**Sexuality in older age: essential considerations for healthcare professionals**

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**Abstract**

This review describes the fact that many elderly people enjoy an active sex life and examines the evidence against the general perception of an ‘asexual’ old age. It offers an overview of the evidence for healthcare professionals who had not previously considered the sexuality of their older patients. It also describes some of the sexual problems faced by older people, especially the difficulties experienced in disclosing such problems to healthcare professionals. It examines why healthcare professionals routinely avoid discussing sexual problems with older patients, and how this can be improved. It also offers some recommendations for future research in the area, as well as a word of caution regarding the temptation of over-sexualising the ageing process.

**Keywords:** sexuality, sexual problems, communication skills, elderly

**Introduction**

The population is ageing and this trend is expected to continue. By 2033, it is predicted that 23% of the UK population will be >65 [1]. Therefore, issues affecting older people are becoming increasingly more important. In 2001, the UK Department of Health published The National Service Framework for Older People [2], setting out a programme of action and reform to address problems in the management of elderly patients. There was, however, no mention of sexuality or the problems older people may face related to sexual issues. Likewise, The National Strategy for Sexual Health and HIV (2001) [3] is primarily aimed at younger people, with no mention of how sexual issues may affect older people. This gap in government policy mirrors the general perception and prejudices of an ‘asexual’ old age, of sex in older people being disgusting, or simply funny. Research suggests, however, that many older people enjoy an active sex life [4], although they may face several problems. If healthcare professionals (HCPs) do not accept that older people may enjoy sex, then it is unlikely that sexual problems will be effectively explored, diagnosed and treated. This article aims to investigate some of the pertinent research dispelling the myth of a totally ‘asexual’ old age, and offer recommendations for HCPs including general practitioners (GPs), geriatricians and old age psychiatrists.

**Background—are older people even interested in sex? Do they have sex?**

Research into such a deeply personal area is fraught with difficulties including embarrassment in one-to-one interviews, self-reporting biases and poor response rates to postal questionnaires. As such, there is limited good-quality research into the sex lives of older people. Large, global studies such as one by Nicolosi et al. [5] from 29 countries have poor response rates (19%) and methodological difficulties, and smaller studies may not be generalisable.

However, the available research consistently suggests that increasing age is associated with a decreased interest in sex. A postal survey with a high response rate (73%) was of Swedish men aged 50–80 [6]. It showed that older respondents had less interest in sex, with 98% of 50–59 year olds giving it at least ‘some importance’ compared with 72% of 70–80 year olds. An Italian study [7] looking at quality of life found significantly less interest in sex among the older participants—all 38 centenarians had lost interest in sex. (It is interesting, however, that the centenarians did report...
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greater satisfaction with life and family relationships than the younger age groups.) A large study using face-to-face interviews of a national probability sample of 3,005 adults in the USA (response rate 75%) showed that although interest in sex was lower in older age groups, 59% of 75–85 year olds still attributed some importance to sex [4].

Gott and Hinchliff [8] used questionnaires and face-to-face interviews with a smaller sample size in the UK (44 people aged 50–92), to investigate how important sex is to older people. Although the numbers were small, this study did show some interesting findings. The qualitative nature demonstrated well the diversity, ranging from a 73-year-old lady who had regularly been using a sex aid since her husband’s death to a 78-year-old widow where the ‘sexual desire has died’. In general, the responses showed that those aged >70 placed less importance on sex than the younger participants.

There are also gender differences, with the greatest difference being in the older age groups [9] (41.2% of males aged 75–85 stated an interest in sex compared with 11.4% of females the same age). In a study of sexual behaviour in elderly institutionalised patients with dementia, the men nearly always initiated the sexual interactions rather than the women [10]. Of cases directed towards staff, it was always a male patient towards female staff. Research also suggests that interest in sex among older men has increased over the last 10 years [9], possibly due to the effective and well-publicised drugs for erectile dysfunction (ED) starting with Viagra in 1998.

As well as older age groups having less interest in sex they actually had sex less often and sexual functioning was less [4]. The survey of Swedish men mentioned above [6] also looked at sexual function across four domains (desire, erection, orgasm and ejaculatory functions) and found a decrease in all with increasing age. However, even among the oldest men (aged 70–80), 46% reported orgasm at least monthly.

Problems faced—what causes the decrease in sexual interest and function in older adults?

There are multiple causes for this decrease in sexual interest and frequency of sexual activity. These include general physical health, psychological causes, male or female sexual dysfunction and practical problems. In reality, these combine—sexual desire and function are affected by a complex interaction between psychological factors and physiological functioning.

General physical health

Gott and Hinchliff [8] suggested that it was not age per se that led to a decrease in the importance placed on sex, but more the health problems experienced by the participant (or their partner) which led to reprioritising the value placed on sex. Poor physical health (as self-reported) is associated with decreased interest in sex (odds ratio 1.6 females and 2.2 males) [4, 9].

Psychological causes

Psychological problems such as depression and its treatment are associated with poor sexual function in all age groups [11]; however, sexual dysfunction in depressed older people may be less well recognised and less appropriately treated than in younger patients [12]. This study showed that psychiatrists are less likely to take a sexual history from older patients presenting with depressive symptoms compared with younger patients, and they are also less likely to refer to appropriate services if sexual dysfunction is identified.

Male sexual dysfunction

Of the causes of male sexual dysfunction, ED and hypogonadism are most prevalent, and increase with age [13]. There are many recognised causes of ED, including medications [11], prostatic surgery or disease [14], diabetes [4, 15, 16] and vascular disease [13]. Physiological potency (ability to have an erection sufficient for intercourse most of the time) decreases with age: one cross-sectional study [6] showed a decrease from 97% aged 50–59 to 76% aged 60–69 and 51% aged 70–80. The researchers could not explain this decrease solely by medications or illnesses, suggesting that age may be an independent factor. The treatments for ED are beyond the scope of this article but include oral phosphodiesterase inhibitors (e.g. Viagra) and less commonly intraurethral suppositories, penile injections, vacuum devices and penile prostheses [13].

Female sexual dysfunction

Unlike male ED there is some ambiguity over the diagnosis of female sexual dysfunction, which includes decreased desire or arousal, anorgasmia and dyspareunia. As with male sexual dysfunction the diagnosis covers the various ways in which an individual is unable to participate in a sexual relationship that they would wish; however, there is not such objective criteria for the diagnosis of female sexual dysfunction as there is for ED. Subsequently, there are fewer good-quality trials and treatments for women suffering from sexual problems. The diagnosis itself has actually been called into question as simply a way for drug companies to make money offering ‘treatments’ for a ‘disease’ defined by people who have significant ties to the drug companies [17]. However, it is clear that urogenital atrophy (identified subjectively as vaginal itching/soreness/dryness/pain during sex) does commonly causes problems especially in post-menopausal women. It has an effect not only on sexual functioning, but also emotional well-being, interpersonal relationships, body image and everyday activities such as bike riding or prolonged sitting [18]. One study
used focus groups to more carefully assess women's feelings about their symptoms [18]. These symptoms had caused some women to completely lose interest in sex as it became a 'primarily painful experience'. Many women were frustrated by what they saw as an inadequacy of treatments for female sexual problems such as dryness, compared with male ED. As noted above, female sexuality in older age is also heavily influenced by psychosocial factors and physical health problems including urinary incontinence, cancers and their medical or surgical treatments [19].

Practical

Practical problems, including lack of a partner or a partner's poor health, are another cause of decreased sexual activity and interest in sex with increasing age [8]. Another practical problem occurs when elderly people become institutionalised and are unable to have any privacy with their partner [10].

Delays in seeking help

Seeking treatment for sexual dysfunction is commonly inhibited by embarrassment [20]. Older people regard GPs as the main source of professional help regarding sexual difficulties [21]. However, many older people are reluctant to seek help for sexual problems even if they have a severe effect on quality of life [18, 20]. In one study of patients with ED [20], 78% had not discussed it with their primary care physician—82% of these patients said they would have liked the doctor to have initiated a conversation on the topic, and would have felt less embarrassed than raising it themselves. A focus group study of women with urogenital atrophy [18] noted that the reasons for not seeking help earlier were mainly embarrassment, feeling that they were the only one experiencing the symptoms and incorrect beliefs about the aetiology of their symptoms. Many of these women had also delayed discussions with their partner for the same reasons. Other reasons for not seeking help included worries that the GP may think of the patient as a 'sex maniac' or abnormal for still engaging in sexual activity [21], concerns about wasting the doctor's time or using up valuable resources (e.g. medication) which younger people should use. This is an interesting issue and probably varies across nations with different healthcare systems. Older people may also internalise the stereotype of sex in older age being 'wrong' or 'inappropriate': A Finnish study [22] showed that although many elderly people have an active sex life, over half of the older people in their study did not think it was somehow 'proper' for older people to be sexually active. Kaas [23] coined the term Geriatric Sexuality Breakdown Syndrome to describe the steps involved in internalising societal attitudes towards sexuality in older age. As the stereotype of an asexual old age seems fairly pervasive and ingrained in society it may be beneficial to include information on elderly sexuality in schools during sex education classes [24], which may allow greater acceptance of sex in older age.

Response of HCPs

HCPs find sex a difficult topic to talk about, and this is compounded when discussing sex with an older person [25, 26]. Gott et al. [25] used in-depth interviews with Sheffield GPs to examine their attitudes to discussing sexual issues with older patients. Although the GPs recognise that they are the main point of contact for older patients regarding sexual health, they feel undertrained in this area and are not proactive in discussing sexual issues with older patients. Their attitude to discussing sexual health with older people was primarily based on stereotypes and prejudices, rather than what they had personally experienced with patients. These stereotypes included those relating to the asexuality of older age, and the monogamous and heterosexual nature of older adults in relationships. The GPs interviewed did not discuss with older adults the risks of unprotected sex, rationalising their responses by referring to decreased rates (although not negligible) of sexually transmitted infections among this age group. This mirrors the government policy (as noted above) whereby The National Sexual Health Strategy and sexual health clinics are aimed at younger people. Some GPs were also concerned about causing offence to older patients by bringing up sexual issues although none could think of an occasion where they had caused serious offence by doing so. There were also some apparently deep-rooted issues relating to personal beliefs, with one GP saying she was disgusted and felt repugnant at the thought of an 85-year-old man asking for Viagra, and another saying he had to be careful not to let his Catholic beliefs influence patients ‘...from my upbringing as a Catholic... as soon as you stop producing children what on earth do you want to do it [sex] for... we have got to move away from that attitude'. Research from the USA [27] describes how a significant proportion of physicians may not discuss information about morally controversial issues. If individual physicians do not think it is right for older people to be sexually active then issues may not be discussed at all.

Gott et al. [26] also interviewed practice nurses in Sheffield GP surgeries. Interestingly, the GPs, but not the nurses, were concerned that the professional relationship with elderly patients might be jeopardised by discussions about sexual issues. Both identified lack of time during consultations and lack of expertise or training as the main barriers to discussing sexual issues with patients, and were concerned that they may open a ‘can of worms’ which there was no time to explore.

Doctors treating women with gynaecological cancers do recognise that sexual problems may occur but few discuss these with the women [28]. Reasons given include embarrassment and lack of knowledge or experience. The patients interviewed by the researchers said they would have liked to have
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been told about the changes in sexual function they could expect and to have opportunities to ask questions [28].

An Israeli study [10] examined the reactions of staff in psychogeriatric care homes to sexualised behaviour among their elderly institutionalised patients with dementia. It classified sexualised behaviours into three groups: love/caring including affection and handholding; romance including idealisation and excessive complimenting; and eroticism including sexual excitement or desire. The staff were accepting and encouraging of behaviour at the level of love and caring. Behaviour at the level of romance evoked mixed reactions including amusement. Behaviour at the level of eroticism evoked strong feelings of anger and disgust among staff. The authors reported occasions when a visiting spouse was treated patronisingly and with ‘derision’ by staff, without regard to the couple’s erotic needs. Although the expression of sexuality is a basic human right, many members of staff found it disturbing. There are of course also issues surrounding consent in patients with dementia and there must be careful consideration to ensure older adults are safeguarded against non-consensual sexual activity.

A word of caution…

Although it is important to be aware of older people’s sexuality, care must be taken not to over-sexualise the ageing process, nor to over-medicalise declining sexual function and interest. The heavy involvement of drug companies in the definition of female sexual dysfunction as a medical diagnosis is potentially worrying [17]. Moynihan describes how ‘the potential risks, in a process so heavily sponsored by drug companies, is that the complex social, personal, and physical causes of sexual difficulties—and the range of solutions to them—will be swept away in the rush to diagnose, label, and prescribe’ [17]. Katz and Marshall [29] describe the changing attitudes towards sexual decline in older age, with it now being seen primarily as a ‘modifiable para-aging phenomena’ rather than an inevitable consequence of ageing. They describe how changing attitudes in the 1960s among geriatricians meant that sexual activity began to be seen as a healthy and even necessary part of successful ageing. Some older women feel that there is too much pressure on them from society to remain interested in sex [18]. HCPs must also be aware of the huge profits to be made by companies from the rebranding of normal processes as ‘dysfunctional’. In an ageing population there would be large sums of money involved in pathologising, and therefore being able to offer ‘treatment’ for any aspect of normal ageing whether or not it causes a problem to the person themselves.

Recommendations—how can HCPs help improve the sex lives of older people?

HCPs should screen for sexual dysfunction in their older patients [30], especially those with chronic diseases, on certain medications, or men presenting with lower urinary tract symptoms [14]. Where appropriate, post-menopausal women should be asked directly about symptoms of urogenital atrophy as the environment of care may not feel appropriate for patients to initiate the conversation even if it is causing significant distress [18]. It may be helpful to open the conversation by first asking permission to ask more personal questions [31, p. 120]. Questions such as those in Box 1 may offer patients an opportunity to discuss such issues. Patients tend not to feel comfortable discussing topics such as sexuality unless they feel there is adequate time to discuss the issue [16], and privacy also needs to be considered. Elderly patients often attend with their adult children, and might not be comfortable discussing sexual issues in front of them [31, p. 104]. GPs should recognise that many elderly people would prefer discussing sexual issues with a doctor of the same gender and as close to their age range as possible [21]; appointments with colleagues should be offered as appropriate. Educating patients is an important task. This includes educating about ‘lifestyle factors’ (e.g. smoking, obesity, diabetic control) which can affect sexual functioning—using the concept of remaining sexually active life years [9] may assist patients in making healthier choices. Patients should also be educated about the changes they can expect in sexual functioning as they age, and the options available to help them [31]. HCPs also need to be educated to increase awareness of sexuality in older age and improve communication skills [25, 26]. There is a lack of education surrounding the sexual needs of elderly institutionalised people; staff in elderly care homes and psychogeriatric units should be trained to better appreciate the sexual needs of older people [10]. There is a need for a change in culture whereby all staff concerned are comfortable with issues of sexuality in the elderly, such that it becomes a basic part of training [32]. Some research has suggested that home visits for nursing home residents should be

Box 1. Questions for clinicians to consider

- Are you experiencing any problems in your sexual life?
- Some people on these medications notice sexual problems. Is that something that has affected you at all?
- Sometimes when people feel very low and depressed they lose all interest in sex. Do you think that is an issue for you?
- Often women around the time of the menopause can suffer not only with the hot flushes you have described but also with sexual problems such as vaginal dryness. Is that something you have experienced?

These can all be followed up as appropriate by stating that if there are problems identified now or in the future, there are a range of treatments to help.
facilitated if a sexual partner is available [33]. At the very least, privacy should be respected where at all possible. HCPs also need to be very aware of and deal with their own emotional reactions and attitudes to the patient (the countertransference) without letting any prejudices they may have affect patient management [31, pp. 41–4]. This can be helped by appropriate supervision and a multidisciplinary approach when possible (e.g. in a residential home or on a ward) (Box 2).

Conclusions

Many older people enjoy an active sex life, although they are likely to experience problems. In general, the environment of care does not lend itself to discussions about sex and many patients find it difficult and embarrassing to talk to HCPs about sexual problems. Conversely, many HCPs believe that their older patients are not (or should not be) sexually active. More training is needed for HCPs who work with older people both to impart knowledge of elderly sexuality and the skills required to discuss it sensitively.

In conclusion, sexual problems in older people should be managed sensitively and practically by HCPs, with respect to individual differences in sexual interest and activity.

Key points

• Many older people enjoy an active sex life.
• Some older people face sexual problems which they find embarrassing to discuss with healthcare professionals.
• Healthcare professionals do not ask older patients about sex even when highly relevant such as in assessing depression.
• The problems caused by a healthcare professionals’ embarrassment can impact on the patient.

Conflicts of interest

None declared

References

Joint geriatric and psychiatric wards: a review of the literature

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Abstract

Joint geriatric/psychiatric wards are a potential solution to improving care of older patients with both psychiatric and medical illnesses in acute hospitals. A literature search using Medline, PsychINFO, Embase and CINAHL between 1980 and 2010 was carried out for information about joint wards for older people. Thirteen relevant papers were identified. These wards share common characteristics and there is evidence that they may reduce length of stay and be cost-effective, but there are no high-quality randomised controlled trials. Further research is needed, particularly regarding cost-effectiveness.

Keywords: psychogeriatric, geriatric psychiatry, evaluation, assessment, elderly

Introduction

Up to 60% of over sixty-fives in acute hospitals have dementia, delirium or depression [1]. Acute hospitals are a hostile environment for older people with mental health problems [2, 3] and medical and nursing staff are often poorly trained to cope with their needs [4]. On the other hand, a significant proportion of older patients in psychiatric hospitals have serious medical problems which go untreated [5].

A potential solution to this problem is to have a joint geriatric/psychiatric ward. Many such wards have arisen out