Sexuality in the Aged

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Un médecin qui travaille dans une clinique de sexualité discute les problèmes d'ordre sexuel chez les hommes et les femmes âgés.

From the day we are born until the day we die we are all sexual beings. Sexuality refers not only to our genitals and their activities, but sexuality comprises the feelings we have about ourselves as persons, both males and females. Thus, sexuality is ageless as is the lifelong need for warmth, closeness and physical contact. In spite of this, our society gives elderly people a strongly negative message about their sexuality.

In order to enhance the quality of life of the elderly, all of us, regardless of our own age, must learn to accept the sexuality of older persons. To help us overcome this difficulty, we must begin to understand how society's messages mould our attitudes towards sexuality in general and towards sexuality of the aged in particular.

The cultural taboo about sex and old age in our society results from a number of factors. First and foremost is the concept that many of us have been raised with — that sex is for procreation and must not be separated from that role. If we begin to think of many of the sexual activities that are culturally frowned upon, we realize that they are the activities which cannot lead to reproduction. I refer specifically to masturbation, oral sex, homosexuality, etc. Into this category must fall also sexual activity between post-menopausal women and elderly partners. Closely linked to this is the belief that sex equals intercourse. The result is that all other forms of sexual contact, which may be equally pleasurable and stimulating, such as flirting, caressing, hugging and so on become downgraded and those who, for one reason or another, cannot or do not wish to have sexual intercourse, immediately see themselves as being unable to have sex.

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Our own society equates youth and beauty as being synonymous and the elderly are consequently seen as extremely unattractive. We know from Masters and Johnson's study that the feeling of self-attractiveness was an important factor in whether or not the elderly continued sexual activity. And yet, in one study of elderly nursing home residents, 58 per cent of the men and 78 per cent of the women felt unattractive.

Many of our elderly citizens are economically deprived and cannot afford the privacy that is necessary for them to continue to be involved in sexual activity — whether this be in the home of their children or in institutions.

Certainly our nursing homes are not set up to cater to the sexual needs of their residents. Men and women are segregated, double beds are rarely seen and very few institutions provide rooms with locked doors for their residents. Nursing home operators are very sensitive to the anticipated criticism of adult children who find it extremely difficult to see their elderly parents as sexual beings and also to the criticism of the community which finds the open expression of sexuality uncomfortable in anyone, but particularly in the aged. Certainly, while sexual activity, as defined by the continuing incidence of intercourse does decline with age, age is not the only factor. One study from Duke University found a decrease in the intercourse activity of many of the subjects from their early 60s onwards. However, a significant proportion of the aged showed rising patterns of sexual activity and interest. In fact, those who were still married at the time of the study reported that more than half of them were sexually active and, in those over 75 years of age, one-quarter were still sexually active.

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Certain physical changes occur in the reproductive tracts of both men and women with

aging. These changes are normal and in no way need interfere with the capacity to enjoy a full range of sexual activity. However, for those who are not aware of these normal changes, their appearance is often viewed with alarm. And thus, sexual activity frequently comes to an end not because of an actual disability, but as a result of this mistaken belief. What are the changes that do occur? For the female, as estrogen production decreases after the menopause, there may be some thinning of the lining of the vagina and a decrease both in the length and width of the vagina. There may also be a decrease in the amount of lubrication developed during sexual arousal. However, and this is critical to note, the capacity for orgasm remains throughout the life of a woman. What has been found is that regular sexual activity is critical in maintaining sexual capacity and effective performance.

In the male, some physiologic changes occur as well. Erection may take longer to achieve and may require more direct stimulation of the penis. Once achieved, the aging man's erection may be maintained for fairly long periods of time without ejaculation. In fact, the ability to maintain this erection over longer periods of time may prove to be a bonus to those men who previously worried about 'premature ejaculation'. The amount of ejaculation may be somewhat decreased in amount and may come out with less force. Finally, the period of time required for another erection after ejaculation may lengthen to 12 to 24 hours. Unfortunately, in the male, the ability to get an erection and to maintain it is frequently undermined by anxiety or, as we call it, 'performance pressure'. And so, a man who begins to worry that these normal changes will afford him or his partner less pleasure may be creating his own self-fulfilling prophecy.

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If then, as we say, both men and women retain the capacity for sexual enjoyment throughout their life, what are some of the reasons or the factors which lead to a significant decrease in sexual activity?

Aside from age, one of the most important factors here is marital status and the availability of a partner is critical in many cases. Indeed, in one study of nursing home residents, 40 per cent of the women there responded that they would be sexually active if they had an active partner available. Again, our societal taboos are such that it makes it very difficult for elderly women to find partners, particularly frowning upon women who become sexually involved with younger men and upon women who live with partners 'out-of wedlock'. When we remember that women generally outlive men and that women generally marry men who are older than themselves, we can begin to see what a major problem the lack of partners is for many elderly women.

A second area to look at deals with belief systems. And here it is important for us to remember that the majority of elderly people were raised in the years when Victorian morality still prevailed. Many of these people have incorporated within themselves strong taboos against sexuality which does not lead to reproduction and they continue to accept these beliefs in rigid definitions of what is proper. In addition, they have relatively little knowledge about sexuality in general and the changes of aging in particular, With respect to this, it is interesting to note that in one study done among nursing home residents, the authors found that higher knowledge about sexuality coincided with a more permissive attitude towards sexual activity, whereas a restricted attitude was indicated by low factual knowledge. Furthermore, a higher religious adherence was associated with a poor overall sex knowledge score. Indeed, *experts* believe that the widespread ignorance about sex and the high frequency in our society of excessive inhibition about the release of sexual tensions, makes sexual problems one of the most common causes of helpless feelings among the aging.

... difficult for elderly women to find partners ...

A third important determinant is that of the prior patterns of sexual expression. We know that those who enjoyed sexual experiences and a high sexual drive throughout life are more likely to continue in the same way as they become elderly. On the other side of the coin, we know that age can offer many elderly men and women who have had sexual conflicts in their youth an acceptable alibi to release themselves from the burdens of anxiety connected with sexual behaviour. Such men and women accept with relative ease, indeed welcome, the 'end of their sexual lives'. For those who have always derived pleasure and sexual satisfaction from stroking, other non-intercourse activities for one's self and one's partner, or for whom variability of position has been part of their repertoire, the adjustments required by the normal or disease-caused changes in later life can be taken as a matter of course. On the other hand, those whose definition of proper sexual activity is confined to intercourse in the 'male on top' position, preferably accompanied by simultaneous orgasm and no talking, may find the changes well nigh impossible.

At this point, I think it is important to look at the

effects of health status of the aging person on his or her sexual activity. Again, many myths abound about the energy cost of sexual activity and the fact that it is believed that the elderly are too frail to engage in sexual activity and that if they do so, serious harm will befall them.

Certainly there are some fairly common physical diseases which cause concern for people with respect to their sexuality.

Many studies have shown that following a heart attack, a significant number of patients fail to return to the level of sexual activity they enjoyed before their illness. In only a portion of these is this due to the physical disability which follows the heart attack. In the vast majority of cases there is a great element of fear that the sexual activity may lead to another coronary or even to death. Furthermore, for those patients who have always restricted their sexual activity to intercourse alone, the belief that cuddling and caressing must always be a forerunner to intercourse precludes them from enjoying physical contact which does not include this option. Often, this occurs just when this is most important to both members of the couple. Too often we hear the story that the couple has taken to sleeping in separate beds or separate bedrooms because they fear that physical closeness may turn them on and that this in itself is dangerous or may inevitably lead to intercourse with expected harmful consequences.

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What we do know is that intercourse with a familiar partner uses up no more energy than the effort involved in walking up two flights of stairs. Furthermore, we know that there is very little difference to this energy cost whether the man is on top or on the bottom. We do know, however, that many patients are not advised about this and other aspects of sexuality following a coronary and that many spouses are afraid to raise the subject for fear of being seen to pressure the partner. I think it is very important that hospitalized patients with heart disease discuss freely with their doctors many of these questions prior to, as well as after, their discharge so that they will have the knowledge and comfort to enable them to engage in whatever level of sexual activity they wish.

There are a number of other common diseases which may affect the ability to have or maintain an erection or may cause difficulty with position and body movements during sexual activity. Included here are such problems as diabetes (in which erection difficulties are frequently seen and may even be the first symptom of the disease), previous prostate surgery, (depending on the type of operation and whether or not some of the nerve supply to the penis was damaged), as well as strokes, arthritis and other physical ailments which can impose limitations on mobility. In all these cases, the sexual difficulties may be compounded by anxiety, concern and performance pressure. For each of these diseases, an understanding of the totality of sexual response and an acceptance of a wider definition of sexuality by both the patient and by health care professionals who are looking after that patient are essential to successfully making satisfactory adjustments.

Alcoholism is another disease which needs consideration. This is certainly not a disease limited to the elderly, but we do know that chronic alcoholism frequently leads to difficulties with an erection and, in the elderly, will accelerate the sexual changes that normally occur with aging. As well, an acute alcoholic bout may lead to a single episode of impotence. For an elderly patient already wary about his 'failing abilities' this single episode may then lead to a permanent problem as a result of anxiety about performance.

... sexual difficulties may be compounded by anxiety ...

Depression is another important illness to watch for. Just as depression suppresses other appetites such as want for food, it will invariably be accompanied by loss of sexual appetite. Correction of the depression will often lead to an increase in sexual interest. It is important to recognize that many elderly suffer from depression as a result of the many losses that they face. These include loss of job, loss of self esteem, loss of friends and close relatives and loss of health. Of course, depression may be seen as the cause of the loss of sexual interest or activity or conversely, it may be seen as a consequence of that loss.

Given this information, what can be done to help the older person in this area? It should be obvious from what has been discussed here that the underlying need in dealing with many of these issues is education. This education is, first, about normal physiologic facts — data which has only begun to accumulate in the last decade or so and which is only now being taught to our health care professionals.

I believe that this type of education must begin early in life and continue throughout life. Certainly, as long as women constitute a large proportion of our elderly population and have in the past been so restricted by stereotypic roles, they are particularly in need of this type of education and the granting of permission to be sexual beings freed to enjoy their sexuality ◑