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Sexual Disorders in Elderly Patients

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- Much of the early research into both human sexuality and sexual dysfunction focused on relatively young, sexually active couples.

- The terms *sexuality* and *intercourse* were used synonymously, and sexual disorders were assumed to be psychological in origin

- Today, however, the average individual seeking help for a sexual problem is likely to be middle-aged or older and to have a number of medical and/or psychiatric problems that are having direct, *organic* effects on sexual function.

- At the same time, sexuality is playing an increasingly important and vital role for these aging individuals, who are living longer and healthier life spans

- Several large surveys have found that the majority of older individuals continue to be sexually active (typically defined by the rate of sexual intercourse) in late life, men more so than women, but at a rate lower than that of younger cohorts

- For example, in a 1999 American Association for Retired Persons (AARP)–commissioned survey of! over 1,300 men and women ages 45 years and older,
- 75% of respondents reported that they remained sexually active and 66% said they were extremely or somewhat satisfied with sex (Jacoby 1999).

Sexual Function and Dysfunction in Late Life

- Clinical work with older individuals who have sexual problems requires an understanding of how sexual function changes over time.

- For older women, the onset of menopause heralds a 2- to 10-year process of declining levels and eventual cessation of ovarian estrogen production that usually concludes in the early 50s

- Although the impact of menopause on sexual behavior is quite variable,
- all women experience atrophy of urogenital tissue and diminished vaginal lubrication that can negatively impact sexual function
- Concomitant loss of testosterone production may lessen libido in some women

- Beginning in their 50s, most men begin to experience a general slowing of sexual response, meaning that
- erections take longer to achieve,
- are less rigid,
- and do not last as long,
- and orgasm requires greater degrees of stimulation.

- In addition, the refractory period after orgasm lengthens considerably (Westheimer and Lopater 2002)

- Although these changes in men may be related to declining levels of testosterone, they are not as predictable as menopausal changes in women and typically occur gradually over years or even decades

- By age 80, average levels of male testosterone decline by 35%, with some men developing hypogonadism when levels drop below 200 ng/dL (Morley 2003)

- Several researchers have proposed the concept of a *male menopause* syndrome or *andropause*,
- resulting from loss of testosterone and
- involving not only
- decreased libido and sexual function
- but also loss of bone and muscle mass (Morley and Perry 2003).

- The impact of these age-related physiological changes on sexual function depends on several key physical and psychosocial factors.

Case Example 1

- Malcolm, a 62-year-old divorced man, had been sexually active several times a month with his second wife.
- He was a heavy smoker and suffered from hypertension and hypercholesterolemia.
- He began to notice that achieving an erection was taking longer, and on several occasions he had suffered from erectile dysfunction.

- In his mind, he initially blamed his new wife for his problem, thinking that he no longer found her attractive.
- Malcolm panicked, however, when the problem occurred when he was with another woman, and he concluded that he had a serious sexual problem.
- He made an appointment to see his doctor to ask for a prescription for an “erection pill.”

- Contrary to his own self-diagnosis, Malcolm might not even be suffering from true erectile dysfunction.
- Instead, he may be overreacting to a normal decline in erectile function and making the problem
- worse by blaming his new wife and seeking another partner to “test” himself,
- rather than communicating with his new wife and adapting their sexual activity (e.g., through more foreplay or the use of a lubricant).

- His anxiety, in turn, activates his sympathetic nervous system, which then inhibits erectile function.
- Malcolm is also more susceptible to erectile dysfunction given the likely underlying atherosclerotic disease of his genital vasculature.
- In addition, his medical regimen likely includes the use of both a statin medication and a beta-blocker, which could be contributing to the erectile dysfunction.

- Malcolm's case suggests some more insidious factors that may affect sexual behavior in aging individuals.
- A decline in sexual function may reinforce fears of aging and cause individuals to silently agree with stereotypes of sexual activity as potentially inappropriate or dangerous.
- Partners may also misinterpret changes in the other partner as indicating lack of interest or even aversion.

- Medical illness can further damage a person's sexual self-esteem, especially when physical appearance has been altered by surgery or medication effects.
- Equally important are psychiatric symptoms such as depression, anxiety, and cognitive impairment that can impair sexual desire and require the use of medications that often have sexual side effects.
- Many of these factors are listed in Tables

Table 14–1. Potential sexual impact of menopause

Erotic sensitivity of nipple, clitoral, and vulvar tissue is decreased.
Sexual desire is decreased.
Sexual arousal (e.g., vaginal lubrication and vasocongestion) requires more time.
Sexual intercourse may be uncomfortable due to increased dryness and sensitivity of urogenital tissue.
Orgasms may take longer to achieve and may feel less intense.

Table 14–2. Medical and psychiatric causes of sexual dysfunction in late life

Alcohol abuse and other substance use disorders
Alzheimer's disease and other dementias
Anxiety disorders
Arthritis
Cancer (especially urological and genital cancers)
Cardiac disease (e.g., congestive heart failure)
Chronic obstructive pulmonary disease
Diabetes mellitus
Major depression and other mood disorders
Multiple sclerosis
Parkinson's disease
Peripheral vascular disease
Schizophrenia and other chronic psychotic disorders
Stroke

- In general, rates of sexual dysfunction do increase with age,
- with erectile dysfunction affecting about
- one-third of men age 40 and greater than
- two thirds of men age 70,
- and low desire,
- difficult lubrication,
- and anorgasmia affecting approximately
- 40% of older women (Althof and Seftel 1995; Lindau et al. 2007).

- These rates are higher in older individuals who have debilitating physical or psychiatric illness, especially dementia.

Assessment

- Although the assessment of sexual problems in older individuals follows the same general guidelines as in younger patients, several unique considerations are important

- Many clinicians are not comfortable discussing sexuality with older patients and are stymied by ageist beliefs that sex is not common or appropriate in later life.
- Clinicians' counter transferential reactions in which they view older patients as parents or grandparents can add to the discomfort about discussing sex.

- These attitudes not only can prevent important discussions with patients but also can fundamentally disrupt the doctor-patient relationship.

Case Example 2

- Simon is an 82-year-old married man with Parkinson's disease and associated depression.
- His psychiatrist had been treating him for several months with a selective serotonin reuptake inhibitor. Simon's wife Magda often accompanied him to the appointments.
- At their last meeting, Simon asked whether he could take a medication to help with erectile dysfunction that had started while taking the antidepressant.

- The clinician was shocked to hear that Simon and Magda were having sex, and had to suppress a smile while looking at Simon and his elderly, rotund wife sitting next to him. “Why do you need such a pill?” he questioned.

- Simon was upset by the response, and detected an expression of both surprise and disgust on the clinician’s face.
- He wondered to himself whether he was doing something wrong, and felt ashamed and confused.
- After the appointment, he stopped taking the antidepressant and refused to return to the clinician

- Even the most experienced clinician may fail to communicate about sex in a comfortable and appropriate manner.
- The antidote is for clinicians not only to educate themselves about sexual issues, but also to role-play asking patients about sex and verbalizing sexual terminology repeatedly until they can confidently and fluently ask necessary questions (Agronin and Westheimer 2006)

- A basic sexual status examination for the older patient is composed of questions about
- recent changes in sexual function,
- attitudes toward these changes,
- previous history of sexual behaviors and problems,
- and potential psychological and physical causes

- When assessing an older patient, the clinician should ask these questions without any assumptions about what the patient may or may not be doing.

- Questions should center on several main determining factors of late-life sex:
- the individual's interpretation of age related changes in sexual function;
- medical or medication-related physical comorbidities;
- psychiatric illness;
- and the availability, health, and interest of a partner.

- The last issue is particularly relevant, especially now that many older men assume that a single pill might restore not only their erections but also their sexual relationships.

- Sometimes the problem is not physical but rather a result of the poor quality of the relationship with the partner or the lack of interest or sexual ability of the partner.
- Therefore, the clinician should inquire not only about the availability of a partner but also about the state of the relationship.
- Involving the partner in the assessment process can be useful to obtain more information and begin the process of conjoint treatment.

- The medical and psychiatric history and review of systems takes on greater importance in assessing older patients, because their sexual dysfunction likely has an organic cause.
- A combination of factors typically causes the sexual problem, with diabetes, medications, and atherosclerosis being the biggest culprits. Factors that are often overlooked include chronic pain and poor self-image, both of which can lead to loss of libido.

- During the interview, patients should be asked to review all of their prescribed and over-the-counter medications, including dosages and schedules.
- Table lists medications that are commonly associated with sexual dysfunction in late life.
- Identification of all these factors helps to provide numerous avenues for therapy with individuals who may present as quite hopeless about restoring their sexual function.

Table 14–3. Medications associated with sexual dysfunction in late life

Antiandrogens
Anticonvulsants
Antidepressants (e.g., selective serotonin reuptake inhibitors, tricyclic antidepressants)
Antihistamines
Antihypertensives (e.g., diuretics, α-adrenergic blockers, beta-blockers)
Antipsychotics
Cardiac medications (e.g., digoxin, amiodarone)
Corticosteroids

Source. Agronin 2005; Crenshaw and Goldberg 1996; Thomas 2003.

- Laboratory and other more invasive diagnostic tests are sometimes helpful when a suspected endocrine, vascular, or neurological problem may be causing the sexual dysfunction.
- In such a case, the clinician should defer to a consulting urologist, gynecologist, and/or endocrinologist to select the most appropriate diagnostic studies and then evaluate the results.

- For example, a low testosterone level might seem to be an obvious cause of low libido or erectile dysfunction, but more significant abnormalities, especially in older individuals with multiple comorbid diseases, may require the knowledge of a specialist.

- For individuals living in either assisted living or long-term care facilities, the clinician should inquire about sexual interest and barriers to sexuality

Case Example 3

- Charles is an 85-year-old nursing home resident and is dating 78-year-old Sarah, who lives on his floor.
- They often spend time sitting together in the garden holding hands and kissing, which has resulted in some jealous and nasty comments from other residents.
- Charles and Sarah are upset over their lack of privacy, and were extremely embarrassed on one occasion when they heard several nurses giggling outside their doorway.
- The nursing supervisor even called their children without permission and notified them of their sexual behaviors

- Negative attitudes on the part of both staff and residents toward sexuality, coupled with physical illness and disability, loss of libido, and lack of privacy, are some of the main reasons for low rates of sexual activity among long-term care residents

- As a matter of procedure, long-term care institutions should include questions about sexuality during the admission process to assess the needs of each resident
- The facility must inform residents about their rights to associate with whomever they wish, including for intimate purposes, as well as provide beauty services (e.g., hairstylists, barbers, manicurists) and sufficient privacy for couples (e.g., locks on doors, “Do not disturb” signs, and reminders to staff and other residents to always knock before entering someone’s room).

- Clinicians should educate staff members about how sexuality is an important part of well-being that does not cease the moment someone is admitted to a facility (White and Catania 1982)

Treatment

- Many older individuals approach a clinician with a very specific problem (e.g., erectile dysfunction) and request a specific treatment (e.g., an erectogenic pill).

- Clinicians must keep in mind, however, that multiple causes are usually involved, and treatment should involve educating both patient and partner (when available and willing to participate)
- about their sexual concerns,
- ways to enhance sexual function,
- communication skills,
- safe sex, and
- treatment for the specific problem

- This process helps to build trust with the patient so that he or she will feel comfortable returning for follow-up.
- It can also prevent a patient from
- engaging in risky sexual behaviors,
- getting discouraged too quickly when things do not work as expected, and
- avoiding hazardous situations such as using an erectogenic agent while also taking a nitrate medication.

- The treatment process involves liaison with other specialists, such as urologists, gynecologists, cardiologists, and primary care physicians, to help select and implement specific strategies

- Never assume that an older patient is necessarily a more experienced and wiser patient when it comes to sex.
- Certain older cohorts of patients may have been raised in environments or time periods in which sex was not discussed openly or was viewed in a sexist or highly restricted manner, such as only involving sexual intercourse.

- many individuals ignore the risks of STDs, assuming that barrier contraceptives are not needed because pregnancy is not a possibility.
- Finally, patients may be knowledgeable and experienced with sex but feel embarrassed by, unaware of, or overwhelmed by mental or physical issues that are causing the problem.

- Psychotherapy and sex therapy for older individuals and couples will be similar in form to those for younger patients.

Education

- Educating older patients about normal versus abnormal changes in sexual function is critical.
- This will enable them to understand what has changed in their bodies and may prompt their own thoughts about underlying causes.
- Education also informs patients of the basic terminology for sexual function and builds a comfort level to help them discuss it with their clinician and partner.

- Ideally, education should also help patients feel positive and hopeful about their own sexual functioning.

- Several ways to teach the patient to enhance sexuality in late life are listed in Table
- Patients should be taught, first and foremost, that sexuality is normal and expected in later life, regardless of what they perceive others may be thinking or saying.

Table 14–4. Maximizing sexual function in late life

Maintain a positive attitude toward sexuality.
Communicate with partner about sexual changes.
Increase sexual foreplay.
Use lubricants to increase comfort.
Recognize that sexual intercourse is not the only means of sexual gratification.
Treat physical symptoms (e.g., shortness of breath, pain) and medical problems that may interfere with sex.
Treat depression or other psychiatric conditions that may interfere with sex.
Reduce psychological stress.
Find creative ways to adapt to physical disabilities.
Identify and address problematic medication side effects.
Participate in physical exercise.
Avoid tobacco use and excessive alcohol intake.

- Sexual performance can be enhanced by optimizing physical and mental health, which may involve
- regular exercise,
- reduction of stress,
- dietary changes,
- avoidance use of alcohol,
- and avoidance of tobacco products.

- patients should know about the use of foreplay to increase sexual arousal, especially in later life when more sustained stimulation may be necessary to achieve orgasm.
- Numerous water-based lubricants, sold in drugstores, can increase pleasurable stimulation, especially for postmenopausal women whose genital tissue is drier and thinner and tends to lubricate less during sexual activity. Safe sexual practices should also be taught

Addressing Physical Symptoms and Disabilities

- For some patients, the major barrier to sexual activity is a physical symptom ,
- such as pain or shortness of breath,
- or a disability, such as hemiparesis due to stroke or
- bradykinesia resulting from Parkinson's disease.

- Some individuals, such as those who have had a recent myocardial infarction or who have pulmonary disease, may fear that physical exertion will be dangerous.

- Individuals who have had urological or gynecological surgery or certain treatments for cancer (e.g., radiation) may have diminished or even painful sexual arousal because of nerve or vascular damage, or because of more sensitive and friable erogenous tissue

- Finally, some individuals may be embarrassed by changes in physical appearance due to illness (e.g., having to wear a colostomy bag) or may feel too encumbered by in-dwelling catheters or oxygen tanks to even consider sexual activity

- For each of these situations, the clinician needs to keep in mind that both physical barriers and psychological attitudes have to be addressed.
- A first step in treatment is to define not only the sexual problem but also the goals.

- For some individuals, sensual kissing and genital stimulation may be a more realistic goal than sexual intercourse.
- In other cases, intercourse may be possible but require both time and creativity to account for limitations.
- For still other couples, just talking about sex or trying to be intimate can be as gratifying as sex itself.

Case Example 4

- Edgar and Mary have been married for over 45 years.
- Edgar has Parkinson's disease and significant bradykinesia.
- Mary recently had a mastectomy for treatment of breast cancer and is self-conscious about her physical appearance.

- The last time they attempted intercourse, Edgar was able to get an erection but had a very difficult time maneuvering on the bed to vaginally penetrate Mary.
- They were eventually able to have intercourse, but it was uncomfortable for Mary, and neither was able to achieve orgasm

- The clinician discovered that the main strength that Edgar and Mary have
  is a long-standing stable and loving marriage.
- From the assessment, the clinician needs to ascertain what the couple's sex life was like in previous years, because that information will help establish their overall goals.

- Partners who have had only intermittent sexual intercourse rarely both want suddenly to have sex all the time, and the pressure for more sex from one partner (such as from a man who begins using an erectogenic agent) could actually be a destabilizing factor.
- In this case, the clinician learned that Edgar and Mary used to have sexual intercourse about once a month and that their current goal is quite modest.

- Given their initial limitations, a first step in treatment might be to talk about other ways in which they could be physically intimate in addition to intercourse
- A lubricant would help Mary feel more comfortable with genital stimulation and vaginal penetration.

- Because Mary is self-conscious about her appearance, the therapist could initiate some discussion with her alone about her feelings in the wake of surviving breast cancer, and then with the couple together to increase her comfort level.

- One helpful suggestion to reduce her self-consciousness and increase arousal for both partners might be for her to wear lingerie that helps her feel sexy without being too revealing of surgical scars.
- For Edgar, a discussion with his neurologist is important to maximize treatment for his Parkinson's disease and improve his bradykinesia

- The timing of his medications could potentially be adapted to optimize his physical movements around the
usual time of lovemaking.
- Similarly, some patients can be advised to pretreat their pain with analgesics or their shortness of breath with inhalers prior to sexual exertion.

- Also, Edgar's lack of motivation and libido may be due to depression, commonly associated with Parkinson's disease, that warrants evaluation and treatment.
- Finally, even under the best circumstances, Edgar has limitations in the speed and dexterity of his movements, and might be able to perform sexual intercourse better while lying on his back with Mary astride him, or while kneeling on the bed with Mary in front of him.

- Such simple strategizing about positions during sexual intercourse not only enhances intimate communication but often leads to a solution to the problem.

- Edgar and other men with erectile dysfunction, a phosphodiesterase type 5 (PDE5) inhibitor, such as sildenafil, tadalafil, or vardenafil, is the simplest and most effective treatment.
- Sildenafil and vardenafil can be taken 30 minutes to 4 hours before anticipated sexual activity,
- and tadalafil can be taken up to 30 hours earlier.

- No single agent has been shown to be safer or more efficacious than another in the older patient

- Patients who are taking PDE5 inhibitors need to be educated that erections do not occur spontaneously but require physical stimulation.
- They should also be warned about potential side effects, including
- headache,
- skin flushing,
- dizziness,
- gastrointestinal discomfort,
- blurred vision,
- and the potential for blood pressure decreases when combined with nitrates (e.g., isosorbide, sublingual nitroglycerin).

- PDE5 inhibitors should be used with caution in men with
- orthostatic hypotension,
- severe renal or hepatic disease,
- abnormal penile shape, and
- diseases that increase the risk of priapism, such as
- sickle cell anemia,
- multiple myeloma, and leukemia,
- as well as men concomitantly using certain antiviral and antifungal medications.

- A rare but potentially devastating side effect of PDE5 inhibitors is non arteritic anterior ischemic optic neuropathy, characterized by the rapid onset of visual loss. Changes in visual acuity that occur while taking a PDE5 inhibitor require immediate assessment.

- If low testosterone or hypogonadism is found to be the main cause of erectile dysfunction, treatment will require testosterone replacement therapy in the form of a pill, transdermal gel or patch, intramuscular injection, or subcutaneous implant

- For men who cannot tolerate or have contraindications to the use of either a PDE5 inhibitor or testosterone replacement (e.g., a history of prostate or bladder cancer or bladder outlet obstruction), alternative treatments include penile injections or urethral suppositories of erectogenic agents, such as alprostadil,or the use of a vacuum constriction device

- These latter techniques may be less convenient than an erectogenic pill but can still restore erectile function in the majority of men with erectile dysfunction

- When medication-induced side effects are problematic, the clinician should involve the primary care physician and other prescribing physicians to seek dose reductions or alternate medications, when possible.
- Medication induced erectile dysfunction can also be treated with oral erectogenic agents.

- Medication-induced loss of libido, delayed arousal, or anorgasmia can be more difficult to treat and sometimes must be tolerated when the offending medication is critical for survival.

- Although couples may face myriad other situations, the basic principlesused to treat Edgar and Mary apply across the board:
- identify all aspects of the problem and
- set realistic goals,
- adapt sexual behaviors and positions to physical limitations,
- treat interfering medical symptoms and
- conditions prior to sexual activity, and
- communicate about creative ways to address concerns about physical appearance.

Sexuality and Dementia

- When working with individuals who have Alzheimer's disease or other forms of dementia, clinicians should keep in mind that sexuality often remains an important nonverbal means of communication for couples

- However, rates of sexual dysfunction do increase because dementia often impairs the knowledge and mental concentration for proper lovemaking

- One study found that 27% of couples with a partner affected by Alzheimer's disease were sexually active, compared with 82% of couples without dementia

- For individuals with dementia, erectile dysfunction is common in men, occurring in more than 50% of men in one sample and inhibited orgasm is common in women

- Acetylcholinesterase inhibitors and the *N*-methyl D-aspartate antagonist memantine, which are used to treat Alzheimer's disease, have not been associated with sexual dysfunction.

- Navigating sexual activity can be particularly challenging for many partners of individuals with dementia, because they may worry that they are coercing the partner who cannot truly provide consent.
- They may also feel turned off by the dementia symptoms or guilty about desires for extramarital affection.

- Some spouses are upset by disinhibited or uncharacteristic sexual desires or behaviors expressed by their partners with dementia or by repeated requests for sex from partners who cannot remember the last time they had sex

- Sexually inappropriate behaviors are seen in 2%–7% of patients with dementia in the community and in up to 25% of those in long-term care facilities

- These inappropriate behaviors include
- hypersexual behaviors (e.g., repeated requests for sex, compulsive masturbation),
- disinhibition (e.g., publicly exposing or sexually stimulating oneself), and
- sexually aggressive behaviors (e.g., forcibly groping, fondling, or forcing sexual activity on another person)

- In the assessment, the clinician should look for the following factors that may increase the risk of these behaviors:
- frontal and temporal lobe pathology,
- underlying mania or psychosis,
- medications such as psychostimulants or dopaminergic agents,
- substance abuse,
- head trauma,
- delirium, and
- lack of sufficient mental or physical stimulation in the environment

- The clinician should also keep in mind that most individuals, even in severe states of dementia, still benefit from soothing physical contact of a nonsexual nature.
- In addition, not all problematic behaviors are sexual in nature.

Case Example 5

- A psychiatrist was asked to see a 92-year-old nursing home resident with dementia for reports of sexually inappropriate behaviors.
- The patient reportedly was disrobing in public and inappropriately touching female staff.
- Further investigation revealed that the patient often leaves the bathroom with his pants down and genitals exposed because his apraxia prevents him from knowing how to pull up and zip his pants.

- In addition, he has moderate aphasia and is unable to adequately express his needs.
- Instead, he often becomes agitated and reaches out physically at staff when he needs help.

- In this case, the behaviors under assessment are not sexual in nature, but reflect cognitive impairment and require more attentive caregiving.
- Unfortunately , many individuals in such settings are incorrectly labeled as sexually aggressive and are in effect punished for their behaviors by physical isolation or chemical restraints.
- A thorough clinical assessment should prevent such mistakes.

- Sometimes the most important thing that a therapist can offer to a couple affected by dementia is reassurance that sexuality can continue to be part of their relationship.
- As the dementia progresses, however, the clinician should assess the individual's cognitive capacity to make sure that he or she understands the nature of the relationship and is still able to consent to sex

- Inappropriate sexual behaviors by individuals with dementia can be quite upsetting for partners and for caregivers, and are generally challenging to treat.
- Such behaviors require verbal limit setting and redirection to more appropriate activities or settings without ever reinforcing them by laughing or joking in response to them.

- Sometimes one can identify and treat an underlying cause, such as hypersexuality due to mania or psychosis, which may respond to the removal of offending stimulating medications or to the addition of appropriate psychotropic medications.
- When sexual behaviors appear to reflect unmet needs for intimate contact, available partners can sometimes provide additional physical or even sexual stimulation.
- This approach is risky , however, and can sometimes backfire

Case Example 6

- Marvin was an 82-year-old divorced man with moderate dementia who had always had a very strong libido and an active sex life.
- When he was caught forcing himself sexually on another resident in the nursing home, staff informed the son that his father might have to be discharged.
- The son began bringing in a masseuse to pleasure his father in the privacy of his room on a regular basis

- Although Marvin enjoyed this immensely, it only seemed to fuel his libido, and he was again caught forcibly fondling another female resident.
  He was subsequently discharged from the facility

- In Marvin's case, sexual stimulation worsened the situation.
- Given the degree of his dementia, a better strategy would have been to try to lessen his libido and impulsivity with one of several medications
- an antidepressant,
- an antipsychotic,
- or a mood stabilizer.

- Just as these classes of medications are used to treat agitated behaviors, they sometimes can improve sexually inappropriate behaviors as well .
- When these fail, hormone therapy with either estrogen or the antiandrogen medroxyprogesterone can be considered, although these run the risk of problematic side effects such as gynecomastia, glucose intolerance, and liver dysfunction.

Key Points

- Sexuality continues to be an important part of the lives of older individuals, and surveys indicate that a significant percentage of older people remain sexually active and are generally satisfied with their relationships.

- Sexual dysfunction increases with age, with erectile dysfunction most common in older men and low desire most common in older women.

- Assessment of sexual dysfunction in late life must focus on identifying causative factors that can often be treated, such as
- pain,
- depression,
- medication side effects, and
- chronic medical or psychiatric conditions.

- Sexuality continues to be an important aspect of well-being in long-term care facilities and requires proper staff education and the provision of appropriate accommodations, such as beauty services and adequate privacy.

- Dementia poses a unique challenge to sexuality, because it can cause increased rates of sexual dysfunction and rob individuals of their capacity to engage in and consent to sex.
- It can also cause sexually inappropriate behaviors.

Older Adults & Sexuality Quiz
True or False

- Sexual activity in aged persons is often dangerous to their health (F)
- Sexuality is typically a lifelong need (T)
- The sex urge typically increases with age in males over 65 (F)
- There is a decrease in frequency of sexual activity with older age in males (T)
- Prescription drugs may alter a person's sex drive (T)
- Sexual behavior in older people (65+) increases the risk of heart attack (F)
- Most older females are sexually unresponsive (F)

- The firmness of erection in aged males is often less that that of younger persons (T)
- There is evidence that sexual activity in older persons has beneficial physical effects on the participants (T)
- There is a greater decrease in male sexuality with age than there is in female sexuality (T)

- Fear of the inability to perform sexually may bring about an inability to perform sexually in older males (T)
- There is an inevitable loss of sexual satisfaction in post-menopausal women (F)
- In the absence of severe physical disability males and females may maintain sexual interest and activity well into their 80s and 90s (T)