ISSN 2348-9995

Volume 1 | Issue 1 | Jan-Jun 2014

Journal of geriatric Mental Health

JGMH

Official Publication of
Indian Association of Geriatric Mental Health

Wolters Kluwer

ORATION PAPER

Forbidden fruit in the golden years: Elderly sexuality

Telkar Srinivasa Sathyanarayana Rao

Department of Psychiatry, JSS Medical College, JSS University, Mysore, Karnataka, India

"Those who love deeply never grow old, they may die of old age but they die young"

~Sir Arthur Wing Penero

Mr. President and esteemed members of Indian Association for Geriatric Mental Health. I am really honoured to receive Dr. Shiv Gautam Oration Award for the year 2013. I am grateful to the Award Committee for choosing me for this Oration Award. I have chosen the topic of elderly sexuality as this is one of the most neglected area in general and this aspect of relationship and intimacy in geriatric population is hardly emphasized.

Across all civilizations, old age is viewed as a repository of wisdom, tradition, and cultural memories. The aged have been labelled as disengaged from the community, lacking in self-esteem, sexless and unattractive, burdened by physical and mental disorders. They are also considered as dependent and passive, expecting economic and social support…a notion further emphasised by the media.[1]

Human sexual behavior implies to the expression of sexuality which is a multidimensional concept, a bio-psychosocial phenomenon. Intimacy is a must for a successful relationship and involves trust, loyalty and love. Sexuality is a life-long process and goes against the common misconception that elderly are asexual individuals.[2] A taken-for-granted premise is that it is not quite acceptable for older people to have sexual needs or to indulge in the act. Evidently, with such wide spread and deep rooted denial of the validity of sexual expression in the 'golden years' of life, sex remains indeed 'a forbidden fruit', for many, being a source of confusion and frustration as age advances, with a sense of impending gloom and doom![3]

Access this article online	
Quick Response Code:	Website: www.jgmh.org
	DOI: 10.4103/2348-9995.141917

ROLE OF INTIMACY IN SEXUAL BEHAVIOUR

What is Intimacy? Although the systematic study of intimate relationships is fairly recent, social thought and analysis of intimate relationships dates back to early Greek philosophers.[3] Most people confuse love, closeness and intimacy. Derived from the Latin word *intima,* meaning inner or innermost, *Webster's Dictionary* goes on to defining intimate as 'belonging to or characterizing one's deepest nature; suggesting informal warmth or privacy; of a very personal or private nature'. *Contra-sexual transition,* a term given by Carl Jung, occurs typically at midlife when men and women cross sexual and psychological paths; men become more intimate in their relationships whereas women become more assertive and independent. In broad terms Love "is a strong feeling of deep affection"[4] Sternberg has described three components of love: Intimacy, commitment and passion.[5]

Some key ingredients like romance, affection and intimacy continue into the golden years of life and result in rich harvests of enjoyment and nurturance. Relationships mature and change over time. The pleasures and priorities turn into interests and hobbies in a spirit of accommodation. Exploring many shared interests together is an important step to start as well as strengthen relationships. Some of the characteristics of high quality relationships include companionship, supportive communication, sexual expression, empathy

Corresponding Author:
Dr. TS Sathyanarayana Rao, Department of Psychiatry, JSS Medical College, JSS University, Mysore, Karnataka, India.
E-mail: tssrao19@yahoo.com

and compassion.[6]

Characteristic traits of matured individuals as supported by Allport[7] are:

- Objective view of self
- Ability and willingness to extend sense of self
- Warm relating of self to his/her environment
- Emotional security including self acceptance
- Realistic perceptions, skills, assignments and expectations
- The unifying philosophy of life- finding a feasible, personal theory of life's meaning.

Factors affecting sexual arousal and response in the elderly include:

Psychological factors

- Moods, fantasies, expectations, performance demand
- Sexual experience and responsiveness
- Habituation

Physical

- Atmosphere of comfort and emotional safety

Biological

- Hormones

The study of biology-anatomy and physiology of reproduction and the psychology of sexual behavior has made us realize that an individual's sexual behavior is influenced by both genes and the environment. Hormones have proved to be the propellants of human sexual behavior; with complex interplay between testosterone, oestrogen, dopamine, vasopressin and oxytocin. Individuals identify themselves as man or woman based on the sociocultural conditioning.[8] Human sexual behavior is thus a bio-psycho-social phenomenon.

The impact of menopause on female sexuality is immense. The changes accompanying menopause include physiological, anatomical and hormonal, mainly, lowered levels of estrogen. Mood swings become a predominant feature at this time. Sometimes depression and/or anxiety may also be seen, often without a precipitating cause in the psychosocial milieu. Anger and/or irritability may lace the relationship when there is apparently little or no reason. Difficulty in concentration, changes in sleep pattern, appetite, osteoporosis and irregularity in the menstruation cycle may also be observed. Occurrences of diminished vaginal secretion and hot flashes can be some of the changes quite disconcerting, causing discomfort to various degrees.

Although hormone replacement therapy is advocated, immediate psychological management in the form of correcting emotional dysregulation is essential. Kaufert[9] observed that a large number of factors in a woman's wider psychosocial atmosphere also influence whether she is prone to depression during menopause. Studies by McCoy[10] indicate that vaginal dryness and diminished lubrication usually begin about 2 years before a woman's last menstrual cycle with declining sexual interest and diminished frequency of intercourse occurring within a year.

Andropause (the supposed male counterpart of menopause) differs significantly from menopause in various aspects. Particularly, there is no clear end point to most men's fertility, nor there is any abrupt fall in male hormone levels. Lower androgen levels begin to manifest in ways such as lessened muscle mass and muscular strength, decreased bone mass, diminished pubic hair, low sex drive and plummeting frequency of sexual intercourse.

This discourse would be incomplete without a mention of 'Aphrodisiacs'. With its roots in "Aphrodite", the Greek goddess of sensuality and love, an aphrodisiac is a substance used in the belief that it enhances sexual desire. Some of the common foods appearing in this category are avocado, chilli, chocolate, celery, fig, drumstick, nutmeg, fennel, garlic, licorice, honey etc.

The use and dependence on drugs and substances such as alcohol, negatively impacts sexual health, in the elderly to a much greater extent , as compared to the young. Thanks to growing awareness about balanced diet and health enhancing life style changes. Older people are accounting for a progressively larger segment of the population in almost all nations. Sexual cha(lle)nges in the golden years are closely related to those that occur during normal aging. According to Segraves and Segraves,[11] sexual function is influenced by the availability of a partner, the relationship with that partner and the partner's general health.

It has been an established fact that one's level of sexual intimacy in later life is an echo of one's sexual behaviour in earlier years.[12] Sexual feelings and their expressions are, more often than not, echoes of one's wider social incinations and the significant figures in it. A study suggested that for the older man, sexual performance

and attractiveness to the other sex appeared to be crucial for engendering feelings of well-being. For the older women, feeling sexually attractive to the other sex was more important.[13]

Developing awareness about normal and sexual aging may help older people avoid falling into the trap of 'unrealistic expectations'.

Myths and Misconceptions

Many sexual myths and stereotypes work against older people and challenge whether the expression of sexuality in old age is appropriate. The notion that sexuality is a lifelong process goes contrary to the thinking of some elderly people, their children, and health care providers.[8]

Society devalues older people's sexuality with humor, ridicule and distaste.[14] Kass theorized a *Geriatric Sexuality Breakdown Syndrome* through which elderly people internalize the negative attitudes to which they are exposed and perceive themselves as nonsexual.[15] Masters and Johnson[15] discovered that "human sexual response may be slowed by the aging process, but it is certainly not terminated". Some common myths include:

1. The quality of sex declines for both men and women as they age.
2. If a women does not lubricate sufficiently or a man does not become erect immediately, he or she is not aroused.
3. Erection problems are inevitable and incurable without medical intervention.
4. Female desire declines dramatically after menopause.
5. Once a man is no longer aroused by the mere sight of his wife, he will have great difficulty making love to her.
6. Men peak in their teens.
7. Women peak in their 30's.
8. Youthful orgasms are more intense.
9. Sex has to end in orgasm.
10. Oral sex is for the very young.
11. Intercourse is the only kind of sex that counts; anything else isn't sex.
12. Sex is only for procreation, not recreation.
13. Arousal depends on physical attractiveness.
14. Sexual anatomy "deteriorates" as one ages.
15. Older people are too frail to fully participate in sexual intimacy.
16. Men and women with heart or other problems should avoid sexual activity.
17. Older people cannot control their sexual desires.

Some tips on defying stereotypes of aging include:

- Becoming consciously aware of the pleasure of being touched and caressed
- Rekindling a sense of romance
- Remembering to 'SAY YES TO LIFE' that has been worthwhile because of the quality of intimate relationships that have been developed
- Participating in the continued sensual growth and experience

Sexual dysfunctions

"Age is an issue of mind over matter. If you don't mind, it doesn't matter" ~Mark Twain

Frequent occurrences in the area of elderly sexuality are sexual dysfunctions, being common in men and women. Observations conclude that the major contributory factors are the misconceptions, beliefs and attitudes held by the individuals. It pays to remember that "YOU ARE AS OLD (OR YOUNG) AS YOU FEEL!"

Classification of sexual disorders

Male

a. Desire disorders: Hypoactive/Hyperactive
b. Erectile dysfunctions
c. Premature ejaculation
d. Inhibited/retrograde ejaculation

Female

a. Desire disorders: Hypoactive/inhibited
b. Arousal disorders
c. Orgasmic disorders — Anorgasmia
d. Dyspareunia
e. Vaginismus

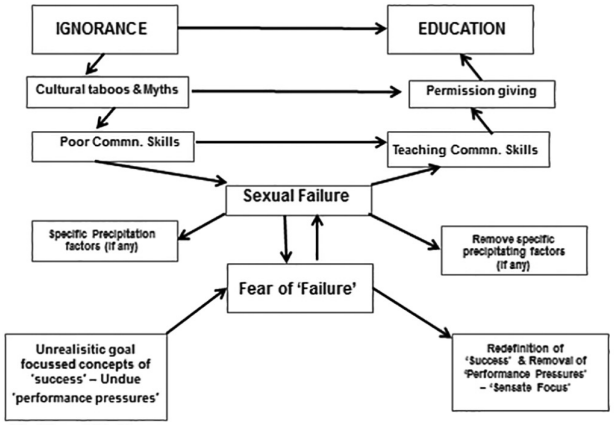

Figure 1: Causes and management of sexual problems

Treatment

The comprehensive treatment[16] is shown in Figure 1.

The treatment involves:

Specific therapy

1. Prevention: Providing adequate information on aging and sex.
2. Relation therapy: Supportive counselling, communicative skills, re-establishment of bonds.
3. Sexual assignments: Self- pleasuring, sensate focus and genital stimulation.
4. Avoidance of fatigue.
5. Improving body image: Diet, exercise, hairstyle, clothes, cosmetics, personal hygiene.
6. Social support: For single individuals, privacy for intimate relationships, at home and in nursing homes or institutions.
7. Emotional problems: Managing anger, rejection, performance anxiety, fear of hurting and vulnerability.

Management[16] includes the following basic principles

Adjusting to sexual changes with adult aging

- Medical treatment as appropriate for general illnesses.

If conflict is present over sexual frequency

- Treatment of underlying medical problem.
- Relevant sexual education.
- Mutual couple therapy.

Hypoactive sexual desire (low desire)

- Medical treatment for any underlying causes of the sexual problem.
- Hormonal replacement (testosterone, thyroid medication).
- Judicious use of antidepressant pharmacological agents when HSD is assessed as caused by depression.

Hyperactive sexual disorder

- Evaluate to establish the cure.
- Pharmacological treatment, notably drugs approved for obsessive compulsive disorder or some antidepressants and anxiolytics.

Female sexual dysfunction

- Pharmacologic therapy.
- Physical devices - Vibrators.
- Vaginal supplemental lubricants (e.g. K.Y. Jelly, etc).

Male sexual arousal disorder (erectile dysfunction)

Pharmacological therapy:

- Oral therapies (e.g. PDE inhibitors: Sildenafil,vardanafil and tadalafil).
- Central Initiator: Apomorphine SL (SubLingual).
- Central Conditioner: Hormone replacement – Testosterone.
- Intracavernosal injection of Vasoactive drugs (ICIVAD) e.g. Papeverine, E1-prostaglandin.
- Intraurethral therapies (e.g., MUSE (Medicated Urethral System for Erection).
- Vacuum devices.
- Penile Prosthetic implants (e.g., Malleable prosthesis, hydraulic or inflatable prosthesis).
- Arterial and venous vascular surgery wherever indicated.

Female orgasmic disorder (Inhibited orgasm)

- Pharmacological therapy such as sympathomemetic agents.

Male orgasmic disorder (Inhibited or "retarded" ejaculation)

- Pharmacological therapy (sympathomemetic agents, e.g., pseudoepinephrine hydrochloride)

Premature or rapid ejaculation

Pharmacological therapy:

- Antidepressants, especially the SSRIs; also some tricyclics, monoamine oxidase inhibitors.
- Anxiolytics may offer some ejaculatory delay.
- Antipsychotics delay but have significant risks (use with caution).
- Anesthetic creams (e.g. benzocaine, lidocaine).
- Testicular restraint devices.

Dyspareunia

Male

Address physical cause determined by comprehensive medical evaluation.

Female

Address physical cause determined by comprehensive medical evaluation. If common postmenopausal features present- use lubricant such as K.Y. Jelly, Astroglide etc.

Vaginismus

Assess and treat potential physical cause (e.g., dyspareunia) that could cause reflexive vaginismus. Gradual dilator (device) therapy.

Substance — induced dysfunction

Removal of substance wherever appropriate. If health benefit requires medication that has negative

sexual side effect, change to other medication that meets the same health need but may not have sexual side effect.

Paraphilia

Medical treatment to address findings of comprehensive medical evaluation (e.g. neurologic disease). Pharmacologic therapy to address any medical cause or to help manage detrimental sexual behaviour.

Treatment: General issues

Overall good physical health of individuals paves the road towards sexual wellbeing. Disorders namely, coronary artery disease, depression, diabetes, chronic use of drugs, endocrinopathy, gynecological problems, loss of hearing and sight, neurological disorders leave their mark on sexual functioning. Masters has commented that good health and an interested and interesting partner coupled with a loving relationship with mutuality of interests combined with regular sexual activity can result in a gratifying sex life even into the 80's.[15]

Byer and Shaingerg[17] state that sexual interest and pleasure are not the prerogative of youngsters only. Painful conditions such as arthritis or advancing age are not necessarily hindrance to sexual activity or enjoyment in the elderly. When older couples are willing to try different sexual techniques or positions, they can usually find comfortable ways to achieve sexual pleasure.

Research on elderly sexuality

There is a paucity of research on issues related to elderly sexuality with very limited literature available. A common viewpoint across the research articles is that sexuality in older adults is a part of healthy aging.[18,19]

A PubMed search in the 'title' of articles with words 'sexual and elderly', gave just 94 results, and with words 'sexual and aging' gave 151 results. Modifying the search word 'sexual' to 'sexuality' gave 73 and 74 results respectively; this points to the dire need of innovative research in this area. Gerontological literature contains relatively little content about issues of sexuality (0.5% of total publications),[20] and is practically non-existent in the developing world.

Research publications in last two decades challenge popular stereotypes of old individuals as nonsexual beings and conclude that asserting one's sexuality is a natural, necessary component for healthy aging-an image that has implications for research and policy.[21]

Issues related to elderly male's state that age related physiological changes do not render a meaningful sexual relationship impossible or even necessarily difficult. In men, greater physical stimulation is required to attain and maintain erections, and orgasms are less intense.[12] Numerous endocrine, vascular, and neurological disorders may interfere in sexual function, as may many forms of medications and surgery. These changes need not have any functional impact on the subjective enjoyment of the sexual encounter. However, knowledge that these changes are not dysfunctional and assistance with the adjustment of sexual practices may be crucial in preventing dysfunction due to performance anxiety.[21]

In the elderly females, the physiological effects of aging on sexual function are primarily caused by decreased amounts of circulating estrogen after menopause. Vaginal dryness and dyspareunia (pain with sexual intercourse) are the most important factors in reducing the sexual desire and frequency in women.[22] Other factors include medical disorders, effect of medications, previous negative sexual experiences and lack of able sexual partner. A study assessing the sexual healthcare needs of older women reported that they had concerns similar to younger women, but were less likely to discuss these concerns.[23] They were, however, willing to address their concerns if brought up by a physician — an important message to primary care physicians.

The expression of sexual behavior is constrained and is significantly influenced by environmental, social and cultural factors, especially in our country where sexual behavior is considered to be appropriate only for the young. Need for privacy, medical attention towards sexual dysfunctions, social and cultural inhibitions are factors at the core of this issue and need further research.

Sex involves merging emotional, spiritual and physical intimacies. Quality, in a sense, is more important than quantity when it comes to sexual relations and it comes only with time as the couple get to know each other better.[24] Any performance concerns makes the act only more difficulty; the very act of experimenting can lead to failure at times which can be overcome easily in an intimate relationship.[16]

As our life expectancy is increasing it is heartening to know that those in their sixties and beyond can expect a sensual, sexually active and intimate relationship with their partners.

As the saying poignantly quotes,

"The best and most beautiful things in this world cannot be seen or even heard, but must be felt with the heart."

~Helen Keller

REFERENCES

1. Prakash O, Kumar CN, Shivakumar PT, Bharath S, Varghese M. Clinical presentation of mania compared with depression: Data from a geriatric clinic in India. Int Psychogeriatr 2009;21:764-7.
2. Hodson DS, Skeen P. Sexuality and Aging: The hammerlock of myths. J Appl Gerontol 1994;13:219-35.
3. Asha MR, Hithamani G, Rashmi R, Basavaraj KH, Jagannath Rao KS, Sathyanarayana Rao TS. History, mystery and chemistry of eroticism: Emphasis on sexual health and dysfunction. Indian J Psychiatry 2009;51:141-9.
4. Hornby AS, Crowther J, editors. Oxford Advanced Learner's Dictionary of Current English. 5th ed. Oxford, United Kingdom, London: Oxford University Press; 1996. p. 699-700.
5. Sternberg R. A triangular theory of love. Psychological Review 1986;93:119-35.
6. Rowland M, Daniel P. Intimate Relationships. 5th ed. McGraw-Hill; 2008.
7. Carducci BJ. The Psychology of Personality: Viewpoints, Research, and Applications. Allport's Personalistic Viewpoint: In search of Uniqueness of individuals. The Trait Viewpoint. John Wiley & Sons 2009;Ch 7:267.
8. Panksepp J. Affective Neuroscience: The Foundations of Human and Animal Emotions. New York: Oxford University Press; 1998.
9. Kaufert PA. Menopause and depression: A sociological perspective. In: Berg G, Hammar M, editors. The Modern Management of the Menopause. New York: The Parthenon Publishing Group; 1994. p. 151-9.
10. McCoy NL. Survey research on the menopause and women's sexuality. In: Berg G, Hammar M, editors. The Modern Management of the Menopause. New York: The Parthenon Publishing Group; 1994. p. 151-9.
11. Segraves RT, Segraves KB. Human sexuality and aging. J Sex Educ Ther 1995;21:88-102.
12. Stimson A, Wase JF, Stimson J. Sexuality and self-esteem among the aged. Res Aging 1981;3:228-39.
13. Thienhaus OJ, Counter EA, Bosmann HB. Sexuality and aging. Ageing Soc 1986;6:39-54.
14. Schlesinger B. The sexless years or sex rediscovered. J Gerontol Soc Work 1996;26:117-31.
15. Masters WH, Johnson VE. Human Sexual Response. Boston: Little Brown; 1966.
16. Rao TSS, Rao VS. Approaches to Common Sexual problems in Medical Practice. 2nd ed. Sumana, Mandya: Reliance Phamaceuticals; 2001.
17. Byer CO, Shainberg LW. Dimensions of Human Sexuality. 4th ed. Madison, WI: Brown & Benchmark; 1994.
18. Prakash O, Rao TS. Sexuality research in India: An update. Indian J Psychiatry 2010;52(Suppl 1):S260-3.
19. Fullmer E, Shenk D, Eastland LJ. Negating identity: A feminist analysis of the social invisibility of older lesbians. J Women Aging 1999;11: 131-48.
20. Howell LC, Beth A. Pioneers in our own lives: Grounded theory of lesbians' midlife development. J Women Aging 2004;16:133-47.
21. Deacon S, Minichiello V, Plummer D. Sexuality and older people: Revisiting the assumptions. Educ Gerontol 1995;21:497-513.
22. Spence SH. Psychosexual dysfunction in the elderly. Behav Change 1992;9:55-64.
23. Owens AF, Tepper MS. Chronic illnesses and disabilities affecting women's sexuality. Female Patient (Parsippany) 2003;28:35-8.
24. Rao TSS, Tandon A. Intimacy, Sensuality and Sexuality. In:Rao TSS, Gupta S, Tandon A(Eds). Elderly Sexuality: Intimacy Matters.IAGMH 2011:17-23.

How to cite this article: Rao TS. Forbidden fruit in the golden years: Elderly sexuality. J Geriatr Ment Health 2014;1:8-13.
Source of Support: Nil, **Conflict of Interest:** Nil.