003), that older Asian men and women engage in sex with significantly less frequency than their Western counterparts. In response to the integrative biopsychosocial model, it is essential to go beyond the simple identification of cultural differences to explore potential, underlying social and psychological mechanisms that may account for those differences (c.f., Lewis 2004). This difference in frequency of sexual intercourse between Asian and Western elders may be attributed, in part, to traditional Asian belief systems (e.g., Confucianism, Taoism, and Buddhism) that place value upon sexual behavior primarily for procreation (Guan 2004; Moore 2010.)

What Is Average and What Is Normal?

In discussing the relative frequency with which middle-aged and older adults engage in sexual activity, it becomes vital to make the distinction between “average” frequencies and participation in types of behavior and “normal” frequencies and types of behavior. As among other age groups and subject populations, it is vital that both patients and practitioners understand the difference between average and normal participation rates. Average frequencies simply represent our best guess at a numerical mean for a specific sexual behavior, based on a specific sample of older adults using a specific research methodology. For example, in one of the earliest reports of sexuality and aging, Starr and Weiner (1981) reported that the participants in their study aged 80 years and older engaged in sexual intercourse 1.2 times per week, on average. However, these figures told us nothing about whether these particular older adults were satisfied with their sexual relationships, whether they desired more or less sexual contact, whether or not they had consistent access to a consenting sexual partner, and if they were healthy enough to engage in certain sexual activities. In other words, what is “normal” or personally acceptable to one older adult may or may not be personally acceptable to another.

Unfortunately, many patients regard clinical averages as a benchmark that they must match or exceed in order to demonstrate that they are aging well. What is normal about sexuality must be assessed on a case-by-case basis, with substantial emphasis placed on the perceptions, feelings, and expectations of the middle-aged or older adult in question. Patients often express incredible relief when they learn from their health care provider that the number that they read in a magazine article (e.g., the AARP magazine) indicating how often they “should be having sex each week” does not indicate what is normal for them. Productive collaborative work between patient and practitioner begins when patients are able to focus on the nature and quality of their own sexual relationships instead of the relations that they believe they should be having in order to meet some primarily arbitrary, albeit “normal, national average.”

Alfredo

Consider the following case example. Alfredo was a 76-year-old, decorated Air Force veteran of World War II. He attended group therapy at a day hospital program for older adults in order to help him work through residual issues from posttraumatic stress disorder. During the war, Alfredo was one of the few men to survive an unexpected enemy attack on his squadron. He interpreted this event as a divine sign that he was specially chosen to survive. This narcissistic interpretation of events helped him to assuage his guilt and to proceed through life with confidence, but at a costly emotional price. Alfredo was particularly fearful of aging because “such a special person as myself should be allowed to remain on this earth for as long as possible.” Regardless of the weather, Alfredo always seemed to wear his leather bomber jacket. He spoke daily about his vigorous exercise routine, feeling “as healthy as a horse,” and still being lucky enough to have all of his hair. Although many of Alfredo’s peers from the group therapy hospital program were irritated by his need to flaunt his wealth, status, and health, they tolerated his displays as if they knew that he could not easily tolerate this narcissistic insult.

Unlike his peers in group therapy, his 72-year-old wife, Aleni, was less tolerant of Alfredo’s narcissistic displays. Aleni sometimes traveled to the hospital with her husband for treatment team meetings and occasional couple’s sessions. In contrast to her husband, Aleni appeared comfortable with her own aging. She appeared happy and confident with her healthy and slightly plump figure. However, she sometimes appeared overly tired, particularly on the days after Alfredo insisted that they take a strenuous sightseeing trip or bike ride. Aleni also admitted to the staff psychologist that her husband was equally demanding in their bedroom. Aleni admitted that although she was pleased that her husband found her attractive and sexy, she sometimes wondered whether he really wanted to make love to her, or if he just wanted to prove something to himself.

When asked to broach the subject as a couple, Alfredo remarked that he just wanted to engage in sex with his wife as much as everybody else. When asked how he knew what “everybody else” did, he spoke about an article that he read in a popular men’s health magazine. The article presented the results from a reader’s poll in which the few elderly men who responded reported that they had sexual intercourse three times a week on average. Alfredo was highly motivated to remain as healthy, sexy, and competitive as the other elderly men. Although it certainly was not possible to address Alfredo’s core narcissistic issues in a few couples session, Alfredo was able to understand that this average number of three essentially was arbitrary. When asked directly, Alfredo also noted that the article did not provide any information about whether these men who engaged in sex many times a week were satisfied with their physical or emotional relationships. The social worker further explained that the elderly men who chose to answer a survey for this young men’s health magazine probably felt pressured to artificially inflate the number of times that they had sex each week.

More importantly, Aleni was able to tell her husband that she only wanted to have sex with him when they *both* wanted to feel close. With support from the

psychologist, she was able to assert her rights to her own body. She told Alfredo that she would think more of him as a man if they had sex less often, but with more emotion and intensity instead of “just going through the motions so you can say you had it with me.” She told him that she wanted to be a special part of his life, and not just some number that he had to live up to. The psychologist was able to draw a parallel to Alfredo’s combat experience; she remarked that while Alfredo was very proud of how many enemy kills he had painted on the side of his aircraft, his wife wanted to be more than just a number to him in his own private war against aging. Alfredo initially balked at the idea, but soon recognized that his wife was being honest and forthright. He learned that his wife based his masculinity and youthfulness on the quality, and not the quantity, of their sexual relations. He also reported that he might feel more relaxed knowing that there was one less area in his life in which he had to measure up to some youthful standard in order to prove that he was special.

Predictors of Sexual Behavior and Satisfaction

In order to aid clinicians in their work with middle-aged and older adults, it becomes important to gather additional information beyond that of simple frequency data or base rates for participation in sexual activity. Equally important underlying factors are related to an aging individual’s physical health, mental health, and level of sexual satisfaction, including the likelihood of sexual dysfunction. In addition to findings from the EMAS, the AARP survey, and the NSHAP, additional information can be gleaned from a Finnish representative national sex survey (Kontula and Haavio-Mannila 2009) and the Australian Longitudinal Assessment of Ageing in Women (LAW) Study (Howard et al. 2006). Relevant participant reports are provided in Table 2.1 by age and gender.

Availability of a Partner

Regarding predictors of middle-aged and older adult’s sexual activity, Matthias et al. (1997) were some of the first researchers to identify aspects of older adults’ lives that may limit or curtail participation in sex. They discovered that older men and women responded differently to life stressors in terms of how they impacted upon their sex lives. For example, marriage appears to be a significant predictor for sexual activity (with the exception of masturbation) among older women, but not for older men. Among women, being single, widowed, or divorced meant that they were less likely to have an active sex life than their married counterparts. As noted previously, as women move from middle-adulthood to older adulthood their likelihood of having an available sexual partner declines significantly.

A variety of factors account for this difference in partner status as a predictor of sexual activity. First, the US culture maintains a double standard in which men are

viewed as hypersexual beings who require a variety of sexual outlets. Although it is more acceptable for men to satisfy those sexual needs within the context of marriage, seeking sexual gratification outside of marriage is tolerated and sometimes viewed as exciting or accepted. The vast majority of prostitutes are women, who often work for married, male clients. Women, alternatively and traditionally, are expected to honor their marriage vows for their entire lives. A female adulterer typically is viewed with contempt, as an ungrateful and selfish spouse. Although recent statistics suggest that women, particularly women who work outside the home, are becoming increasingly likely to engage in affairs in similar numbers as their male counterparts (Fisher 2010), this represents a likely cohort effect in which young adult women appear significantly more likely to engage in sexual affairs than older women.

Perhaps more importantly, the numbers of single older women in the USA greatly exceed the numbers of single older men. Women have a longer life span than men and tend to marry men who are older than them. Due to the basic principles of supply and demand, it is much easier for an older man to seek out a romantic or sexual relationship with a single middle-aged or older woman than it is for her to establish such a relationship with a single middle-aged or older man. Many older men in nursing homes, for example, find that they are not used to all of the attention that they receive from the multitude of single women in their midst. One elderly gentleman in a Florida retirement community took five elderly women at a time with him for breakfast at a local restaurant. Another five women had to “wait their turn” to be one of his guests at lunch. One of these women was noted wryly as saying, “Well, who am I to hurt his feelings and turn down a free lunch?” Another older female resident regarded the situation plaintively and replied, “Sometimes you’ve got to take what you can get.” Clinicians certainly must be aware of the self-esteem issues that come into play in such highly competitive environments.

Physical Health

Another factor that is related to sexual activity among middle-aged and older adults is physical health. Older adults suffering from arthritis, high blood pressure, heart disease, stroke, diabetes, and kidney problems were found to engage in less sexual activity than those older adults who suffered from fewer of these chronic ailments (Matthias et al. 1997). Physical disability, in relation to functional status, also was related to engagement in sexual activity. Both community-living and institutionalized older adults who reported that they had difficulty getting in and out of bed, bathing themselves, and getting dressed and undressed had fewer sexual interludes than those who were independently mobile. Although this finding certainly is not surprising, it can provide relief to older adults who are suffering from medical problems; they learn that they are not alone or unique in their plight. In other words, it is normal for an older person who suffers from physical disabilities to engage in sexual behavior with lesser frequency than an older person in the best of health. However, it also is vital that older adults who suffer from physical illness and

disabilities know that such difficulties do not automatically preclude them from satisfying, enjoyable, and frequent sexual relations if they so choose.

For middle-aged and older adults who are community-living and generally physically independent, physical health still plays a significant role in sexual activity, as reported in a variety of population-based studies including the NSHAP (Lindau et al. 2007), the EMAS (Corona et al. 2010), the AARP 2010 survey (Fisher 2010), and the LAW (Howard et al. 2006). In the AARP survey, the vast majority or 78% of the total sample report that their health is at least “good,” with nearly half or 40% of the total sample reporting that their health is “very good” or “excellent.” Only 21% report their health as “fair” or “poor,” and men, regardless of their age, report being in better health than women. (Of course, it is unclear whether this is a self-report bias in which men choose to view their health more positively than women, if their health status is better than women’s, or if women have higher expectations for their health status than men.) More importantly, 40% of those women and men who rated their health as “excellent” were likely to have sex weekly, versus only 14% of those who rated their health as “poor.” Primary health problems in this community-based sample included high blood pressure (44% of the respondents), back problems (36%), arthritis (32%), diabetes (16%), and depression (16%). It also is notable that, by definition, one of depression’s primary symptoms is a lack of interest in sex. The links between high blood pressure, diabetes, and erectile dysfunction will be discussed in depth in Chaps. 5 and 8.

Sexual Dysfunction

Although sexual dysfunction includes a myriad of disorders and symptoms, most population-based surveys do include some assessment of erectile dysfunction for men and difficulty with lubrication (e.g., vaginal dryness) for women. (Please refer to Table 2.2.) Among middle-aged respondents, the percentage of men who reported some degree of ED ranged from a low of 6% in the European EMAS (Corona et al. 2010) to a high of 31% in the US NSHAP (Lindau et al. 2007). Among the older male respondents, rates of ED ranged from 30% in the Finnish National Sex Survey (Kontula and Haavio-Mannila 2009) to a high of 56% in the US AARP survey (2010) and 64% in the European EMAS (Corona et al. 2010). One trend is clear; self-reported rates of ED increase significantly as men age. Conservatively, approximately half of the men over the age of 70 report some degree of ED. Of course, it also is important to note that among middle-aged and older men, rates of reported premature ejaculation, a different type of sexual dysfunction, decline significantly with age. In other words, increased age appears to provide some protection from premature ejaculation as well as increased likelihood of ED.

In terms of self-reported difficulties with vaginal lubrication among middle-aged women, rates of vaginal dryness range from 13 to 43% (Finnish National Sex Survey; Kontula and Haavio-Mannila 2009 & LAW; Howard et al. 2006, respectively). Among older women, rates of vaginal dryness range from a low of 31% in the

Table 2.2 Sexual dysfunction and satisfaction by age and gender

US National Social Life, Health, and Aging Project (NSHAP) 2007 survey					
		Percentage agreement			
		Age range			
		57–64	65–74	75–85	
Men	Erectile dysfunction				
	Self-reported	31	45	44	
	Sexual satisfaction ^a	96	93	95	
Women	Vaginal dryness	36	43	44	
	Sexual satisfaction ^a	76	78	75	
Finnish National Sex Survey, 2009					
		Age range			
		45–54	55–64	65–74	
Men	Erectile dysfunction				
	Self-reported	8	16	30	
	Sexual satisfaction	82	79	80	
Women	Vaginal dryness	13	36	31	
	Sexual satisfaction	80	70	75	
American Association of Retired Persons (AARP) 2010 national survey					
		Age range			
		45–49	50–59	60–69	70+
Men	Erectile dysfunction				
	Self-reported	13	18	38	56
	Diagnosed	6	16	29	48
	Sexual satisfaction	60	50	52	26
Women	Vaginal dryness ^b	1	5	5	3
	Sexual satisfaction	48	40	41	27
European Male Ageing Study (EMAS) cross-national 2010 survey					
		Age range			
		40–49	50–59	60–69	70+
Men	Erectile dysfunction				
	Self-reported	6	19	38	64
	Sexual satisfaction	60	57	51	43
Australian Longitudinal Assessment of Ageing in Women (LAW) 2006 study					
		Age range			
		40–49	50–59	60–69	70–79
Women	Vaginal dryness	43	43	43	43
	Sexual satisfaction	55	41	38	23

Note. Regarding sexual satisfaction, participants indicated that they were “satisfied, somewhat satisfied, highly satisfied, extremely satisfied, or had pleasure” in their sex life

^aLimited to participants who reported having sex in the past year

^bParticipants who reported taking a prescription medication for vaginal dryness

Finnish National Survey (Kontula and Haavio-Mannila 2009) to a high self-reported rating of 44% in the US NSHAP (Lindau et al. 2007) survey. Although approximately one in three women reported having difficulty with vaginal lubrication, unlike the significant increase in incidence of ED in men with age, vaginal dryness does not appear to become an increasing problem among women with age. (Significant additional information is devoted to both women's and men's issues in sexuality and aging in Chaps. 7 and 8, respectively.)

Among women who actually reported receiving treatment for vaginal dryness, the rates dropped precipitously to 1% among middle-aged women and 5% of older women (AARP; Fisher 2010). Similarly, fewer men, in all age ranges, reported being officially diagnosed with ED than those who made a self-report or "self-diagnosis" of ED. Additional data from the AARP (2010) survey indicate that approximately 69% of the respondents who reported having some type of sexual dysfunction sought help from a physician, mental health provider, or sex therapist, and approximately half of those individuals who sought help (53%) showed improvement. For those 30% who did not seek treatment, virtually half indicated that they felt uncomfortable discussing sexual issues and nearly 20% cited high financial cost as a limitation. Because these are self-report measures, it is unclear exactly what led these men and women to seek or not to seek treatment. What is clear, however, is that clinicians can assume that many of the middle-aged and older patients they see may have an undisclosed sexual problem that the potential to be improved significantly with treatment.

Sexual Satisfaction

Across both the USA and European population-based studies, overall rates of sexual satisfaction for women were varied, with a range of 40–80% of middle-aged women indicating that they were satisfied, and a range of 23–78% of older women indicating that they were satisfied. It is likely that the lack of availability of a partner influenced lower numbers of older women to respond negatively about their sex lives. For example, in the US NSHAP (Lindau et al. 2007) survey, sexual satisfaction among older adults was assessed only among those who had sex within the past year, and at least 75% of older women responded affirmatively that they were satisfied. (Among a convenience sample of approximately 100 older lesbians, 33% of the women sampled that they were celibate, and the vast majority indicated that this was not by choice. Only one-third of the total sample indicated that they were satisfied with their sex lives, but it was unclear if these were the women who had available partners. Virtually no other information is available regarding sexual satisfaction among LGBT versus heterosexual aging adults; Goldberg et al. 2005.)

Among the large-scale American and European studies, male rates of sexual satisfaction also were varied, with 50–96% of middle-aged men reporting positive appraisals of their sex life, and 43–95% of older men being pleased. Among older men, aged 65 and older, who had sex within the past year (NSHAP, Lindau et al. 2007),

at least 93% reported sexual satisfaction, whereas rates of satisfaction among all older men with and without a partner ranged widely between 26 and 80%. It also is important to note that rates of ED rose from those in the middle-aged to older male cohort.

The AARP study (Fisher 2010) provides additional information regarding predictors of aging adults' sex lives and found that for men, frequency of sexual intercourse, sexual dysfunction, and physical health emerged as additional predictors of sexual satisfaction. Although more of the sexually active participants were younger, healthy men, it appears that current sexual involvement is not necessarily a requirement for satisfaction with one's level of sexual activity. Results from these studies also suggest that engaging in sexual activity is no guarantee of personal satisfaction. In some cases, sexual satisfaction and participation in sexual activity may be completely unrelated. This is an important concept for both patients and practitioners alike. One can expect that even among the oldest-old, a relatively high level of sexual activity (or virtual inactivity) can be a normal part of an older person's life. Greater variability in sexual expression, not an inevitable cessation in sexual activity, appears to be the norm with aging. It also remains unchallenged that despite societal myths, older adults often possess sexual urges and interests late into the final decades of life.

To highlight some of the clinically relevant findings from population-based studies:

- Physical health appears related to participation in sexual intercourse for both men and women.
- Approximately one-third of middle-aged and older women report experiencing vaginal dryness.
- Approximately one out of three middle-aged men and one out of two older men report some degree of ED; older men are significantly more likely to experience ED than middle-aged men.
- Nearly half of middle-aged and older women and men fail to seek help for sexual problems, citing embarrassment and financial expense as reasons.
- More than half of those men and women who do seek help from a professional report improvement in sexual function.
- The presence of an available partner is a greater predictor of sexual activity for aging women, whereas physical health and ED are greater predictors of sexual activity for aging men.
- Although older women and men with partners are more likely to report sexual satisfaction, significant numbers of middle-aged and older adults without partners do report being satisfied with their sex lives.
- Virtually no information from large-scale studies is available regarding the reported sexual satisfaction or dysfunction among older LGBT individuals.

When conducting an intake interview, particularly with an older adult, collecting information about that person's sexual history and current level of sexual activity is often one of the last things on a health care provider's mind. Practitioners usually have a brief, circumscribed period of time for this initial interview in which they are consumed with assessing their patient's mental status, gathering pertinent medical

information, building rapport, developing a treatment plan, evaluating the underlying family or group dynamic, mobilizing their patient's support system, and discussing the precipitating incident that brought the patient for help. Because older adults often have a wealth of life experience compared with many of their younger counterparts, gathering an elderly patient's social history can be very time consuming. Difficulties in gathering such information can be compounded further, particularly if the older adult displays a sensory deficit or presents with an impaired mental status. Despite the strenuous demands placed on a clinician when conducting such an interview, it remains vital that the discussion of an older patient's sexual activity, both current and historical, be granted high priority. The same premise holds true for middle-aged as well as older adults. One way that a clinician can become better prepared to elicit such information is to become familiar with some basic knowledge of sexuality and aging.

Sexuality Across the Life Span

Sexual behavior and its related goals, frequencies, types, and expectations all can be expected to change throughout the life span. Among adolescents, sexual behavior can provide a formal sense of identity, an opportunity to test limits, an experience of emotional intimacy, and the chance to explore and become comfortable with one's own body. For young adults in their 20s and 30s, sexual behavior can provide an outlet for tension, opportunities for recreation and pleasure, the expression of love and intimacy, the consummation of a marriage, and last, but certainly not least, the ability to become parents. Psychobiology suggests that sexual behavior among young adults serves the primary purpose of procreation and the solidification of pair bonds. Sex was biologically designed to "feel good" in order to promote childbearing and child rearing among healthy adults. In midlife, with the advent of menopause for women and some parallel hormonal changes in men, the biological goals of sexual behavior appear to change. Sexuality generally does not lead to parenthood; the pleasure, emotional intimacy, individual expression, and the desire to satisfy individual, familial, and societal expectations typically take precedence as the primary motivating factors for sexual behavior.

In later life, as compared with early adulthood and midlife, sexual activity enters a new realm in which its expression is related more directly to the personal motivation, needs, and satisfaction of the participants. Sexual activity in later life may be associated with desires to:

- Foster emotional intimacy.
- Experience and enjoy physical pleasure.
- Satisfy continuing biological urges.
- Assert independence and to experiment with new things.
- Feel youthful.
- Challenge societal myths and stereotypes.

- Reestablish a sexual identity.
- Heighten bodily awareness.
- Engender comfort and familiarity with a changing body.

Issues of privacy, physical health, and the availability of a partner become a significantly greater factor in the expression of sexual behavior for older adults. Even though clinicians and researchers often focus on the actual rates of sexual intercourse among older adults, it remains even more important to remember that the motivating (and limiting) factors for sexual relations among both older and middle-aged adults may be *similar* to or *very different from* those of their younger counterparts.

What Is Abnormal?

Although anecdotal reports exist to substantiate that older adults engage in fetishes, bondage, bisexuality, cross-dressing, ménage à trios (threesomes), swinging, and other deviations from traditional sexual norms, virtually no research findings exist regarding the frequencies or predictors of these behaviors.

What becomes more important when dealing with a middle-aged or older client who presents with an atypical or deviant sexual behavior is to determine to what extent this behavior is abnormal, and whether attempts should be made to help the individual change the type or frequency of this behavior. As in work with younger clients, it is important that clinicians not project their own values and expectations into their evaluation of a specific sexual activity or relationship. Important aspects to consider include:

- Is this behavior hurtful or harmful to the older person?
- Is this behavior hurtful or harmful to other people?
- Does this behavior disrupt the patient's daily functioning?
- Does this behavior disrupt the older person's interpersonal relationships?
- Is this behavior illegal?
- Are there violations of privacy or consent for other people?
- Does this behavior run counter to the patient's religious beliefs?
- Is involvement in this behavior ego syntonic or ego dystonic?
- Does performing this behavior put the patient at high risk for acquiring sexually transmitted illnesses such as HIV?

Discussing involvement in such intensely private behaviors requires tact and sensitivity, regardless of the age of the patient. Many older adults are from a cohort in which sexual deviance, much less traditional sexual behavior, is considered an embarrassing topic to discuss even with health care professionals. Clinicians can expect that if an older patient does broach the subject of potentially deviant sexual behavior (e.g., voyeurism, bondage), it probably indicates a high level of trust in the professional relationship and the high level of stress and discomfort that the patient probably wants to alleviate. Among baby boomers, in contrast, who have lived through the sexual revolution, lesser hesitation in discussing sexual matters

with a professional may be present. It remains vital not to make generalizations or assumptions, however, simply based upon a patient's age and generational cohort. As noted previously, both middle-aged boomers and older adults were less likely to report a formal diagnosis for ED or vaginal dryness than a self-report, indicating hesitance to discuss sexual issues with health care providers, regardless of their age cohort.

Anna

Anna, a 68-year-old married woman, was in weekly psychotherapy for treatment of moderately severe clinical depression. About 6 months into treatment, Anna had begun to gain the weight that she had lost, to develop some same-sex friendships outside of her marriage, to exercise on a weekly basis, and to become more assertive with her adult children about not wanting to babysit her grandson on a full-time basis. The transference in the therapeutic relationship was positive and Anna had begun to engage in more, appropriate self disclosure with each subsequent session. Once Anna's mood began to stabilize, she and her therapist began to explore other issues.

In her next session, with only a few minutes remaining in the therapy hour, Anna announced quietly that she had a secret that she wanted to share. She said that she had never told anyone else about it, either inside or outside of her family, and that she was very hesitant to talk about it. Her therapist suggested, "Well, because you feel so hesitant about telling this secret, maybe it would be easier to start by telling me about how you think you would feel if you told me about it, or what you think my reaction would be." Anna sighed and responded, "Well...I guess I am afraid that you would think I am a terrible wife...and that there is something really wrong with my husband." Her therapist retorted, "Even if I were to think that way, which I'm not sure I would, would that really be so terrible?" Anna smiled sheepishly and then frowned. She looked down at the floor, and said that a few months ago she walked into the master bedroom without knocking, and found her husband standing in front of the bureau, looking in the mirror, wearing a pair of her panties and one of her bras.

Anna kept looking at the ground and said that she knew then that her husband must "be a queer ... a homo." She balled her hand into a fist and pounded it against her leg. Her gaze remained fixed on the ground. Anna began to cry and said, "It makes me feel so sick. ... After it happened, Curt got dressed and ran out after me. He tried to tell me that he never wanted me to see him that way, that he was still a man, that he still loved me. I haven't really talked about it with him. We just pretend like things are going along as usual ... I mean, we haven't made love much in the past few years anyway; I guess this is part of the reason why. I'm surprised he could force himself on me all of those years ... I mean, if he really didn't like women after all ... maybe he just wanted to 'do the right thing' and have children. I thought" Anna's voice grew thick and she began to sob.

Anna's therapist asked her if she would like to know what her husband's behavior was called. After nodding yes, Anna was told that her husband was engaging in *cross-dressing*. Anna looked up and said, "So there is a name for this ... thing he does, or they do?" Her therapist decided that additional information regarding her husband's behavior was warranted before delving into the emotional baggage associated with it, in order to dispel any additional myths. Anna's therapist continued, "Cross-dressing is when a man wears women's clothing in order to help feel aroused. Sometimes these men wear only women's underwear, and sometimes under their own clothes. The other important thing to know about this behavior is that most of the men who engage in cross-dressing are not homosexual or 'queer,' but heterosexual; they love women and find women sexually attractive, not men." Anna sat up a little straighter in her chair and asked, "So, you mean that Curt isn't gay or queer or whatever, like he was saying?" Her therapist responded, "Yes, based upon most research and my clinical experience, it is more likely that he is not [gay].... Now, you just told me something very important that you have kept a secret for a very long time, and we have only a few minutes left in our session. We unfortunately will have to stop very soon. I think it's important that we wrap up and prepare to talk more about it next time...How did you think I would respond when you told me about your husband's cross-dressing?"

It is notable that Anna missed her next two appointments. When asked matter of factly about her absence, Anna was able to articulate, "I guess I wasn't ready to talk about it just yet." Her therapy changed dramatically as the original precipitant to her depression was revealed, and Anna began to express her anger, fear, humiliation, and concerns about her husband's behavior. She also began to discuss adjunctive couples therapy in order to confront Curt's behavior and its effect on her. (Anna said, "Why does he want to do that? I mean, that's sickening to me...aren't I good enough for him to want me the way I am?") Anna's therapist also was able to provide important factual information about fetishes and the ways in which they are formed. For example, the initiation of Curt's cross-dressing probably had little or nothing to do with Anna, and it may have begun even before he knew her.

In this case, Anna was able to discuss her feelings openly and to become angry about Curt's behavior instead of remaining paralyzed by it. It also was crucial that Anna's therapist did not become "paralyzed" in session over this revelation with her own countertransference; Anna's therapist herself was shocked that her first encounter with cross-dressing occurred in the context of therapy with an elderly couple.

A Self-Test for Knowledge

Based on the work of Charles White (1982), the Aging Sexual Knowledge and Attitudes Scale (ASKAS) has been used extensively among adult children of older adults, college students (Allen et al. 2009), doctoral-level psychology students, medical students (Snyder and Zweig 2010), health care providers including gynecologists (Langer-Most and Langer 2010), nursing home and long-term care staff

members (Bouman et al. 2006; Hinrichs and Vacha-Haase 2010), health care educators, and older people themselves. Helping mental health and primary care professionals become versed in sexuality and aging appears vital. As noted in the (NSHAP, Lindau et al. 2007), approximately 1 in 3 middle-aged and older men, and only 1 in 5 middle-aged and older women reported that they discussed sexual issues with a primary care physician since their 50th birthday. Findings from various research studies incorporating the ASKAS (White 1982) reveal that both medical school students (Snyder and Zweig 2010) and even gynecologists (Langer-Most and Langer 2010) maintain only moderate levels of knowledge of sexuality and aging.

Although the ASKAS has been used primarily in research settings, it also can be employed successfully as a valuable educational tool for older adult patients. Asking a couple to complete the knowledge section of the scale separately and to then score their answers jointly often allows for a discussion of previously taboo topics. It also allows the practitioner to gain insight into the knowledge base of her clients. Many clients admit relief when they learn that some of the very stereotypes that they had ascribed to were false. Others realize for the first time that it is acceptable to discuss intimate sexual issues and concerns with their health care provider. This 35-item knowledge subtest of the ASKAS can be administered as a self-report paper-and-pencil test, or as a clinician-administered interview. This assessment instrument employs nonscientific language and is suitable for individuals who have acquired less than a high school education. Presented in the appendix at the end of this chapter, the knowledge section of the ASKAS can be used as a self-test for clinicians as well. Some selected items from this knowledge section will be reviewed here.

Although entire chapters are devoted to both men's and women's issues in sexuality and aging, a basic review of the physiological sex-related changes in aging adults will be presented here briefly. As men age, they can expect to experience a decline in testosterone production, a decline in sperm production, changes in the amount and consistency of their seminal ejaculate, diminished force of ejaculation, a likely increase in the size of the prostate gland, longer periods of time to stimulate sexual excitement and erections, longer-lasting erections (with decreased likelihood of premature ejaculation), less-frequent ejaculations, and longer refractory periods. The need for increased stimulation, typically tactile stimulation, to achieve an erection also is likely to occur with increased age. It also is important to note that all men, regardless of age, have an orgasm that is independent from the act of ejaculation; most individuals assume that ejaculation and male orgasm are inseparable. In other words men, including those who have had surgeries or injuries that impair or prevent their ability to ejaculate, are still able to experience orgasm (e.g., Martinez 2005). In contrast, as women age the most common physiological changes include, particularly after menopause, a decline in production of estrogen and progesterone, shrinking of the external genitalia, a decrease in growth of pubic hair, shrinkage and thinning of the vaginal wall, a decline in natural vaginal secretions, and longer periods of time to achieve sexual excitement and related vaginal lubrication (see Croft 1982; Willert and Semans 2000).

Sample Items from the Knowledge Section of the ASKAS

2. Males over the age of 65 typically take longer to attain an erection of their penis than do younger males.

TRUE:

Because of changes in the internal structure of the penis over the age of 60 (i.e., most men develop more venous blood vessels that are larger in diameter), most middle-aged and older men require increased blood flow to the penis in order to attain an erection. It takes more time for an older man to have an erection, related in large part to the increased time it takes to provide increased blood flow to the penis. Many middle-aged and older men also find that they need more tactile stimulation in order to attain a full erection. The need for additional physical stimulation of the penis in order to obtain an erection may sometimes require significant negotiation between a man and his partner as the “script” for foreplay, which often becomes ritualized or rigid (e.g., Willert and Semans 2000), must change and evolve.

4. The firmness of erection in aged males is often less than that of younger persons.

TRUE:

Because of changes in the blood flow to the penis, older adult males often have a less firm and erect erection than younger males, sometimes impeding their ability to penetrate a partner during intercourse. As noted, conservative estimates suggest that up to one-half of US men over the age of 65 have some degree of erectile dysfunction.

7. The older female may experience painful vaginal intercourse due to reduced elasticity of the vagina and reduced vaginal lubrication.

TRUE:

Many older adult women benefit from the use of lubricants (e.g., KY Jelly) in order to alleviate any discomfort during intercourse associated with vaginal dryness. Some researchers suggest that up to two-thirds of elderly women experience discomfort during intercourse, related primarily to a lack of lubrication. The more positive aspect of this finding is that the problem is usually readily treatable with over-the-counter lubricants, prescription lubricants, and hormone therapies.

8. Sexuality is typically a lifelong need.

TRUE:

Masters and Johnson (1966) were among the first researchers to point out that older adults have as much interest in and need for sexual contact as their younger counterparts. Even though an older person can no longer produce offspring, the underlying biological urge to engage in sexual (and sensual) activity does not appear to diminish significantly with age. In the recent survey by the AARP (Fisher 2010), a number of healthy older men and women were found to engage in sexual activity well into their 80s and 90s.

9. Sexual behavior in older people increases the risk of heart attack.

FALSE:

Unless an older adult is under a physician’s orders to limit his or her physical activity, sexual activity can be actively pursued without fear of life-threatening exertion.

Among healthy older adults, sexual activity can provide some of the benefits of cardiovascular exercise. There also is evidence that sexual activity in older persons has beneficial physical effects on the participants. Increased blood flow to the genital area can provide an older woman with increased vaginal lubrication and can provide an older man with more sustained erections in future sexual activity.

11. The relatively more sexually active younger people tend to become the relatively more sexually active older people.

TRUE:

As discovered in earlier research, one predictor of an older adult's sexual activity is his or her prior level of sexual activity. Men and women who did not engage in sexual relations in their younger years are less likely to engage in sexual relations during their later years (Call et al. 1995). Of course, availability of a partner and physical health, among other factors, can limit this trend. It also is interesting to note that newer research decade generally ignores this factor of prior sexual activity and focuses instead upon aspects of physical health (Bancroft 2007).

13. Sexual activity may be psychologically beneficial to older person participants.

TRUE:

Many older adults cite that they enjoy their sexual relationships even more than they did when they were younger. Others point out that even though they may engage in sexual activities less frequently than they did when they were younger, they cherish and enjoy them more. It also is common to hear older adults mention that they typically feel more comfortable with their partner and no longer have "unrealistic expectations" about the sex act. Participation in foreplay, including kissing, hugging, and caressing appears to remain consistent throughout later life (Fisher 2010).

16. Prescription drugs may alter a person's sex drive.

TRUE:

A variety of prescription medications for depression, blood pressure, and diabetes can negatively impact on an older person's level of sexual interest and sexual functioning. Clinicians should be aware of all medications that middle-aged and older adult patients are taking.

21. The most common determinant of the frequency of sexual activity in older couples is the interest or lack of interest of the husband in a sexual relationship with his wife.

TRUE:

For married older adults, studies do suggest that the rates of sexual intercourse are determined primarily by the interest level of the husband. It remains unclear, however, to what extent this can be accounted for by a cohort effect. In this current elderly cohort, the husband is primarily responsible for making sexual advances; "good wives" were unlikely to initiate sexual behavior. In this cohort, the elderly wife also has been inculcated with the expectation that "a good wife does not say 'no' to her husband." Both of these beliefs further increase the likelihood that the

frequency of sexual activity among current older couples is influenced primarily by the husband's level of interest and desire.

22. Barbiturates, tranquilizers, and alcohol may lower the sexual arousal levels of aged persons and interfere with sexual responsiveness.

TRUE:

Many over-the-counter medications and substances can alter sexual function. Because older adults metabolize alcohol more slowly than younger adults due to changes in body composition (e.g., increased fat-to-muscle ratios) and a general decline in liver function (Schmucker 2005), even one or two alcoholic drinks can negatively affect sexual performance. Heavy consumption of cigarettes also may diminish sexual desire, and nicotine also has been related to ED among older men.

23. Sexual disinterest in aged persons may be a reflection of a psychological state of depression.

TRUE:

One of the most common symptoms of depression is a loss of interest in sexual activity. Among older adults without available sexual partners, it is appropriate (and recommended) that clinicians ask that older adult if her or his own interest in sexuality has changed. One might ask, "Even if you haven't been engaged in sexual relations for a few years, do you find yourself thinking about sex less frequently than you used to in the past few months?"

28. Fear of the inability to perform sexually may bring about an inability to perform sexually in older males.

TRUE:

Erectile dysfunction certainly can be initiated or compounded by psychological causes. Fear of intimacy and fear of attaining or not being able to attain an erection have been identified as some of these common concerns. "Widower's syndrome" also been identified, in which a recent widower who is not yet emotionally prepared for intimacy with another woman (particularly if he had been married in a relationship spanning many decades) experiences ED with a new partner. Clinicians also must consider and rule out organic causes for erectile dysfunction among their middle-aged and older adult patients, even if psychological factors appear present.

29. The ending of sexual activity in old age is most likely and primarily due to social and psychological causes rather than biological and physical causes.

TRUE:

Many of the physical problems associated with aging can be addressed. Even older adults with chronic illness can engage in a variety of sexual behaviors if they so choose. Many older adults cease to become sexual beings simply from perceived societal pressures and stereotypes. Societal myths suggest that older adults are asexual beings who are not entitled to the benefits and joys of sexuality (and sensuality) that seem to belong exclusively to the young and physically fit.

35. Masturbation in older males and females has beneficial effects on the maintenance of sexual responsiveness.

TRUE:

For men, masturbation can improve blood flow to the penis and help prevent future incidents of ED. For women, masturbation has been shown to increase blood flow to the vaginal area and promote premenopausal levels of lubrication. Some clinicians have successfully “prescribed” masturbation to middle-aged and older women, who later reported that they were able to experiment with and enjoy self-stimulation for the first time in their lives after receiving approval from their health care provider.

Reviewing aspects of sexuality and aging is vital. As noted, studies show that doctoral-level psychology and medical students (Snyder and Zweig 2010), health care providers (Langer-Most and Langer 2010), and health care educators (Glass and Webb 1995), as well as older persons themselves (Adams et al. 1990; Smith and Schmall 1983) often have limited knowledge of sexuality and aging. As clinicians, we owe it to our patients and ourselves to be informed.

The Importance of Sexual Histories at Intake

Although many older patients, like their younger counterparts, seem to reveal important aspects of their sex life only after they have been in treatment for an extended period of time, most information about an older person’s sex life can be gathered effectively during the initial intake interview. (Unfortunately, various research findings suggest that both general practitioners and psychiatrists are significantly less likely to take sexual histories and discuss sexual issues in general with their older, as compared to younger, patients; Bouman and Arcelus 2001; Gott et al. 2004.)

It is important that all clinicians place value on this information and recognize that obtaining such information represents much more than just finding about how many times a week their patient or client has sex with a significant other. Additional studies suggest that aging adults with sexual dysfunction would welcome and even prefer the initiation of such questions by their health care provider (e.g., Gott and Hinchliff 2003). Asking aging patients about their sex lives provides clinicians with valuable opportunities early in treatment to discuss and assess:

- Emotional intimacy
- Body image
- Physical health
- Medical history
- Self-esteem
- Quality of interpersonal relationships
- Ascribed sex roles
- Sexual identity and orientation
- Attitudes toward aging

- Knowledge of sexuality and aging
- Religion
- Potential sexual dysfunction
- Potential partner abuse
- Sense of humor

How to Gather Information

Interviewing an older client about sexual matters can pose unique problems as well opportunities. Many older adults are reticent to discuss such personal matters without proper groundwork by the clinician. Before addressing issues of sexuality and sexual behavior, it often can be helpful to simply ask the patient permission to inquire about such matters (e.g., “May I ask you some questions about your love and sex life?”) Asking the patient for such permission can instill a sense of respect and concern; the patient is given control in a potentially anxiety-provoking situation.

Another tactic is to present the questions as part of the standard interview that is used with all patients who come to the clinic. Likening sexual information to medical information also can allow older patients to feel more comfortable discussing such personal issues. In some cases, admitting that “it is not always an easy thing for health care providers or patients to talk about, but it is important that we gather some information about your love and sex life” normalizes the stress and anxiety that an older person may feel about discussing sexual issues with a clinician.

When asking questions about sexual behaviors, it is important to word questions in “the affirmative.” In other words, it is helpful to provide older adults with an opportunity to answer the question without appearing as though they are admitting something wrong, immoral, or embarrassing. For example, instead of asking, “How many affairs have you had?” it would be preferable to say, “Some people become unhappy in their relationships, for any number of reasons, and engage in extramarital affairs or seek out other lovers. Can you tell me about any affairs you may have had?” It also is beneficial to allow for humor in the process. Sometimes humor (on the part of the clinician or the patient) is appropriate and helps to dispel tension.

Requisite Information

It is important to gather a variety of information regarding both middle-aged and older adults’ sexuality. Sometimes it helps to have a checklist or other guideline available during the course of the clinical interview. Some relevant questions for both older men and women include (see also Galindo and Kaiser 1995):

- What would you consider a satisfactory sex life? Some people are satisfied while other people are dissatisfied with their sex lives. How do you feel about your sex life?

- How long has it been since you have engaged in any sexual activity?
- Do you have any current sexual partners? Do you have an exclusive relationship or do either of you have other partners as well? (Gather activity about the sex, numbers, and potential high-risk behavior of the partners such as prostitution or drug use.)
- Does your religion influence how you feel about sex or influence your current sexual activities in any way? Can you tell me about your religious views?
- Having sex means different things to different people. For some people it means having sexual intercourse and to others it means holding hands. What different types of intimate sexual activity [vaginal intercourse, oral sex, anal sex, petting, cuddling, holding hands] do you engage in?
- How often do you masturbate or touch yourself to feel good? How do you feel about it? (This is often a good opportunity to tell an older adult about the potential emotional and physical benefits of masturbation.)
- As people age, they sometimes experience pain or discomfort during sexual intercourse. Do you ever experience such pain or discomfort? Have you discussed this with anyone [like a partner or health care provider], or have you tried to do anything about it?
- The average person experiences some kind of sexual difficulty at some point in their life. Could you tell me about any trouble or problems that you, or a partner of yours, may have had in the past? Do you have any concerns about your sexual behavior or functioning right now that you could tell me about?
- Some people experience changes in their body as they age, either slowly over time or more suddenly through illness or surgery. How do you feel about your body? How does your partner feel about your body?
- Do you use any lubricating gels or liquids when you engage in sex? What kind do you use? (Does the client use something inappropriate like an oil-based lubricant such as Vaseline with a condom, or does she use something water soluble like KY jelly?)
- Have you ever used condoms when you have sex? Do you use condoms now? Why or why not? How does your partner(s) feel about condoms?
- Do you have any concerns or worries about your sexual performance or your sex life in general? Do you have any concerns or worries about your [a] partner?
- [Whether or not you have had sexual relations lately] have you been thinking more or less about sex than you typically have in the last few months?
- Do you have enough privacy for the sexual activities that you want to engage in?
- Is there anything about your sex life that you wish were different?
- Do you ever feel hurt or threatened by your [a] partner? (Unfortunately, sexual and physical abuse are not limited to younger adults.)
- How easy or difficult is it for you to talk about your sexual behavior with your partner? Your physician? With me right now? (You can inform patients that they are doing a wonderful job talking about such a personal topic, if in fact they are. This also can provide an opportunity to talk about how many people

feel uneasy talking about sexual matters and to empathize with their fears and concerns.)

- Many people have fantasies about sex. What kind of sexual fantasies can you tell me about?
- People often have questions they would like to ask about sex. Do you have some questions about sexual activity that you would like to ask me?

Some gender-specific questions also should be addressed. For example, older women can be asked about potential discomfort during intercourse and age of menopause. Similarly, middle-aged women can be asked about potential discomfort or pain during sex (i.e., dyspareunia) and about menopausal symptoms. Both middle-aged and older men can be asked about their erections and their frequency of urination. Depending on the numbers of types of partners that both aging men and women have (especially if high-risk behaviors are involved), pointed questions should be asked about condom use. Older people also should be asked if they know how to properly put on a condom, and whether they know that a new condom should be used for each subsequent act of intercourse. Many middle-aged and older adults underestimate their risk of contracting a sexually transmitted disease outside of a long-term monogamous relationship, or even within the context of infidelity in a long-term relationship, and focus mainly on their freedom from fear of unwanted conception.

Because so many prescription and over-the-counter medications can be associated with a decrease in sexual desire and function (see Galindo and Kaiser 1995), clinicians should make a concerted effort to gather detailed information about a patient's medication history. As gathering such medication information is already a prerequisite for a thorough geriatric intake, no additional time will be lost during an interview with an older patient who may (or may not) initially discuss concerns about changes in their sexual functioning. Many middle-aged and older adults are surprised to learn that a variety of drugs, including those listed in Table 2.3, can interfere with sexual functioning. Older adults are at increased risk for such side effects when compared to younger adults because they take, on average, more than four prescription drugs each day, metabolize drugs less effectively, and less than one-third inquire consistently about potential side effects or drug interactions (Barrett 2005).

With older adults often taking a large number of prescription and over-the-counter medications, it may be difficult to get a proper assessment of daily intake. One way to circumvent these problems is to ask all patients to bring a "brown bag" that contains all of their current medications with them to the intake interview. Names of medications, as well as the names of the prescribing physicians, can be taken directly from pill bottles. Important information also can be gleaned as to whether older clients are taking their medication as instructed on the label, whether they are non-compliant based upon the number of pills remaining in the bottle, or whether they misunderstood the directions for administration in the first place.

Table 2.3 Drugs with reported sexual side effects

Medication class	Name	Trade name	Common side effects
<i>Prescription medications</i>			
Antidepressants	Clomipramine	Anafranil	Anorgasmia, dysorgasmia
	Fluoxetine	Prozac	Dysorgasmia
	Paroxetine ^a	Paxil	Anorgasmia, dysorgasmia
	Sertraline ^a	Zoloft	Anorgasmia, dysorgasmia
	Venlafaxine	Effexor	Anorgasmia, dysorgasmia
Antianxiety	Alprazolam ^a	Xanax	Decreased libido
	Lorazepam ^a	Ativan	Decreased libido
	Temazepam ^a	(Generic)	Decreased libido
Antihypertensives	Atenolol ^a	(Generic)	ED
	Clonidine	Catapress	Decreased libido, ED
	Digoxin ^a	Lanoxin, Digibind	ED
	Hydrochlorothiazide ^a	Lopressor	Decreased libido, ED
Antiparkinsonian	Levodopa	Sinemet	ED
Antipsychotics	Haloperidol	Haldol	Dysorgasmia, ED
	Mesoridazine	Serentil	Decreased libido, dysorgasmia
Antiseizure	Trifluoperazine	Stelazine, Suprazine	Decreased libido, ED
	Phenytoin ^a	Dilantin	ED
Chemotherapy	Tamoxifen	Nolvadex	Vaginal dryness, ED
Mood stabilizers	Lithium	Eskalith, Lithonate	ED
	Topiramate	Topomax	ED
Sleeping aids	Zolpidem	Ambien	ED
Miscellaneous	Celebrex	Celecoxib	ED
	Donepezil ^a	Aricept	ED
<i>Over-the-counter medications and herbs</i>			
Antihistamines	Diphenhydramine	Benadryl	ED
	Drixoril	Tavist-D	ED
	Cimetidine	Tagamet	Decreased libido, ED
	Ranitidine	Zantac	ED
Herbs	Alkaloids	Rauwolfia	ED
	Hypericum	St. John's Wort	Dysorgasmia
<i>Recreational drugs</i>			
	Ethyl alcohol	Beer, wine, liquor	Decreased libido, ED
	Nicotine	Cigarettes, chew	ED
	Narcotics	Cocaine, heroin	Decreased libido, ED

Notes: This list of drugs is meant to be illustrative rather than comprehensive. Attention to older patients' sometimes atypical side effects remains essential

ED erectile dysfunction

^aIdentified as one of the 50 most frequently prescribed oral drugs among older adults (Steinmetz et al. 2005)

Summary

Gathering information about an older client's sex life is challenging, rewarding, and a requisite part of a geriatric intake interview. In order to make this practice more effective and efficient, clinicians themselves can become more informed about basic aspects of sexuality and aging. For example, older adults can be sexually active well into the last decades of life. The best predictors of older adults' sexual activity are prior levels of sexual activity and satisfaction; the availability of a partner, particularly for women; and their physical health. Many middle-aged and older adults are uninformed about the physiological changes associated with aging and sexuality; many do not know that ED may be treatable or that masturbation can promote improved sexual lubrication in women. Many middle-aged and older adults, as well as health care providers, are unaware that commonly prescribed medications and over-the-counter drugs can significantly impair sexual function. As noted, gathering information about an older client's past and current sex life can reveal important information about close relationships, body image, knowledge of sexuality and aging, medical history, and self-esteem. As informed clinicians, the chance to discuss issues of sexuality with our middle-aged and older clients presents us with unique opportunities and benefits.

APPENDIX: Knowledge Section of the ASKAS¹

Answer Key: T = True; F = False; DK = Don't know

Correct answers are in **BOLD**.

1. T/F/DK Sexual activity in aged persons is often dangerous to their health.
2. **T/F/DK** Males over the age of 65 typically take longer to attain an erection of their penis than do younger males.
3. **T/F/DK** Males over the age of 65 usually experience a reduction in intensity of orgasm relative to younger males.
4. **T/F/DK** The firmness of erection in aged males is often less than that of younger persons.
5. **T/F/DK** The older female (65+ years of age) has reduced vaginal lubrication secretion relative to younger females.
6. **T/F/DK** The aged female takes longer to achieve adequate vaginal lubrication relative to younger females.
7. **T/F/DK** The older female may experience painful vaginal intercourse due to reduced elasticity of the vagina and reduced vaginal lubrication.
8. **T/F/DK** Sexuality is typically a lifelong need.
9. **T/F/DK** Sexual behavior in older people increases the risk of heart attack.
10. **T/F/DK** Most males over the age of 65 are unable to engage in sexual intercourse.
11. **T/F/DK** The relatively more sexually active younger people tend to become the relatively more sexually active older people.

¹These items from the ASKAS appear from White (1982) with permission.

12. **T/F/DK** There is evidence that sexual activity in older persons has beneficial physical effects on the participants.
13. **T/F/DK** Sexual activity may be psychologically beneficial to older person participants.
14. **T/F/DK** Most older females are sexually unresponsive.
15. **T/F/DK** The sex urge typically increases with age in males over 65.
16. **T/F/DK** Prescription drugs may alter a person's sex drive.
17. **T/F/DK** Females, after menopause, have a physiologically induced need for sexual activity.
18. **T/F/DK** Basically, changes with advanced age (65+) in sexuality involve a slowing of response time rather than a reduction of interest in sex.
19. **T/F/DK** Older males typically experience a reduced need to ejaculate and hence may maintain an erection of the penis for a longer time than younger males.
20. **T/F/DK** Older males and females cannot act as sex partners as both need younger partners for stimulation.
21. **T/F/DK** The most common determinant of the frequency of sexual activity in older couples is the interest or lack of interest of the husband in a sexual relationship with his wife.
22. **T/F/DK** Barbiturates, tranquilizers, and alcohol may lower the sexual arousal levels of aged persons and interfere with sexual responsiveness.
23. **T/F/DK** Sexual disinterest in aged persons may be a reflection of a psychological state of depression.
24. **T/F/DK** There is a decrease in frequency of sexual activity with older age in males.
25. **T/F/DK** There is a greater decrease in male sexuality with age than there is in female sexuality.
26. **T/F/DK** Heavy consumption of cigarettes may diminish sexual desire.
27. **T/F/DK** An important factor in the maintenance of sexual responsiveness in the aging male is the consistency of sexual activity throughout his life.
28. **T/F/DK** Fear of the inability to perform sexually may bring about an inability to perform sexually in older males.
29. **T/F/DK** The ending of sexual activity in old age is most likely and primarily due to social and psychological causes rather than biological and physical causes.
30. **T/F/DK** Excessive masturbation may bring about an early onset of mental confusion and dementia in the aged.
31. **T/F/DK** There is an inevitable loss of sexual satisfaction in postmenopausal women.
32. **T/F/DK** Secondary impotence (or non-physiologically caused) increases in males over the age of 60 relative to younger males.
33. **T/F/DK** Impotence in aged males may literally be effectively treated and cured in many instances.
34. **T/F/DK** In the absence of severe physical disability, males and females may maintain sexual interest and activity well into their 80s and 90s.
35. **T/F/DK** Masturbation in older males and females has beneficial effects on the maintenance of sexual responsiveness.



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