Aging, Sexuality and Relationships

By Tyler Buchiero, LCSW and Pebble Kranz, MD, FECSM, IF

It's a typical day in the office. One of your dearest long-term patients, an 85 year-old woman who is recently widowed, says shyly at the end of her routine visit, "I have one more thing I'd like to discuss. I'm in a new relationship that is giving me great joy. He's a wonderful companion. Our relationship is going in a new direction recently, and we are getting more 'intimate'… I've noticed some vaginal dryness and itching and the last time we had sex it was pretty painful."

Family physicians naturally find themselves on the front lines of a wide variety of health struggles including our patients' concerns about sex. As population trends skew towards people aged 65 and over, the role of primary care in promoting sexual health conversations and facilitating patients' optimal sexual experiences rises. Indeed, aging trends suggest that people aged 65 and over are expected to number 77 million in 2035.[1] An often overlooked, yet chief component of health in later life is the desire and need to be close to others as we age, which may include the desire to continue an active, satisfying sex life.

Lindau et al found that almost half of partnered older adults engage in sexual activity and more than two thirds engaged in a variety of forms of physical tenderness. They found that overall greatest barrier to being sexually active at an older age is lack of a partner, which particularly affects women, but that 73% of 57-64 year-olds engage in some form of sexual intimacy, 53% among 65-74 year-olds , and 26% among 75-85 year-olds.[2] A 2022 Belgian study found that 31% of 70-99 year-olds participated in some form of sexual play and that 47% of those non-sexually active experienced some form of physical tenderness (cuddling and kissing).[3] Given these statistics, and other data that indicate that only about a third of primary care providers engage their patients in conversations about sexual function and satisfaction, we may be missing a major opportunity to engage our patients on a topic fundamental to their current life experience.

Unfortunately, healthcare communication about sexual issues is not occurring with a frequency one would hope. Wimberly et al found that while almost three in five primary care providers asked about sexual activity at a routine visit, many fewer (12-34%) asked about important aspects of sexual health such as asking about partners or about sexual orientation. They ultimately concluded that sexual histories as part of routine and preventive healthcare are less common, and many physicians miss essential components of a comprehensive sexual history.[12] Sexual histories tend to focus on STDs and reproduction and even fewer primary care providers are discussing sexual function and satisfaction with their patients of any age. The rates of sexual history taking were even less for geriatricians. In a study of 120 geriatricians regarding the frequency of sexual history taking, 76 (63.3%) of the total group were of the opinion that sexual history taking should not be routine, 32 (26.6%) thought it should be routine, and 11 (9.1%) would take a history where they felt it was appropriate.[13]

Meanwhile, sexuality remains paramount for many older adults seeking primary care services and in multiple studies, it is clear that patients want their health care providers to be the ones to raise the topic. Existing as a sexual being can be a major aspect of continued life satisfaction. A handful of studies have indicated that an active and trouble-free sex life may be associated with reduced risk of disease outcomes among older adults.[4] A US study of 1046 men and 1158 women (aged 57-85 years) indicated that the frequency and quality of sex protected against cardiovascular events in later life and has also been shown to be associated with reduced risk of fatal coronary events, and prostate and breast cancer.[4] Moreover, sexual activity is a form of physical activity and is associated with positive mental and physical health.[5] Many relational benefits exist as well, as sexual activity can act as a bulwark against the social isolation that older adults are more likely to experience, thus reducing mental health comorbidities as well.[6] In this way, focus on the sexual heath of older adults in primary care may augment preventative and responsive care already being provided. Ultimately, simply having these discussions with older patients may be an effective way to improving health outcomes in these patients.

What then is the role for family medicine in sexual health interventions for older adults, and what are the barriers?

Our role, to begin with, may seem clear; that providers need only initiate these discussions with their patients about their sexual health and wellbeing, including asking questions about sexual function and satisfaction. These conversations must go beyond generalized screeners on most pre-appointment patient forms. Indeed, the presence of questions about sexual function and satisfaction on most screeners is rare, and even then, rather vague. Even when there are specific screener questions about sexual function and satisfaction, it may be rarer still that there is follow up during the appointment. This leaves practitioners and patients in a difficult situation. By appearing to

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open the door with screener questions focusing on sexuality and then failing to follow through with greater discussion in session, we may inadvertently send the message that discussion of sexuality is neither an appropriate use of time nor of great importance.

The question of why sexuality topics are avoided is a multifaceted one. A questionnaire survey of 133 GPs reported that most participants identified more than one barrier to sexual health conversation, with the most commonly cited barriers including concerns about their own knowledge and expertise in this area, fears of opening a 'floodgate' and personal embarrassment.[7] Similarly, a questionnaire survey of 234 nurses identified similar barriers, including lack of time, lack of training, and concerns about not being able to cope with the issues raised by the patient.[8] These studies were focused on sexual health discussions in a range of patient populations and there may be further barriers when considering sexual health conversations with older adults. There are significant misperceptions about the importance of later life sexuality including the culturally driven idea that sexuality and old age are often seen as incompatible. Societal images of sexuality revolve around youth, ability, and health, often to the exclusion and marginalization of groups not fitting that narrow profile. In summary, it seems that the primary barriers are both internal (erasure and the taboo of sexuality in later life) and external (lack of training for family medicine practitioners with emphasis on the specific sexual needs of older adults). Those who work in family medicine have a unique opportunity to improve quality of life for their older adult patients through recognition and challenge of these internal biases and pursuing education as to the sexual health needs in later life.

Sexuality does change with age. It is simply not going to look the same as it did for our patients in their 20's and 30's. Older adults often must adapt sexual activity to accommodate changes in physical health. For instance, circulatory and neurologic conditions may contribute to changes to arousal, with concerns such as erectile dysfunction and decreased vaginal lubrication. Hormonal changes with age may have an impact on all phases of sexual function including desire, arousal, and orgasm. Untreated genitourinary syndrome of menopause, previously termed "vulvovaginal atrophy," as well as vulvar dermatoses, may lead to either sexual pain or persistent and unwanted feelings of genital arousal (called persistent genital arousal disorder/genitopelvic dysesthesia). A wide variety of chronic health conditions, more prevalent in older adults, may also impact the hormonal, neurologic, vascular, or musculoskeletal physiology necessary for desire, arousal and orgasm. Additionally, the treatments for cancer and other chronic health conditions may cause anatomic, neurologic, and hormonal changes altering sexual function. The embarrassment and inconveniences associated with fecal and urinary incontinence can affect sexual behaviors and satisfaction. There may need to be adaptations to bowel or bladder incontinence, as well as adaptations to joint mobility and stiffness limiting positioning or even cognitive changes or dementia.[9]

While all this may seem insurmountable, solutions exist for many of these changes in sexual functioning – from proactive assessment and treatment of genitourinary syndrome of menopause to the use of PDE5i medications to adjustments of medical regimens to facilitate sexual function. It's equally important to understand that changes and differences in anatomy and physiology need not have ANY effect on sexual pleasure. Sexual pleasure is healthy in ALL bodies and is a dynamic and adaptable human process.

Family physicians can help their older adult patients simply by opening the discussion on sexuality. This includes assessment of sexual function and satisfaction including normal aging changes, disability, chronic health issues, medications, and environmental factors, and how these changes may be impacting a patient's ability to have the sex that they want and deserve.

Furthermore, the sexual activities that older adults are more likely to engage in will again look different. For example, older adults are less likely to engage in penis-vagina intercourse with a greater emphasis instead on oral sex and other forms of sexual play. The function of all these sexual behaviors remains the same; to express intimacy, feel connected, please their partner, and feel pleasure themselves.[10] There also needs to be consideration of sexual risks for older adults, as there is a statistically elevated presence of STIs in a population less accustomed to including barrier methods in their sexual behaviors.

If older adults are already a de-eroticized population, than the intersectional stigma of LGBT+ older adults is all the more so. APA reports that more than 39 million people in the U.S. are age 65 years or older including 2.4 million people who identify as lesbian, gay, bisexual or transgender (LGBT). As the baby boomer generation ages, the older adult population will increase from 12.8 percent to an estimated 19 percent in 2030.[11] Adding to the disproportionate impact of mental health concerns and societal stressors they are already at risk of experiencing, LGBT+ older adults may find greater difficulty in accessing competent and affirming services in primary care, in sexual health as well as other aspects of their healthcare needs.

Fortunately, the practice of avoiding sexual conversations with our older adult patients is alterable. At least insofar as providers are able to manage their own internal discomfort. The intervention, simply, is to ask all of our patients – at multiple times and in multiple ways. The goal here is twofold; to build internal comfort with the inquiry and to create a culture of openness with our patients. When we engage with them about their sexual health with genuine curiosity and a commitment to their pleasure, it communicates that we feel it is worth the time. The conversation should be started by the provider, which requires getting permission to have a sexual health conversation that is non-pressuring and shame free. In fact, demonstrating such curiosity to a patient's sexual life can be a healing and destigmatizing intervention in itself. The assumption must be that all of your patients are having some kind of sex and that many would value the opportunity to share some concerns.

In the event that the patient responds with a sexual health concern, or merely wishes to share that all is going well, the way that we engage subsequently sets the tone for the overall helpfulness of the intervention. Remember, providers need not have all of the answers or a remedy in that very moment. The most important thing is establishing oneself as a resource to patients; somewhere they can turn for conversations that might otherwise be awkward. Notably, we want to hold to some principles of clear communication while discussing sexual health with patients. Using specific language as

providers and inviting our patients to do so as well helps to set the tone for collaboration and relaxed conversation. The priority is to get to the bottom of their concern, in which case providers may need to use facilitating language. "Would it be alright with you if we talked a bit more about your sexual experience? Your overall health, including sexual health, is important to me. You can be as candid with me as you would like and use what language feels best to you, and we will figure it out along the way." "Many of my older adult patients have questions and concerns about sexual function and satisfaction, do you have any questions or concerns?"). Practice in maintaining an ethos of openness and specificity helps to dispel both the provider's own discomfort and the patient's.

Knowledge of where to turn for patients whose sexual concerns remain unresolved is also important. Sexual medicine specialists can be found in provider listings for several national and international organizations (International Society for the Study of Women's Sexual Health (ISSWSH), Sexual Medicine Society of North America (SMSNA), and the International Society of Sexual Medicine (ISSM)) and certified sex therapists can be found in provider listings for the American Association of Sexuality Educators Counselors and Therapists (AASECT) and the Society for Sex Therapy and Research (SSTAR). Menopause specialists can be found at National American Menopause Society (NAMS). ISSWSH, ISSM, SMSNA, and NAMS also offer excellent educational opportunities for family medicine providers who want to learn more about these important, and undertaught, areas of medical care.

It can be difficult in primary care to overcome the constraints of time, practice, as well as how many of us have been socialized. However, conveying to patients our genuine interest and openness to their sexual health concerns must begin to take a more prominent place in the care we provide. Not just for the clear health and relational benefits, but also in the hopes that we can shift the larger conversations and care around sexual health to be inclusive, competent, and in pursuit of the sexual pleasure all people deserve.

Endnotes

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