# Old People Are Still Doing It!

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## Abstract

Research suggesting that a high proportion of men and women remain sexually active well into later life refutes the prevailing illusion that ageing and sexual dysfunction are unequivocally linked. Age related physiological changes do not render a meaningful sexual relationship impossible or even necessarily difficult. Many of these physiological changes are modifiable. There are various therapeutic options available to patients to achieve maximum sexual capacity in old age.

In this article I review the physiological sex-related changes that occur as part of the normal ageing process in men and women. I address the effect of illness on sexual function. In addition, I will summarise the attitudes and perceptions of the media and general public towards sexual activity and ageing. An understanding of the sexual changes that accompany the ageing process may help general practitioners and other doctors to give practical and useful advice on sexuality as well as refute the misconception that ageing equates to celibacy. A thorough awareness of this aspect of older people's quality of life can raise meaningful expectations for ageing patients.


## Introduction

The proportion of people alive over the age of 60 years is growing faster than any other age group[1]. In the UK the population aged 65 years and older is set to increase by two thirds to reach 15.8 million in 2031[2]. Evidently, the healthcare systems around the world will have to learn to cope with the increasing needs of this sector of the population.

Sexuality is broadly defined as the dynamic outcome of physical capacity, motivation, attitudes, opportunity for partnership and sexual conduct[3]. Sexuality may include touching, caressing, fantasy, masturbation, physical closeness and the warmth created by emotionality[4]. Although sexuality is an important means of expressing love and caring in older persons[5] it receives scanty attention in the education and training of health care professionals and is rarely detailed when taking a history and conducting a physical examination. While much has been written about adolescent and adult sexuality, relatively little is available that highlights the nature of sexuality in older age groups.

## Sexual Activity of Ageing Men

Holden *et al* (2005) surveyed approximately 6000 men in Australia; this study reported 37% of men aged 70 years and older were still sexually active[6]. Baumeister *et al* (2001) surveyed a broad range of available evidence on the relative strength of sex drive and found that, by all measures, men have a stronger sex drive than women[7]. Lindau *et al* (2010) concluded that sexual activity, good quality sex life and interest in sex were higher for men than for women and this gender gap widened with age. Furthermore, sexually active life expectancy was longer for men, but men lost more years of sexually active life as a result of poor health than women[8]. An increasing number of older men, who retain fertility for life, have the desire for an active sex life and possibly children[9].

Among men, the most prevalent sexual problems are difficulty in achieving or maintaining an erection (37%), lack of interest in sex (28%), climaxing too quickly (28%), anxiety about performance (27%), and inability to climax (20%)[10]. Chew *et al* (2009) carried out a study in general medical practices in Australia and found that 52% of male attendees aged 60–69 years had experienced erectile dysfunction compared with 69% aged 70–79 years and 76% aged 80 years or older[11].

Sexual stimulation of the human male results in a series of psychological, neuronal, vascular, and local genital changes. Erection is the ultimate

response to multiple psychogenic and sensory stimuli from imaginative, visual, auditory, olfactory, gustatory, tactile, and genital reflexogenic sources, which affect several neurological and vascular cascades that lead to penile tumescence and rigidity for vaginal penetration. Significant changes in penile structure occur with ageing. The concentration of elastic fibres and collagen decreases with age. In addition, it is estimated that there is a decrease of up to 35% in the smooth muscle content of the penis in men over 60 years. Mechanical sensitivity of the penis is decreased. These changes may contribute to the development of erectile dysfunction in older men[12].

Therapies for erectile dysfunction include oral and non-oral treatments. Non-oral approaches include vacuum constriction devices, penile self-injection therapy, hormone injections, counselling, and penile prostheses. Oral therapy includes medications such as sildenafil[13].

## Sexual Activity of Ageing Women

The majority of the older population is female. By the year 2050, it is predicted that 65% of octogenarians will be women[14]. The 2006 Irish Census concluded that by age 85 years or older, there are 2.25 women for every man[15]. Thus, lack of opportunity may well account for a large proportion of the gender differences in prevalence of sexual activity.

### Clinical Points:

- The proportion of people alive over the age of 65 years is growing faster than any other age group; in the UK the population aged ≥65 years is set to increase by two thirds to reach 15.8 million in 2031.
- An understanding of the sexual changes that accompany the ageing process may help general practitioners and other doctors to give practical and useful advice on sexuality as well as refute the misconception that ageing equates to celibacy.
- Contrary to common misconception, sexual activity is still highly prevalent among people over 65.
- For ageing women, a decline in sexual interest and desire is frequently reported to be more severe than for ageing men.
- Female sexual dysfunction is divided into four categories: desire, arousal, orgasmic and sexual pain disorders.
- Male sexual dysfunction can include erectile, orgasmic or ejaculatory dysfunction. anxiety and libido problems.

The sexuality of older women is influenced by many factors including general physical and mental well-being, quality of relationship, life situation, marriage status, menopausal status, education, social class, stressors and self-perception[16-19].

One of the most significant periods in female reproductive ageing is the menopause. The menopause is the cessation of the menstrual cycle and signals the end of female fertility. 'Perimenopause' refers to the period when oestrogen levels begin to fall, follicle-stimulating hormone levels begin to rise, and menstrual cycles become variable. Postmenopause is considered to begin approximately one year after the final menstrual cycle[20]. Women live on average 30 years after the menopause[21]. This indicates the importance to healthcare providers of a thorough knowledge of postmenopausal health. Menopausal changes that arise from the loss of oestrogen include decreased vaginal lubrication, vasomotor symptoms, and neurologic and psycho-sexual changes including mood, irritability, anorgasmia, decreased libido and impaired sexual performance[22,23].

The prevalence of sexual dysfunction is high; Laumann *et al* (1999) reported 43%[24] while Lindau *et al* (2007) reported 50%[25] prevalence, illustrating the lack of progress in this area over the course of the decade. In the Yale midlife study (1990) 68% of 130 postmenopausal women reported sexual problems. Specific complaints included vaginal dryness (58%), dyspareunia (39%), as well as decreased clitoral sensitivity (36%), orgasmic intensity (35%) and orgasmic frequency (29%)[26]. In 1998, the American Foundation of Urologic Disease Consensus Panel classified female sexual dysfunction into four categories: desire, arousal, orgasmic and sexual pain disorders[26]. These include Hypoactive Sexual Desire Disorder, Sexual Arousal Disorder, Orgasmic Disorder and Sexual Pain Disorders such as dyspareunia (genital pain with intercourse) and vaginismus (involuntary muscle spasms of the outer third of

the vagina).

Therapies for female sexual dysfunction include dilators to improve dyspareunia, vaginal lubricants and topical or oral oestrogen may help with vaginal thinning and dryness[27].

## The Influence of Illness on Sexual Activity

Physical illness can affect sexual function directly by interfering with endocrine, neural and vascular processes that mediate the sexual response, indirectly by causing weakness or pain and psychologically by provoking changes in body image or self-esteem[28].

Males and females can experience sexual dysfunction secondary to diabetes mellitus, cardiovascular disease, hypertension, peripheral vascular disease and tobacco abuse[29]. Dysfunction is also associated with psychological disorders. Depression, low self-esteem, anxiety, obsessive-compulsive disorder, chronic stress and a history of sexual abuse can all negatively impact on sexual function[30]. Medications can also play a role; Feldman *et al* (1994) reported above-average prevalence for erectile dysfunction among men treated with vasodilators, cardiac drugs, antihyperglycaemic and antihypertensive agents[31]. Good health and high quality of life are strongly linked to a satisfactory sex life.

## Role of the Healthcare Professional in Sexual Activity and Ageing

Lindau *et al* (2006) reported in the U.S. that most women thought that doctors should ask about sex (75%), yet only 55% reported a doctor discussing sex with them since they turned 60 years[32]. It is likely that this figure is lower in the United Kingdom and Ireland. A study by De Boer *et al* (2005) in the Netherlands found that 85.3% of men with erectile dysfunction wanted help, but only 10.4% of men received medical care[33]. Reasons given by care providers for rarely initiating conversation about sexuality included: prioritisation of competing interests, limited time, sex not perceived as a concern of the patient and lack of expertise in the discussing sexuality issues. Providers assumed older couples would be less interested in sexuality and intimacy, yet these issues were raised as important uniformly among patients and spouses of all ages[34].

Physicians can provide education about alternative means of achieving intimacy with old age such as masturbation, alternative positions for intercourse, holding or kissing[35]. An understanding of the sexual needs of older people should become an integral part of the training and continued education of health care professionals. This should improve patient education and counselling, as well as the ability to clinically identify a highly prevalent spectrum of health-related and potentially treatable sexual problems.

## Attitudes towards Sexual Activity and Ageing

Many people and the media have a negative attitude toward sexuality and ageing[36-38]. In reporting the findings by Lindau *et al* (2007) on sexuality and health among older adults, NBC wrote “many older people are surprisingly frisky” and older people take part in “intimate acts that would make their grandchildren blush”[39]. Holden *et al* (2005) concluded that older persons tend to be excluded from studies because they are considered to be at a low risk of HIV/AIDS, have negligible contraceptive needs and are often perceived to be sexually inactive[40].

Attitudes towards sex are both a product and a cause of social and sexual experiences, choices and behaviours. Negative societal attitudes about older people’s sexuality may inhibit the discussions between patients and their doctors[41]. With the existing stereotypic image of older people being sexually inactive, improved research, education and policy is needed to ensure that age-related barriers to seeking information and treatment for reproductive health issues do not persist for older adults.

# Conclusion

I conclude that regular sexual activity is a normal finding in advanced age. Many older men and women are sexually active despite the increase of sexual dysfunction with age; appropriate consideration must therefore be given to the needs of the ageing population in the planning and delivery of healthcare, institutional and support services to help sustain their right to a sex life after 65. The last few decades have seen a marked increase in mean life expectancy in the developed world. This has made older people and their quality of life a matter of ever-increasing medical concern. It is imperative to understand the sexual behaviour and concerns of older adults and to ensure that education programmes, research, policy and services are available to both the public and professional communities in order to provide a more comprehensive service to this growing sector of the population.

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