

Sexual Issues and Aging Within the Context of Work With Older Adult Patients

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Recent studies suggest that the majority of older men and women maintain moderate or high levels of sexual interest well into their 70s but often experience sexual dysfunction. Given the burgeoning of the older adult population, psychologists are increasingly likely to find older patients in their practice with questions or concerns about sexuality. The goal of this article is to provide psychologists with current information regarding sexuality and aging, including general prevalence data, age-related biological changes (e.g., menopause), incontinence, erectile dysfunction, prostate changes, male performance-enhancing drugs (e.g., Viagra), medications' sexual side effects, and sexually transmitted diseases, including HIV/AIDS. Practice guidelines endorse a biopsychosocial perspective, in which stereotypes, gender, partner availability, socioeconomic status, ethnicity, religious beliefs, and sexual orientation are examined. Clinicians' potentially negative countertransference also should be recognized and worked through. Case examples illustrate many of these concepts, and directions for future research and patient care are offered.

Keywords: sexual behavior, older adults, HIV/AIDS, erectile dysfunction, side effects

The majority of older adults (defined here as those individuals ages 65 and older) report moderate or high levels of sexual interest well into their 70s (DeLamater & Sill, 2005). With the burgeoning of our country's diverse older adult population, psychologists are increasingly likely to see older patients in their practice who may have questions or concerns about their sexuality. A report from the U.S. Census Bureau (He, Sengupta, Velkoff, & DeBarros, 2005) indicated that more than 35 million men and women, or 12% of the current population, are ages 65 and older, with approximately 18 million ages 65 to 74, 13 million ages 75 to 84, and 4 million ages 85 and older. The entire older adult population is projected to more than double in size, to 72 million, by the year 2030, representing 20% of all Americans. The American Psychological Association's (2004) "Guidelines for Psychological Practice With Older Adults" advised psychologists to adopt a biopsychosocial approach and become familiar "with current information about biological and health-related aspects of aging" (p. 237), including sexuality,

within the context of typically interrelated individual patient and social factors.

Thus, the goal of this article is to provide psychologists with current information regarding sexuality and aging, including general prevalence data and related social stereotypes, normative biological changes (e.g., menopause), the impact of chronic and acute illness (e.g., arthritis, heart disease), sexual side effects of prescription drugs (e.g., Prozac, hypertensive agents), incontinence, erectile dysfunction (ED), prostate changes, male performance-enhancing drugs, and STDs, including HIV/AIDS. (Please note that this sample of topics is illustrative rather than exhaustive in relation to the sexuality of older adults.) Associated psychological and socioenvironmental factors, including gender, partner availability and relationship status, socioeconomic status, religious beliefs, ethnicity, and sexual orientation and identity, among others, are addressed. Case vignettes and general practice guidelines also are offered to highlight these issues in work with older adult patients, who may live independently or in assisted or institutional settings.

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Prevalence Data and Societal Stereotypes

The experience of sexuality and aging appears as diverse as our population of older adults themselves. Although relatively limited information is available regarding older adults' sexual attitudes and behaviors, a recent national study revealed that sexual interest remained moderate to high for the majority of women and men in their 70s (DeLamater & Sill, 2005). Additional data reported that 54% of men and 21% of women ages 70 to 80 had had sexual intercourse within the past year and that nearly one quarter of those men and women had intercourse more than once a week. Chronic or infrequent sexual dysfunction, including low sexual desire, inability to climax, and ED, also was reported among nearly half of the adults in this age group (Nicolosi et al., 2006). Partner

availability appears related to type and frequency of sexual behavior, particularly for older nonmarried women, who significantly outnumber their older male counterparts (Hillman, 2000). It also is vital to recognize that the sexuality of older adults encompasses an array of behaviors (e.g., self-stimulation, noncoital activity with partners) as well as sexual activity in both long-term and new relationships.

Traditional views of the sexuality of older adults are negative, suggesting that older adults are either asexual or “dirty old” men and women for showing interest in sexual activity (Hillman, 2000). More recent portrayals of the sexuality of older adults, including those appearing in television and print advertising for male performance-enhancing drugs (e.g., Viagra), provide a mixed message. That is, such product advertisements assert that older adults have the right to engage in sexual activity and that they deserve appropriate diagnosis and treatment if they are dissatisfied with their current level of sexual functioning. Unfortunately, these same media messages imply that sexual activity among older adults is defined solely by penetrative, heterosexual intercourse and that participation in such activity is now requisite for successful aging, particularly for older men. It is important to let older adult patients know that there is no correct or clearly defined manner in which sexuality in later life should manifest itself.

Normative Biological Changes

For women, menopause represents a normal, long-term biological change that can affect sexuality in various ways. With a significant decline in estrogen production in menopause, the muscles of the vaginal wall may receive less blood flow, become less elastic, and atrophy. Decreased production of natural secretions can lead to vaginal dryness. Painful intercourse can result, which can be treated with over-the-counter personal lubricants or a prescription estrogen cream or vaginal ring (Berman & Goldstein, 2001). It also remains unclear whether the decrease in sexual interest reported by postmenopausal women is related to hormonal changes; lifestyle changes; or internalized, ageist attitudes that older women should not be interested in sex. Regardless, the inability to have children with menopause can lead some women to find increased enjoyment in their sexual activity because they no longer fear becoming pregnant, whereas other women may find it difficult to feel sexy or desirable because they have difficulty integrating their new physical state with their own perception of what it means to be a woman. In essence, psychologists should not make assumptions about how menopause affects any patient and should ask their patients directly about this event and its effect on self-view, emotional state, and sexual functioning.

Chronic and Acute Illness

The role of both chronic and acute illness must be considered in the assessment of an older patient’s sexual activity and interest (see Hillman, 2000, for a review). Many disorders encountered in advancing age, including arthritis, heart disease, diabetes, Parkinson’s disease, stroke, cancer, and depression, can negatively impact on an individual’s interest or participation in sexual activity. For example, arthritis can make participation in sex uncomfortable or painful. (Sometimes one can find a relatively simple solution by switching to a new position or soaking in a tub before sexual

activity.) Fears about resuming sexual activity can accompany recovery from a heart attack or stroke, particularly if health care providers fail to address this topic directly. Decreased blood flow in diabetes can lead to vaginal dryness in women and ED in men. All of these disorders, including the diagnosis and treatment of cancer (e.g., mastectomy), can impinge on older adults’ body image, particularly for those who struggle with general society’s admonishments to appear youthful and perfect at virtually any cost.

Medications and Sexual Side Effects

Estimates suggest that more than 80% of Americans take at least one prescription drug, over-the-counter medication, or dietary supplement weekly (Kaufman, Kelly, Rosenberg, Anderson, & Mitchell, 2002). Many prescription drugs, over-the-counter medications, and herbal supplements pose significant side effects that can alter or impair sexual function, including decreased libido, vaginal dryness, ED, dysorgasmia (i.e., delayed or attenuated orgasm), and anorgasmia (i.e., absence of orgasm). (Please refer to Table 1).

Unique Risks for Older Adults

Older adults are at increased risk for such side effects when compared with younger adults because they take, on average, more than four different prescription drugs each day, they metabolize drugs less effectively, and fewer than one third inquire consistently about potential side effects or drug interactions (Barrett, 2005). Commonly prescribed medications for older adults include psychotropic (e.g., selective serotonin reuptake inhibitor, antipsychotic), central nervous system, and cardiovascular agents (Steinmetz, Coley, & Pollock, 2005). Psychologists can help patients communicate with health care providers to make informed medication choices, particularly given that some providers regard sexual side effects as an unrelated or minimally important concern for older adults. Some older patients may find a medication’s sexual side effects more unpleasant than the original presenting problem and become afraid to report this information or meet with dismissive responses from care providers.

Case Example

Roy was a 70-year-old man being treated for major depression in individual psychotherapy at his local hospital’s outpatient mental health center. He came at the urging of both his primary care physician and his common law wife of 14 years. Roy had been a dock worker who prided himself on his physical strength and his ability to “hold his own” when he drank socially. He became depressed when he was diagnosed with Type II diabetes and could no longer drink with his friends. Roy also was treated by a psychiatrist at the clinic.

During a recent session, Roy arrived for individual psychotherapy swearing and slamming the office door. He said, “This is the last straw, and I’m giving up on this therapy crap for good now. . . . Hell, I might as well just start drinking again.” When asked to explain what had happened, Roy reported that he had had side effects but “didn’t want to get into it.” When his psychologist asked him again to explain, Roy reported,

Table 1
Drugs With Reported Sexual Side Effects

Medication class	Name	Trade name	Most common side effects
Prescription medications			
Antidepressant	Clomipramine	Anafranil	Anorgasmia, dysorgasmia
	Fluoxetine	Prozac	Dysorgasmia
	Paroxetine ^a	Paxil	Anorgasmia, dysorgasmia
	Sertraline ^a	Zoloft	Anorgasmia, dysorgasmia
	Venlafaxine	Effexor	Anorgasmia, dysorgasmia
Antimania	Lithium	Eskalith, Lithonate	ED
	Topamarete	Topomax	ED
Antianxiety	Alprazolam ^a	Xanax	Decreased libido
	Lorazepam ^a	Ativan	Decreased libido
	Temazepam ^a	Generic	Decreased libido
Antipsychotic	Haloperidol	Haldol	Dysorgasmia, ED
	Mesoridazine	Serentil	Decreased libido, dysorgasmia
	Trifluoperazine	Stelazine, Suprazine	Decreased libido, ED
Antihypertensive	Atenolol ^a	Generic	ED
	Clonidine	Catapress	Decreased libido, ED
	Digoxin ^a	Lanoxin, Digibind	ED
	Hydrochlorothiazide ^a	Lopressor	Decreased libido, ED
	Levodopa	Sinemet	ED
Antiparkinsonian	Phenytoin ^a	Dilantin	ED
Antiseizure	Tamoxifen	Nolvadex	Vaginal dryness, ED
Chemotherapeutic	Celebrex	Celecoxib	ED
Miscellaneous	Donepezil ^a	Aricept	ED
	Zolpidem	Ambien	ED
Over-the-counter medications and herbs			
Antihistamine	Diphenhydramine	Benadryl	ED
	Drixoril	Tavist-D	ED
	Cimetidine	Tagamet	Decreased libido, ED
	Ranitidine	Zantac	ED
Herb	Alkaloids	Rauwolfia	ED
	Hypericum	St. John's Wort	Dysorgasmia

Note. This list of drugs is meant to be illustrative rather than comprehensive. Attention to older patients' sometimes atypical side effects remains essential. ED = erectile dysfunction.

^a Identified as one of the 50 most frequently prescribed oral drugs among older adult patients (Steinmetz et al., 2005).

Taking this crap [Prozac] is making me shoot blanks, if you know what I mean. I mean, I can get all wound up, but nothing happens. It's so goddamn frustrating. Patty told me she could care less, but . . . I do. . . . My shrink [psychiatrist] doesn't seem to think it's that big a deal since I'm starting to feel better [less depressed.] Well, if I have to make a choice between doing it [having sex] and getting this [depression] out of my head, I know what I'm going to pick.

Roy also was surprised to learn that his psychologist believed that Roy was entitled to work with his psychiatrist to identify an antidepressant that had minimal or different side effects.

With some coaching and role play during psychotherapy, Roy developed a plan to discuss these concerns with his psychiatrist. Two weeks later, Roy was pleased to report that he and his psychiatrist had opted to begin a trial of Wellbutrin, which typically has fewer sexual side effects. He told his psychologist, "I guess I thought you medical types just always thought you knew [everything]. In my day, I guess we weren't used to planning things with the doctor. . . . This is all right." In subsequent sessions, Roy began to work through fears about developing ED as a function of his diabetes. However, because Roy felt he had more control over his own treatment, he had significantly less anxiety about a negative outcome.

Incontinence

Recent studies suggest that between 17% and 55% of older community-living women experience some type of urinary incontinence, which has been associated with fear of leaking urine during sex, decreased sexual desire and interest, embarrassment, and clinical depression (see Tannenbaum, Corcos, & Assalian, 2006, for a review). Although men are less likely to suffer from incontinence, virtually nothing is known about its impact on their sexuality. Even though incontinence often can be treated successfully with some combination of specialized muscle training or strengthening, prescription medication, and surgery, many older adults assume incorrectly that incontinence is an unavoidable part of aging. As one 65-year-old woman noted, "I just figured that having accidents, especially when I coughed or sneezed, was just part of life at my age, and that's why all those ads for Depends [adult diapers] are on TV." Incorrect assumptions about incontinence lead affected women to avoid discussing their symptoms with health care providers and sexual partners. Even after successful surgery for unwanted voiding, some women express unfounded fears that sexual activity will reverse or interfere with the surgical repair (Rogers

et al., 2006). Psychologists can provide appropriate care by helping older patients address incontinence with partners and health care providers. Such communication and information sharing becomes essential for assessment, treatment, and successful long-term follow-up.

ED

Although its etiology may be related to a variety of factors, including andropause (i.e., men normally produce less testosterone with advancing age), typical decreases in vascularization with age, the presence of certain disorders or their treatment (e.g., prostate cancer or enlargement), medication side effects, depression, anxiety, and substance abuse, a number of studies suggest that by middle age, nearly 40% of all men experience some degree of ED (Feldman, Goldstein, Hatzichristou, Krane, & McKinlay, 1994; Laumann, Paik, & Rosen, 1999). By age 70, the majority of men (67%) are expected to experience mild to severe ED (Feldman et al., 1994). Although older adults may be more familiar with the term *impotence*, some health care professionals often use the presumably less pejorative term *erectile disorder* or *dysfunction*. It remains unclear whether older men and women are more likely to discuss ED among themselves and their care providers than *impotence*, so it is important for psychologists to use the terminology used or preferred by their individual patients.

Prostate Changes

Special care must also be taken to acknowledge the experience of prostate cancer, screening, and treatment, which may include ED, among older men. In the United States, prostate cancer is the second most common and most deadly form of cancer among men (Schiavi, 1999). For African American men, it is both the most commonly diagnosed and the most deadly form of cancer. Fear and embarrassment about recommended annual screening for prostate cancer (particularly for the digital rectal exam portion of the screening when compared with the blood test for prostate-specific antigen), combined with lack of knowledge, hesitancy to discuss sex-related health problems, and concerns about impotence related to a positive diagnosis or treatment, have been identified as significant barriers to screening (Forrester-Anderson, 2005). Although psychologists certainly cannot provide medical treatment or advice, they can use psychological principles to help patients identify and work through their rational and irrational fears about prostate cancer or changes and engage in appropriate, age-related screening measures.

Case Example

Ralph was a 67-year-old retired electrical engineer who was referred to an outpatient mental health clinic for treatment of “overwhelming anxiety” by his wife of 35 years. Ralph reported to his psychologist in individual psychotherapy, “My wife is driving me nuts. I mean, absolutely nuts. . . . She is just getting relentless about this thing.” When asked what he was referring to, Ralph responded that he must have some kind of prostate trouble because he was going to the bathroom

all the time . . . in the middle of the night a few times, whenever we go for a trip in the car, at a restaurant, visiting friends. . . . I don't even want to go to the mall half the time.

Reluctantly, Ralph admitted that he was probably worried about his health, too. When asked whether he was going to the doctor for a check-up, he responded,

Yeah, I know, “Cough.” I'm not looking forward to that. And, what are they going to find anyway—[prostate] cancer? I hear that you're a real “lame duck” after they fix you up for that. So, I don't know why I want to find out anyway. I've got a good thing going with my wife in the bedroom, and I know all of that stuff is important to her. It always has been. So why mess with it now? I'm going to die anyway, right? And, no offense [Ralph's psychologist was a woman], but our insurance assigned me to a female urologist on top of all this. Can you believe that?

Ralph's psychologist was able to explore Ralph's anxiety about the digital rectal exam related to embarrassment and fear of pain, particularly within the context of seeing a younger female physician, and provide vital, basic education about prostate cancer and screening. The psychologist helped Ralph to come up with a plan in which he first scheduled a consultation with the urologist, in her office with his clothing on, before proceeding to the examination room for the screening. The psychologist also helped Ralph find resources that explained that not all treatments for prostate cancer, if he indeed had cancer, resulted in short- or long-term sexual dysfunction. Most important, Ralph was amenable to having his wife come along for two psychotherapy sessions to discuss his concerns about possible changes to their sex life.

Fortunately, Ralph's fears were unfounded, as his wife assured him that although she “might miss it [having intercourse],” she would rather have Ralph as her husband for many more years than lose him because he did not think that “love and cuddling, kissing, and heavy petting now and then” could sustain their relationship. Future medical exams and a biopsy revealed that Ralph did not have prostate cancer but had a benign enlarged prostate. Psychotherapy helped Ralph cope with the anxiety related to his biopsy and the brief period of ED he encountered while recovering from that procedure. Prescription medication was successful in managing his urinary symptoms. Ralph reported that he was pleased to discuss this issue openly with his wife and to know that she thought he was “a man” whether or not they could have “sex proper.” Additional work in psychotherapy helped Ralph with identity issues related to his initial belief that masculinity was inexorably tied to specific types of sexual performance.

Male Performance-Enhancing Drugs

Viagra (sildenafil), the first phosphodiesterase-5 inhibitor, was introduced in 1998, followed by Levitra (vardenfil) and Cialis (tadalafil) in 2003. A review of available clinical trials (Carson, 2006) suggests that Viagra has the most robust data on patient safety, Levitra may resolve severe ED among men who do not respond to Viagra, and Cialis has the longest half-life and the ability to help men achieve an erection within a 36-hr or “week-end” period after they take one dose. Unfortunately, virtually no empirical research is available regarding the psychological impact of phosphodiesterase-5 inhibitors on the men who take these performance-enhancing drugs and their female or male partners. Existing qualitative research suggests that older men may revel in the ability to engage in intercourse or become fearful of potential side effects. Similarly, available data for older female sexual

partners suggest that there are both positive and negative aspects of this drug use (Loe, 2004). Positive aspects reported include the ability to maintain previous levels of sexual activity and explore new sexual experiences, whereas negative aspects include the fear of cardiac events, increased demand for unwanted sexual activity, pain and injury during sex if appropriate care (e.g., use of personal lubricants, adequate foreplay) is not taken (Kingsberg, 2002), and increased exposure to STDs. The relatively high cost of these medications may also play a role in their use.

Case Example

Martha was a 67-year-old married woman who sought psychotherapy for anxiety and depression after the divorce of her youngest son. During the course of her individual psychotherapy, Martha's husband of 47 years had prostate surgery and experienced ED. Unbeknownst to Martha, his urologist suggested Viagra and gave him a free sample packet. (The couple previously had engaged in sexual intercourse approximately two times a month.) Martha complained in a session that she felt

like a real hussy because [using Viagra] seemed like paying for sex somehow . . . and my husband was so anxious about doing it at a certain time, when the medicine was working . . . and I think [it made] my husband . . . feel like some "big man" again, and I just could care less.

She also complained, "Now I found out that this stuff costs 10 dollars a pill, and our insurance will only pay for five . . . a month. Like some accountant [will] decide our sex life. It just makes me sick."

When the issue was examined further, it appeared that the part that made Martha "feel sick" was based on her fears that her husband was only interested in the physical act of penetration rather than their emotional closeness and typically extended foreplay. She expressed that "prostitutes . . . have sex without feeling anything [emotionally], and I don't want to end up like that." When she was able to work through her own wishes and speak openly to her husband about them, they decided that they would use Viagra only when they both agreed and that her husband would handle all insurance paperwork. The couple also agreed that foreplay would remain a vital part of their sexual repertoire and that they would engage in foreplay from time to time without having to engage in intercourse. Martha's husband also felt pleased that she valued his emotional presence more than his ability to engage in what he originally perceived to be "manly" duties, such as intercourse.

Other case illustrations provide different vantage points. For example, Patrick, a 71-year-old widowed man in psychotherapy, stated,

Most of us [older men] just joke about it now, that what we used to do for hours now we're lucky to do once a month for a few minutes. . . . I tried that damn Viagra with my lady friend last month and I will never use it again. I was so worried about having a heart attack or something, and while it's great to have that "loaded gun" in my pants, I saw spots the last time I used it. I don't need sex so bad that I'm going to die for it. . . . My girlfriend told me to just relax and enjoy it, that she enjoyed it, but that's easy for her to say. She's not taking the pill.

Another 81-year-old female widow who lived in an assisted living community reported,

I hate this drug [Viagra] stuff. Now all the available men act like you have to have sex with them or they won't spend time with you. I've paid my dues, and I don't want to do that anymore. Besides, I think it's the vain men who need that stuff anyway. The rest don't have anything to prove.

Her comment also highlights the sometimes competitive nature of finding an available male partner among larger numbers of older single women.

Increase in STDs

Each year, approximately 15 million Americans contract an STD, and approximately half of those individuals develop lifelong infections (e.g., genital herpes, HIV; Wilson, 2003). Unfortunately, virtually no surveillance data are available regarding the prevalence of STDs among older adults. Few reporting agencies, including the Centers for Disease Control, routinely assess rates of infection or disease among men and women over the age of 50. Extrapolation from available data suggests that older adults account for 1.3% of all STDs, with genital herpes reported most often for older women and nongonococcal urethritis (bacterial infection and inflammation of the urethra) for older men (Xu, Schillinger, Aubin, St. Louis, & Markowitz, 2001). This figure may significantly underestimate actual prevalence rates for a number of reasons. Older adults are more likely to engage in unprotected sex than younger adults because of a lack of knowledge and experience with condom use as well as decreased fears of pregnancy (Hillman, 2000). Health care providers typically fail to assess older patients' sexual health (Wilson, 2003), and many STD symptoms are overlooked as generalized symptoms of aging.

It also is essential to consider the impact of gender and ethnicity in relation to STDs among older adults. Older women face unique risks (Hillman, in press). For example, postmenopausal women face greater likelihood of micro- and macroscopic tearing of the vaginal wall during intercourse, which provides viruses and other agents greater access to the blood stream per episode of unprotected sex. Older women may fear offending or losing their partner if they discuss condom use, and older Latino women have identified cultural norms (e.g., machismo) that can make asserting oneself in relation to safer sex practices much more challenging.

HIV and AIDS

One critically important area for attention is the increasing number of older adults diagnosed with HIV and AIDS. Approximately 12% to 20% of all new AIDS cases are among men and women over the age of 65 (see Orel, Spence, & Steele, 2005). Older adults may develop HIV/AIDS by aging successfully with a previous infection or by contracting a new infection via participation in unprotected sex or other high-risk behaviors (e.g., IV drug use). Compared with younger adults, older adults are at increased risk for antiviral medication side effects, HIV-associated dementia (including misdiagnosis as Alzheimer's disease), and increased mortality. The greatest increase in AIDS cases currently exists among older, inner city minority group women, who are less likely to have access to health care and education.

Unfortunately, no national health campaigns exist regarding STD transmission, testing, or treatment for older adults (e.g., HIV/AIDS; Orel et al., 2005). Psychologists, other health care providers, and community-living older adults themselves possess only moderate levels of knowledge of STDs, including HIV/AIDS, among this burgeoning age group (Hillman, 2000). Thus, psychologists can become educated and play a vital role in disseminating this information to both patients and other professionals.

Case Example

Peta was a 73-year-old divorced woman brought by her adult daughter to a mental health clinic to be assessed for depression and “forgetfulness.” After the psychologist asked to interview Peta alone, Peta reported that she had been dating a man from her apartment complex but that she had never told her children for fear of upsetting them. Unprotected sex was part of their dating relationship. Additional testing revealed that Peta had HIV-associated dementia. With aggressive antiviral treatment, many of her symptoms abated, and, in conjunction with family therapy, Peta decided to talk to her children about her condition to gain vital support.

Additional Patient Factors

Additional patient and environmental factors play a critical role in aging and sexual expression. One commonly underestimated factor is that of gender. The current cohort of older women, when compared with both their younger counterparts and older men, are less likely to have experience with birth control (e.g., condoms), are less likely to discuss sexual matters with their physician, and have lower levels of education and financial resources (see Hillman, in press). Partner availability is also tied to gender in that older women are significantly greater in number than older men. Religious beliefs and cohort effects can also play a significant role in any patient’s sexuality. For example, older adult gay men and lesbians came of age when their sexual orientation was regarded as a form of mental illness. Even changes in basic living arrangements can contribute to otherwise unexpected changes in sexuality. Psychologists need to be attuned to any influence from a variety of personal and environmental factors.

Case Example

John, a 69-year-old married man seen in individual psychotherapy for anxiety, stated that he and his wife had started getting into arguments about not having sex as often as he would like. John assumed that his wife did not love him anymore and worried constantly about the state of their relationship: “We used to have sex all the time [approximately once a week] and now she’s always got a headache or some such thing.” When John was able to calm down and ask his wife directly why she frequently turned down his advances, she reported that since their 5-year-old grandson often came to stay with them during the week (their adult daughter, a single mother, traveled frequently on business), she felt inhibited and ashamed that “he might hear them [having sex].” Simple changes in the arrangement of their bedrooms and the decision to occasionally have sex during the day, when their grandson was in day care, helped both John and his wife adapt to their new living arrangement.

Cultural and Ethnic Diversity

Culture and ethnicity also must be examined carefully within the context of the sexuality of older adults. Among African American men, distrust of government-sponsored agencies and medical practitioners, lack of knowledge about prostate disease, and limited access to health care have been identified as significant barriers to prostate cancer screening (Forrester-Anderson, 2005). A qualitative study of older Asian men revealed that although the majority acknowledged medical causes for ED, excessive sexual activity and spiritual forces were incorrectly identified as contributing factors (Low, Ng, Choo, & Tan, 2006). In traditional Indian culture, the sexuality of older individuals remains much of an enigma. As one 64-year-old man from India noted, “In my country, we all know what sex and what aging is, but you never hear those two words in the same sentence.” Of course, clinicians must not resort to generalizations or assumptions about any patient’s background; each patient requires individual assessment and intervention.

Guidelines for Clinical Practice

Psychologists are in a unique position to assist older adults by making a discussion of sexuality part of their regular practice, particularly during initial patient interviews. Such dialogue demonstrates to older patients that talking about sexuality is appropriate in a professional, empathetic setting; helps dispel ageist myths; supports basic sex education and the gathering of additional information; and helps patients develop the skills to communicate more effectively with sexual partners and health care providers. Psychologists also are uniquely qualified to assist older adults who experience depression or anxiety in relation to sexual changes or dysfunction within the context of their intimate, family, or peer relationships.

Taking a Sexual and Medical History

Some general guidelines can be offered to psychologists who encounter older adults in their practice. As with any patient, taking a sexual history is vitally important. In addition, it remains critical to avoid making any assumptions about older patients’ sexual orientation and interest or participation in a variety of sexual behaviors, regardless of their marital or health status (e.g., masturbation, noncoital sex, affairs, visits to prostitutes). Asking a patient’s formal permission to discuss the subject (e.g., “Is it all right to ask you some questions about your sex life?”) can convey a sense of sensitivity, control, and respect. Psychologists can also normalize and examine the experience by making statements such as, “It may be unusual for you to discuss matters related to your sexuality, but this kind of information sharing is important for your care. . . . What is this like for you?” Using the patient’s vernacular when appropriate (e.g., *wetness* vs. *incontinence*) can also help reduce overall levels of tension and stress.

In response to the biological dimensions of the sexuality of older adults, obtaining a medical history is also important. Asking patients to bring along a small bag with all of the pills they take during the week, including both prescription and over-the-counter medications and supplements, can typically provide more accurate information than asking for verbal reports. Asking an older patient

to obtain a physical exam from his or her primary care physician as part of the intake procedure for psychotherapy can also provide opportunities for guided discussion and eventual participation in various medical tests (e.g., mammograms, prostate screening, HIV testing).

Recognition of Countertransference

The management of countertransference often encountered in work with older patients is critically important. Most psychologists have limited education or training in relation to the sexuality of older adults, and it is common for therapists (and other health care professionals; Loe, 2004) to experience negative countertransference, including anxiety, confusion, disdain, and denial. Common themes reported include feeling as though the older patient represents a parent's sexuality or the denial or exacerbation of existing fears of aging (Gussaroff, 1998; Hillman, 2000). Peer consultation can often provide clinicians with essential insight and support.

Case Example

Stephanie was working with Walt, a 68-year-old patient, in psychotherapy for treatment of major depression in response to a diagnosis of prostate cancer. Despite having had a surgical procedure designed to spare vital nerve function, Walt developed ED during radiation therapy. Stephanie found that she began to over-identify with Walt's wife, who, according to Walt, would rather ignore the fact that he had difficulty having an erection than discuss it. Stephanie felt that it was more important that Walt focus on his overall prognosis than on his likely temporary inability to have intercourse. After discussing the case with a colleague, Stephanie realized that Walt's similarity in age to her own father made her uncomfortable about discussing her patient's sexuality. Once Stephanie acknowledged that talking to an older patient about sex was challenging for her, as well as for many clinicians, she was able to respond more empathically and directly to Walt's fears that ED diminished his masculinity and personal value.

Future Issues in Sexuality and Aging

In 2011, the first baby boomers will become 65 years of age and officially enter older adulthood. The role of cohort effects becomes critical when one examines the sexuality of these baby boomers, our country's largest demographic. Because members of this generation have been described as nonconformist and grew up conversant about sexual expression, birth control (Loe, 2004), and psychotherapy, psychologists are likely to find more older patients in their practice seeking help related to sexuality and sexual function.

The Internet is likely to play a role in the future of sexuality and aging, as older adults represent a rapidly growing segment of Internet users. However, virtually no empirical data are available regarding the types and content of Web sites related to sexuality and aging and the extent to which older adults view such Web sites or participate in sexual activity via online activity. The Internet is unique in that older adults can engage in sexual activity as well as find information related to sex and medical education (e.g., www.nihseniorhealth.gov, www.health.nih.gov, www.apa.org/pi/aging/sexuality.html, www.urologyhealth.org, www.drugs.com),

with anonymity and without encountering typical ageism in response to revelation of age or related physical characteristics (Adams, Oye, & Parker, 2003). Psychologists can help older patients decide for themselves what constitutes appropriate, enjoyable use as well as become familiar with available educational information. For example, one 67-year-old man noted in psychotherapy,

It's a lot easier for me to look up diabetes and impotence on the Internet, print it out, and read about it . . . before I talk about it with [my physician] and [my partner.] It gives me time to think, without feeling put on the spot.

If better patient care is to be provided, significantly more clinical research is needed regarding understudied and often marginalized populations, including older gay men and lesbians, as well as the overarching economic, cultural, and racial issues related to the sexuality of older adults. Psychologists also can guide the development and delivery of effective primary prevention programs for STDs among older men and women. Additional research and clinical attention must also be focused on the expression of sexuality within the context of long-term care settings (e.g., nursing homes, assisted living facilities) and alterations in mental status (e.g., Alzheimer's disease). Older adults who move into a nursing home do not suddenly become asexual, and psychologists can be instrumental in helping staff members, residents, and family members develop appropriate policies and care management to better ensure older residents' rights to both sexual expression and safety (Hillman, 2000).

In sum, sexuality and aging present a complex clinical picture. Older adults are more heterogeneous than homogenous along a variety of dimensions, and their sexuality is likely to be just as varied. Because the sexuality of older adults is established within a matrix of biopsychosocial factors, psychologists need to become familiar with various aspects of sexuality and aging and open to seeking additional information and consultation when appropriate. With the impending increase in older adult patients, including those from the baby boom generation, our patients will only benefit from closer examination of this critically important but typically understudied topic.

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