

COMMENTARY

Sexuality in the older person

In this review I will examine what sexuality is, the fallacies and the facts of sexuality in elderly people and sexuality of people in institutions. I will also offer some solutions to some of the problems encountered.

Whilst the term 'sex' refers to physical aspects, particularly the act of sexual intercourse, 'sexuality' has a broader meaning, encompassing not only the physical but also social and mental aspects. Ingram-Fogel [1] suggested that "sexuality underpins much of who and what a person is and has significance throughout everyone's life". Stuart and Sundeen [2] defined sexuality as "an integral part of the whole person", continuing: "To a large extent, human sexuality determines who we are. It is an integral factor in the uniqueness of every person". Sexuality is an essential part of a person's make-up or psyche and expressing it is a basic human right.

Fallacies of sexuality in the older person

In general, people view sex and sexuality in older people in one of three ways.

Sexuality simply does not exist

Brogan [3] states "there is a general societal belief that old people are, or should be, asexual and a false assumption exists that physical attractiveness depends on youth and beauty". Many young people have difficulty believing that older people are sexual beings, possibly because this would mean accepting their parents as having sexual interests.

There is a paucity of information on sexuality in elderly people in documents such as *The Health of the Nation* [4] and *Our Healthier Nation* [5]. Booth [6] studied groups of nurses and found that many of them did not believe that people in their seventies had sexual needs. However, some groups are more enlightened: a sex manual published by Age Concern entitled *Living, Loving and Ageing* [7] is specifically written for elderly people.

Sexuality is funny

This is shown by the number of birthday cards which deal with sexuality in later life as a humorous topic. Bytheway [8] found that comical cards and ones on old

age had messages about physical weakness and failures in sexual performance.

Sexuality is disgusting

Drench and Losee [9] noted that an "elderly person who deviates from the stereotype and wants an active sexual life may be derided as foolish (a 'dirty old man')". However, as Griffiths [10] points out, "the elderly themselves are reluctant to verbalise their sexual feelings, for fear of being seen as depraved, or lecherous, so that myths about their sexuality are internalised".

Facts about sexuality in the older person

Many older people engage in sexual activities until their eighties or even their nineties. Kinsey and colleagues were the originators of studies in sexual behaviour of men [11] and then women [12]. Their population samples, however, included very few older people (only three women and two men over 80). Bretchneider and McCoy [13] studied healthy residents of retirement homes in California and found that 62% of men and 30% of women over 80 had had recent sexual intercourse, while 87% of men and 68% of women had had physical intimacy of some sort. Matthias and colleagues [14] found that, of a sample of 1216 elderly people in Los Angeles, nearly 30% had participated in sexual activity in the last month and 67% were satisfied with the current level of sexual activity.

Helgason and colleagues [15] studied 319 Swedish men and found that 46% of the oldest men (70–80 years) reported orgasm at least once a month. In a case study, Feilo and Warren [16] describe a 95-year-old man who was still having relations with prostitutes. In the longitudinal studies at Duke University [17], sexual activity actually increased with age in 15% of elderly subjects. Kaluger and Kaluger [18] found that people with active sex lives and keen sexual interests in their younger days were more likely to continue to remain active in later life.

Problems encountered

In general, sexual activity declines with advancing years. The causes for this may be time-related, medical or psychosocial.

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Time-related factors

Natural ageing tends to lead to a need for more time to engage in sexual activities. Masters and Johnson [19] described:

1. Delay in arousal, with greater need of genital stimulation;
2. Reduced penile rigidity and vaginal lubrication;
3. Loss of the sensation of ejaculatory inevitability; and
4. Increasing anorgasmia.

Medical factors

Medical causes which increase with age include:

1. Drugs which can cause impotence or lack of libido;
2. Diseases (such as diabetes mellitus) which lead to impotence;
3. Surgery of the prostate or uterus;
4. Physical barriers (such as catheters or pessaries);
5. Poor mobility due to arthritis or stroke;
6. Change of body image (e.g. after mastectomy or limb amputation); and
7. Depression, leading to loss of interest in sex.

Psychosocial factors

Psychosocial problems linked to the process of ageing include:

1. Having no partner;
2. A lack of privacy (e.g. in nursing and residential homes); and
3. Social conditioning.

Sexuality in institutions

An area of taboo is sexuality in institutional care, particularly if the residents are demented. Many hospitals, rehabilitation facilities and homes for older people ignore the issue of sexuality. Kaas [20] reported that “the aged in nursing homes must frequently live in celibacy”. This may be because of ignorance, mistaken beliefs and prejudices of carers about both their own and older people’s sexuality. Ehrenfeld and colleagues [21] found that many staff in geriatric institutions reported feelings of confusion, embarrassment, helplessness and even negative responses and rejection when confronted with sexual situations.

Ehrenfeld *et al.* [22] studied specific incidents and ways of dealing with them by the staff of several homes for demented people. The study separated the incidents into: loving and caring, romantic and erotic. At the love and caring level, staff accepted and supported residents’ behaviour. With ‘romantic’ incidents, reactions were more mixed, with staff often seeing the situation as humorous or treating the residents like children. Reactions were quite hostile towards

eroticism, with expressions of anger and disgust. There was often a worry of sexual abuse—especially if one of the couple concerned was frail. Relatives’ views were variable. In cases where the woman had made sexual advances, her relatives were invariably upset and angry and demanded that she be protected by the staff.

McCartney and colleagues [23] also looked at attitudes of staff towards elderly people in care. Masturbation, particularly if it occurred openly, provoked the strongest negative responses. However, there was a paternalistic view towards demented residents who paired off. The authors felt that too little attention was paid to the residents’ physical and emotional needs. A couple may not have fully understood and consented, but this does not mean abuse was taking place. There were more liberal attitudes if the couple were thought not to be cognitively impaired.

Strategies for sexual problems

Firstly, it is important to exclude medical causes for sexual problems by taking a detailed history, and performing an examination. If there is a medical cause, it should be dealt with appropriately and the situation reassessed:

1. For women with vaginal dryness, oestrogen creams and pessaries, hormone replacement therapy or lubricants can be helpful [24].
2. Urinary incontinence can sometimes be managed successfully by intermittent catheterization or pelvic floor exercises. An indwelling catheter does not preclude sexual intercourse in women [25].
3. For men with impotence, drugs such as sildenafil (Viagra) and alprostadil (Muse and Caverjet) can be used. The original study of sildenafil involved men up to the age of 87 [26]. Men over 65 have a decreased clearance rate of sildenafil, with free plasma concentrations 40% greater than younger volunteers [27].
4. If men have an indwelling catheter, they can still have intercourse using a condom or suprapubic catheter [28].

Fitness for sexual intercourse—particularly after cardiac events—is often questioned. The exertion required equates to polishing and ironing at the lower end of sexual activity and equivalent to a round of golf, digging the garden or making the beds at the more vigorous end [29]. Keeping fit decreases the risks [30].

For psychosocial problems, forthright discussion by the doctor is important. Both Byers [31] and Johnson [32] found that openness, knowledge and frankness encourages elderly people to discuss their sexual problems. Professionals should advise that sex is good for you and orgasm achieved by masturbation may relieve anxiety and promote well being [10]. Intimate

contact without sexual intercourse may be what is desired [23]. Advice on spicing up the sex life does not change with age, and Riley gives some sensible suggestions [33]. Again, it is as important for professionals to remain non-judgemental about variations on sexual practices and homosexuality in this age group as much as in any other group.

In institutions, education of the professional carers is important. Hillman and Stricker reviewed the literature and found that "educational intervention strategies have been effective in increasing knowledge and cultivating permissive attitudes" [34]. If the caregivers acknowledge that residents may still have sexual thoughts and desires, they will then 'give permission' to them to express themselves. Caregivers should be encouraged to have a more liberal attitude to residents' sexual preferences—even if these differ from their own (for instance towards homosexuality) [20, 35, 36].

Avoiding segregation of the sexes allows social interaction [10, 23]. Kaas [20] recommended changing restrictions on personal visits from partners. Roberts [37] advised that double rooms should be available and doors should lock from the inside.

The touching involved with grooming is often the only physical contact an elderly person may have and is often therapeutic. Grigg [36] advised that hair care, massage and aromatherapy should be available as acceptable ways of providing a sense of wellbeing.

Ehrenfeld and co-workers [21, 22] showed that staff found group discussions very helpful, particularly with situations of conflict with relatives of the residents or if sexual abuse was suspected. McCartney [23] found that open discussions amongst staff and supervisors prevented inappropriate or paternalistic behaviour by the staff being imposed on the residents.

Key points

- Sexuality may remain important throughout a person's life.
- Maintaining sexuality in its many forms should be encouraged to promote health and wellbeing in older people.
- An open and receptive attitude by professionals should encourage older people to discuss their sexual problems.
- Many sexual problems in older people can be addressed in a similar way to those in younger people.

BELINDA KESSEL

*Specialist Registrar in Elderly Medicine,
Flat 1, 100 Cavendish Road, Clapham South,
London SW12 0DF, UK
Email: belkessel@doctors.org.uk*

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