Sexuality in older people

Sexuality in older people is affected by various factors including, sexual physiology in old age, physical illness, medication and mental illness; therefore, a thorough sexual history should form part of a comprehensive psychiatric assessment. Also, several sexual problems arise in people suffering from dementia, which range from decreased sexual activity to inappropriate sexual behaviours. Management of inappropriate sexual behaviours include psychological and pharmacological interventions.

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Sexuality is an essential part of any person, and expressing it is a basic human need and right regardless of age, gender, ethnicity, religion, disability or sexual orientation. However, sexuality is a difficult concept to define. Even when it becomes a topic of academic research, it is rarely explicitly defined.

Hogan[1] argued that sexuality comprised: "Much more than the sex act; the quality of being human, all that we are as men and women." Hillman[2] tries to clarify this further by defining sexuality as a broad-based term that indicates any combination of sexual behaviour, sensual activity, emotional intimacy or sense of sexual identity. Any individual's wish to engage in any of these activities can also be considered as an aspect of sexuality. Thus sexuality encompasses a vast number of issues including body image, masturbation, love, libido, intercourse, homophobia, relationship satisfaction, marital satisfaction, and desire for sexual or sensual experience.

Liberalisation of the western society has led to more positive and less restrictive attitudes and views in the population regarding many aspects of sexuality, including later life sexuality. This is reflected in a large number of studies in recent years exploring sexuality and ageing. However there is a clear absence of national policies, directives and research in the UK that focus on the sexuality and sexual health of older people. Neither the *National Service Framework for Older People*[3] nor the *National Sexual Health Strategy*[4] make any reference to sex or sexual health in later life.

There are many myths about sexuality and older people, and these affect how society views sexuality in this age group. For example, "older people are asexual" or "after 60 years, sex is unimportant and rarely indulged".

Myths regarding sexuality usually arise from social, political, religious, cultural, and moral values and the media's portrayal of later life sexuality. Most of the research shows predominantly negative views about sexuality in older people. However recent studies reflect society's increasingly liberal attitudes towards ageing sexuality.[5]

Views about sexuality

Early studies of young people's attitudes towards sexuality in older people showed that they thought that sex was "negligible and unimportant" for older people.[6] La Torre[7] found, in 1977, that people viewed sexuality activity in older people to be significantly less credible and less moral than sexual activity in younger people. But in the 1980s, studies of younger people's attitudes indicated that they viewed the sexually active older person as significantly more mentally alert, cheerful, and better adjusted, with

warmer family relations, than the sexually inactive older person.[8,9]

A decade later, Pouline and Mishara compared the attitudes of adult children towards the sexuality of their older parents with their parents' own attitudes toward sexuality.[10] They found the attitudes toward sexuality were positive both among the parents and their children. However, the adult children had significantly more positive attitudes than their parents, which may be reflective of a difference in attitude between younger and older generations.

Some older people may view themselves as being too old for sex. This might be because of society's values at the time of their upbringing; for most older people, during their youth, sexual health information was not readily available and not widely discussed. In the 1950s, older people had poor self image and saw themselves as being less attractive than younger people.[2] Their attitudes were conservative and they felt uncomfortable about discussing sex with an interviewer. One of the largest samples studied in 1984 for later life sexuality found that the majority of older people had a positive attitude towards later life sexuality.[11]

Unfortunately, negative attitudes towards sexuality and old age are not uncommon among health professionals today. Ageist stereotypes have affected the development of health policies (eg, the NSF for older people).

Assessment of sexual problems

The effects of mental illness on sexual functioning, the psychological impact of sexual dysfunction on mental health, and the effects of psychotropic medication on sexuality all suggest that high rates of sexual dysfunction will be found among psychiatric patients.[12,13]

The prevalence of sexual problems is likely to be higher in older people with mental illnesses than it is in younger people with mental illnesses because there is an increased sensitivity to side effects of medication, and because of the effects of ageing and physical illness on sexual responses. Hence a comprehensive psychiatric assessment should include a thorough sexual history, subject always to the consent of the patient.

However, many clinicians lack confidence about their ability to take an appropriate sexual history. This is possibly because of feelings of embarrassment and ambivalence in clinicians and patients, which produces a reluctance to raise the topic. At times, this can lead to complete avoidance of the issue. However, Ende[14] noted that more than 91% of patients think it is appropriate for the doctor to take a sexual history.

Risen[15] and Tomlinson[16] give an account of the principles of taking a sexual history. These principles are the same whatever the age of the patient (see box 1). Further assessment of a sexual problem should take place when appropriate. These include the following.

- A thorough physical examination
- Blood investigations including a full blood count, liver function, thyroid function, fasting blood glucose, cholesterol, prolactin, testosterone and sex hormone binding globulin (SHBG)
- Use of validated self-report questionnaires, such as the Golombok Rust Inventory of Sexual Satisfaction (GRISS),[17] The Brief Index of Sexual Functioning for Women (BISF-W)[18] and The International Inventory of Erectile Dysfunction (IIEF).[19]

The IIEF also measures response to treatment. When the assessment is completed, a careful and unhurried explanation should be given to the person (or couple) concerning the nature of the problem and the predisposing, precipitating and maintaining factors that may be present. This should be presented in a way that does not lay blame on anybody. The formulation of the problem is followed by time and encouragement for the person (or couple) to ask questions, through which the doctor is satisfied that they understood what has been said.

Sexuality and mental illness

Various mental disorders can cause problems with sexuality. Patients suffering from depression have loss of sexual interest and desire. Depression can also cause inability to have an erection in men and loss of vaginal lubrication in women. However, sexual activity can provide a sense of comfort and positive emotional and physical response, which may ease the depression.[20] Those suffering from alcohol abuse, bipolar disorder and schizophrenia can have impaired decision making and perhaps increased sexual arousal and disinhibition.

The development of dementia does not erase sexuality, but it can alter the way it is expressed and perceived by both the person and

their partner. Sexual problems are not uncommon in dementia, although the professionals often fail to address this in the assessment unless the carer and/or sexual partner raises the issue first.

Box 1: Principles of taking a sexual history

- Ensuring that the patient is in a private comfortable clinic room, which is free from interruption
- Assuring patient of complete confidentiality
- Interviewing both partners in a relationship where possible, both separately and together
- Establishing a language that is comfortable for the patient and the clinician where information can be exchanged
- Using open and non-threatening questions first that enables the patient to reflect on their sexual functioning
- The ideal time for taking a sexual history is at the time of collecting psychosocial history and developmental information
- Taking a longitudinal view of sexual development and the onset of the problem
- The importance of medical and psychiatric history
- Formulating the problems in terms of predisposing, precipitating and maintaining factors; presenting the formulation to the patients and ensuring that the patient (or the couple) have understood it and find it acceptable.

Sexuality and dementia

Sexuality within the context of cognitive impairment is regarded as a particular problem. Professional concerns are reflected in, and reinforced by, the fact much of the literature in this area highlights problems of inappropriate or uncharacteristic sexual behaviours among people with dementia. However, the limited data available indicate that such behaviours are actually relatively rare. Burns[21] found sexually inappropriate behaviour expressed among only 12 of 178 patients with dementia with no differences by gender. Derouesne[22] reported the results of a questionnaire about sexual relations before and after the onset of Alzheimer's dementia. Indifference to sexual activity was common among patients (63% of respondents). Most respondents who reported a change in sexual activity noted a decrease in such activity. Increased sexual demands were rare in this study (only 8% of respondents), but this problem may be more common in other types of dementia, especially frontal lobe dementia and Pick's disease.[6]

Duffy[23] interviewed 38 couples in which one partner had Alzheimer's disease over a one-year period to assess the impact of the disease and its progression on the couple's pattern of sexual behaviour. Most of the healthy partners stated that the sexual relationship had changed since the onset of the disease. There were few reports of behaviours characterised as bizarre or inappropriately expressed outside the marital relationship. Common sources of distress were awkward sequencing of sexual activity, request of activities outside the couple's sexual repertoire and lack of regard for the sexual satisfaction of the healthy partner. Other problems included loss of sexual interest, increased sexual demands, and inadequate sexual advances by the patient with dementia.

While sexually disinhibited behaviours are expressed by a minority of people with dementia, they will be of great concern to the families and carers of patients who display them.

Inappropriate sexual behaviour is defined as sexual behaviours that are not suited to their context and that impair the care of the patient in a given environment.[24] The fine distinction between appropriate and inappropriate behaviour often depends upon the values and attitudes of the staff and the relatives of the patient concerned. Various authors have tried to classify inappropriate sexual behaviours into common types (box 2).[24,25]

A thorough assessment of the type of behaviour is very important to formulate a management plan. This includes the type of behaviour, its frequency, when and where they occur and with whom. A simple and most commonly used method of recording behaviours is the ABC system, where staff records the antecedents (A), behaviour (B), and consequences (C).

The management mainly involves psychological interventions, and pharmacotherapy should only be used when all other

interventions have failed. The main psychological intervention consists of behavioural modification that includes a range of approaches, such as removing reinforcement of the undesired behaviour and increasing the reinforcement of the desired behaviour and using distraction techniques. Some may benefit from avoidance of an external cue such as an over stimulating radio or television programme, and others may benefit from wearing modified clothes that make it difficult to undress if they tend to expose themselves or masturbate publicly.

Currently no medication is licensed in UK for the treatment of inappropriate sexual behaviour in patients with dementia. Serotonin reuptake inhibitors, antipsychotics, mood stabilisers, and hormonal agents, such as anti-androgens, oestrogens and luteinizing hormone releasing hormone (LHRH) agonists are some of the classes of medication that are found to be helpful. This requires specialist input and close monitoring of the patient.

Mental capacity and sexuality in dementia

It is not an uncommon occurrence, particularly in an institutional setting like a residential or nursing home, for a patient with dementia to attempt to start a sexual relationship with a new partner. This presents ethical dilemmas for health professionals and relatives as they debate the mental capacity of the couple to consent to sexual activity. Teitelman and Copolillo[26] suggest that for some people with dementia, impaired judgement and limited awareness may mean that they are vulnerable and unable to achieve a fully informed decision when it comes to sexual activity with a partner. Older people should be protected if they are unable to make an informed decision but at the same time, staff and carers should be careful about making proxy decisions for the person when they are unable to consent. Whether a non-competent patient should be allowed to have a sexual relationship is a difficult decision, and this should be carefully considered in the light of the person's background and previous choices, and the nature of the contact. A discussion with the all the relevant parties and family may be helpful.[6]

If, on the other hand, a patient is deemed competent to understand, consent to and form a relationship with another competent adult, then staff have a role in supporting the patients' decision.

Box 2: Inappropriate sexual behaviour

- Inappropriate sexual talk: this involves using sexually explicit language in a manner that is out of keeping with the patient's pre-morbid personality
- Sexual acting out: these include clear sexual acts that occur inappropriately, either solitary, or involving staff or other residents, in private or in public areas. Examples are acts of grabbing, exposing, publicly masturbating and fondling, making sexual advances towards staff, and getting (uninvited) into bed with other residents
- Implied sexual acts: these include openly reading pornographic material or requesting unnecessary genital care
- False sexual allegation: these may occur as part of various psychopathological symptoms occurring in dementia such as hallucination and delusions. The possibility that the patient's allegation is true must always be considered.

Sexual abuse

There is not much written in the literature regarding sexual abuse in elderly but the general consensus seems to be that this type of abuse may occur more frequently than is generally recognised.[6] Generally, sexual abuse may happen to any older person in any setting, at home or in any institution, perpetuated by family members, formal or informal carers or staff, or complete strangers. Haddad and Benbow[25] define sexual abuse in the context of dementia as occurring when an individual initiates a sexual relationship with a person with dementia without that person's informed consent. People with dementia may be physically frail and may not be able to resist sexual advances, and may not be able to report abuse when it occurs. Sexual abuse could be easily missed without a high index of suspicion and addressing the issues explicitly. Clear policies and procedures for monitoring and protecting vulnerable older people in care facilities should be in place.

Conclusion

Sex is a difficult topic to discuss with older people. Society's attitudes towards sexuality in later life and attitudes among older people themselves lead to unrecognised sexual problems in this age group. Professionals often fail to recognise these problems for various reasons, including lack of training, their own beliefs about sexuality in later life and sexual health priorities not perceived as being relevant to older people. Sexual problems are more likely to occur in older people with mental illness. This might be because of the condition itself (eg, depression causing reduced sexual desire) or from the treatment (eg, orgasmic problems with selective serotonin reuptake inhibitors). The onset of dementia does not automatically erase sexuality but it tends to alter sexual behaviour and expression. Inappropriate sexual behaviour in dementia can be assessed by ABC techniques and should be managed through non-pharmacological methods first. Capacity and consent issues may arise when in people suffering from dementia, especially when they develop new sexual relationships.

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