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Sex and the Elderly: What Physicians Should Know About Their Older Patients

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Sex and the Elderly: What Physicians Should Know About Their Older Patients

A Thesis Submitted to the
Yale University School of Medicine
In Partial Fulfillment of the Requirements for the
Degree of Doctor of Medicine

by
Jana Colton
2007

Abstract

SEX AND THE ELDERLY: WHAT PHYSICIANS SHOULD KNOW ABOUT THEIR OLDER PATIENTS. Jana A. Colton (Sponsored by Margaret Drickamer). Section of Geriatrics, Department of Internal Medicine, Yale University, School of Medicine, New Haven, CT.

This study is intended to explore how physicians can best help their older patients attain a better quality of life through sexual healthcare by eliciting older patients' perceptions and experiences regarding their sexual health needs and what role their physician should play in meeting those needs. Participants consisted of individuals and couples over the age of 65 recruited from a continuing care retirement community and from a VA Geriatric Clinic. Twenty in-depth, one-on-one interviews were conducted, and transcripts were analyzed using qualitative methodology. Analysis of transcripts revealed a broad range of findings including seniors perceptions of: the definitions of "sexual activity" and "sexual health," their own sexual status, their own sexual health needs, the barriers to meeting their sexual health needs, and the ageist beliefs of others and themselves. This study exposed older patients' self-perceived sexual health needs and the barriers to having those needs met; this knowledge should help physicians improve the quality of life for their senior patients through improved sexual health care.

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SECTION I: Introduction

"Life without sex might be safer but it would be unbearably dull. It is the sex instinct which makes women seem beautiful, which they are once in a blue moon, and men seem wise and brave, which they never are at all. Throttle it, denaturalize it, take it away, and human existence would be reduced to the prosaic, laborious, boresome, imbecile level of life in an anthill." (Mencken)

I first became interested in the topic of sexual health and the elderly after a colleague of mine at medical school told the following story from her internal medicine rotation. As medical students we had been taught during our preclinical years that we should take a comprehensive medical history on every patient including a complete sexual history, but once we got to the wards it became increasingly clear that the sexual history did not receive the same level of importance in practice as it did in the classroom. However, this particular medical student had not yet abandoned her quite thorough interviews for the shortened version practiced by most senior doctors. She met her new patient, a male in his early 90s (who she described as having a hunched back and no teeth) and went through the sexual history format we had learned:

“Are you sexually active sir?”

“Why yes,” he replied.

“With men women or both?”

“With men.”

Naturally when she reported on rounds the next morning that this patient had recently engaged in homosexual intercourse, the other residents and interns on her team were floored. One resident verbalized the sentiments of the group: “Never in a million years would I have thought this man was even capable of having sex!”

I was then reminded of the topic a few months later when I was visiting my parent's house. On the bookshelf in the study I found a book titled Sex after 50. When I opened the book, I found all 200 of the pages were completely blank – it had been a gag gift for my father's 50th birthday. The present shocked me. Most people are disgusted at the thought of their parents having sex. I on the other hand, was somewhat worried my parents weren't having sex. After all, they grew up in the 60's and were products of the sexual revolution. What happened to all that sexuality? Is it true that everyone loses their sexuality as they age? Was the 90 year-old man in the hospital just a sexual aberration? Maybe most doctors don't routinely take a sexual history of their elderly patients because it is largely irrelevant?

I went in search of more information. I looked on amazon.com and found that several books devoted to sex and aging have been published, but it was hard to distinguish one book from another with the minimal information posted on the website. I decided I should look through the books in person, and I figured a bookstore in my hometown, Boca Raton, Florida, would have many of the titles I had found listed on amazon.com. After all, Boca Raton is notable for a sizable elderly community; according to a recent census, people 65 yrs and older account for 25% of the total population. So I went to the largest bookstore in the area, a two story Barnes and Noble. To my surprise, I could not find a single book amongst the shelves of sexuality books that broached the subject of sex and the elderly. I went to the help desk with a list of titles I had copied from Amazon, and not a single one of these books was in stock. I then went to the other major bookstore in town and found

ONE title: A Guide to Sex over 40 (emphasis added). Is sexual activity after the age of 40 really astonishing enough to have an entire book devoted to the topic? What does that imply about the average 80 year-old?

So it seems that older people hoping to seek out information pertaining to their sexuality will not find much help at the bookstore. Could they ask their doctors? Maybe we doctors know something in our medical literature that has yet to make its way to popular literature. My next stop was the medical school library. I opened about 8 different geriatrics textbooks and I was pleasantly surprised when 6 of 8 textbooks had a chapter devoted to sexuality. Each of these chapters generally covered 3 concepts:

- 1) They all explained that sexuality of the elderly is often ignored in our society, but it exists, and can be important to quality of life.
- 2) They then delineate the “normal” changes in sexual physiology that occur with age.
- 3) They conclude by outlining a brief medical approach to “sexual problems” or “sexual dysfunction.”

(I was unable to find information about elderly sexuality in any other kind of textbook — except for 2 OB/Gyn textbooks which each included 1-2 sentences confirming that elderly people can have sexual needs. No mention of sex and aging was identified in any of the internal medicine, family medicine, or urology textbooks I reviewed.)

This omission of sexual topics by both medical professionals and medical literature reflects a general discomfort with elderly sex within the health care community. Not that physicians are alone – uneasiness with sex and aging can be found throughout our society. In fact, Western civilization has a long history of treating older people as asexual beings. In ancient Rome, the topic of sexual activity in older age was addressed by several prominent figures of the period. Ovid’s famous statement “*turpe senilis amor*” sums up the general attitude of the ancient world that “older people are not fit” to be engaging in sexual activity (Parkin 2003). Roman law actually set a specific age at which men and women are no longer legally recognized as fertile – age 50 for women and 60 for men – and thus all sexual expression beyond this age was viewed as disgusting and unnatural. Romans did not necessarily think older people should become solitary with age; an older married couple who still cared for each other was seen as the ideal situation, so long as the sexual relations between the couple had disappeared (Parkin 2003). Cicero in his writings on old age explains that loss of sexuality as a person ages should be seen as a blessing not a curse: “we ought to be very grateful to old age for depriving us of all inclination for that which it was wrong to do. For pleasure hinders thought, is a foe to reason, and, so to speak, blinds the eyes of the mind” (Cicero). In other words, once incapable of procreation, older people can be freed from sexual activities so they can instead engage in more lofty pursuits.

The negative attitudes of the Romans have persisted through 2 millennia of Western history.¹ The Catholic Church adopted the Roman belief that sex beyond the reproductive years is unnatural, and then the Medieval Church took this position one step further, claiming that elderly sex was a crime against nature, and thus, a crime against God (Sharpe 2004). In the 19th century, Darwinism added a new spin to this ancient ideology. According to the theory of natural selection, sex beyond procreative years serves no evolutionary purpose, and is almost never observed in other animal species; it is no surprise then, that many people concluded that sex in old age is contradictory to the natural order of the earth (Smith 2002). The theory of natural selection revolutionized the biological sciences of the 19th century, and therefore, it is not surprising that the medical community of the day adopted a Darwinian attitude towards healthcare. In fact, many medical texts of the 1800s recommend that men and women over the age of 50 should abstain from sex; physicians of that era reasoned that once sex no longer served a biological purpose, it probably would become “unhealthy” and might actually hasten death (Smith 2002).

Although modern medicine no longer discourages elderly sex, the attitude of sex belonging to the healthy and the young has persisted and is evident in many sexology

¹ There is evidence indicating that negative stereotypes about elderly sexuality exist not only in the Western history, but in the history of many other societies as well. According to Chinichian (2005), in Iran, it is assumed that older people, especially older women, have no sexual needs. Chinichian, M. (2005). "Insights from a Canadian sexuality conference: Reflections of a midwife from Iran." Canadian Journal of Human Sexuality 14(1-2): 57-59. In a study of sex and aging in Singapore, researchers found that the idea that “no sex is allowed after menopause” was one of the major reasons given by older subjects to explain decline in sexual activities. Goh, V. H., C. F. Tain, et al. (2004). "Sex and aging in the city: Singapore." Aging Male 7(3): 219-26.. In China, Guan found over 1/3 of rural elderly agreed with the larger societal belief that elderly sex was abnormal. Guan, J. (2004). "Correlates of spouse relationship with sexual attitude, interest, and activity among Chinese elderly." Sexuality & Culture: An Interdisciplinary Quarterly 8(1): 104-131.

studies of the 20th Century. In the famous Kinsey studies on human sexuality, only 10% of 5300 males surveyed were over age 50, and less than 5 percent were over age 60 (Gott 2005). The experiences of older women were even less represented than their male counterparts; of 5940 females surveyed, less than 5% were over age 50 and less than 1% were over age 60 (Gott 2005). In the other landmark sexual research of the past century, the Masters and Johnson studies in the late 1960's, hundreds of subjects were recruited to help identify the "normal" human sexual response; however, of the 700 men and women surveyed, only 31 were over the age of 60 (Levy 1994).

However, evidence is growing that although frequency of sexual activity tends to decrease with age, older adults (in America) continue to be sexually interested and/or sexually active well into later life (Bretschneider and McCoy 1988; Diokno, Brown et al. 1990; Janus and Janus 1993; Clements 1996). In their study of elderly caregivers (mean age 72.4), Svetik et al. (2005) found that half of older men and women valued remaining sexually active. In a Medicare-population survey, 30% of respondents reported engaging in a "sexual relationship" within the previous month (Matthias, Lubben et al. 1997). Sexual interest and activity may depend on the presence or absence of a sexual partner; Doikno et al. (1990) found that among married individuals age 60 and over in a Michigan survey, 74% of married men and 56% of married women reported being sexually active. (In contrast, only 31% of unmarried men and 5% of unmarried woman were sexually active.) Not only do older people continue to have intercourse, there is also evidence that they continue to

masturbate, and some people (usually women) may even discover masturbation for the first time in their later years. In fact, one study (Hodson and Skeen 1994) reported that in a survey of people over age 70, 43% of men and 33% of women admitted to masturbating.

Studies focusing on nursing home residents have shown that sexual interest can even extend well beyond independent living. White (1982) found that 8% of nursing home residents are sexually active, and of the sexually inactive patients, 17% reported they were sexually interested but lacked the opportunity to express these interests. Mulligan and Palgutta (1991) interviewed residents of a VA nursing home and found that although few considered themselves sexually active, two-thirds of interviewees expressed sexual desires. Of nursing home residents with partners, 17% reported at least monthly coitus, and 73% described other forms of sexual expression such as hugging and kissing on at least a monthly basis. All the above evidence suggests that sexuality and sexual activity is relevant to a sizable number of older adults.

Medicine's Role

Now that we have seen that sexuality continues into old age, another question arises: what is the role medicine should play in older patients' sexual health? Traditionally, the physician's responsibility in "sexual health" has been limited to pregnancy and

sexually transmitted diseases. Recently, however, the emergence of erectile dysfunction drugs such as Viagra has forced the medical community to re-evaluate its participation in older patients' sex lives. Now the issue really has become: *how involved* should doctors become in the sex lives of their elderly patients?

Gott writes about the current attitude in gerontology: "asking older people about sex is still seen as too difficult, too intrusive, and fundamentally, unnecessary" (2005). Gott, Hinchliff et al. (2004) interviewed approximately 50 General Practitioners in the UK about their views on later life sexuality and sexual health. Many of the doctors interviewed reported "that they were much less likely to initiate discussions of sexual issues with older patients than younger patients and required more distinct (often social) cues to do so." The authors identified the following as barriers to talking with older patients about sex: 1) beliefs that sex is irrelevant to older people, 2) beliefs that initiating discussions of sexual health would offend older patients, 3) sexual health training in medical school that focused on issues of pregnancy and STDs – topics older people are largely felt to be immune from. Furthermore, several GPs questioned whether or not "sexual health" is really a medical problem at all.

Even when doctors choose to involve themselves in the sex lives of their patients, they often remain uneasy discussing sexual issues. Bedell, Gaboys et al. (2002) evaluated conversations between cardiologists and their patients at the specific office visit when the doctor prescribed Viagra. Even in the context of treating erectile dysfunction, 73% of patients felt their doctor was uncomfortable talking with them

about sex. Only 60% said that doctor talked with them about erectile dysfunction when suggesting treatment with Viagra, and far fewer patients, only 15%, felt they have ever had a discussion with the physician about their own specific sexual difficulties during intercourse.

However, despite physician doubts and discomfort with medical involvement in sexual health for seniors, studies show that older patients overwhelmingly identify their primary care physician as their preferred source of help for sexual concerns or problems (Read, King et al. 1997; Gott and Hinchliff 2003). And there is evidence that older patients routinely have sexual health concerns that they would like to discuss with their doctors. Nusbaum, Singh et al. (2004) found that in a family practice in Washington State, female patients aged 65 and older had a similar number of sexual concerns as their younger counterparts; however, the sexual concerns most important to the older women were not necessarily the same as the concerns of the younger women.

What Are the Sexual Health Concerns of Older Patients?

Sexually Transmitted Diseases

Although many doctors may question their role in the sexual health of their patients, physicians almost always agree that sexually transmitted diseases (STDs) fall clearly

within the boundaries of traditional healthcare. As explained above, doctors often do not investigate the sexual health of their older patients because they feel STDs are not an issue for this patient population (Gott, Hinchliff et al. 2004). This attitude is not limited to physicians; public health campaigns addressing STD prevention have almost exclusively targeted younger segments of the population (Gott 2005).

However, there is increasing evidence demonstrating that sexually transmitted diseases can be a concern for patients at any age. Data from both the USA and the UK (Leigh, Temple et al. 1993; Stall and Catania 1994; Wellings, Field et al. 1994; Gott 2001) show that people over 50 engage in risky sexual behaviors, are less likely than younger people to discuss STD concerns with their doctor, and are less likely than any other age group to use condoms. Although rates of STDs in the elderly are less than the rates for younger groups, prevalence of certain diseases (including HIV) have risen in this group, and will likely continue to rise as the cohort raised with Victorian values is replaced by a cohort raised in a more sexually liberated era (George and Weiler 1981).

Sexual Dysfunction

While it is clear that seniors do indeed have interest in sex and do engage in sexual activities, there is also evidence that on average, sexual interest and activity declines as people age (Brubaker and Roberto 1993; Araujo, Mohr et al. 2004). What causes this decline is not entirely clear. Physicians agree that at least some of this sexual

decline is associated with age-related physiologic changes. In women, the most common physical changes occur after menopause and include: thinning of vaginal walls and decreased genital lubrication (due to decreased estrogen production), decreased libido (likely due to decreases in testosterone), less frequent orgasms, and reduction in the duration of orgasms (Croft 1982; Applegate 1986; Gentili and Mulligan 1998; Gelfand 2000; Willert and Semans 2000; Zeiss and Kasl-Godley 2001). In men, common age-related changes are at least partially due to decreased testosterone levels and include: decreased sperm/seminal fluid production, greater stimulation to achieve erections, need to maintain erections for longer periods prior to ejaculation, less frequent ejaculation, decreased force of ejaculation, lengthened refractory period, and decreased libido (Croft 1982; Applegate 1986; Gentili and Mulligan 1998; Willert and Semans 2000). Interestingly, Masters and Johnson found that despite the numerous changes in the sexual response of the aging male, a man's subjective level of pleasure derived from sexual activities does not diminish with age (Applegate 1986).

Since sexual changes are part of physiologic aging, there is much dispute over what is "normal" and what is "dysfunctional." There is also a dispute over how much of the changes listed above are due to the aging process itself, and how much of these changes are really due to factors *associated with* aging such as other disease processes, medication use, psychological factors, etc (Araujo, Mohr et al. 2004). Regardless of the etiology of the physical changes associated with growing older, it is important to recognize that these changes do not, in and of themselves, preclude

sexual activity (Willert and Semans 2000; Zeiss and Kasl-Godley 2001). It is only when patients feel they cannot adjust or adapt to a particular sexual change that the *change* then becomes a sexual *problem*.

The DSM IV classifies dysfunction as a disruption in the “normal sex cycle” as defined by Masters and Johnson (sex drive, sexual desire, arousal, and orgasm) or pain during intercourse (Gott 2005). Among older females, the most common sexual complaints are decreased sexual interest and painful intercourse (dyspareunia), but other sexual issues include vaginal dryness, vaginismus, and lack of orgasm (Croft 1982; Willert and Semans 2000; Zeiss and Kasl-Godley 2001). Among older males the most common complaint is erectile dysfunction, but other sexual problems include diminished libido, premature/retarded ejaculation, and inability to achieve orgasm (Davidson 1985; Morley, Korenman et al. 1987; Willert and Semans 2000; Zeiss and Kasl-Godley 2001). Many authors make the point that sexual problems in the elderly can most often be attributed to medication side-effects and/or other organic disease. Common culprits include diabetes, vascular disease, hypertension, hormonal changes, and depression. The other primary cause of sexual problems is psychological factors, which may either be the primary problem or may be compounding other organic diseases (Croft 1982; Morley, Korenman et al. 1987; Barber, Lewis et al. 1989; Leiblum 1990; Mooradian 1991; Willert and Semans 2000). It should be noted that all articles reviewed focused on sexual problems with heterosexual intercourse, and we should therefore be cautious in applying the data to homosexual problems.

Sexual dysfunction has gotten minimal medical attention in the past, but it is increasingly being accepted as a pertinent health concern. However, not all types of dysfunction have received equal consideration. According to Marshall (2002), “The full and firm erection is viewed as the lynchpin on which the whole business of sex depends.” Perhaps this is why a disproportionate amount of attention has been directed at diagnosing and treating erectile dysfunction. Of course, evidence shows that erectile dysfunction is an extremely prevalent sexual problem; The Massachusetts Male Aging Study revealed that over 50% of men age 40-70 experience erectile dysfunction (Araujo, Mohr et al. 2004). It can be assumed then, that a *majority* of men over the age of 70 have erectile problems.

The emergence of Sildenafil Citrate (Viagra) as a pharmaceutical treatment for impotence, as well as the extensive media attention devoted to the drug appears to have altered the public perception of erectile dysfunction over the last decade. No longer is impotence treated like a shameful problem; now it is viewed as a common health issue that doctors treat every day (Loe 2004). Such public awareness and destigmatization of erectile dysfunction may have “trickled-down” to lessen the stigma of other types of sexual problems, but even so, medical understanding of problems other than erectile dysfunction is still largely unchanged. In my communications with several leading physicians in sexual research, there seems to be a consensus that female sexual problems, in particular, continue to be ignored by

the medical community. Neither the causes of most female sexual difficulties nor the treatment of these difficulties have been the subject of serious research to date.

Precipitants of Sexual Problems: Medication and Disease

Sexual health is not isolated from other aspects of health; in fact, it is well established that many medical conditions and medical and surgical therapies can have significant effects on a person's sexual health. Common conditions among the elderly such as arthritis, back pain, and other physical disabilities may greatly restrict mobility, and thus, sexual activities (Blake, Maisiak et al. 1987; Butler and Lewis 2002). Cardiovascular disease and pulmonary disease can impair sexual ability by imposing limits on physical exertion (Applegate 1986; Mooradian 1991; Butler and Lewis 2002). Chronic diseases such as hypertension and diabetes can disrupt endocrine, vascular, or neural components of the normal sexual response (Applegate 1986; Mooradian 1991). Even incontinence seems to be strongly associated with sexual dysfunction (Mulligan, Retchin et al. 1988). Two studies have measured the relationship between sexual desire with overall health, and both have found that general wellness is a strong predictor of libido in older patients (Bergstrom-Walan and Nielsen 1990; Laumann, Michael et al. 1994).

Many (if not most) drugs and medical therapies are also known to have sexual side-effects. In fact, it is estimated that 25% of sexual problems in males are caused or

exacerbated by pharmaceuticals. Less is known about the effects of drugs in women, but the assumption is that medications known to cause sexual problems in men likely precipitate parallel problems in women (Butler and Lewis 2002). Many drugs have been shown to have sexual side-effects, but the drugs most commonly associated with sexual problems are anti-hypertensives, hypoglycemics, tranquilizers, and anti-depressants. These drugs are known to cause erectile dysfunction, difficulty achieving orgasm, and decreased sexual desire (Applegate 1986; Deamer and Thompson 1991; Zeiss and Kasl-Godley 2001; Butler and Lewis 2002). In fact, experiencing an adverse sexual side-effect is one of the most commonly cited reasons for non-compliance with medication (Butler and Lewis 2002). Furthermore, since older adults take more prescription and over-the-counter medications than any other segment of the population, many elderly patients may be experiencing the side-effects of several drugs simultaneously (Deamer and Thompson 1991).

Surgical treatments can lead to sexual problems for numerous reasons. First, some surgeries, such as gynecologic and urologic procedures, can have a direct effect on sexual organs (Zeiss and Kasl-Godley 2001). Prostate surgery, in particular, seems to be a common culprit for causing sexual problems; according to a recent study (Poulakis, Ferakis et al. 2006), the incidence of postoperative, newly reported cases of erectile dysfunction after transurethral prostatectomy (TURP) was 12%. It should be noted that TURP is one of the most common procedures in America, with 300,000 cases performed each year. Thus, TURP needs to be acknowledged as a major contributor to sexual dysfunction in older men.

A second cause of surgery-related sexual problems is a long or difficult recovery. Diminished energy, decreased mobility, weakness, pain, and medications for pain are just some of the possible post-surgical experiences that can lead to sexual problems. Complicating matters further is the likelihood that surgical recoveries will only become prolonged and more difficult as patients age. Finally, surgeries can impair sexual function simply by provoking anxiety or causing other psychological distress (Butler and Lewis 2002).

Psychosocial Precipitants of Sexual Problems

There is a popular saying that alleges that the largest sex organ is not between the legs - (it's between the ears), which may not be far from the truth. Psychiatric wellbeing is essential to healthy sexual activity and expression. For example, Matthias, Lubben et al. (1997) found a high correlation between sexual activity and positive mental health scores for both men and women in the over 65 age bracket. Casper, Redmond et al. (1985) reported a strong relationship between clinical depression and diminished sexual drive. In fact, more than 70 percent of depressed patients had a loss of sexual interest when their depression was left untreated. The study also found that libido actually declined with increasing severity of depression. Not only may mental health improve sexual expression, there is some evidence to suggest that the reverse is true - sexual activity may actually improve psychiatric

wellbeing. Svetlik, Dooley et al. (2005) evaluated physical intimacy in caregiver relationships and found that “remaining sexually active fostered [caregiver] wellbeing and feelings of self-worth” (pg 73).

Beyond the psychosocial issues that can impair sexual function at any age, there are several psychosocial factors unique to older adults. One major issue that affects many older individuals is the societal attitude discussed earlier that sex belongs to the young. As Ginsberg, Pomerantz et al. (2005) writes, “Older individuals may internalize that message, may feel ashamed of their ongoing sexual interests and may abstain from participating in sexual behaviors.”

Sexual activity can also be hindered by anxiety about aging and deteriorating health. Butler and Lewis (2002) write, “[Man’s] very fear of impotence can cause potency problems.”² Butler and Lewis also describe a common fear of what they call “death by sex:” the fear that too much physical exertion during intercourse can cause a heart attack. If a patient is truly worried about this possibility, the resultant unwillingness to overexert himself or herself can interfere with sexual activity.

Another barrier to continued sexual activity is society’s rigid definition of sex and sexual roles. For example, the belief that intercourse is the only “normal” sexual activity can restrict sexual relations if intercourse becomes difficult (Zeiss and Kasl-

² Sexual abilities are not the only area where buying into negative stereotypes of aging can impair performance. There is a body of literature which shows that activating such negative stereotypes can worsen seniors’ cognitive performance. Levy, B. (1996). "Improving memory in old age through implicit self-stereotyping." *J Pers Soc Psychol* **71**(6): 1092-107.

Godley 2001). Also, in a relationship where the male is expected to be the more “dominant” one, sexual interest can dwindle if the man’s health deteriorates, prompting the female to assume the role of caregiver. This kind of reversal of gender-roles can be perceived as diminishing the man’s masculinity (Willert and Semans 2000; Zeiss and Kasl-Godley 2001).

While psychosocial factors influence the sexuality of both men and women, negative societal attitudes may have a disproportionate impact on women. Fooker (1994) presents data showing that health variables can only minimally explain the maintenance of sexual interest and activity in older women. What appears to be more predictive of a woman’s sexual interest is her body image and perception of her own attractiveness. Of course, maintaining a positive body image in a society that is so obsessed with youth can be quite challenging. Not only are elderly women commonly portrayed as sexually unattractive (Davidson 1985), popular culture often depicts the older woman’s body as particularly revolting. In 2002, the actress Kathy Bates caused quite an uproar when she exposed her aging body in a nude scene for the movie About Schmidt. A similar disgust with the female body becomes quickly apparent when surveying jokes about the elderly. For example, consider this joke, which appears on at least three websites:

“An old man in the nursing home got a bottle of wine for his birthday. He talked the old lady in the next room into sharing it with him. After they were both totally bombed, he started groping the old lady and pulling at her clothes. He managed to get her blouse and bra off before she stopped him. She said, “I can't do this, I have acute angina.” The old guy says, “God, I hope so, you've got the ugliest tits I've ever seen.”

Interestingly, no jokes were found poking fun at the unattractiveness of the older male body. The aging man is often portrayed as impotent, but this problem, as many jokes point out, can be “fixed” with a pill. Surveying jokes about elderly sex did highlight one myth which may be psychologically detrimental to older males – the myth of “the dirty old man.” It seems that older males who are sexually expressive are often regarded as perverted or deviant. “The dirty old man” of popular jokes is lewd and inappropriate; he may even try to molest young girls, who do not suspect he could have anything but the best intentions. Attitudes such as these may discourage or shame older men who would like to pursue a sexual relationship, especially if it is a relationship with a younger woman.

Sometimes the largest factor in determining sexual activity is a person’s social situation. An older person living in their child’s home or in an extended care facility will have significantly less opportunity to engage in sexual relations than a person living independently in a senior community. Barriers to activities of daily living such as transportation, clothing, or grooming can have a significant effect on sexual expression. Furthermore, older individuals may be dealing not only with the effects of their own social situation and physical decline, but also with the effects of a partner’s health, the loss of a partner, or the lack of a partner (Willert and Semans 2000; Zeiss and Kasl-Godley 2001; Ginsberg, Pomerantz et al. 2005). As mentioned earlier, many older patients report that they are interested in sex but remain sexually inactive simply because they have no partner (Diokno, Brown et al. 1990; Ginsberg,

Pomerantz et al. 2005). This is a particularly common problem for elderly (heterosexual) women in America; according to a US Census Bureau Report, the ratio of men to women steadily declines after middle age. Of people in 2002 aged 65-74 there were 83 men for every 100 women; of people over 85 years old, the gender gap widens to only 46 men for every 100 women (Smith 2003).

Special Populations

While the changes that come with advanced age can make sexual activity more problematic for all older patients, two patient populations in particular – long-term-care residents and demented patients – have especially complex sexual health issues. The lack of privacy in most long-term-care settings can be a major obstacle to sexual expression. Also, nursing home residents are particularly vulnerable to societal taboos; both staff and family members may interpret the sexual expression of a resident as deviant behavior, and then they may discourage or even prevent further sexual expression (Applegate 1986). Not surprisingly, older residents report that because of a lack of privacy and negative staff attitudes towards elderly sex, patients in long-term care have little opportunity to experience intimacy (Deacon, Minichiello et al. 1995).

Demented patients pose perhaps the most complicated sexual health issues of any group. On one hand, cognitively impaired individuals lose learned sexual inhibitions;

therefore, they will often exhibit a wide range of sexual behaviors, some of which can be perceived as inappropriate. For example, public nudity, verbal obscenities, masturbation, or sexual advances are all common among dementia patients (Renshaw 1988). On the other hand, these patients may not be competent enough to consent to sexual activity. Research by Lichtenberg and Strzepek (1990) in a dementia ward of a Virginia hospital showed that when they interviewed patient couples who had formed relationships in the hospital, 4 out of 5 of those couples did not know they had formed any relationship at all. Determining at what point over the course of the illness a patient becomes too demented to consent to sexual activities can be extremely difficult. Of course, the escalation of sexual expression that often accompanies the decline in cognition makes ethical and legal decisions even more challenging.

The Physician's Role

In terms of sexual health in the elderly, there seems to be a significant gap between what is recommended in the literature and what is actually practiced by physicians. Recent publications acknowledge the importance of sexual health at all ages, and they often suggest that physicians take a more proactive role in addressing sexual health issues with their older patients (Gott and Hinchliff 2003). Kligman (1991 Feb) advocates regular screening of sexual health problems in older patients; he argues “Because over 80% of sexual complaints can be successfully managed in the primary

care setting, it is important for physicians to include an evaluation of sexual health in the routine health examination.” Mooradian (1991) writes on the subject of geriatric sexual expression and chronic disease, “Many elderly patients would benefit if, in addition to optimization of their underlying physical condition, they receive instructions on alternate sexual techniques and coital positions.”³ Davidson (1985) stresses the importance of educating patients about self-stimulation and “nonorgasmic sex” when intercourse is no longer an option. All of this advice may highlight what is best for the patient, but for doctors who are uncomfortable talking about more traditional aspects of sexual health, illustrating specific coital techniques may be an overly ambitious foray into discussions of sexual health. Perhaps a more reasonable starting point is one of the interview programs suggested in various Geriatrics textbooks (Gill and Ducharme 1992; Burke and Laramie 2002).⁴

Areas of Further Research

It has been established above that several aspects of “sexual health” are medically relevant, even by traditional medicine standards; however, it can be argued that other

³ The Arthritis Foundation publishes a pamphlet which discusses a variety of sexual topics including a section explaining a range of sexual techniques for the aging patient (Applegate 1986).

⁴ Burke and Laramie suggest “questions for assessing sexual concerns,” and organize the interview questions with the following categories: general sexual satisfaction, sexual satisfaction for men, sexual satisfaction for women, alterations in self-perception, relationships with others, and environment. Gill and Ducharme suggest an even more detailed sexual interview for older patients; after a thoughtful introduction of the topic, they suggest asking questions about each of the following issues: current sexual functioning, gender-specific sexual functioning, partner satisfaction/relationship history, physical effects on sexual functioning, and other effects on sexual functioning (such as moral values, religion, and past sexual experiences). See Burke and Laramie 2000 pg 19 or Gill and Ducharme 1992 pg 278 for two suggested sexual interview formats in more detail.

aspects of “sexual health” are really more quality of life issues, and thus, are beyond the scope of medicine. What becomes apparent in the debate over medical relevance is that the patients’ opinions on the matter are not known. Doctors argue about the best interests of their patients without actually having any input from them. It seems that in order to make an informed decision, several questions need to be answered:

- 1) To what extent does sexual health affect a patient’s quality of life?
- 2) Which aspects of sexuality are most important to aging people?
- 3) What kind of medical involvement do patients want in terms of their sexual health?

In reviewing medical literature, the paucity of data gathered from the patient perspective is astonishing. Investigators usually design studies by starting with certain assumptions about sexual practices and sexual priorities of older patients. For example, much of the research in elderly sexuality has focused on coitus, narrowly defining sexual activity as penile-vaginal intercourse and sexual dysfunction as inability to have penile-vaginal intercourse (Cogen and Steinman 1990; Matthias, Lubben et al. 1997; May and Riley 2002). However, other literature and several geriatrics textbooks suggest that as a person ages, there may be a changing nature of “sexuality” in which intercourse may decrease in importance and other factors such as emotional intimacy, touching, cuddling, kissing, and masturbating increase in importance (Kligman 1991 Feb; Gill and Ducharme 1992; Willert and Semans 2000; Kaiser 2003 Aug). Starr et al. (1985) come to the conclusion that while education about elderly sexuality is important, what is equally significant is a greater acceptance of “the range and variability of sexual expression in later life.” In other

words, the medical community must broaden their definition of sexual expression and sexual activity.

The next logical question becomes, “What falls within the range and variability of sexual expression in older life?” Many authors assert that there may be a changing definition of sex that develops as people age, but no data exists to show that older people do indeed define “sexual activity” differently than their younger counterparts. Furthermore, the research discussed thus far is helpful in terms of highlighting that sexual health is an issue among at least *some* older patients, but it does not adequately describe the spectrum of sexual health concerns these patients may have. Exactly what kind of involvement do aging patients want their doctors to have in their sexual health? Instead of imputing what the needs are and then designing a study to prove or disprove those predictions, a simpler approach may be just to ask older patients what their needs are. After all, the best authorities on the sexual health needs of the elderly are elderly people themselves.

Theoretical Considerations

In designing my research, I aimed to fill-in 4 large gaps in the elderly sex research. First, there has been very little research devoted to understanding the diversity of sexual experience for older people. As I discussed earlier, many authors suggest that there may be “a changing nature of sex” with age, but there is no evidence to show

that this is true. My study was designed to explore the sexual experience from an older person's perspective in order to see if the definition of sex does change, and if it does, to describe what those changes are.

The second gap in the literature is the paucity of data on adults over the age of 70. The definition of what age group is "elderly" varies widely from researcher to researcher. Many studies of "older patients" include people in their 50's and 60's. However, at least in America, popular culture tells us that "50 is the new 30" and "70 is the new 50." When most Americans today use the term "elderly" they are usually describing people over age 65, when social security begins.

The third major missing piece of research regards the importance of sex and sexual health to the lives of elderly patients. The little data that exists has largely been quantitative and generated from questionnaires. Unfortunately, it is hard to fully understand patient preferences when the only options to a question are "yes" or "no." The one exception here is a study by Gott and Hinchcliff (2003) in which 44 patients age 50-92 from a general practitioner's office in the UK were interviewed about the importance of their sex lives. This research generated a wide diversity of responses, from 9 people who described sex as "not important" to 11 people who felt sex was "very important." Furthermore, the study found that there were many different reasons someone might find sex important or unimportant, and therefore, it highlights the limitations of the quantitative approaches in previous studies. Gott's study is the most useful research to date in understanding the feelings and

experiences of aging adults. However, there are several limitations of the study from the perspective as medical professionals in America: 1) the patients of the UK may not be representative of patients in the USA, 2) the patients' definitions of "sex" and "sexual activity" were not explored, and 3) researchers defined "older" patients as anyone older than 50.

Finally, there is a paucity of data describing older patients' perspectives on their own sexual health. Specifically, from the point of view of the elderly patient, what are their needs and have they been met? Have their discussions with physicians about their sexual health been satisfactory? What do they perceive to be the barriers that inhibit doctor-patient communication about sex? What role do older patients want their physician to play in meeting their sexual health needs?

With these gaps in mind, I went about defining my research goals. As a medical student, I decided my primary interest was in exploring the role physicians *should* play in the sexual health of their patients. In other words, how can physicians help their older patients achieve a better quality of life through sexual healthcare?

Statement of Purpose

Null Hypothesis

Although the medical profession has deemed sexual health an important part of the medical encounter in younger patients, sexuality and sexual health become irrelevant as the patient ages.

Aims of the study

This study is intended to explore how physicians can best help their older patients attain a better quality of life through sexual healthcare. This will be achieved by eliciting older patients' perceptions and experiences regarding:

- 1) Their sexual health needs
- 2) What role their physician should play in meeting those needs
- 3) The barriers preventing the needs from being met (i.e. communication problems, societal norms, lack of medical knowledge and treatment options, etc.)
- 4) The degree to which their sexual health affects their overall quality of life

Methods

Study Design

Since no qualitative research on patient preferences exists (with the exception of the Gott and Hinchcliff study described above), I decided that it would be best to talk to individuals who represented the average American senior citizen. Therefore, 3 special populations of seniors were excluded: dementia patients, long-term care residents, and patients physically disabled enough to be confined to wheelchairs. Of course, the specific needs of these groups raise very important issues in sexual health, and each deserves to be the subject of extensive research in the future.

To determine an age cut-off for interviewees, I asked several medical leaders in geriatrics for their definition of “elderly.” Most felt the term describes either people over 65 or people over 70. To be inclusive, my minimum cut-off was set at 65 years of age; however, I didn’t want to ignore the experiences of the “older old,” and so I continued recruiting patients until I had interviewed several subjects in their 80’s and early 90’s.

The question of where to recruit interviewees was not only theoretical, but practical as well. As many authors point out, sexual health research is often limited by general societal discomfort with this topic (Gott 2004). In order to minimize uneasiness for both the researcher and the subject, a primary concern in choosing a recruitment site

was finding a setting where privacy could be maximized. Also, the study was interested in the experiences of both men and women; however, with the large gender gap, finding a decent number of male subjects was a priority. For these reasons, two locations were chosen for recruitment: an independent living community for seniors, and the Geriatrics/Geropsychiatry clinic at a VA Hospital. Both sites offered a good degree of privacy, and together, they provided representatives from both genders, from diverse educational backgrounds, and from various socioeconomic groups.

Patient Recruitment

The center where I recruited half of the interviewees is a senior residence in New England which offers both assisted and independent living. The people who choose to live by themselves in one of the apartments usually move to the facility to become part of a larger community. The independent living center offers many amenities and services including a pool, a gymnasium, a library, weekly housekeeping, and transportation. It also offers many social opportunities including community dining, dance classes, parties, and lectures. Not surprisingly, most of the residents in this community are affluent.

Subjects from the independent living community were recruited by mail. A flier was placed in the mailbox of each independent resident which briefly described the study and then requested they contact the researcher by phone or e-mail if interested. [see

Appendix A]. Of approximately 200 residents, 15 replied to my letter, and 12 interviews were conducted. It should be noted that although all interviews were arranged with individuals, often a spouse or partner joined the conversation. I never objected, and in fact, I hoped that talking to the couple might generate a richer discussion than simply talking to the individual. Therefore, within the 12 interviews at the independent living facility, 11 were with individuals and 1 was with a couple, making a total of 13 subjects from this location. All interviews were conducted in the subjects' apartments at their convenience. (The one exception was an interview with a man who felt "more comfortable" talking about sex outside of his home; this interview was conducted in one of the community rooms in the facility.) Of course, this sampling method is clearly limited by participation bias; however, since almost no interview-based sex research has been done for fear of "offending" or "embarrassing" the people involved, I reasoned that biased data was preferable to no data at all.

I recruited the other half of the research participants from a Veterans Administration (VA) Hospital, which holds a joint geriatrics and geropsychiatry clinic every Monday afternoon. In general, the patients at this clinic are from lower socioeconomic groups, and the vast majority of patients in this clinic are male. I attended the clinic on 5 Monday afternoons, and on those afternoons, I asked the geriatric and geriatric psychiatry fellows to describe my research project to all eligible patients. If the patient was interested in hearing more about the study, he was then referred to talk to me in another examination room. Patients willing to

participate had the choice of being interviewed that afternoon or being interviewed at a later date in their homes. Over 5 afternoons, 13 patients agreed to participate, but only 8 were eventually interviewed. However, since spouses/partners of patients were allowed to participate if they wished, I interviewed 3 individuals and 5 couples, for a total of 13 participants. Of the 8 interviews, 4 interviews were conducted in a private exam room in the clinic and 4 were in the patient's home.

Data Collection

Interviews lasted from 40-90 minutes in length and were guided by a set of open-ended questions including: "What does the term 'sexual activity' mean to you?," "Are you satisfied with your sexual health?," "Are there any sexual issues you would like to talk to discuss with your doctor but are afraid to ask?," and "Was there ever a time a doctor was helpful in treating a sexual problem?" (Please refer to Appendix B to review the full list of interview questions.) In addition to these questions, more specific questions were often inserted into the interview schedule, either when interviewee responses were vague or when interviewees' comments generated new questions. However, since the goal of using primarily open-ended questions was to avoid pursuing the interviewer's preconceived ideas, I only asked specific questions to follow-up on responses already given to the open-ended questions. Often, the content of these specific inquiries reflected questions found in the existing literature.

All interviews were audiotaped and then professionally transcribed. In the transcriptions, the interviewer is indicated by the letter “I” and the study participant is indicated by the letter “P.” If the interview was conducted with a couple, the male participant is notated as “MP” and the female participant as notated as “FP.”

In total, twenty patient interviews were conducted. Sample size was determined by the concept of theoretical saturation whereby “analysis occurs simultaneously with data collection, and enrollment ends when new interviews do not add to the analytic framework” (Glaser and Strauss 1967). One interview (with a single male participant from the independent living facility) could not be transcribed due to the poor quality of the recording, and therefore this interview was not included in the analysis. Within the remaining 19 interviews, seven of the interviews were with men, six were with women, and six were with married couples, yielding a total of 13 male participants and 12 female participants. Interviewees were between the ages of 68 and 90, and the average age was 81. Please refer to Table A for a summary of the descriptive statistics.

TABLE A: DESCRIPTIVE STATISTICS BY SITE

	Independent Living Center	Veterans Administration
TOTAL	12	13
Men	4	8
Women	8	5
Average Age	86	77

Average Education	graduated college	some high school
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TABLE B: DESCRIPTIVE STATISTICS BY GENDER

	MEN	WOMEN
TOTAL	13	12
Average Age	80	83
Average Education	some college	graduated high school

Analysis

Interview transcripts were analyzed with many close readings. In the tradition of grounded theory, the interview transcripts were reviewed without “pre-selected ideas” (Loe, 2004), and instead were evaluated according to common themes that arose naturally. Themes were then compared across different groups. Major comparison groups were be male/female, single/married, and “younger old”/“older old.” Coding and content analyses were facilitated using a software program designed for coding-and-retrieval of qualitative data ((NUD*ST®)8 2002). (See Appendix C for a copy of the coding tree.)

RESULTS

Analysis of transcripts revealed several overarching themes. The following discussion separates the data into the following categories: sexual activity, sexual health, communication and communication barriers, ageism of others, and ageist self- perceptions.

Sexual Activity

Definitions

The first question of almost every interview was: “What does the term ‘sexually active’ mean to you?” Interestingly, although I asked an intentionally open-ended question to elicit a large variety of opinions, interviewee responses were quite uniform. Every interviewee mentioned intercourse, and most agreed that the terms “sexual activity” and “intercourse” are synonymous:

I: What does the term sexually active mean to you?

P: Well I guess it means having sexual intercourse.

I: Are there any other aspects of being sexually active that you can think of?

P: No

P: I don't think there's any mystery really about sexual activity.

At least not on a regular basis. Involves a sexual partner and being naked... That's about it.”

I: What does [sexual activity] mean to you?

P: She or he is involved with another person and are practicing the sexual act.

One participant did implicate that “sexual activity” could evolve with age; however, on further questioning, it became clear that his concept of the changing nature of sexual activity was limited to frequency of intercourse and methods used to achieve intercourse. Just like the other interviewees, this participant agreed that the “activity” in “sexual activity” was coitus, regardless of age:

I: Ok, so why don't we start with you telling me what the term sexually active means to you.

P: At this age or at any age?

I: Yeah, just to you.

P: Well, I mean many men, although not all I suppose, have sexual desires up until their seventies and eighties. And if they don't have it, they promote it with Viagra and I would imagine that would mean number one, living with a woman or holding a woman in bed and having sexual intercourse maybe at this age once a week or something of that sort.

When pressed further, he was able to elaborate on all the different ways people can have intercourse, but he did not consider other types of “sexual activities”:

I: Are there any other aspects of sexual activity that you can think of?

P: Well, they have a form of normal intercourse. But I haven't engaged in them. I can think of... there's oral sex and there's anal sex and there's gay sex...

While most participants focused on intercourse, a few subjects expanded their definitions of “sexual activity” to include kissing, and “messaging around.” A small number of interviewees even mentioned sexual climax in their definitions:

I: So tell me what “making love” means to you.

P: Making love? Cuddling, kissing, hugging and also continuing on and having actual activity where you end up in an orgasm.

I: Ok. But the term sexually active means something that ends in an orgasm?

P: To me, it's something that would lead up to an orgasm.

It is interesting that although this participant used the term “making love,” she was really using it as a euphemism for “intercourse.” In fact, even though every interviewee implies that having a partner was a necessary condition for being “sexually active”, nobody discussed emotions or relationships when defining sexual activity. One participant explicitly stated that love and sex are two separate phenomena:

“...Sexually active is different for everyone in the sense that uh – you can have lots of love and affection without being sexually active. But sexually active can mean with or without love and affection.”

Overall, participants felt that being sexually active meant having intercourse with a partner on a somewhat regular basis. Some extended their definition to include intercourse that ends in orgasm. Most felt that the term “sexual activity” described only a physical act, regardless of the relationships and feelings of the people engaging in the act.

Self Identification: Do you consider yourself sexually active?

After defining sexual activity, interviewees were asked to discuss whether they considered themselves to be sexually active. Only a small number of participants viewed themselves as sexually active (4 men, 2 women), while the majority of participants identified themselves as sexually inactive at the time of the interview (9 men, 12 women). Several of the self-identified sexually inactive participants said they had been sexually active well into their seventies and eighties. Contrary to

conventional wisdom, the average age of self-identified sexually active participants was no younger than the sexually inactive participants; in fact the average age for both groups was exactly the same (81 years old). What was different about the two groups, however, was the gender ratio - twice as many men than women identified as sexually active.

While the majority of subjects said they were no longer sexually active, all participants reported being sexually active when they were younger. Some of the interviewees who were no longer sexually active described a gradual decline in their sexual activity over the years, which was usually attributed to a parallel decline in health – either their own or their partner’s health – from chronic diseases such as cancer or dementia. However, the majority of sexually inactive interviewees described a more abrupt cessation of sexual activity, which was most often a result of the death of a partner, or an acute change in health. One male participant talked about his sexual status prior to a stroke at age 79:

“Prior to the stroke, from the age of twenty-one on, sex has been a vital part of my life. It continued right through to the age of seventy-nine with of course, some decreasing frequency.”

Even though the majority of participants described themselves as sexually inactive at the time of the study, a number of those participants, including the interviewee in the previous excerpt, revealed that they had only become inactive recently. The following widow was in her late 80s when her husband died:

I: During the time when [your husband] was sick, did you feel that his health was affecting your sex life?

FP: That's a hard question to answer because I think off and on we still had sex until the end.

While sexually inactive participants stopped having intercourse for a variety of reasons, almost all felt that becoming sexually active again was highly unlikely.

Several people indicated that they had “moved-on” with their life, because the sexual part of their life was “over”:

P: Well, as I say, I have always felt that sexual activity with somebody that I liked was pleasant. And that is not a part of my life anymore and it's not likely to be and I don't sit around and wring my hands over it. I just go and do something else.

Sexual Activity and Sexuality

When interviewees said that their sex lives were “over,” they were referring specifically to intercourse and the high probability they would never have intercourse again. However, throughout the interviews, a large number of participants spoke of other ways in which they still expressed their sexuality. One conversation with a female participant examines the distinction between sexual activity and sexuality:

I: Do you see yourself as sexually active?

P: No. I would say that sometimes I might involve a little masturbation, but no, I'm not...I can't imagine not becoming sexually involved with another female, and I really can't even imagine myself becoming involved with another male...And at my age, in my exposure to people, I think that is so far removed from anything that is likely to happen to me, and I'm not concerned about it.

I: Right. So, it seems unlikely to you that if you're going to become sexually involved with another person.

P: Right.

I: But, does that mean that you're not a sexually active person? I mean, you admit to occasional masturbation...so does that make you sexually active or not?

P: ... only for an occasional masturbation.

I: Ok. So, you see yourself as not sexually involved with other people, but I think you still see yourself as a sexual being.

P: Right. Oh yeah. As a matter of fact, I always enjoyed sex. If I had any sort of permanent sexual involvement with somebody, I could see how it would be very pleasing. At the same time, I can not imagine right now any situation in my life at this point where that's likely to happen.

In interviews such as this one, it became clear that terminology really plays a big role in conversations about sex. As discussed already, for most of the subjects, the term “sexual activity” meant intercourse. However, that did not mean that intercourse was the only form of sexual expression participants cared about. When the term “sexuality” was employed, participants discussed a much more diverse range of sexual topics. As with the interviewee above, several other people talked about libido, sexual desire, and masturbation, as is illustrated in the following quotes from 3 different interviewees:

“You know? I tell you, I still look at a pretty girl walking down the hallway. Hey – I’m normal!”

“Actually, I participate in auto-erotic stimulation”

“I certainly do feel somewhat aroused in certain situations.”

Other participants talked about sexual expression through enjoyment of movies, books, jokes, and even dreams about sex, as is evidenced by the following four excerpts:

“And I also have the quality of enjoying the dirty jokes and things. There are some people that may not...may do that and won't admit it, but I think some of them are just as funny as they can be.”

“If you're interested in watching sexual movies, I suppose those could be considered sexual.”

“I like to read books about sex and things like that...and movies.”

“As I say on occasion I still get a great thrill out of a dream where I'm... most of the times I wake up before the act but it's a very thrilling thing to have that dream.”

Some participants even talked about sexual expression in their relationships. The following female participant describes a sexually charged relationship with her younger male dance instructor, which involved attraction, flirtation, and desire, but which never progressed to intercourse:

P: I have an absolutely stunning dance teacher but we've talked it all out. He's forty-two and I'm ninety. And we've had some very honest conversations.

I: Really?

P: And we're the closest of friends. But whether part of that, every now and then bothers me that it's got to be this kind of a friendship and nothing else.... If it were possible sensibly to sleep with this guy, I would. And he would with me.

I: Really?

P: Sure. But it's not sensible.

I: Why is it not sensible?

P: Well, because it's just too disparate in age difference and other things. We decided we'd rather have a long term friendship.

Even though this participant labeled herself as sexually inactive, her sexuality was evidently not dead.

It is clear that interviewees continued to express their sexuality well beyond the age in when they identified themselves as no longer sexually active. Almost all subjects acknowledged that they engage in some form of sexual expression, such as having sexual thoughts, enjoying sexual humor, masturbating, flirting, etc. In most conversations about sex, the almost exclusive use of the term “sexual activity” limited the scope of the conversation to a discussion of intercourse. In such cases, some people falsely assumed that “sexually inactive” was the same as “asexual.” As we have seen, however, the participants of this study expressed their sexuality in many ways other than intercourse.

Importance of Sex

Participants were then asked: “How important is sex and sexual expression to overall quality of life?” Unlike the question about the definition of sexual activity, which produced quite uniform answers, the question about the importance of sex produced a diverse spectrum of responses. Two people (one male and one female) said that sex had never been an important part of their lives. Nine interviewees (four males and five females) felt that sex was no longer a very significant part of life, even though it had been very important when they were younger. Eight other participants (three males and five females) said sex was still significant, but not quite as essential as when they were younger. Finally, six interviewees (five males and one female) explained that sex had always been a critical part of their lives.

Subjects who said sex became less important over time often suggested putting the value of sex “into perspective”; many said that being confronted with serious medical problems diminished the overall importance of sexual activity in their life when compared with their general health:

I: So your libido has decreased?

FP: Indeed.

I: Ok And is that something that bothers you or not really?

FP: No, not a bit because of things going on with [my husband], and that's far more important for having a nice life.

In fact, more than one participant expressed annoyance when asked about the effects of a partner's health on the couple's sex life; usually their irritation was due to a sense of misguided priorities on the part of the interviewer:

I: Ok. Have you ever felt that your partner's health, any one of your partners have affected your own sex life?

P: Sure. Did I mind? No... And so, a man who has a leaky heart valve or lungs that are building up fluid...interferes with intimacy? (laughs)...I mean what's important?

Other subjects did not feel that the importance of sex changes with age; rather, they believed that every person values sex differently, and argued that the individual value of sex changes very little throughout a person's life. For example, one participant contrasted her lifelong disinterest in sex with her mother-in-law's enjoyment of sex, and ascribed the difference to some innate quality:

P: No, I don't think I was really a sexy person. I had a cousin and her husband said, you are not very sexually active people. Not sexually oriented or something like that I think. And on the other hand, this mother-in-law and my step children are much more

sexually active, but my half is not. So there is a difference innately I think.

Another participant, who has always highly valued sex, also said that differences in personality account for the difference in people's attitudes about sex:

I: To what degree do you think sexual health affects your quality of life?

P: My quality of life would be very poor if I didn't have sexual relationships. I can understand where there would be other people who, well as an example my brother. Sex was never that important at all to him. It just was one of those things that you have to do to satisfy your wife and he was happy with his level of sexual desires or needs. And I was happy with mine. So who's to say if I were restrained completely, yes my life would be – wouldn't have been as satisfactory as it was. So it's a matter of personalities I guess.

Finally, a number of interviewees felt that sex had always been important and lamented the decline in their sex lives. One married couple openly talked about missing the role sex had played in their lives when they were younger:

I: To what degree does your sexual health affect your quality of life?

MP: Well we've had – when we were sexual active it was a very good quality to our life. Is it bad now? It's not bad now. It depends on how your mind works or what you're thinking about, how you're living. If you push for sexuality and you don't get it at home, you're going to find it some place else...If you feel you've got to have it. But if you don't need it and you learn how to live without it, you live without it!

I: Right.

FP: Once a girl says to me, 'gee, your husbands gone ahead and died?' She says, 'don't you ever long for it?' I says, 'I long for it, but I never get it.' (laughing)

I: So if – if he were, if he didn't have Parkinson's, would you be interested in continuing?

FP: Oh yes! I would enjoy it. I enjoyed it with him.

I: So I guess my question is, you have a certain quality of life. How important is your sexual health to maintaining your overall quality of life?

MP: If – if – if it was part of life it would be that much better, sure.
FP: Yeah.

Sexual Health

Definitions

After discussing sexual activity, participants were asked, “What does the term ‘sexual health’ mean to you?” As with the question about sexual activity, initial responses were surprisingly uniform. Almost every person said that sexual health was the absence of any sexually transmitted diseases (STDs):

P: “Sexual health? Someone who has none of those virus infections that are called sexual. Well, it’s a person who will not transmit another disease to his partner.”

P: “It means to take care of yourself and you don’t have any problems that come up sometimes with sexually active... like AIDS or something. I think [it means] you’re clean.”

Some of the details in the conversations about sexual health were gender-specific.

Several women (but no men) added that sexual health also involved “making sure the woman doesn’t get pregnant.” Half of the men (but none of the women) mentioned the importance of condoms (also called “rubbers” and “safeties”) to promoting sexual health.

Beyond STDs and pregnancy, several male participants also focused on the frequency or quality of sexual activity as a measure of sexual health. One male interviewee talked about his sexual promiscuity in the navy as the period of his life when he was at the peak of his sexual health:

I: Ok. What does the term sexual health mean to you?

P: Sexual health? When I was twenty years old I could do anything I wanted to.

I: So, could you just elaborate a little more?

P: I was a merchant seamen. My sexual health was strong. Every port I...I had a girl in every port.

I: So you were sexually healthy because you had a strong libido...

P: Yes.

I: And then you were able to carry through?

P: Carry through, yes.

Another element of sexual health discussed frequently by both male and female interviewees was the notion that in order for sex to be healthy sex, it should be enjoyable for everyone involved. The following three quotes highlight this:

FP: "I think that sexual relationships and sexual activity are a very important part of everybody's life. Whether that person wants to admit it or not, because if you are...if it's a horror to you, you have a relationship with it[sex] and it's not a healthy one."

MP: "Well, there are four basic things involved in any animal that keeps that species alive. Breathing is one. Eating is another. Defecation, these are all pleasant things. Defecation is a third and sex is a fourth. Sex being a very gratifying thing. If it isn't, it is not being used the way it should be."

FP: "Satisfaction and vitality. Sex is fun! It's not a lot of work to do."

An additional factor in sexual health, which was discussed in many interviews, was the interrelationship of sexual health and general physical health. A number of subjects discussed the impact of general physical wellbeing on an individual's sexual health. For example, one male participant said, "If you're physically unfit you may

have great difficulties being sexually active.” Another female interviewee explained, “If you don’t feel good, you don’t want to put out.”

While these interviewees described the impact of general health on sexual health, others argued that the reverse is true as well – that sexual activity can also play an important role in maintaining physical wellbeing. One participant explained why he believed that sexual activity is “good for you”:

I: It sounds like you’re saying that sexual health is also very related to medical health...

MP: ...That’s – that’s true. Some of the – some of the reasons why medical health drops is because you’re not sexually active anymore. Sexual activity has a way of releasing a certain amount of tension. And without it, you have that – you still have that tension, but you have no way to release it... And when you’re a young fellow you could, you know, you could release it. But now you can’t anymore because your libido is all but gone.

Even more frequently discussed was the interrelationship between mental health and sexual health. In fact, a few interviewees argued that the mind influences the quality of an individual’s sexual health in dramatic ways. One woman expressed her belief that the main determinant of staying sexually active in later life was a person’s attitude. Arguing that people could overcome obstacles (like deteriorating health) if they put “mind over matter,” she said, “I think – I really, really believe – that a lot of that [sexual health] is what they think – what you feel is going to happen.” Another interviewee expressed a similar sentiment stating, “It’s the mind that – the mind works with sexuality. But if you destroy the mind, the sexuality is gone.” A third

interviewee articulated her contention that sexual health and psychological health are often mutually influential on each other:

I: Do you think that sexual health is related to depression and other forms of mental...?

P: Well I think so. I think they influence each other...

I: How do they influence each other do you think?

P: Well, if you're a person who is really clinically depressed and you're not just a little sad or lonely, but you really are clinically depressed, I think that there's very little erotic feeling and it [sexuality] is depressed like all the other feelings are depressed. And if you are sexually active and get some sexual satisfaction I think it raises your feeling of comfort. You're happier! Less...more up than down. So the two influence each other.

Not only did participants think healthy sex could improve their own physical and mental wellbeing, a few participants talked about improving their marriages and other relationships through health sexual activity. One male participant said:

P: Well, to have a libido is a healthy condition. And if you practice sex at any age, that's a healthy thing to do. And it's also a good religious thing to do, since I'm a religious person. You're supposed to be doing that religiously. It's - It's the companionship and the closeness and the oneness of a husband and wife together – should be done.

I: So it sounds like you're saying, sexual health, it makes your relationship - your marriage - healthier.

P: That's correct.

One issue that came up several times with the interviewees was the importance of having a sexual partner. In fact, many of the single participants felt that their sexual health needs completely changed when they lost their spouse. For example, the following interviewee said that sexual side-effects of medications became unimportant to her when she became a widow:

I: And if a doctor were to give you a medicine that did have a sexual, a potential sexual side effect, would that be something you would be interested in hearing about?...

P: I might be concerned about it if I had a husband and had a sex life.

I: So if you were married would that be something you would be interested in hearing about?

P: I think so."

Similarly another participant said he was willing to accept impotence because he no longer had a sexual partner, but claimed he would have felt differently about his erectile problems if his wife was still alive:

I: Now let's say you became impotent a few years before your wife had passed away. Do you think at that point it would've been important for you to try and seek medical...

P: Oh sure. It would've been good for both of us.

Sometimes the impotence or sexual disinterest of an interviewee's partner had similar effects on sexual health needs as the loss of a partner. As one wife explained to me during an interview:

I: So basically I think what you're saying ... is that neither of you feel that you really have needs because you're not interested and you're often not interested in sex? Right? Like, if somebody could offer you a treatment that would give you sexual interest, would you want it?

FP: Well no, not if he couldn't...So why I should I get that way and not have any way to get out of it?

I: Right.

FP: Although, the other day when it was raining, and if it was back in the old days, we could've spent the day in bed. Now, if we spend the day in bed we'd be sleeping.

Sexual Dysfunction

Interestingly, one large factor in sexual health for the elderly, sexual dysfunction, was rarely mentioned until I raised the topic. This does not mean, however, that interviewees were not concerned or affected by dysfunction. In fact, almost every male participant eventually mentioned having problems with achieving or maintaining an erection, and a majority of the men indicated that they were impotent. Every man with dysfunction had a clear idea about what caused the problem. One man, blaming his arteriosclerosis said, “I know it’s my blood circulation...that’s killed everything.” Similarly, another participant identified “diabetes” as the cause of his impotence. Three men talked about the deleterious effects of treatment for prostate cancer (either medical or surgical treatment), while two other interviewees felt that their Parkinson’s disease was the culprit. Rounding out the list of reasons for impotence include: chemotherapy, stroke, and alcohol.

Erectile problems were viewed by both males and females a major barrier to sexual activity. In other words, because intercourse is generally held to be the only activity that “counts” as sexual activity, a man’s inability to achieve and maintain an erection might undermine a couple’s entire sexual relationship. One participant, endorsing the notion that tumescence is critical, said: “If [my husband] couldn’t get an erection, there’s really not a whole lot we could do.”

Not only did men talk about erectile dysfunction, many males also discussed the effects of age, disease, and medication on their libido. One man described the drastic effects of luproliide (hormone) therapy (for prostate cancer) on his interest in sex:

P: There was a fourth option [for prostate cancer treatment] which is an injection of a drug called Lupron which is the best sterilizing agent there is under the sun because it kills testosterone and any and all sexual desire. So ever since then I not only have not had sexual relations but I haven't even thought about sex.. I mean it's that effective.

I: Wow.

P: And I don't understand why this isn't given to arrant priests. I mean it would be the best remedy to prevent any pedophiles from continuing...

Interestingly, loss of sexual libido was often regarded as a blessing and not a curse, if it coincided with impotence. In fact, the perceived importance of restoring erectile function (in the minds of both patients and doctors) seemed to be related to the level of sexual desire in the impotent male. One male participant said:

"I became impotent and I went to my doctor and at that time he sent me to a urologist and...he gave me, as I recall, he gave me some shots with testosterone, I guess, and then he had me come back, and he wanted to know if I had any reaction. I guess he was worried about my...that I had a libido. So that was about the size of it."

In other words, the physician was worried about the participant's impotence because, in this case, he still had sexual desires, and thus, he had the potential to become frustrated and distraught; on the other hand, a man with no libido should theoretically not care whether or not he could maintain an erection.

Of course, as discussed earlier, acts of sexual expression are important to many older people, even if intercourse is no longer possible. Therefore while the loss of libido did not matter to some impotent men, for other men, losing their libido was devastating; without sexual desires, several men stopped participating in other, non-

coital sexual acts that they had previously enjoyed. For this reason, loss of libido was particularly problematic for men in a relationship. One male participant expressed hope that his new Parkinson's medication might restore some of his previous sexuality, whether or not it restored his erectile function:

“What I read in the book that it's – [the medicine] brings back your libido and brings back the desire of sex... If it brings it back a hundred percent I don't know, it did bring some of it back. Did it bring a hundred percent? I don't know because I haven't – there's no way. What's a hundred percent? A hundred percent is an erection that holds, that can use – it can be used, that will be able to finish intercourse. That's – I consider that a hundred percent. But maybe it brings back touching and petting and caressing and holding and whatever else goes with it.”

While male participants and their wives spoke a good deal about problems with erectile function and libido in men, only a small number of women discussed any of their own problems with sex. A few talked about a decline in their libido, often euphemistically with phrases such as “the energy for sexual intercourse is mainly missing” or “I don't need [sex] that much anymore.” Only one woman cited a specific health problem – arthritis – which she said hindered sexual activity. Another woman mentioned vaginal dryness, but dismissed that as an insignificant problem because of the wide availability of lubricants. Only a small number of women had ever considered that a medication might affect their sexual health, and no women could identify a time in which they believed they may have experienced a sexual side-effect of a medication.

Satisfaction

Participants were asked to discuss their satisfaction with their current sexual health status. Overall, 3 interviewees said they were satisfied with their sexual health unconditionally; 11 said that given their advanced age, they were satisfied; 8 participants said they were not satisfied with their sexual health, and 3 interviewees said that they no longer have any sexual health needs, so they are neither satisfied or dissatisfied.

Participants who were satisfied with their sexual health fell into two groups: those who were unconditionally satisfied and those who were only satisfied because of their age. Interestingly, all three of the unconditionally satisfied participants were women who were not actually participating in any sexual activities at the time of the interview. Two of these women expressed contentment with all of their past experiences; they felt that since they had had a full life, they did not need any new sexual experiences to be satisfied:

P: I've had enough pain and I've also had enough of the good things for forty years.

I: You feel satisfied.

P: And I raised a family and I have wonderful grandchildren that I enjoy and it's enough. I don't know what would induce me to do something different but I am perfectly satisfied today and right now.

The other “satisfied” woman reported feeling content because she was no longer “bothered” by sex or even by a libido:

“I feel healthy and I don’t have any of that. I can remember when I was married the second time, my husbands mother-in-law had been taking care of his children. And she was in her eighties at one point and she told me, she said...anyway, she implied that she would love to have some sexual life or that she had never lost that sexual urge. Well, luckily I don’t suffer that way.”

A much larger number of interviewees were satisfied, but only in the context of their advanced age. These participants said that they would not have been satisfied with the same level of sexual health if they were younger. Many of the individuals in this category were still sexually active, but felt their sexual health had deteriorated over time. One married woman described her current level of sexual satisfaction:

I: So for your peer group you’re pretty satisfied with your sexual health. But compared to youth you’re not as satisfied. Can you explain that to me?

P: Because when we were young we could have sex much more often than we do now. We would have more orgasms. We never had intercourse where it didn’t end in orgasm. When I was young I could have multiple orgasms! Not so now. And it can take longer to achieve one.

Another participant who was intermittently unable to have intercourse, described using “improvisation” to compensate for the sexual difficulties that come with ageing:

P: When sexual activities are not available, I suppose those are the times where you just practice improvisation.

I: Ah. So you’ve found another way to be intimate?

P: Yes.

Eight interviewees reported feeling sexually dissatisfied, and all were male. Not surprisingly, then, many of these interviewees spoke specifically about the difficulties of dealing with impotence:

I: Are you satisfied with your sexual health....at the present day?

P: Unfortunately, shortly after, but not shortly, but after my stroke sexual intercourse became impossible. It is something that I very seriously am disappointed with. It always has been a very intimate part of my life. Those have been a pleasant experience, both for myself and whatever partner I might have had. And I miss that intimacy that I would've continued to have.

Other dissatisfied men just lamented a decline in their sexual abilities in general:

I: Are you satisfied with your sexual health?

P: No. I'd like to be able to achieve what I used to...Pushing eighty that's far fetched.

Finally, three interviewees argued that that since their sex life was “over,” and since therefore, they had no more sexual needs, the term “sexual health” did not even apply to them:

I: Do you feel your sexual health needs are being met?

P: How can they be being met? The desire is not there.

I: Right. So you feel like you don't really have many needs?

P: No, I don't have needs.

In summary, women were much more likely to report being satisfied with their sexual health than men; 83% of women said they were at least conditionally satisfied, while only 23% of men acknowledged being satisfied. Of those who did feel content with their sexual health at the time of the interview, the majority stated that they would be very dissatisfied with the same level of sexual health if they were younger. All of the participants who felt dissatisfied (regardless of age) were male,

and each one identified the decline in their own sexual health as the source of their dissatisfaction. The remaining three participants felt that sexual satisfaction was not applicable to them because they no longer had a sex life.

Realistic Expectations

Many participants felt that an important element in remaining sexually healthy over time was an individual's ability to adapt his or her sexual expectations with age. Of course, the assumption here is that sexual health inevitably declines with age; therefore, anyone who expects the sexual experience at the age of 75 to be what it was like at age 35 is setting him or herself up for disappointment and frustration. As one interviewee said, "I mean we all have to come to grips with ourselves and our own limitations. And I'm being a hard-headed realist because there's no other way to be." Another participant had a similar opinion: "there is a distinct difference now in what you want and anticipate and what you are willing to be satisfied with."

A large number of interviewees emphasized the importance of not only "facing reality," but also being able to "move on" and stop dwelling in past memories. One participant discussed her own strategy for moving on:

"Well, as I say, I have always felt that sexual activity with somebody that I liked was pleasant. And that is not a part of my life anymore and it's not likely to be and I don't sit around and wring my hands over it. I just go and do something else."

Depression and Contradictions

At least two of the women who claimed to be somewhat satisfied with their sexual health admitted to feelings of depression related to the deterioration or absence of sexual activity in their lives:

“I: Has anyone ever counseled you about how his [your husband’s] health was affecting your sex life?”

FP: No...

I: Do you think that [your husband’s lack of sexual interest] was contributing to your depression?”

FP: Probably, in the beginning.”

“I: To what degree does your sexual health affect your overall quality of life?”

P: Well probably in ways I don’t know of. I don’t know if on the days I get depressed, which I do, if that’s part of it. I have an absolutely stunning dance teacher but we’ve talked it all out. He’s forty-two and I’m ninety. And we’ve had some very honest conversations.

I: Really?”

P: And we’re the closest of friends. But whether part of that, every now and then bothers me that it’s got to be this kind of a friendship and nothing else...”

What is interesting here is that these women both claimed to be satisfied with their sexual health, yet both contradicted that assertion by admitting to feelings of depression which were related to their less-than-ideal sexual situations. Perhaps the source of this contradiction emanated from ideas about what society expects of them. These women may have felt that they *had* to be satisfied with their poor sexual health because otherwise they would have been seen as having unrealistic expectations, or worse, seen as pathetically trying to recapture their youth.

Sexual Safety

The two final sexual health questions I had planned to ask during interviews were: 1) What does the term “sexual safety” mean to you; and 2) Have you ever worried that your sex life might somehow be unsafe? In general, the majority of participants gave a similar definition of “sexual safety” as they had given for “sexual health”; in both instances, the theme of STD prevention predominated the discussion, but perhaps STDs were discussed in even greater depth when explaining “sexual safety.” Some people also mentioned “preventing pregnancy” as an important element of sexual safety. What was particularly interesting was not the initial definition given, but rather, the large number of interviewees who gave an almost immediate disclaimer that these problems did not pertain to them. About half of the participants answered my final question before I had even had a chance to ask it. For example, the following excerpt was a typical exchange:

I: What does the term sexual safety mean to you?

P: Well, I've never had to deal with it. I've never felt unsafe sexually.

I: So when somebody says the term “sexual safety,” what does that term mean... to you...?

P: I would assume that it would mean, if you're talking to me about my sexual safety, I would assume that – the only two things that I can think of would be whether or not that person has a sexual disease that might transmit to me, or pregnancy. And I'm not likely to become pregnant...and I'm not likely to be exposed to any sexual disease because I've had my, as I say, I've not been pursued unremittingly by anyone who's trying to get me in bed.

Participants beliefs about their risk of exposure to STDs echoed the ideas in popular culture that STDs are not a health problem for that applies to seniors. As one participant said, “I don’t think I ever worried about that.” In fact, only one interviewee talked about the well publicized statistics which show that STDs are increasingly being diagnosed in the geriatric population:

P: I was flabbergasted when I heard that the incidence of sexually transmitted diseases was rising in the older population...

I: Why do you [think] that we all respond with surprise when we learn that?

P: Well, I think most of us think of older people as not, not as promiscuous as teenagers or you know, young people or as some younger people are. The question is where do you pick it up?...So, it may be that we just don’t know and have forgotten what people do.

This participant was “flabbergasted” because she, like society at large, generally did not imagine older people to be sexually active. What is interesting, though, is her assumption that at least some older people must be as “promiscuous as teenagers” for disease to spread. In general, almost every interviewee implicitly endorsed the idea that older people are largely immune from STDs, unless they engage in reckless behavior.

Although most participants talked mainly about STDs when discussing sexual safety, when I included that question in the interview schedule, I had envisioned a variety of possible ways older people might feel unsafe. For example, judging from the multitude of jokes about older people dying of heart attacks while having sex, I assumed cardiac risks might be a cause for worry for seniors who engage in sexual

activities. However, only one interviewee expressed concern about a possible heart attack related to sex, and only because his daughter was concerned:

“My daughter was very upset with my wife when a month after my bypass we had intercourse. My daughter felt that my wife was putting me in terrible danger.”

The participant said he was never worried about his health, despite his daughter's admonishments. Other possible health risks were similarly dismissed by participants; in fact, when I asked interviewees if they ever worried about getting injured during sex, most people said that the thought of getting injured had never crossed their minds. But while participants did not worry about the risks of sexual activity, one concern shared by several (mainly male) participants was that Viagra might cause a heart attack. Just to clarify, these men were not worried about an infarction during sex that was facilitated by Viagra, rather, most felt that merely taking the pill might put them at a greater risk for a cardiac event. These discussions with interviewees about Viagra will be discussed more thoroughly in a later section of this paper.

Doctor-Patient Communication

Participants were asked to describe their experiences talking to doctors about sexual health. While a few interviewees could recall times when sexual health was discussed in a medical setting, the vast majority of interviewees claimed to have no memory of ever talking to a physician (or any other medical professional) about sexual health in their senior years:

“There aren’t many doctors that I know of that you sit down with – orthopedic or general practitioners or internists – that are going to sit down and talk about sexual things with you.”

When participants could recall times the topic of sex came-up in a medical setting, they described the incidents as brief and awkward. Participants indicated that when sex was mentioned, minimal information was ever exchanged. Only four interviewees (three males and one female) could recall a conversation that had been satisfying or productive. Overall, poor communication between patients and doctors around geriatric sexual issues seemed to be the norm.

But why don’t doctors and patients communicate better? Based on analysis of transcripts, I have identified several major barriers to communication, including: demographic barriers, patient avoidance of sexual conversations, and physician avoidance of discussions of geriatric sex. I will describe each of these barriers in detail below.

Demographic Barriers

Participants were asked to discuss how factors such as gender, age, race, and physician specialty play a role, if any, in facilitating or impeding communication with their doctors. Of these four physician characteristics, gender was important to the greatest number of interviewees. The majority of participants reported that their physician's gender influenced how comfortable they were with discussing sex with their doctor. The general sentiment was that women preferred female doctors and men preferred male doctors. One female subject described the ease with which male doctors and male patients communicate about sex: "I would wager that sometimes...two men together there's the same deal as a boys club." On the other hand, for female participants, discussing sex with a male doctor made an uncomfortable subject even more uncomfortable. One female interviewee talked about an experience where she had to ask a "cute" male doctor a question about sex, which she described as particularly embarrassing.

Male participants also talked about their discomfort with discussing their sexual issues with a female physician:

"Certainly there are many men, I don't know – again what percentage, but many men would feel very, very more than uncomfortable speaking about sex to a lady. Myself included."

While many participants did care about the sex of their physician, about a third of interviewees said that their doctor's gender was not important. One participant spoke about physician attributes that she feels are more relevant than gender:

I: Does it matter if the doctor is male or female?

P: Depends entirely on the personality of the person.

I: For you?

P: For me. It wouldn't matter politically or...

I: It's just more...

P: If I could talk...

I: The relationship?

P: Yeah. Somebody who – whose empathy I could feel.

When it came to the issue of physician age, about half of the participants said that age doesn't matter. The other half of interviewees were split between preferring older doctors or younger doctors. Those subjects who preferred older doctors talked about young physicians not "being able to relate" to their problems; furthermore, these participants spoke of elderly physicians having "more experience" and being more understanding because maybe "they're going through the same thing" as their elderly patients. Interviewees who preferred younger physicians talked about the younger generation being more "open-minded" about sexual issues, while older physicians are more likely to be "old codgers." In fact, one participant believed middle-aged doctors are the ideal because they have some of the understanding of an older doctor combined with some of the sexual open-mindedness of a younger doctor.

As for physician specialty, most participants had a clear idea about which type of doctor they would feel most comfortable going to with their sexual health issues.

Many interviewees identified their primary care doctor/internist as the easiest person to talk to, often because they felt they have a better relationship with their GP than with other doctors. As one subject remarked, “Well I’d find it easiest to go to my internist, my regular doctor. I know him.” Others said that their internist would be the best to talk to initially because he or she could then direct them to the appropriate specialist, if need be:

“I’d rather go to my primary. You have to evaluate and I’m not that smart to distinguish which [specialist] would be the best one.”

While several female participants identified their GP, almost half of women felt that their gynecologist would be the most comfortable physician for sexual discussions. Gynecologists were described as the specialists of female sexual health issues, and therefore some participants said that gynecologists have a particular duty to facilitate conversations about sex:

“Shame on any kind of gynecologist, obstetrician, who isn’t free and completely open with the ladies. Regular practitioners, I don’t know. But shame on an OBGYN who hesitates to talk.”

Four participants said that they would prefer their psychiatrist over their GP or OB/GYN, unless the problem was clearly limited to the sexual organs. For example one interviewee said:

“It would depend on what the problem was. If it were pain during intercourse, I would go to the gynecologist. But anything else, I would certainly go to a psychiatrist.”

Interestingly, of the thirteen males interviewed, only two said they would prefer to go to a urologist for their sexual problems. Other male participants described their urologist as the doctor with whom they would feel the least comfortable:

P: I don't know...the urologist doesn't seem human... I know that's...

I: They all are very surgical, the urologists?

P: Yeah, they're all very mechanical.

I: So it makes it difficult to bring up these kinds of issues?

P: They don't seem to care. They take a biopsy of my prostate and another biopsy and another biopsy.

Although participants had many opinions about the physician characteristics that facilitate or inhibit conversations about sex, most participants mentioned the importance of having a “good relationship” with the doctor as being the most important element. Many interviewees said that the relationship with the doctor trumps the barriers of age, gender, or specialty. As one participant said:

“Again, I have to say if it's a relationship that's good then you can talk to a forty year old. You know, the two doctors I have are in their forties and fifties. One is an Indian and one is an American and I feel very comfortable with them. They're half my age so I don't think age is as important as the relationship that you have been able to build up or he or she has been able to build up with you.”

Avoidance and Contradiction

Other than demographic factors, participants had many ideas about the barriers that interfere with doctor-patient communication about sex. Most participants acknowledged that both physicians and patients share the responsibility in the

success or failure of sexual health discussions. Interviewees offered many insights into the factors that make it more or less difficult for older patients to talk to doctors about their sexual health issues; however, when it came to explaining their own reluctance to discuss their sexual issues, participants often denied that they had fallen prey to the same barriers that plagued their peers. In analyzing both what interviewees said about their generation as a whole and about themselves in particular, along with their experiences talking to doctors, two major themes that interfere with communication about geriatric sex emerge: (1) avoidance of conversations, and (2) contradictory feelings about sexual health for seniors. Instances of interviewee avoidance and contradiction fell into four main categories: embarrassment, fear of treatment, uncertainty over whether their problem is a medical problem, and assumptions about age-related sexual health changes.

Embarrassment

Perhaps the largest and most obvious reason seniors avoid talking to their doctors about their sexual health is embarrassment. Sex is a tricky subject to discuss at any age, so it is no surprise that discussing geriatric sex, especially for a cohort raised with Victorian values, might prove to be a particularly uncomfortable task. Several subjects talked about the embarrassment associated with admitting, as seniors, that they are still sexually active or sexually interested:

I: What do you think prevents older people from talking to their doctors about their sexual problems?

P: Because they think they're too old to have sex and they're ashamed to ask the doctor. Just because they're too old they can't have sex anymore.

I: Do you feel that as you get older it's less comfortable to bring it up [sex] to the doctor?

P: Yeah, like I...right now I'm pushing eighty. I think I'd be a weirdo.

On top of the discomfort of talking about geriatric sexual activity, discussions about sexual health can create two further reasons for embarrassment for seniors. First, in order to get treatment, patients must confess to having a problem with sex. Second, by bringing up the sexual issues with their physician, seniors would have to implicitly admit that they care enough about maintaining their sexual health to actively pursue medical care. Often participants could not articulate these varied reasons for feeling embarrassment, but when I offered various possible sources of discomfort, interviewees often said that any or all of those reasons might have been correct. For example:

I: Why do you think they have this trouble talking to a doctor about their sexual concerns?

FP: Well, I think that it's embarrassment more than anything.

I: And why do you think they feel embarrassment?

FP: I don't know.

I: Do you think it's embarrassment because they're having difficulty having sex or do you think it's an embarrassment to admit that they are having sex? Or...?

MP: I'd say it's some of both.

However, the feelings of shame in being a sexually active/interested senior and the feelings of embarrassment in being perceived as an impotent or asexual adult are

quite contradictory; therefore, it was curious that a handful of subjects talked about experiencing these contradictory feelings simultaneously. For example, one subject described her husband's mixed feelings about the image he is trying to project about his sexual status:

“We have a couple of other really, really close friends who cracked some comments one night...he won't admit generally that we don't do it...And he'd get very insulted if anybody insinuated that we didn't...And then in the next breath he might even say, hey we don't do that anymore. So, I do believe it's more men than women, but you know, men don't want to talk about it unless they're bragging about it.”

In this case, the husband's contradictory feelings of embarrassment create a formidable barrier to his ability to communicate honestly about his sexual health.

Another area where contradictory feelings created embarrassment was in participant descriptions of their attitudes towards their physicians. Specifically, a few interviewees spoke of a physician's disregard for their sexual health, but then expressed guilt for seeming ungrateful to doctors who had, in some cases, performed a live-saving procedure. One male participant grappled with his contradictory feelings towards the urologists who performed his prostate surgery:

I: Do you feel at that time [of your prostate surgery] that the doctors assumed that having sex wasn't that important to you? That because they just went on ahead and did it without even saying anything to you, did that make you feel like they were...

P: Well that's the way I look it. On account of my age, you know? He's sixty-one years old, you know, a lot of the young doctors now, they sort of, they think you're over the hill. Well I got news for those doctors! So anyway, nah. I'm okay now.

I: Right. What news do you have for those doctors who think you're over the hill at sixty?

P: I don't want to say. They've been pretty good. They saved my life two times.

Even though this interviewee was dismayed that he became impotent after the surgery without any forewarning from his physicians, he was embarrassed by the thought of expressing his concerns with his physician because he did not want to seem ungrateful for a procedure that cured him of cancer.

There was one other reason mentioned for feeling embarrassed to talk with a doctor about sex. A small number of participants made comments about blaming themselves if they ever developed a sexual “infection”. One female interviewee talked about feelings of shame associated with these “infections”:

“You can get an infection from yourself you know...and I think when you infect yourself, its because you're careless and obviously, you don't want him [the doctor] to think that you're...admit that you'd be so careless to do that.”

In other words, this interviewee was under the impression that some sexual problems were due to personal hygiene negligence and therefore, admitting to these problems required admitting to a character flaw.

Fear of Treatment and Fear of Failure

A second factor that discouraged older patients from talking to their doctors about their sexual issues is their fear of medical treatment. Patients often talked about

sexual health as a mysterious aspect of medicine, and spoke of treatments for sexual problems as less scientific than treatments for other types of problems.

I: What do you think prevents older people from discussing sexual problems with their doctor?

MP: Shame. Afraid of the unknown. What's going to become an operation? Medicine that you can't tolerate. All kinds of gimmicks.

This interviewee used the term “gimmicks,” implying that modern medicine cannot be fully trusted when it comes to treatment of sexual problems. Trust came up in many other interviews as well, mostly with male participants, and most often in regards to treatment for erectile dysfunction. In particular, a large number of male participants expressed skepticism towards Sildenafil Citrate. (Note: I will use the brand name for Sildenafil Citrate, Viagra, throughout this section, because the participants of the study referred to the drug by its brand name.) As I mentioned earlier, only one of the thirteen men I interviewed stated he had used Viagra more than once. The vast majority of male participants said they had been interested in treating their erectile dysfunction at one time in their lives, but either they never discussed it with their doctor, or they did get a prescription, but later decided the Viagra was unsafe. Even when their physician had written them a prescription or given them samples, most male interviewees were unwilling to use the Viagra for fear that it might adversely affect their health, and their cardiac health in particular:

I: So has a doctor ever talked to you about the possible sexual side effects of a medication he or she has prescribed?

MP: Yeah. On Viagra...They do say that it could affect your heart...Or they say, 'Do you have a heart condition?' First thing is 'Do you have a heart condition?' Ok. Now why wouldn't they ask you if you have a heart condition? Because they're going to give you a pill

that might give you a heart condition. Ok. That pill must do something to your heart. It almost – it almost – it's almost good common sense... And if you push the heart right down – why are you pushing your heart like that? Maybe it's necessary for some people. Some people it's not necessary to do it... So I don't – even when he gives me samples, I don't even want them.

I: Right. Because you feel they're unsafe?

MP: I feel they're unsafe.

This participant unhesitatingly admitted that he did not trust his doctor's judgment in determining which erectile dysfunction treatments were safe. Similarly, another interviewee talked about his fear of becoming blind as a side effect of Viagra, even though this complication was never mentioned by his physician:

P: Years ago I had a primary and we used to talk about it. I told him 'I just can't achieve an erection.' And he said, 'well we have means for that.' Then they put a rod in you. And that never came to pass. Now, you have Viagra and all this...that and this...now you have blindness. No way in the world I'd want that.

I: Have you ever brought up the possibility of trying something like Viagra with the doctor, or you're just not interested?

P: I don't think I have that much desire. I have a prescription for Viagra. They gave it to me. Once I heard about this blindness, I'd rather have nothing.

Again, this participant lacked faith that the physician would weigh all the possible adverse effects of the treatments before deciding on a therapy. In general, male interviewees talked about trusting their own judgment and their own research as much or more than they trusted the doctor's judgment about Viagra:

*I: Is that something you would've liked to discuss with your doctor?
The risks of Viagra?*

MP: No, no. This is something I discussed with myself.

I: Ok. Did you look it up? I mean where did you...

MP: Oh, I'm aware of the possibility of Viagra doing some damage.

Just as the interviewees in the last three excerpts, almost all male participants justified their decision not to use Viagra by explaining that they were prioritizing their general health over their sexual health. Subjects often spoke of maintaining overall health and sexual health as two separate and contradictory endeavors, and in the contest between these two opposing types of health, general health/cardiac health would obviously be deemed more important:

I: You thought you might like to try Viagra but then sometime after filling the prescription or after getting the prescription you decided that it was probably best not to take it?

MP: I hesitated and hesitated and decided that as much as I in the past have enjoyed these actions of - well I've had quite a bit of experience, medically speaking. Two bypasses and an aorta that was replaced with about six or eight inches of tubing. So I think I've taken enough risks or I shouldn't be taking any greater risks now that might occur. Is it worth it?...And the answer to that was, I don't think it's worth it.

On top of health concerns, a number of participants talked about their aversion to Viagra because they were afraid that it would not “work,” as is illustrated in the following two excerpts:

MP: We don't go to [doctors] with having sex problems...

FP: When [my husband] finally did tell the doctor... Well of course at that time didn't even want to bother with Viagra. Ten dollars each they were, because it was way back in the beginning... And they didn't work. So [my husband] never questioned anything further, and [the doctor] never did anything for him.

P: ...[The doctor] gave me like, seven pills [of Viagra]. I only took one pill... I only took one and that didn't seem to... it didn't help, so I didn't...

I: Did you discuss it with him that that didn't work or did you just drop it at that point?

P: I just dropped it.

I: Why did you drop it?...why didn't you bring it up again with him?

P: Well, probably because it didn't work. And another thing is probably not, well, it's not too practical.

The interviewee in the second excerpt went on to explain why he doubted Viagra could help him:

P: Everybody says [Viagra is] so great for them, you know? For some people, yeah. Some people are in good health when...you know what I mean?...

Rather than giving Viagra a second chance, this participant was so afraid of failing again that he convinced himself that he was just not “healthy” enough to benefit from the drug.

But the fear of failure was not just isolated to the inability to achieve an erection; a few men worried about that the possibility that they might successfully initiate sexual activities, but then they might fail to “following through”:

FP: We don't touch. He's cold.

MP: You see that?

FP: You don't even pet my little booty when I walk by.

MP: What's the use of starting something that's not going to even get finished?

One participant said that he realized he might be hurting his wife with his disinterest in having sex with her, but he was convinced that trying and failing to have sex would probably have even worse consequences:

“I don’t know whether I’m being fair to my wife or not. That bothers me...I think her feelings are hurt. And what I don’t want to...I keep telling her, I don’t want to get involved with foreplay or caressing, holding. Nothing happens. It just doesn’t...I wouldn’t achieve an erection probably...So I’d be very, very much disappointed and so she’d be hurt.”

In both of these two relationships, the fear of failing at sex prevents both men from expressing any sexuality or seeking help for their sexual health problems.

Overall, male participants were concerned with treatment failure. The fear of failure was so great for some of the men that they said unsuccessfully attempting to have sex would be much worse than no attempt at all; it is no surprise, then, that fear of failure discouraged these participants from initiating conversations with their doctors. Mistrust of the physician’s ability to be scientifically objective about treatments for sexual problems was another reason participants avoided communication. Finally, contradictive feelings about wanting an improved sex life, but also fearing the safety or efficacy of treatments deterred interviewees from talking to their doctor about erectile dysfunction and Viagra.

Is this a medical problem?

A third major reason cited for not initiating discussions about sexual health with the physician was uncertainty over whether a sexual problem could be considered a medical problem. After all, if a physician did not bring up the issue of sex, some

participants concluded that sexual health was probably not within the doctor's domain. One interviewee, who said that she never even considered going to a doctor with her sexual problems, explained: "I don't know *anyone* that talks to their doctor about sex."

A number of participants felt that while there were a few sexual issues with which physicians should become involved, the majority of sexual issues did not concern the medical community. The issues that interviewees identified as sexual, as well as medical, were issues in which clear medical treatments were available – which translated mainly as treatments for STDs and for erectile dysfunction. All other sexual problems were described on several occasions as "none of [the doctor's] business." The following discussion illustrates a participant's limits in discussing his sexual health with his doctor:

I: Right. So, what do you think prevents you and other older people from discussing sexual problems with the doctor?

FP: I really don't know.

MP: ...you don't talk about it.

I: So you feel...so it sounds like what you're saying is that a large part of it is that, you know, sex is not the doctor's business?

MP: No. You don't talk about it.

I: Unless you're going for Viagra?

MP: Well, yeah. Go to a doctor for sex...not to talk about sex.

Even within the group of the participants who had a broader opinion about which sexual issues were appropriate to discuss in a medical setting, some of them revealed a tendency to discount their own sexual problems as medically irrelevant:

I: How long did you wait to bring it up to the doctor after the [sex] problem started?

MP: Not very long.

FP: Actually, it was quite a few years because we'd had a problem. And in the beginning I think it was because of... he was embarrassed and I think that is why. And then I figure it was because he was drinking too much at the time. By the time we got past that that was when I started hollering, 'go and find out what's wrong!'...So, I'd say four or five years.

I: Ok. And...if you don't want to answer, that's fine...but what was the initial problem that you felt was contributing to the inability to have sex?

FP: Actually, he'd had an affair.

I: Ok...So, first it was a psychological issue, then there was the alcohol that you thought was the issue. And so do you think the reason is that you didn't bring it up to the doctor was because you didn't think that the doctor could offer a solution to the first two problems?

FP: I just...I don't know. It's not the kind of thing you talk about with the doctor.

I: It didn't seem like a medical problem?

MP: No

It took this couple 4-5 years of sexual problems to even consider discussing the situation with their doctor.

Overall, uncertainty about which sexual problems were medically relevant discouraged seniors from initiating discussions of their problems with their doctors. Contradictory feelings about wanting improved sexual health but not wanting to discuss their private sexual concerns with their doctor lead participants to convince themselves that their problem was beyond the domain of medicine.

Assumptions about Age-Related Sexual Changes

The last major area of avoidance and contradiction was in older patients' assumptions about the changes in sexual health during the senior years of a person's life. In general, interviewees talked about the inevitability of a deteriorating quality of life with old age. As mentioned in an earlier section, most participants felt that accepting their decline was essential. Therefore, several interviewees felt that seeking treatment for sexual problems in their senior years was essentially an inability to accept the realities of life. One male participant talked about accepting his erectile dysfunction:

“[Getting Viagra] just because [other men] have to have sex. I don't have sex. I can – I can live without it. I'm living with this condition and I'm living with it and that's it. That's part of life.”

Other interviewees not only felt that seeking treatment was embarrassing, they also felt that it would be ineffective. Several interviewees endorsed the idea that the treatments which were successful when given to a younger person would somehow be ineffective when given to a senior. This bias against sexual treatments for geriatric patients is evident in the following two interviews:

I: Right. Do you think if you had been younger, with the same problem, you would've pursued this?

P: Oh, yes.

I: Why is it that you being older now that makes you less likely to seek treatment for the sexual...?

P: Well, I really don't know much more than what they could do or if they could do something... I wish they could. But I really don't know.

I: Right. You don't think there is something.

P: I wish there were.

I: Did you ever think of asking a doctor if there were some medical reasons behind the problem [erectile dysfunction] or any medical treatment?

FP: No, I didn't.

MP: No.

I: Today, you still don't think there's any medical intervention that...

FP: He's almost eighty-eight. No, I don't.

Participants described many instances where there was a failure to discuss the sexual side-effects of a treatment, often because they had avoided the conversation during their medical visits. Several interviewees said that adverse side-effects were another reality of old age that had to be accepted, and they justified their avoidance of conversations about sexual side-effects by describing the pointlessness of such a discussion:

“Well the only experience I had with [the urologist] was to have a prostate reaming. I never really had to discuss anything with her on a sexual basis. I was aware that there could become an impotency situation, but what is there to talk about? If you have it, fine. If you're impotent talk all you want, you're not doing it.”

I: Did you have the conversation before you got the radiation about what it might do to your sexual health?

MP: I think it was after – after having it.

I: Is that something you would've liked to talk about before selecting the treatment or not really?

MP: I would've had the radiation no matter what. So what's the use of moaning about it before.

In both of these excerpts, the interviewees said their treatment was necessary, and thus, they just tried to prepare themselves for whatever adverse effects these procedures might bring. Both also implied that considering their sexual health as an

important issue when undergoing treatment for cancer would have been evidence of poor prioritization on their part.

Physicians' Avoidance

While participants spoke of many instances when older patients were responsible for avoiding communication about geriatric sexual health, interviewees responses also revealed avoidance on the part of their physicians. In fact, many interviewees could not identify a time a doctor had ever initiated a conversation about sexual issues. Even the few sexual issues that are considered typical topics of conversation in the traditional medical setting, such as STDs, were allegedly never discussed with the majority of interviewees:

I: Do you think sexual safety is something that doctors ever talk to their older patients about?

P: No, no doctors...all fifty doctors I saw never mentioned that to me. Safe Sex? No.

Even when participants were scheduled to undergo procedures which are known to have significant sexual side effects, physician communication about these side effects was minimal or non-existent. Two male participants spoke of the physician's avoidance of conversations about the sexual side-effects of treatment for prostate cancer:

I: So you mentioned your prostate. Before you had the radiation and all the other treatment that you had, did the doctor talk to you about the sexual side effects of that treatment?

P: I – the doctor did not talk to me. I talked to the doctor because I read a number of articles on prostate cancer and what it would do and what the treatment would do and what the radiation would do. And in the end of my reading I had a lot of the answers. All I did was confirm them with the doctor.

I: Before the [prostate] operation, did the doctors talk to you about the fact that you may not be able to have an erection after the operation?

P: No.

I: Nobody told you about it?

P: No. The way they was looking at it, it was a simple, major operation. You know, and after a couple of months I'd be back to normal. But it wasn't.

Perhaps most surprising were the stories patients told of being prescribed Viagra without ever really having a discussion about their symptoms, their sexual health, the treatment indications, proper usage, or side-effects:

I: Do doctors ever talk to you about your sexual health?

P: When I ask for Viagra or something. They say two sentences to me.

I: But you brought it up?

P: Oh yeah.

I: ...the one time that you wanted Viagra you brought it up with the doctor and it was only two sentences that he said back to you? It was very short?

P: Yes.

FP: I know [the doctor] gave him some Viagra, but we never used it did we? I don't think he ever took it.

I: So how did it end up that you got the Viagra in the first place?

FP: She just gave it to him.

MP: She gave it to me.

I: Did she ask you something or did you bring it up or...?

MP: ...I don't think she was, she really was comfortable in talking about it.

I: ... So do you think that you brought up to her that you might like to try Viagra or do think she was the one who suggested it?

MP: She brought it up, she brought it up...she'd come out with different things and this, and this, and this. And yeah, she told me – she didn't really go into any depth about it.

I: Did she try – did she ask you before hand if you were having a need for Viagra, or did she just say, 'oh by the way here's Viagra?'

MP: No.

I: Really? Interesting. And did she explain how to use it or a discussion of side effects or anything like that?

MP: She didn't say anything about it. I think most people I guess... I mean, look most people know what it is...So I don't think you have to really go into any great depth about it, you know?

The male participant in this last passage did not think his doctor's avoidance of a conversation about Viagra was too troubling because "most people know what it is." A similar sentiment was echoed by other interviewees who said that doctors assume that educated and responsible patients can procure most of the basic information on their own; therefore, uncomfortable conversations are unnecessary. Three participants expressed what they perceived as their doctor's trust that they would take care of themselves and their sexual health:

I: So do you think sometimes doctors don't ask you questions because they're afraid to ask you or offend you?

P: No. I don't know. Maybe they figure that I already know what the answer is, that I've already answered that question in my head. I don't know, I don't know.

P: I mean if my doctor feels that I'm an educated person and I make good plans about my physical health and may come when something is wrong, then I would say if there was something that bothered me or that I...leave it to me to manage that, you know? And if they're a little bit shy about that topic, which I think people still are, then they don't...just assume I would, I would come forward if I had issues.

I: You would?

P: I mean I would think...that the doctors think if I am an educated person who comes in when I have symptoms, when I have a little, tiny

bit of something I come and tell them there's a little something here, you know?

I: Right.

P: Then I would also take care of myself in the sexual area.

P: There was nothing personal about it. I didn't ask him deliberately. All I did was tell him I wanted to get some Viagra and he just wrote up a prescription for me.

I: He didn't ask any questions? He just said, 'okay you want Viagra here is a prescription'?

P: No, I've known [him] for a long time and he knows my habits and he knows that I have a pretty good hold on life and my wellbeing.

Rather than feeling frustration at their doctor's unwillingness to talk about sexual health issues with them, all of these participants imply that they are pleased that their doctor trusts them with the responsibility of tending to their own sexual health issues.

On the other hand, many interviewees felt that the real motivation for physician avoidance of sexual conversations was primarily the doctor's own discomfort with geriatric sexual health. In fact, even when physicians did discuss sex, doctors often seemed uncomfortable throughout the discussion:

I: ...Do doctors ever talk to you about your sexual health?

FP: My doctor, my primary doctor has mentioned it lately.

I: Is your primary care doctor male or female?

FP: Female.

I: And what did she say, or how did she bring it up?

FP: I think she said...I have been to her several times before she did bring it up...when she just asked how long it had been and just a few simple questions. She said...I think she was a little...I can't say embarrassed because she's an extremely intelligent person, but she was hesitant on talking about it to me. I think probably she felt as if I were her mother.

As with the doctor described here, who was embarrassed because of the age disparity, several other physicians were described as having difficulty with geriatric sexual discussions because of their age, gender, or race. For example, consider the following exchange:

I: What do you think prevents older people from having their sexual health needs being met?
P: ... the doctor, very likely, will be a forty year old Indian. You know, they're too embarrassed to bring it up.

Some participants said that physician embarrassment was not so much over sexual activity in aging adults, but rather, embarrassment over sexual activity in general. A few interviewees explained that doctors are uncomfortable with most sexual discussions, because ultimately, they are uncomfortable with their own sexuality:

P: The other thing is I think that physicians are embarrassed about talking to old people about sex.
I: And why do you think that is?
P: Their own vulnerability.

Fear of embarrassing or offending patients

Finally, some participants said that it was unclear whether physicians avoid conversations about sex in order to avoid their own discomfort or to avoid making their older patients feel uncomfortable. As one female subject explained:

P: I don't know whether [doctors are] embarrassed or if they don't want to embarrass the patient if the patient is not sexual.

This participant alludes to the challenge (discussed earlier) of determining what might offend to patients: on the one hand, implying that conservative older patients could be sexually active might be perceived as insulting; but on the other hand, forcing seniors to admit they are no longer sexually active might be even more offensive. For these reasons, interviewees conjectured, physicians choose to avoid the topic of geriatric sex altogether.

The issue of patient embarrassment came up often in conversations about the things doctors can do to make their patients feel more comfortable talking about sex.

Almost all of the participants said the best thing a physician could do was to bring-up the topic of sexual health during a routine medical visit:

I: What do you think doctors could do to make it easier for their older patients to ask questions about sex or to come to them about sexual problems?...

MP: Just come out and ask them.

I: So, if the doctor brought up the issue, it would be easier to talk about it?

MP: Yeah.

When I then asked whether or not the doctor's questions might insult some seniors, interviewees' thoughts on the matter were quite varied. Some saw no reason at all to be offended:

I: How did you feel about her asking you [about sex]?

FP: Oh, I didn't mind. I'm...good grief...I'm so old.

I: Well, I've heard some doctors say that one of the reasons they may be hesitant to talk about sex with their older patients is that they're afraid their older patients might be offended if they brought it up. Do you think there's any basis where that sort of...

FP: I don't know. I don't think there's any basis to be offended.

In fact, the vast majority of participants said that they would never be insulted by a doctor's questions about their sexual health; however, many qualified their response by explaining that they could understand why one of their peers might find such questioning offensive. A number of subjects conjectured that some seniors might believe that the doctor was being intrusive and might feel like their sexual life was none of the doctor's business:

FP: Well, if my doctor brought it up and asked me questions, I would answer him the best that I could, but he never did...

I: ... Right. Now some people feel that if doctors bring up sex with their older patients, the older patient will be offended. Do you think that's true?

MP: Yeah, some people may be insulted.

I: If the doctor says, do you have any sexual issues you'd like to talk about?

MP: Yeah.

I: Do you think that would offend some people?

MP: It's really a private thing. Some people really get insulted....And that's by right.

Some interviewees recognized that seniors with Victorian values might be insulted by the implication that they were still sexually active:

I: So what do you think doctors could do to make it easier for their older patients to come to them with their sexual problems?

MP: I don't know. I suppose they could bring up the subject. Or they could ask.

I: Right. If they ask, then it does seem ok to talk about it?

MP: If they ask, you could have a – you have a choice of answering them or say, 'doctor...'

FP: ...Or I don't want to listen to it.

MP: ...Say, 'doc – doctor what are you – what are you talking about?...We're old now. We don't have sex any more. That's – that's why we come here.' Or, 'you know doctor that's – that's dirty'

between older people to do that. That's oh – oh that's dirty. It's a dirty thing to do. We wouldn't do it any more.'

Interestingly, while many of the participants said they could understand why other older people might be offended by being asked about their sex life, only one out of all twenty-five interviewees admitted to actually ever having an experience with a doctor that seemed offensive:

I: Do doctors ever talk to you about your sexual health?

P: Oh, no doctor except [one], and some of it I resented. I thought it was none of his business. He's the only one. Isn't that interesting? Throughout my whole life...from teenage to this age ever, ever discussed it!

I: And the doctor who did talk to you about it, what kind of...

P: Oh, he wanted just to know, were we having sex or how...I can't remember.

I: But you remember feeling a little bit...?

P: Well I just...I felt as if he was invading private territory that didn't, as far as I was concerned, had anything to do with my health.

This participant goes on to explain that it was more the physician's questioning style that was off-putting – she felt that his inquiry was abrupt and unrelated to the rest of the interview – and she stated that had similar questions been asked within a more relevant context, she probably would not have been offended.

Other Barriers

Although logistical issues and avoidance were the main barriers to communication, a few other barriers were mentioned as well. A handful of interviewees discussed the

importance of language to a successful conversation about sex, and explained why the differences in a patient's vocabulary and a doctor's vocabulary might hinder communication. For example, if patients want to talk about their sexual problems, but can't generate the medical words, they may feel too embarrassed to say anything.

As one participant explained:

I: What do you think prevents, not necessarily you, but some older people from discussing sexual problems with their doctor?

FP: They may not know what kind of language to use and then maybe, if they knew the typical words that they ought to have, maybe just common ordinary ones, maybe then their only words are the words that you get in dirty jokes and things like that and they would hate to use those when talking to a doctor.

Of course, the barrier can work both ways. If physicians use medical terminology that is unfamiliar to their patients, they can alienate their patients; even worse, they might offend patients who interpret the doctor's language incorrectly. One participant explained that he wouldn't want his doctor to ask about his "sexual health" because he would not be sure what that term means, and he would feel like the doctor was implying that there was something wrong with him sexually:

I: What if the doctor has, you know, a list of questions, just like I had, and first asked, 'do you have any chest pain? Do you have any stomach pain? Do you have any problems with sexual health?' If they asked it as in a checklist form like that, would it seem as scary?

MP: No. I think the shift from your very first question from define sexual health...it's not exactly what I usually do...if it appeared on a doctor's checklist that way it would seem strange to go immediately into the...you'd say liver...that means something. It's an organ here and various things could be going wrong with it. And you say heart, that means over here and check out on that...you don't say nothing about a penis...

I: Right. So, what you're saying is...correct me if I'm wrong...I asked, you know, chest pains, stomach pain is very concrete and then

I said problems with sexual health, that's very abstract. It makes it harder to answer.

MP: Right

Another surprising barrier that came up during the interviews was a lack of trust of physicians' sexual advice. A few participants admitted that they felt that doctors are less "scientific" and less "professional" in treating sexual health issues than they are in treating other types of health problems. As one participant said:

P: This is something that I've learned a long time ago. Depending on how that particular doctor feels about sex, that will determine how he tells his clients or patient to have or not to have sex after a heart problem...In other words, if the patient feels up to it he should almost disregard what the doctor might tell him. And if he's not up to it and the doctor says you could have sex, he still shouldn't if that's how he feels. If he feels that there could be danger. I didn't speak to my doctor about it and he didn't bring it up to me. I continued having a pleasurable time.

I: So it sounds like no matter what the doctor had said to you, you would've made your own decision about when to resume [sex]?

P: Yes, that would be a fact.

This interviewee went so far as to advise patients to "disregard" their doctors' advice about sex, but the other participants who were wary of their physicians' opinions about sex were less extreme. A female participant said that she questions doctors' ability to give good sex advice because doctors "are not good at sex."

FP: I don't think doctors are very good at sex anyway, do you?

I: What do you mean by that?

FP: I don't know. I think that doctors are – are, you know – first of all they have to be very smart to get through medical school. So that they're sort of nerds. Eggheads... and I think that we associate that are quite sexual with - hanging with the wild life, you know what I mean?

I: Right...So you're saying that doctors are probably not like the most comfortable with sex?

FP: No, I don't think so.

I: ...So it makes it harder for them to talk about sex or it makes it harder for other people to want to talk to their doctors about sex?

FP: Well, um, yeah – I can only go by my own experience.

Overall, several participants implicitly acknowledged that the importance they place on their physician's attitude and life experience when trusting his judgment about sexual health was sometimes greater than the importance they placed on the physician's scientific knowledge on this topic. It is doubtful that the interviewees value their doctors' personal experiences nearly as highly when trusting their judgment about any other aspect of their health.

Ageism and Sexuality

Ageism in the Medical Community

Participants frequently spoke about instances in which they felt society had ageist attitudes towards geriatric sex, and not surprisingly, interviewees said that physicians were not immune from these beliefs. Many participants felt that doctors treated their older and younger patients very differently in terms of their sexual health:

I: Did the doctor talk to you about any side effects of that medicine?

P: Sexual side effects? No, never. There you go again. Whether the doctor would talk about it if [my husband] and I were in our thirties and forties and fifties I don't know.

I: Right.

P: But never when you get old do physicians male or female talk about what medication is going to do for you sexually, or is going to ask. They just stop doing it.

Several people said that doctors rarely have conversations about sexual health with their older patients because they assume sex is irrelevant to seniors, as is discussed in the following two excerpts:

“P: It may be that [doctors] think [sex] is unimportant because of the age of the person. It's unimportant in the later ages... they think it's more important for younger people.”

“I: You feel that doctors assume that their older patients are not sexually active?”

P: Yes.

I: Ok. Do you feel like a doctor has specifically made a false assumption about you and your sexual activity or your sexual health needs?

P: Yeah, false assumptions. They just disregard it.”

Some participants talked about their physicians' assumptions that sexual activity only applied to healthy individuals:

I: Do you think that doctors make false assumptions about the sexuality of their older patients?

P: I think they do a lot of assuming.

I: What do you think they're assuming?

P: [Old people] shouldn't be involved with stuff like that.

I: So they assume, doctors assume that because their patients are older they're no longer sexually interested?

P: I've heard contrived, a lot of facts. They say, 'why you shouldn't be sexually active if you're almost ready to kick it. Put it in a cup.' ...But I disagree.

In this excerpt, the physician and the interviewee had different ideas about the importance of sexual health to the interviewee's quality of life. Similar sentiments were echoed by other participants, who said doctors expect their older patients, particularly their healthier older patients to be satisfied with "how good" their health is "for their age." One interviewee reported an instance when his physician dismissed his sexual complaints, and then implied that the interviewee was not appreciating how good his health was for an octogenarian:

I: Ok. So let's see, do you think that doctors make false assumptions about the sexuality of their older patients?

P: I think so. I think so. What – what's happening with my age is, if I go to a doctor and I say, 'doctor, I don't this, I don't feel that.' And then what happens is, at the end of the conversation he'll say, 'how old are you?' And he'll say, 'you're eighty-four? Boy, you look good for your age. I wish I could look as good as you do at eighty-four.' And, 'you're – you're more active than I am!' So the bill of health is given to you but you don't realize you're as healthy as you are compared to them. So in comparison and you're healthier than you think you are. I – I don't like to be eighty-four. I don't like to be an old man. It's destroying me.

Finally, one participant added that not only do physicians give less sexual health care to their older patients, they also do not give their geriatric patients the same respect they give to their younger patients. This lack of respect for and annoyance at seniors makes doctors less likely to work to improve seniors' quality of life in all areas, and especially in the area of sexuality:

I: What kind of false assumptions do you think doctors make in regard to the sexuality of their older patients, if any at all?

P: ...I don't think they see them as human beings. And there's a tendency to put older persons out of your lives depending on how young and immature the doctor is...And just because he has an MD doesn't mean he understands human beings.

I: Right.

P: And look, that's a human tendency. It's a tendency of nature. It's – it's very few societies that honor the older person. Even though they become philosophers. But then, who studies philosophy? (laughing) But, there's a tendency to see them as problems. Physical problems. And they don't see the rest of their ... and finding their attitudes and etcetera a little annoying, because it's not the same as a younger person.

Privacy

Ageism in medicine is not just limited to physicians and other health care professionals, it also is apparent in medical institutions. In particular, more than one interviewee talked about the disregard for privacy evident in the design of institutions such as hospitals and nursing homes. Long term care facilities, in particular, are problematic, because they are not places of short-term lodging, and therefore, people who move into these facilities are effectively giving up any private space of their own. Of course, because so many people move into long-term care

facilities because of a deterioration in their health and in their ability to live independently, it is often assumed that privacy, and especially privacy for sexual activity, is irrelevant to the residents. One interviewee shared a story of his friend's frustration with his sudden loss of privacy:

P: Oh I think they make false assumptions. Now it didn't happen to me but a very good friend of mine, he was probably sixty-five, sixty-eight, and had a stroke and he wound up in Gaylord and it was hell because everybody assumed that he was, you know, kaput. No more, he's out of it. He was raising hell. So I assume that that was a result of people assuming that he was now, you know, finished...

Even if a married person or couple moves into a skilled nursing facility, there is usually no arranged system for giving the married couple any private time or space. One participant remarked, "Double beds in the health center? I don't think there are any...and I think that's strange..."

Ageist Self Perceptions

While many of the interviewees spoke of other people's ageist attitudes, a large number of subjects also endorsed their own ageist beliefs about elderly sexuality.

Ageist self-perceptions fell into four main categories: definitions of sexual activity, conceptions of "normal" and "abnormal" sexual behavior and interests, ideas about attractiveness and beauty, and notions about quality of life.

Definitions of Sexual Activity

As discussed previously, when participants were asked to define "sexual activity," most of them felt that any sexual expressions that fell short of intercourse did not "count" towards making them a "sexually active" person. For men, erectile dysfunction was seen as a death sentence for the sexual life of both the man experiencing the dysfunction and any partner he might have. As one male participant explained, his impotence made other sexual acts, such as foreplay, irrelevant to him:

I: Does being sexually active necessitate intercourse or can you be sexually active by doing other things like, foreplay, kissing...

P: Well, at my age, course I cannot achieve erections any more, foreplay doesn't mean anything. It's past tense.

I: Ok. So, but sexually active to you means having intercourse?

P: Yes.

I: And you don't see yourself as sexually active?

P: No.

Remaining “sexually active” was seen to be entirely related to the physical act of intercourse, and therefore, being “sexually healthy” was described by many participants as continuing to have intercourse into later life. More than one participant said that sexual health was related almost exclusively to physical sexual abilities. One interviewee denied any role for emotional aspects of sexual health:

I: How do things like touch and intimacy and companionship figure into a definition of sexual health, if at all?

P: Well I don't think at all.

These all-or-nothing definitions endorsed by most interviewees, reveal an ageist bias against the types of sexual expression that are more available to older adults. Also, definitions that make intercourse the crucial element of sexuality reinforce the general idea that sex is only for the young and healthy.

The narrowness of the interviewees' definitions translates into a narrow idea about what is sexually pleasurable both for oneself and for a partner. The responses of two participants illustrate their assumptions about satisfying a partner only through successful intercourse:

I: Ok. Are there any other aspects to being sexually active that you can think of?

P: To being sexually active?

I: Yeah. Any other aspects besides intercourse?

P: I don't know if there are any other ways to please.”

P: I think what's happening in that case is that men, as they get older, you know – are getting closer to death and they're worried about dying, and so they figure a younger person will care to bring back his young days, you know? And that's why they – I can't

imagine they really do it. Because I can't imagine that they could satisfy a young girl, you know?

The interviewee in the second excerpt cannot “imagine” how an old man, who presumably has some degree of erectile dysfunction, could possibly provide the type of sexual experience a younger woman desires. Consider a similar ageist attitude of another participant:

P: I did have a friend who was very devoted to her husband. He had one of the degenerative diseases and he fell in love with this very young nurse and ruined the marriage. And, I don't think he could offer anything. I doubt if he could offer her sex.

This interviewee not only assumes that this older man could not “offer sex,” she also then concludes that he therefore could not offer his younger nurse anything. Somehow his impotence took away any value he might have had as a romantic interest.

Normal and Abnormal Sexual Behavior

Many subjects endorsed the idea that engaging in sexual activities and thoughts after a certain age is “abnormal.” Interviewees spoke of sexual changes, such as decreasing sexual desires and abilities, as indications that they were “too old” for sex. While many interviewees admitted that if their overall health improved they might consider becoming sexually active again, several interviewees expressed

bewilderment that any senior could enjoy sexual relations, regardless of his sexual health status:

FP: [My son-in-law] had a heart attack. His doctor gave him Viagra. And he's seventy. He starts...and I didn't say nothing.

I: You think that there is something strange about that?

FP: Why does he have to be sexually active? And he's seventy.

There's about ten years difference between us and him. And it's the one thing he had asked.

I: Did that seem odd to you that they...they're still sexually active at that age?

FP: Very. I don't know how that's...I don't talk to [my daughter] about it.. but I don't know how she likes it. But maybe she likes it.

A few subjects went a step further, explaining that sexual behavior in old age is not just abnormal, it is unnatural, and that seniors seeking healthcare for their sexual problems are fighting against the will of God:

"Now, I have a very strong conviction against erection disability remedies. I think if the good Lord wanted to have men to have sex, go to heaven, and have the most active sex in our lives...I could talk about love making and on and on at age seventy, eighty or ninety, he would've constructed mankind that way. And on a philosophical, not a religious basis, although that's not prescribed in my religion. I'm totally against Viagra, etcetera."

Some participants felt that sexual dysfunction is normal in old age, and that impotence is to be expected:

"Don't look at us, you know, all we old-timers, we don't do it no more. Nah! Don't look at us older people. I'm seventy-two years old I still get the urge, but I can't do it...Hey, I'm normal."

While many subjects expressed unwillingness to discuss sexual problems with a doctor, one subject identified a problem for which she would seek treatment – too much sexual desire:

I: If the doctor did prescribe something with a sexual side effect, would you like the doctor to tell you about it?

P: Well, it would really depend on what you're talking about. If it had the effect that made me try to seduce other men, I certainly wouldn't want that to happen.

I: So, let's say one of them decreases your libido?

P: Well, I don't have no way...I don't expect my libido anyway so it doesn't really matter.

I: So it doesn't really matter?

P: No, it doesn't matter. That's the part that doesn't matter to me. There are no men who are pursuing me.

This participant would not be concerned about losing her sexual drive, but she expressed a strong aversion to the possibility of having an *increased* sexual drive. Other participants discussed similar societal boundaries that treat sexual expression in older women as particularly abnormal. Consider the remarks of two other female participants:

I: Do you think it's harder for older people to talk about their sexual problems than younger people?

P: Sure.

I: Why do you think that is?

P: Because they're old and think it's inappropriate.

I: So there's some sort of social stigma?

P: Mm-hmm. Our social...I mean, if you're an old lady, you're supposed to knit, baby sit...

P: Well many women don't even want to admit that they enjoy sex. Our society has conditioned older women that, you know, you're over the hill, you're through. So some women may be embarrassed discussing it with the doctor unless their physician brings it up.

In contrast to the negative attitudes about sex and the elderly, participants' attitudes about sex for younger people were almost uniformly positive. Not only did everyone agree that it is normal for younger people to be sexually active, several interviewees endorsed the idea that it would be abnormal for a young person to be uninterested in sex.

I: So when you were younger [sex] was pretty important to you?

P: Oh sure. If it isn't when you're your young I'd say to you, what's wrong? You're talking about twenty, thirty, forty year old people?"

Although many subjects felt sexual activity in older age is unnatural, a few subjects expressed a belief that sex at any age is normal:

"Well I think the doctor's attitude has to be that [sex] is a very normal thing. You know, that it's not unusual. That a person would be OK to be active when you're older. It's perfectly OK to be active when you're older. There's nothing wrong with it. It's wonderful!"

Attractiveness and Beauty

While beauty may be "in the eye of the beholder," there are certain accepted societal norms characterizing what we consider "attractive." One of those norms in contemporary American society (as well as many other societies) is that looking young is an important element in being considered attractive. Therefore, it was not surprising that many of the interviewees endorsed this idea, and described people who look old or sick as unattractive and ugly. What was more interesting was that

female interviewees talked about attractiveness much more frequently than the male interviewees, and that they expressed negative attitudes both towards the physical appearance of elderly men as well their own aging bodies.

The topic of attractiveness came up during several interviews with widows over the possibility of entering in a new sexual relationship in the future. The general sentiment, as discussed earlier, was that the likelihood of ever resuming sexual relations was almost zero. Of course, one reason women said dating a man was an unrealistic expectation was that the ratio of women to men at their age, and even more so, the ratio of single women to single men, was very unbalanced. But some female participants also said that even within the small pool of single men they know, most are completely unattractive and are in much “worse shape” than the women of their age bracket. Consider the statements of two widows:

“P: I don’t find an eighty year old, almost blind person that attractive to me sexually... Even though he may be a wonderful human being... You know what I mean?”

“P: The men are in horrible shape. Nature has been most cruel to men. And I don’t think there are many romantic attachments here. Not because some of the women wouldn’t have it, but because the men offer no romantic possibilities, for lack of words... They walk along, are more humped-back than women. More of them pushing carts. It’s about, it’s hard to say, but more men use the carts. It just makes no sense to me. I say nature has been brutally cruel to men. So, you know, there may be appreciation of what each other thinks, but I don’t think there’s any incentive for romantic words. I can’t talk about the men, but I doubt it with the women because, you know, if the women are integrated, still functioning, these men would not attract them.”

Female interviewees did not limit their judgment of unattractiveness to older men, many also expressed negative attitudes about their own physical appearance. Some self-descriptions include: “old,” “too fat,” and “too tired.” Many female participants expressed doubt that men their age would ever be attracted to women their own age. One woman admitted that she was not anxious to get treatment for her husband’s diminished libido because she believed renewed sexual desires might drive him to cheat with someone younger:

“I find that older men, at least this is what I hear... if they’re going to have sex at this age, they’re pretty interested in getting someone much younger, about twenty-seven years old or younger.”

Another interviewee also was incredulous that she could possibly be attractive to men anymore:

“It’s nice to – to have a nice relationship with a man. But it’s not necessarily the need for a sexual relationship. It’s for understanding, warmth, intimacy and I suppose, you know, there’s still the feeling of being attractive. Even though you’re not. And you know you’re not.”

One participant explained how she was able to maintain the attraction in her marriage, even though both she and her husband were elderly:

*P: The memory of it.
I: The memory of something you guys felt when you were younger?
P: Yeah. I think that as much as anything else...He would always say, “you were gorgeous.”*

In other words, this interviewee admitted that the attraction in her marriage was not due to a mutual appreciation of their physical appearance as seniors; rather, it

stemmed from memories of their attractiveness when she and her husband were younger.

Although it was mostly female participants who had negative attitudes about their physical appearance in their senior years, and although most doubted their attractiveness, many still expressed the desire to be seen as beautiful by the opposite sex. As one subject remarked: “It’s very nice if the male sex thinks you’re interesting or attractive or – or you know, come on.” Overall, female subjects admitted that physical appearance in old age – whether it be the appearance of others or themselves – was unattractive enough to discourage sex. On the other hand, male participants made almost no mention of physical appearances. No man said anything about his looks being a limiting factor in his sex life; instead, as discussed earlier, male interviewees who said resuming sexual activity was unlikely were focused mainly on the issue of sexual dysfunction.

Notions about Quality of Life

One theme that has recurred several times throughout this paper, but has not been specifically discussed in terms of the ageism, is the idea that people should expect and accept a lower quality of life when they reach their senior years. Many interviewee comments reflect a sense that for younger adults, sexual health is a right,

whereas for seniors, sexual health is more of a privilege. This point is well illustrated in the following two short exchanges:

I: What do you think prevents older people from having their sexual health needs met?

P: Well they probably feel maybe that they're not entitled to have sexual needs at their age. I'm talking about people in their seventies or eighties.

I: It sounds like for you, [your husband's] health has really affected your sex life?

FP: Yes.

I: Has anyone ever counseled you about that?

FP: No.

I: Is that something that, you know, as it was happening you would've liked counseling for, or not really?

FP: No. Maybe if I were younger I would've thought about it...But no, not at this age.

While many participants expressed feelings of sexual disentanglement, a few interviewees put quite a different spin on sexual decline, and talked about old age as a time of “freedom” from sex (which was not unlike the writings of Plato that were discussed in the introduction). This idea is illustrated in the following excerpt:

I: If somebody said there was a new treatment that could restore sexual libido, would you be interested in that?

MP: No, too old. Got enough kids now.

FP: We ain't got to worry about that anymore.

According to one interviewee, however, such claims of being “freed” from sex may just be a coping mechanism, and she suggested that perhaps these people are less sexually satisfied than they would like to admit. She shared the following story about her mother:

“My mother lived to age ninety-five ... in a senior center in Boston ... one time she was telling me about some couples who had become friendly and hold hands and kiss and sit together and all this stuff and she thought it was ridiculous. And her words were “enough, enough right? Enough is enough!” And then I received, I used to receive a monthly newsletter from the senior center. And they made mention of these couples that had become friendly, male and female, and who were holding hands and kissing and spending time together. And they [the newsletter editors] said that it was envy on the part of the other residents for these couples, and that’s why they reacted the way they did.”

Regardless of whether sexual decline is viewed as a blessing or a curse, one thing remains constant – older people have not only accepted that their sexual health will decline, they have also accepted the general societal belief that decline or loss of sexual activity in old age should not be challenged.

SECTION V: CONCLUSION

Doctors are not much good at talking about sex because doctors are people and people are not much good at talking about sex. In no other area of medicine does our own guilt, fear and personal experience so affect the consultation and our ability to help.

(Tate 2000) in (Gott 2005)

Let us recall the null hypothesis that inspired this research: “although the medical profession has deemed sexual health an important part of the medical encounter in younger patients, sexuality and sexual health become irrelevant as a patient ages.”

Do the broad range of findings discussed in the previous section prove or disprove

this null hypothesis? In other words, is there evidence that sexual health becomes irrelevant as patients age?

At first glance, because such a large number of participants identified themselves as sexually inactive, it may seem like the data support the null hypothesis, and that sexual health has indeed become irrelevant with age. However, participants who identified themselves as “sexually inactive” were not “asexual;” rather, virtually all interviewees described engaging in other types of sexual expression including: foreplay, touching, flirting, masturbation, and enjoyment of sexual movies, books, and jokes. Furthermore, while many subjects identified themselves as sexually inactive, we cannot then conclude that sexual activity was no longer meaningful to them; in fact, a large majority of participants said that sex was at least somewhat important to their quality of life.

Similarly, the initial responses of participants to questions of sexual health may have seemed to indicate that seniors did not feel they have sexual health needs. After all, “sexual health” was most frequently defined by participants as the prevention of STDs and pregnancy, which most participants were quick to explain were issues that did not pertain to them. After further discussion, however, both male and female interviewees frequently described male sexual problems (namely erectile dysfunction and loss of libido) as issues that negatively impacted the sexual health of both the men with the problems, as well as their sexual partners. Other factors that were identified as important to sexual health included: enjoyment of sex, physical health,

mental health, and partner status. Of course, it could be argued that some of these factors, such as absence of a partner, are beyond the scope of medical care, but the majority are issues that can be addressed by physicians.

Interviewees' satisfaction with their sexual health varied from three women who reported being very satisfied to a few men who were very dissatisfied. A little more than half of the participants reported that they were reasonably satisfied with their current level of sexual health; some might say this high level of contentment calls into question the importance and necessity improving sexual health for seniors.

However, it is important to remember that the majority of participants who said they were satisfied were only conditionally satisfied (in the context of their old age), and they acknowledged that they would be greatly dissatisfied with the same level of sexual health if they were younger.

Participants' comments about sexual problems and treatments indicated that they were not well informed about the medical aspects of these issues. While many participants lamented erectile dysfunction and blamed impotence (either their own or their partner's) for the decline in their sexual activity, the majority of male participants did not use or even try Sildenafil Citrate (Viagra) because they felt it was unsafe. Almost none of the interviewees could recall having a real conversation with their doctor about this issue; in fact, interviewees reported that doctor-patient communication about any sexual issue was rare. In the instances when the topic of sexual health was broached, little information was actually exchanged.

The data presented here clearly indicate that sexual health is relevant to the majority of participants in this study: participants engage in sexual expression, they believe sexuality is important to the quality of their lives, they can identify medically relevant issues that they believe affect their sexual health, and they are only satisfied with their current sexual health because they believe it is unrealistic to expect anything better in their old age. I would therefore contend that this research opposes the claims of our null hypothesis.

Now that we have re-examined the null hypothesis, let us revisit the more specific aims of this study. This purpose of this research was to explore older patients' perceptions and experiences regarding:

- 1) their sexual health needs
- 2) what role their physician should play in meeting those needs
- 3) the barriers preventing the needs from being met
- 4) the degree to which their sexual health affects their overall quality of life

Sexual Health Needs Revisited

My discussions with seniors did not reveal much evidence for a "changing nature" of sex, as was suggested by some authors (Kligman 1991 Feb; Gill and Ducharme 1992; Willert and Semans 2000; Kaiser 2003 Aug). Some participants' sexual

activities did “change” over time, in the sense that intercourse, which had been a very important element of sexual expression, was no longer happening for many of the interviewees, and the cessation of intercourse made some participants cut-off their sexual expression altogether. However, this was not the “change” anticipated by the researchers mentioned above, who had hypothesized that sexual expression would evolve with age, and that other activities would replace intercourse as the central sexual act.

Instead, intercourse remained fundamental to the participants’ ideas about sex, and in fact, most interviewees felt that the terms “sexual activity” and “intercourse” were synonymous. While a few participants did talk about “relationships” and “companionship” becoming more important with age, most continued to see intercourse as the only activity that separates sexually active and inactive people. Even when interviewees were participating in forms of physical and emotional intimacy other than intercourse, they considered themselves sexually *inactive*. Furthermore, participants portrayed these various other forms of intimacy, not as anything new or different, but rather, as a continuation of the forms of sexual expression in which they had participated throughout their lives.

Interviewees indicated that they participate in various non-coital sexual acts such as touching, cuddling, kissing, and masturbating, and also that they express their interest in sex by enjoying sexual movies, books, and jokes. The only participants who denied having any sexual interests were the two participants who stated that sex

had never been important to them at any point in their lives. In other words, nobody who enjoyed sex as a younger person had lost all of their sexuality and sexual interest in old age.

I would argue that participants' propensity to see sexual activity as an "all-or-nothing" phenomenon is the result of rigid societal ideas, and not a reflection of the activities that are important or could be important to the quality of their lives. After all, since penile-vaginal intercourse is seen in society as the all-or-nothing act that separates virgins and non-virgins, it really should not be surprising that the same all-or-nothing categorization of "sexual activity" continues into later life. Furthermore, because senior citizens were largely raised during a more sexually conservative era when sexual definitions were much more rigid than they are today, it is conceivable that many seniors have never considered the possibility that "sexual expression" *could* be different in later life.

I would also argue that this rigid sexual definition limits seniors' ability to conceive of sexual health needs that go beyond the traditional view of sexually transmitted diseases and pregnancy prevention. Recently, the well advertised erectile dysfunction drug, Sildenafil (Viagra), has added impotence to the list of sexual issues that are considered medically relevant. Still, while some participants recalled an experience talking with their physician about STDs, pregnancy, or erectile dysfunction, participants never mentioned a time that they discussed any other sexual dysfunction issues, such as loss of libido, pain during intercourse, and problems with orgasms.

However, this does not mean that participants did not experience these other sexual problems; rather, it suggests that participants never considered these problems as medical problems, and therefore never believed they might be treatable in a medical setting.

When participants did talk about their sexual health issues with their physicians, it was almost always men talking about problems with erections. Marshall's (2002) description of sexual health attitudes was confirmed in this study; he writes: "The full and firm erection is viewed as the lynchpin on which the whole business of sex depends" (pg 137). Indeed, men often regarded any physical sexual act to be impossible without "a full and firm erection." Other than impotence, the sexual problem men mentioned with some frequency was a decrease in libido, but none of the participants ever considered going to a physician to address this problem.

Women, on the other hand, barely said anything about their own sexual health, and almost always attributed their sexual inactivity to either their partner's sexual problems or their lack of a partner. Interviewees were never explicitly asked to discuss their own specific sexual problems, and so the information gathered in the interviews about female sexual dysfunction was vague and difficult to interpret. A few women talked about loss of libido, but in general, they did not see their diminished sexual interest to be a problem. Because their partner developed problems first, and therefore they had become less sexually active before their own

sexual issues developed, women either never realized they had a problem or women didn't consider issues such as sexual disinterest to be a problem.

Physician Involvement and Barriers to Involvement

Participants had very few experiences talking to doctors or other medical professionals about sex. However, since most did not identify many sexual health needs in the first place, interviewees often did not consider this paucity of communication to be a problem. In general, participants did not believe that medicine had much to offer when it came to sex. Sexual decline was felt to be inevitable, and many interviewees, extending that logic, assumed that sexual decline could not be "cured" or even "treated." Therefore, many interviewees saw no reason to raise the issue with their doctor. Similarly, when a doctor recommended a procedure or a medication that had a sexual side-effect, interviewees believed that the side-effect was unavoidable if that particular treatment was essential for their physical health. Again, participants argued that if the treatment was necessary, there was "no point" in discussing the accompanying sexual side-effects.

These assumptions about treatments were only one of many barriers that stood in the way of sexual healthcare. Most notably, poor communication between doctors and patients characterized most experiences the interviewees described. These barriers,

including: demographic differences, patient avoidance of discussions of sexual health (due to embarrassment, fear of treatment, uncertainty about whether their problem was a medical problem, and assumptions about age-related sexual changes), and physician avoidance of sexual health discussions with their geriatric patients (due to their own embarrassment and their fear of embarrassing their patients), as well as the barriers created by ageist beliefs of the medical community and ageist self perceptions of seniors have already been discussed in detail.

So how should physicians interpret these findings? I would recommend that doctors should keep in mind that the vast majority of older patients are not asexual. Simply by keeping an open mind and a liberal attitude, patients will feel more comfortable talking about their issues, and they will worry less about being judged. Another key take-away for physicians is that they should assume a more active role in facilitating sexual discussions with their older patients. In order to do this, doctors must overcome their fear of offending their older patients. While almost every interviewee talked about the anonymous seniors who would be insulted if asked about sex, nobody could name a specific person they knew who had an offensive experience. Only one of the twenty five interviewees could report a time he or she had ever been offended, and the one participant who felt insulted believed she would not have been put-off by sexual health questions if they had been asked in a respectful and non-invasive manner. (Of course, we must keep in mind that this data comes from a biased sample of seniors who agreed to be interviewed about their sexual health;

perhaps in a more random sample, a greater number of subjects would have said they found sexual health questions offensive.)

Quality of Life

One of the important underlying goals of this study is to advance the quality of life for seniors. If participants had revealed that they had many sexual health needs that were important to them, but that those needs were not being met, the results would clearly be useful for advancing quality of life through medical care. However, patients identified very few sexual health needs, and the majority stated that they were satisfied with their sexual health. If seniors are not really unsatisfied with the current state of sexual healthcare, should we leave this issue alone?

I think the more important question here is: Do we think that there are changes we can make to sexual health care which can improve seniors' quality of life? I would argue that the answer is "yes." Just because societal expectations for sexuality in old age are low and, as we have seen here, seniors' expectations are low, that does not mean we should accept the status quo. All we need to do is look at the other sexual attitudes that have changed during the past century. If a researcher had interviewed young women in 1907 and asked them if they had any sexual health needs, I suspect their answers would have been similar to the responses of seniors in this study. The

women of 1907 probably would not report many needs because they probably could not conceive of needs other than staying free of infection and successfully conceiving children. However, one hundred years and a sexual revolution later, today's young women routinely recognize issues like decreased libido, difficulty achieving orgasm, and pain during sexual intercourse to be problems and often seek medical help to address these problems. I doubt difficulty with orgasms or pain during intercourse are new phenomena; what is new is women's expectations about the sexual experience. With higher expectations for sexual pleasure, women are more likely to consider phenomena such as dyspareunia and anorgasmia to be problems that can and should be addressed, which ultimately results in improved sexual experiences for women.

So the important issue is not what sexual health is today, but rather what sexual health could be for seniors in the future. There is no reason that raising expectations and standards of sexual health for seniors can't bring about a similar improvement in sexual experiences, and thus quality of life for that population. After all, the vast majority of seniors in this study acknowledged that they would not have been satisfied with their current level of sexual health if they were younger; in other words, participants' sexual health status is only acceptable to them because they believe that a decline in sexual health in old age is inevitable.

A Word of Caution

While promoting sexual health for seniors could turn out to be an important step in improving quality of life for seniors, we must proceed with caution. The goal is to reduce the sexual stigmas that senior citizens face, not to reverse them so that sexual *inactivity* becomes stigmatized. If physicians begin promoting increased sexual expression for their older patients, there is some implication that being sexually active is “healthy” and that lack of sexual expression is somehow “unhealthy.”

Seniors who are no longer interested in sex (or perhaps have never been interested in sex) should not be made to feel like they “should” be sexually interested. Therefore, the medical community must attempt to be non-judgmental and must treat their older patients’ sexual interest or lack of sexual interest equally.

Furthermore, scientific research about sex has a tendency to regard sex as positive, fun, and healthy, but this is not always the case. Sometimes sex is not healthy and enjoyable, such as when it is not consensual or is painful or is emotionally manipulative. Such negative sexual experiences can happen at any age, and older patients who are engaging in sexual activities may not always be enjoying that experience.

Implications for Medical Education

The ultimate goal of this research is to improve the quality of life for America's seniors by improving their sexual healthcare. This goal can only be achieved by educating physicians and other health care providers about geriatric sexual health needs and improved delivery of care.

What are the implications for the future of medical education about elderly sexuality? I think it is clear that little improvement will be made until the medical community stops assuming that their older patients are asexual. Beginning with medical school training, physicians must be taught that sexual health is both relevant and important to many older patients. Medical students should learn about the specific types of sexual issues that face seniors, including: the distinction between sexual dysfunction and normal physiologic changes in sexual health, the sexual health implications of common medications and diseases, and the important role of psychosocial factors on sexual health (such as the living situation and the absence of a sexual partner).

Second, physicians must learn to broaden their definition of "sexual activity," so that older patients who are no longer engaging in intercourse are not automatically considered "asexual." To this end, it would be wise to revise the questions medical students are taught to ask when screening for sexual health issues. Instead of asking elderly patients, "Are you sexually active?", which generally is considered the same as, "Are you engaging in intercourse?", medical students should learn questions that

are less focused on coitus. For example, the terms “sexuality,” “sexual expression,” and “sexual health” seem to connote a broader range of sexual activities than just intercourse. However, the term “sexuality” also means “sexual orientation” for many people, so asking about “sexuality” might not be the ideal terminology to use. I would suggest that the best question for geriatric sexual health screening is: “Do you have any sexual issues that you would like to discuss?” This question avoids both the terms “sexual activity” and “sexuality,” and is also preferable to the term “sexual problems,” which might be interpreted by some older patients to be an implication that they are sexually abnormal. I also think the term “sexual issues” is more likely to produce a variety of responses than the term “sexual health,” because, as discussed earlier, “sexual health” is often regarded as synonymous with STD prevention and treatment.

Third, physicians should be taught to screen patients of all ages, and in both good and poor health for sexual health issues. Physicians should initiate the conversation during a routine physical and should try to be as open minded as possible. If a patient appears offended or annoyed at the initial screening question, the physician should take that as a cue, and should redirect the conversation. Questioning seniors about their sexual health might feel uncomfortable, but doctors must learn to stop avoiding these conversations. Also, doctors should be taught to avoid making assumptions about what their older patients do and don't know; after all, in this study, even the highly educated older participants were not well informed about sexual health.

Physicians should also be taught that their older patients avoid conversations about sexual health just as much as their doctors and often buy into the same ageist beliefs as everyone else. Through education, doctors can learn simple strategies to help overcome these barriers. For example, physicians can help their elderly patients by validating their concerns, and by assuring them that their sexual problems are medically relevant and that the treatments being offered are safe. Doctors can also help their older patients by reminding them that sexual dysfunction is neither normal nor inevitable. Also, invalidating negative stereotypes about sexuality and aging might actually promote improved sexual performance for older individuals (in the same way that promoting positive aging stereotypes promotes cognitive performance).

Finally, medical students need more training and practice talking about sex with their patients of all ages, and especially with their older patients. Sex can certainly be a difficult topic, but the more medical students are taught how to integrate sexual health questions into a standard patient interview, the less awkward and embarrassing sexual health conversations will feel in the future. Discussing sexual issues more comfortably will also help dispel the image shared by many interviewees that doctors are “nerdy” and thus, not the best authorities on sex.

Overall, future medical educators must promote physician open-mindedness about geriatric sexuality and must teach doctors to engage in more open, comfortable communication with their older patients. These goals are certainly tenable, and I

believe they will greatly improve the state of sexual healthcare for America's seniors.

Limitations and Areas for Future Research

This study had several limitations. By nature of being a qualitative study, the data is descriptive, not statistical, and should be interpreted as such. The sample size was only 25 individuals, and all were Caucasian men and women from New England. While numerical data was presented in the results – for example, the number of participants who identified themselves as sexually active – these numbers were not intended to be statistically relevant, but rather, they were included to illustrate the magnitude of a particular group.

A second limitation of this study is sampling bias. Whereas many seniors in America may be uncomfortable discussing sex, every individual who enrolled in this study knew the topic was sexual health and was willing to discuss this with an interviewer. Participation in the study was elective for all 25 interviewees, and for half of the interviewees, it actually required a proactive response to a mass mailing. It is likely that this enrollment process created selection bias, where seniors who were averse to talking about sexual issues declined to participate, and thus, were underrepresented in the study sample. Furthermore, by recruiting subjects only at the independent living facility and the VA, it is likely that the seniors from both the upper and lower

classes of America are well represented in this research, but that seniors from the middle class were not targeted well by our recruitment methods. (In general, socioeconomic status and educational achievement is quite high in the individuals in the independent living center, while both of these measures are much lower in the VA population. Please refer to Table A in the Methods section for a comparison of the two recruitment sites.) For all of these reasons, readers should be very cautious when generalizing these results to the larger American senior citizen community.

This research was meant to be a first-step in understanding elderly sexuality and the role of the physician, which would help generate hypotheses for future research in the area. A study which includes participants who are a more representative cross-section of American seniors, and designing a study with less selection bias will be an important step in ensuring that a full spectrum of experiences and perceptions are captured.

In future studies of sexual needs of senior citizens, I would suggest that the researchers take care in choosing the vocabulary used in their study. As this study showed, use of the term “sexual activity” versus “sexuality” produced quite different responses. Also, future research would benefit from more in depth examinations of non-coital sexual activities and from more specific questions about sexual health issues. More research in the area of female sexual problems is necessary, but the challenge will be to get women to reveal personal information. Perhaps focus groups of women would generate a richer discussion by allowing women to build off one

another's comments. Another important avenue for future research will be examining physicians' perspectives and opinions about doctor-patient communication around senior sexual health in order to get a more balanced picture of the barriers to improved sexual healthcare.

Future researchers should also investigate seniors' attitudes towards the "medicalization" of sex, with a specific emphasis on assessing whether or not older patients feel that sexual inactivity has gained its own stigma. Investigators should also keep in mind the possibility that sex is not necessarily an enjoyable, positive experience for older patients and therefore, they should examine the assumptions of their studies with this in mind.

Finally, quantitative data will ultimately be necessary for confirming or rejecting hypotheses generated with this and other qualitative data.

References

- (NUD*ST®)8 (2002). NVivo qualitative data analysis program. Melbourne, Australia, QSR International Pty Ltd.
- Applegate, W. (1986). *Sexuality and the Elderly. The Practice of Geriatrics*. D. Calkins, and Ford. Philadelphia, WB Saunders Company.
- Araujo, A. B., B. A. Mohr, et al. (2004). "Changes in sexual function in middle-aged and older men: longitudinal data from the Massachusetts Male Aging Study." *Journal of the American Geriatrics Society* **52**(9): 1502-9.
- Barber, H., R. Lewis, et al. (1989). "Sexual Problems in the Elderly, II: Men's vs. Women's." *Geriatrics* **44**(3): 75-78, 86.
- Bedell, S. E., T. B. Graboys, et al. (2002). "Sildenafil in the cardiologist's office: patients' attitudes and physicians' practices toward discussions about sexual functioning." *Cardiology* **97**(2): 79-82.
- Bergstrom-Walan, M.-B. and H. H. Nielsen (1990). "Sexual expression among 60-80-year-old men and women: A sample from Stockholm, Sweden." *Journal of Sex Research* **27**(2): 289-295.
- Blake, D. J., R. Maisiak, et al. (1987). "Sexual quality-of-life of patients with arthritis compared to arthritis-free controls." *Journal of Rheumatology* **14**(3): 570-6.
- Bretschneider, J. and N. McCoy (1988). "Sexual interest and behavior in healthy 80- to 102-year-olds." *Archives of Sexual Behavior* **17**(2): 109-29.
- Brubaker, T. H. and K. A. Roberto (1993). "Family life education for the later years." *Family Relations: Interdisciplinary Journal of Applied Family Studies* **42**(2): 212-221.
- Burke, M. M. and J. A. Laramie (2002). *Primary care of the older adult: a multidisciplinary approach*, Harcourt Health Sciences Company. Mosby, Inc. (St. Louis, Missouri) ** 2000; 684 p.
- Butler, R. and M. Lewis (2002). *The new love and sex after 60*. New York, Ballantine Publishing Group.
- Casper, R. C., D. E. Redmond, Jr., et al. (1985). "Somatic symptoms in primary affective disorder. Presence and relationship to the classification of depression." *Archives of General Psychiatry* **42**(11): 1098-104.
- Chinichian, M. (2005). "Insights from a Canadian sexuality conference: Reflections of a midwife from Iran." *Canadian Journal of Human Sexuality* **14**(1-2): 57-59.
- Cicero Old Age. *Ancient History Sourcebook*.
- Clements, M. (1996). "Sex after 65 - A Groundbreaking National Survey." *Parade*: 4-6.
- Cogen, R. and W. Steinman (1990). "Sexual Function and Practice in Elderly Men of Low Socioeconomic Status." *Journal of Family Practice* **3**(2): 162-166.
- Croft, L. (1982). *Sexuality in Later Life: A Counseling Guide for Physicians*. Boston, PSG Inc.
- Davidson, J. (1985). *Sexuality and Aging. Principles of Geriatric Medicine*. New York, McGraw-Hill Book Company: 154-161.
- Deacon, S., V. Minichiello, et al. (1995). "Sexuality and older people: Revisiting the assumptions." *Educational Gerontology* **21**(5): 497-513.

- Deamer, R. L. and J. F. Thompson (1991). "The role of medications in geriatric sexual function." Clinics in Geriatric Medicine **7**(1): 95-111.
- Diokno, A. C., M. B. Brown, et al. (1990). "Sexual function in the elderly." Archives of Internal Medicine **150**(1): 197-200.
- Fooker, I. (1994). "Sexuality in the later years--the impact of health and body-image in a sample of older women." Patient Education & Counseling **23**(3): 227-33.
- Gelfand, M. M. (2000). "Sexuality among older women." Journal of Womens Health & Gender Based Medicine **9**(1).
- Gentili, A. and T. Mulligan (1998). "Sexual dysfunction in older adults." Clinics in Geriatric Medicine **14**(2): 383-93.
- George, L. K. and S. J. Weiler (1981). "Sexuality in middle and late life. The effects of age, cohort, and gender." Archives of General Psychiatry **38**(8): 919-23.
- Gill, K. and S. Ducharme (1992). Sexual Concerns of the Elderly. Practice of Geriatrics. Philadelphia, WB Saunders Company: 276-281.
- Ginsberg, T. B., S. C. Pomerantz, et al. (2005). "Sexuality in older adults: behaviours and preferences." Age & Ageing **34**(5): 475-80.
- Glaser, B. and A. Strauss (1967). The Discovery of Grounded Theory. Chicago, Aldine Publishing Company.
- Goh, V. H., C. F. Tain, et al. (2004). "Sex and aging in the city: Singapore." Aging Male **7**(3): 219-26.
- Gott, M. (2001). "Sexual Activity and Risk Taking in Later Life." Health and Social care in the community **9**(2): 72-78.
- Gott, M. (2005). Sexuality, Sexual Health, and Ageing. New York, University Press.
- Gott, M. and S. Hinchliff (2003). "Barriers to seeking treatment for sexual problems in primary care: a qualitative study with older people.[see comment]." Family Practice **20**(6): 690-5.
- Gott, M. and S. Hinchliff (2003). "How important is sex in later life? The views of older people." Social Science & Medicine **56**(8): 1617-28.
- Gott, M., S. Hinchliff, et al. (2004). "General practitioner attitudes to discussing sexual health issues with older people." Social Science & Medicine **58**(11): 2093-103.
- Guan, J. (2004). "Correlates of spouse relationship with sexual attitude, interest, and activity among Chinese elderly." Sexuality & Culture: An Interdisciplinary Quarterly **8**(1): 104-131.
- Hodson, D. S. and P. Skeen (1994). "Sexuality and aging: The hammerlock of myths." Journal of Applied Gerontology **13**(3): 219-235.
- Janus, S. and C. Janus (1993). The Janus Report on Sexual Behavior. New York, John Wiley.
- Kaiser, F. E. (2003 Aug). "Sexual function and the older woman." Clin Geriatr Med **19**(3): 463-72.
- Kligman, E. (1991 Feb). "Office evaluation of sexual function and complaints." Clin Geriatr Med **7**(1): 15-39.
- Laumann, E. O., R. T. Michael, et al. (1994). "A political history of the national sex survey of adults." Family Planning Perspectives **26**(1): 34-8.
- Leiblum, S. R. (1990). "Sexuality and the Midlife Woman." Psychology of women quarterly **14**(4): 495-508.

- Leigh, B. C., M. T. Temple, et al. (1993). "The sexual behavior of US adults: results from a national survey." American Journal of Public Health **83**(10): 1400-8.
- Levy, B. (1996). "Improving memory in old age through implicit self-stereotyping." J Pers Soc Psychol **71**(6): 1092-107.
- Levy, J. A. (1994). Sex and sexuality in later life stages, Rossi, Alice S (Ed). (1994). Sexuality across the life course. (pp. 287-309). xvii, 418 pp. Chicago, IL, US: University of Chicago Press.
- Lichtenberg, P. and D. Strzeppek (1990). "Assessments of institutionalized dementia patients' competencies to participate in intimate relationships." Gerontologist **30**(1): 117-120.
- Loe, M. (2004). "Sex and the Senior Woman: Pleasure and Danger in the Viagra Era." Sexualities **7**(3): 303-326.
- Marshall, B. L. (2002). "'Hard science': Gendered constructions of sexual dysfunction in the 'Viagra age'." Sexualities **5**(2): 131-158.
- Matthias, R. E., J. E. Lubben, et al. (1997). "Sexual activity and satisfaction among very old adults: results from a community-dwelling Medicare population survey." Gerontologist **37**(1): 6-14.
- Matthias, R. E., J. E. Lubben, et al. (1997). "Sexual activity and satisfaction among very old adults: results from a community-dwelling Medicare population survey... a paper presenting this research was delivered on November 2, 1994 at the American Public Health Association Annual Meeting, Washington, DC." Gerontologist **37**(1): 6-14.
- May and Riley (2002). "Sexual function after 60." Journal of the British Menopause Society **8**(3): 112-115.
- Mencken, H. L.
- Mooradian, A. D. (1991). "Geriatric sexuality and chronic diseases." Clinics in Geriatric Medicine **7**(1): 113-31.
- Morley, J. E., S. G. Korenman, et al. (1987). "Sexual dysfunction in the elderly male." Journal of the American Geriatrics Society **35**(11): 1014-22.
- Mulligan, T. and R. F. Palguta, Jr. (1991). "Sexual interest, activity, and satisfaction among male nursing home residents." Archives of Sexual Behavior **20**(2): 199-204.
- Mulligan, T., S. M. Retchin, et al. (1988). "The role of aging and chronic disease in sexual dysfunction." Journal of the American Geriatrics Society **36**(6): 520-4.
- Nusbaum, M. R. H., A. R. Singh, et al. (2004). "Sexual healthcare needs of women aged 65 and older." Journal of the American Geriatrics Society **52**(1): 117-22.
- Parkin, T. G. (2003). Old Age in the Roman World: A Cultural and Social History. Baltimore, The Johns Hopkins University Press.
- Poulakis, V., N. Ferakis, et al. (2006). "Erectile dysfunction after transurethral prostatectomy for lower urinary tract symptoms: results from a center with over 500 patients." Asian Journal of Andrology **8**(1): 69-74.
- Read, S., M. King, et al. (1997). "Sexual dysfunction in primary medical care: prevalence, characteristics and detection by the general practitioner." Journal of Public Health Medicine **19**(4): 387-91.
- Renshaw, D. C. (1988). "Sex and cognitively impaired patients: advice to give caregivers." Consultant **Mar**(28): 133-4.

- Smith, D. (2003). *The Older Population in the United States: March 2002*. Washington, D.C., US Census Bureau: 20-56.
- Smith, S. (2002, May 8, 2002). "The Elderly Freud." 23. from <http://www.rps.psu.edu/0205/freud.html>.
- Stall, R. and J. Catania (1994). "AIDS risk behaviors among late middle-aged and elderly Americans. The National AIDS Behavioral Surveys." Archives of Internal Medicine **154**(1): 57-63.
- Svetlik, D., W. K. Dooley, et al. (2005). "Declines in satisfaction with physical intimacy predict caregiver perceptions of overall relationship loss: a study of elderly caregiving spousal dyads." Sexuality and Disability **23**(2): 65-79.
- Tate, P. (2000). "Sex-lives and videotape: sexual history taking in primary care." Family Practice **17**(1): 100.
- Wellings, K., J. Field, et al. (1994). Sexual Behavior in Britain: The National Survey of Sexual Attitudes and Lifestyles. London, Penguin.
- White, C. B. (1982). "Sexual interest, attitudes, knowledge, and sexual history in relation to sexual behavior in the institutionalized aged." Archives of Sexual Behavior **11**(1): 11-21.
- Willert, A. and M. Semans (2000). "Knowledge and attitudes about later life sexuality: What clinicians need to know about helping the elderly." Contemporary Family Therapy: An International Journal **22**(4): 415-435.
- Zeiss, A. M. and J. Kasl-Godley (2001). "Sexuality in older adults' relationships." Generations **25**(2): 18-25.

Appendix A: Letter to Residents

Dear Resident,

I am a 4th year medical student at Yale University writing my senior thesis with Dr. Margaret Drickamer. Writing a thesis is a graduation requirement for every student at the School of Medicine. I have a special interest in Geriatrics, and have therefore chosen to write my thesis with Dr. Drickamer of the Yale Geriatrics Department.

In order to better understand the complete healthcare needs of older patients, my research will investigate the sexual health needs of patients as they age. If you are interested in discussing this topic with me, I will schedule a one-on-one interview with you at your convenience. The interview should last approximately 30 minutes and will be audiorecorded. For more information, please call 617-416-6823 or e-mail jana.colton@yale.edu.

Thank you for your time.

Sincerely,

Jana Colton

Appendix B: Interview Questions

"As you may know, I am a 4th year medical student at Yale writing my senior thesis on the sexual health needs of older patients. I will gather information on this topic by listening to your opinions and the opinions of other older patients. The interview today will be approximately 45 minutes long, consisting of mainly open-ended discussion questions. The goal of the interview is to better understand your opinions and experiences regarding your sexual health needs and what role you want your physician to play in meeting your sexual health needs. The interview will be audiorecorded through this microphone. All information you tell me will be confidential. If any of the questions I ask makes you feel uncomfortable, please let me know - you certainly don't have to answer if you don't want to. Do you have any questions before we start?"

- 1) What does the term “sexually active” mean to you? Are there any other aspects to being sexually active that you can think of?
- 2) Do you see yourself as sexually active?
- 3) What does the term “sexual health” mean to you? How do things like touch, intimacy, and companionship figure into your definition of sexual health?
- 4) Are you satisfied with your sexual health?
- 5) Do doctors ever talk to you about your sexual health? Which doctors? If yes, what kind of issues did you talk about?
- 6) Have your sexual health needs changed in the last 10-20 years? If so, how? How has the importance of sex changed over your lifetime?
- 7) What kinds of false assumptions do you think doctors make in regard to the sexuality of their older patients? Has a doctor ever made a false assumption about your sexuality or sexual health needs?
- 8) Has your doctor ever talked to you about possible sexual side effects of medicines he/she has prescribed? Have you ever experienced sexual side effects from a medicine, and if so, were you able to discuss this with your doctor? How do you feel about hearing about these side effects?
- 9) Do you have heart disease? Has your doctor ever discussed how this condition would affect your sexual health? Has a doctor discussed how other medical/psychiatric conditions (diabetes, arthritis, back problems, depression, lung disease, incontinence) or surgeries might affect your sexual health?
- 10) What does “sexual safety” mean to you?

- 11) Have you ever worried that your sex life might somehow be unsafe? Are you worried about injuries? Heart attacks? Sexually transmitted diseases? Have you ever discussed these concerns with a doctor?
- 12) Do you feel your sexual health needs are being met? Can you remember a time a doctor was helpful in treating a sexual health concern? Are there issues with your sexual health that you would like to discuss with your doctor but are afraid to ask?
- 13) Was there a time you discussed a sexual problem with your doctor, but little or no treatment was available or offered?
- 14) What prevents you and other older people from discussing sexual problems with a doctor? What could doctors do to make their older patients more comfortable to seek treatment for their sexual health issues?
- 15) When discussing your sexual health, does the doctor's age matter? Does it matter if the doctor is a man or a woman? Do you prefer to talk about this with your general doctor, urologist/gynecologist, or psychiatrist?
- 16) Do doctors treat men and women differently in terms of their sexual health? Do patients who are single get treated differently than married patients or patients in a long-term relationship?
- 17) If you have/had a partner, how does/did his/her health affect your sex life? Has anyone ever counseled you about that?
- 18) To what degree does your sexual health affect your quality of life? Is it as important to you now as it was when you were younger?

Demographics

- 19) How old are you?
- 20) Did you ever have a career?
- 21) What was your highest level of education?
- 22) Are you married or have you ever been married? If you are not married are you currently in a relationship?
- 23) Approximately how many lifetime sexual partners have you had?
- 24) Have you ever been diagnosed with depression and/or have you ever taken anti-depressant medications?

Appendix C: Tree Nodes For Subjects

DEMOGRAPHICS

- I. Site
 - a) Whitney Center
 - b) VA
- II. Interviewee
 - a) Male alone
 - b) Female alone
 - c) Couple
- III. Educational Background
 - a) Some High School
 - b) Graduated High School
 - c) Graduated College
 - d) Professional Degree
- IV. Lifetime Sexual Partners
 - a) 1
 - b) less than 5
 - c) 5-10
 - d) greater than 10
 - e) greater than 50
- V. Current relationship
 - a) married
 - b) dating
 - c) single
- VI. Depression
 - a) never
 - b) yes
 - c) yes and on psych meds
- VII. Age
 - d) 65-69
 - e) 70-74
 - f) 75-79
 - g) 80-84
 - h) 85-89
 - i) 90 +

DEFINITIONS/EXPERIENCES

- A. "Sexually Active"
 - 1) Libido
 - 2) Intercourse versus other sex acts
 - 3) Masturbation
 - 4) Touch
 - 5) Intimacy and Companionship
 - 6) other
- B. "Sexual Health"
 - 1) STDs
 - 2) Impact of Disease

- 3) Impact of Drugs
- 4) Dysfunction/Treatment of Dysfunction
- 5) Psychological
- 6) Aging
- 7) other

C. Identify themselves as sexually active

- 1) Yes
- 2) no

D. Satisfied with own sexual health

- 1) satisfied unconditionally
- 2) satisfied given age, but if younger, would not be satisfied
- 3) no
- 4) N/A
- 5) Satisfied with earlier sex life

E. Experience(s) with doctors talking about sex

- 1) Never discussed with a doctor
- 2) Has been discussed in relation to a medical condition
- 3) Has been discussed in relation to a medication
- 4) Has been discussed in relation to a procedure
- 5) Discussed only when topic raised by the patient

F. Quality of discussion

- 1) patient satisfied
- 2) patient dissatisfied

G. Issues pt would have liked to discuss with doctor but were afraid to ask

H. Barriers/Facilitators for Patients to discuss sex

- 1) Age of Doctor
- 2) Gender of Doctor
- 3) Specialty of doctor
- 4) No time in short visits to bring it up
- 5) Embarrassment/Discomfort of the Patient
- 6) Doesn't have a good relationship with the doctor
- 7) Sexuality of Doctor
- 7a) Interested in pt as a person

I. Barriers/Facilitators for Doctors to discuss sex w/ older patients

- 8) Age/Gender of the patient
- 9) Embarrassment of the doctor
- 10) Lack of Education
- 11) Poor relationship with patient
- 12) Assumptions
- 13) Timing/Approach during visit
- 14) Limited definition of sexuality
- 15) other

J. Suggestions for Doctors

- 1) Initiate a conversation
- 2) Make the patient comfortable
- 3) Written communication
- 4) Sexual health topics doctors should cover with older patients

K. The subjects perspectives of the attitudes of others on geriatric sex

- 1) peers
- 2) children
- 3) doctors
- 4) self
- 5) society

L. Areas of Further Research

M. Life Issues

- 1) Quality of Life
- 2) Life Partner