Future Directions for Research and Practice in Sexual Health for Older Adults

13

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13.1 Introduction

As the world's population is aging, older adults have become the fastest growing subpopulation. Between 1950 and 2017, the number of people aged 60 or older quadrupled. With further doubling projected over the next few decades, the world would see an estimated 2.1 billion people over the age of 60 by 2050 [1]. This demographic shift will create specific new challenges for policy makers given its expected impact on health and social systems. This was already made evident in the United Nation's report on an aging world in 2017, which promoted concepts such as active and healthy aging and mostly focused on prevention of noncommunicable diseases as well as mental and cognitive issues [2]. Despite ever-louder calls for a substantial "life course approach" [2], sexual health remains a so-called "topic of minimal interest" [3, 4]. Policy makers and health researchers tend to consider the topic taboo and often neglect the role that sexuality and intimacy play in quality of life in older adults and maintaining good health in older age [3]. Various chapters in this book detail both the role of sexuality, sexual activities, and intimacy as well as the reasons why they are neglected in research and healthcare of older adults. In this chapter, we will instead outline some of the foci that should be prioritized in the coming decades for better and broader inclusion in both research and practice of the sexual health of older adults. The following is an incomplete list of topics, which existing research and practice have brought to the forefront.

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13.2 Prevention of Sexually Transmitted Infections in Older Adults

There is a considerable gap in the literature on epidemiological trends of sexually transmitted infections (STIs) in older adults. This is mostly connected to the fact that most national and international data gathering efforts do not extend after the age of 45 and also to the lack of routine assessments of sexual health in older adults by healthcare professionals [5]. However, the literature that does exist highlights higher vulnerability of older adults towards STIs. While the overall prevalence and incidence of STIs still seems to be low in older adults (compared to younger adults), some recent literature in the field suggests that overall numbers in this particular population group are indeed rising [5–7]. This may be due to lack of knowledge on measures for protection and prevention of STIs, or physiological issues such as vaginal dryness and erectile dysfunction (for more information see Chap. 7).

Setting "*Prevention of sexually transmitted infections*" as a priority for research in the field of sexual health in older adults is important not only from the point of establishing a good epidemiological overview of the situation, which will aid in creating the appropriate preventive programs targeting this population (and their evaluation), but it will also improve the visibility of these issues among healthcare practitioners which is urgently needed. Late presentation and recognition of STIs in older adults is well established as a problem for public health, leading to late therapeutic intervention detrimental for recovery as well as increasing risk of complications in individuals and spread of disease in the population. With regard to infections with the human immunodeficiency virus (HIV) and its treatment, more research is necessary on the effects of antiretroviral therapy (ART) in older patients, as some studies have recently shown slower response rates in patients over the age of 50 [8]. More so, even though ART has shifted HIV to a chronic lifelong condition, the effects of ART on the aging process is severely understudied and healthcare providers require more data to aid in prescribing the appropriate therapies to their older and aging patients [9].

13.3 Effects of Noncommunicable Diseases and Medication on Sexual Health of Older Adults

Chronic noncommunicable diseases show a rising prevalence in older adults, with multimorbidity—defined as having two or more chronic diseases concurrently—also rising with age. More than 60% of people over the age of 65 have two or more chronic diseases [10, 11]. Yet, good health is an important factor in maintaining sexual activity during the life course. Chronic physical and mental illness has an obvious effect on sexual activity in a large number of older adults. On the other hand, maintaining sexual activity throughout the life course also contributes to better health in later life [12, 13].

Policy makers should feel incentivized to focus more on the health issues of older adults given the demographic shift and the rising pressures it creates on health

and social systems. However, the influence of chronic diseases and multimorbidity on sexual health and well-being in older adults is largely ignored in various policy work and international calls for active and healthy aging. While overall research in this field is lacking, existing studies have shown that chronic diseases and multimorbidity mediate sexual function by limiting physical function, reducing mobility, increasing pain, influencing mood and desire, as well as reducing self-esteem (for more information see Chap. 10). Chronic diseases and conditions such as arthritis, type II diabetes mellitus, cardiac disease, obesity, renal disorders, lung diseases, as well as prostate and ovarian cancer and more have all been associated with sexual dysfunction in older adults [14–16].

The rise in multimorbidity is usually followed by a rise in prescription medication. While these are often needed to maintain the health status and quality of life, older adults are under particularly high risk of receiving more than one prescription medication, often resulting in polypharmacy [17]. Prevalence of polypharmacy varies between countries and studies, but most studies report between 30% and 50% of older adults being prescribed 5 or more medications [18]. Some reports also note between 10% and 15% of older adults showing excessive polypharmacy (meaning the concomitant use of more than 10 medications) [19, 20]. While polypharmacy is a major public health concern as it may lead to dangerous therapeutic combinations and side effects, it may also pose a problem for the sexual health of older adults taking the medication (for more information see Chap. 9). While most healthcare practitioners are aware of this problem, the evidence on the effects of medication and their combinations on sexual function in older adults are largely anecdotal [21]. Sexual dysfunction is most commonly precipitated by the use of antihypertensive medication (beta-blockers and diuretics), antiandrogens, antipsychotics, and antidepressants, but more research in this field is crucial [21–23].

Given the virtual lack of evidence on the effects of chronic illness and medication use on sexual function in older adults, older adults need to be considered and included in clinical trials for new medication in a first instance [24]. However, questions on sexual activities, including experience of potential sexual dysfunction but also sexual satisfaction, are also paramount. Doing so will not only develop this field of research but will also be important for healthcare providers. Older adults do want and need information on sexual activity from their healthcare providers and show much of the same concerns as other patients in younger age groups (information on how to promote a positive atmosphere when talking to older adults on matters of sexual health in the clinic see Chap. 12).

13.4 Research Focusing on Sexual Satisfaction as Well as Positive Effects of Sexual Activity on Health of Older Adults

Overall, the majority of literature on the sexual health of older adults focuses on physiological and negative effects such as vaginal dryness, painful intercourse, anorgasmia, or erectile dysfunction. Only few studies focus either exclusively or

additionally on sexual satisfaction. However, the topic of sexual satisfaction is of key importance for older adults as changes in physical functioning will also affect views and experiences of sex and sexuality. Sexual satisfaction is a highly individual concept that may be difficult to generalize. Overall, it may include positive feelings about one's body, arousal, pleasure, openness, and orgasm, but may also include relational factors such as intimacy, romance, creativity, and emotions among others [25]. Therefore, sexual health and having a "positive sex life" do not relate only to medical issues. Sexual health is personal; it has social, mental, and emotional aspects. More so, even though older adults still report relatively high activity in penetrative sex (vaginal and oral), considerations of sexual activity in older adults must also involve questions on kissing, fondling, (mutual) masturbation, and other activities. There are also differences in how men and women define having a "positive sex life," with men focusing more on the frequency of sexual intercourse and women more on enjoyment of intercourse. These factors have also been found to act as protective factors for premature mortality [26–31].

As noted above, good health is important for sexual activity, but sexual activity is also important for good health. Various studies have established that "frequent sexual intercourse" (equal to or more than twice a month) is associated with improved mental and physical health outcomes. Also, sexual activity—both in terms of intercourse and other activities such as kissing, fondling, and petting—has, for instance, been found to be associated with greater enjoyment of life in older adults in England [32].

It is important to create a safe environment with patients so sexuality can be openly discussed without stigmatization or stereotyping (for more see Chap. 12). This means likewise that future generations of healthcare practitioners need to be taught how to not only retrieve important medical information but also establish meaningful dialogue with their patients and provide them with enough and appropriate information so they can make informed decisions themselves. Such information will have to go beyond preventing or treating sexual dysfunction and include maintaining positive and satisfactory sexual lives far into older age.

13.5 Diversity Aspects in Research and Practice of Sexual Health of Older Adults

With the evidence base on various aspects of sexual health in older adults lacking overall, original research on diversity issues regarding the sexual health of older adults is no exception. The bulk of available research focuses almost exclusively on heterosexual cisgender older men. Moreover, most research in sexual health so far has focused on sexual dysfunction rather than salutogenetic aspects of sexual activity for overall health and well-being. Together, these foci have resulted in an overrepresentation of issues around erectile dysfunction in the literature.

More recently and in light of aspirations for more gender inclusivity in research, a number of articles and meta-analyses have focused on female sexual health—albeit, again, mostly on dysfunction rather than satisfaction. With regard to the latter,

researchers have highlighted the effects of gender inequality in their reports on women's sexual satisfaction. For example, within the Global Study of Sexual Attitudes and Behaviours (2004) and an extensive dataset from 29 countries covering 27,500 men and women, researchers focused on four components of sexual health: satisfaction, physical pleasure, emotional pleasure, and importance of sex. The analyses exposed three different clusters or "sexual regimes": gender equal, mixed, and male-centered [33, 34]. These "regimes" highlighted differences in the way women rate their overall sexual satisfaction with their sexual function across regimes, with satisfaction being highest in "gender equal" regimes (median satisfaction 78%), moderate in "mixed" regimes (median satisfaction 56%), and lowest in "male-centered" regimes (median satisfaction 45%). Similar trends were also seen for other components analyzed. Even more interestingly, women had consistently lower scores across all three regimes compared to men, with differences being larger in more male-centered regimes [33]. These results were further validated by a meta-analysis in 2016 by McCool et al. [35], where a positive correlation between the prevalence of level of gender inequality and sexual dysfunction in women was also demonstrated. Upon further stratification, the authors also found that regions mostly situated in the Global North reported prevalence levels of female sexual dysfunction below 40%, with developing regions reporting rates higher than 62%. In light of the "regimes" identified in the 2004 Global Study, McCool et al. did not find significant differences with regard to sexual satisfaction. However, they did note lower rates of dyspareunia, difficulties with lubrication, and anorgasmia in "gender equal" regimes compared to "male-centered." In 2018, McCool-Myers [36] performed a systematic review update and a qualitative analysis of the results, and reported specific risk factors associated with sexual satisfaction in women in relation to the previously established "sexual regimes." Risk factors in countries with "gender equal sexual regimes" included cardiovascular disease, taking antidepressants, sleep problems, and polypharmacy, while in the "mixed" and "male-centered" regimes risk factors were mostly associated with early partnership and reproduction: young age at marriage, having an older partner, being in an arranged marriage, high number of births, but also nulliparity. They also reported unique predictors including genital mutilation, rural living, dieting, and restrictive upbringing. The study also found that most of the research from European and Western countries reveals a significant gap in the literature. Overall, older age, poor health, and relationship dissatisfaction were found to be significant predictors for female sexual dysfunction across all "sexual regimes." Even as more evidence is being gathered on the experiences of women and female sexuality, much more research is still needed that seriously takes into account socio-medical aspects of gender inequality that is context-specific.

Notably, none of the studies mentioned above include issues of sexual and gender diversity. While we could assume that all study participants are simply heterosexual cisgender men and women, the more likely explanation is that questions of sexual and gender diversity are not even posed during data collection. The reasons for this are multifaceted and may be due to prevalence of heterosexual participants in community-based studies or the reluctance of sexual and gender minorities to disclose their sexuality and gender identity to researchers. Yet, research must also be

assumed to be inherently biased towards assuming heterosexuality and cisgenderism in participants [37, 38].

Lesbian, gay, bisexual, transgender, intersex, and queer people (LGBTIQ+) as a whole report worse physical and mental health outcomes compared to heterosexual and cisgender people [39]. Reasons for this vary, but one of the most prominent is minority stress due to stigma experienced for being nonheterosexual and/or transgendered. Minority stress is caused by (unwilling) nondisclosure of one's identity, as well as having experiences of discrimination, but also having internalized and anticipating discrimination [40, 41]. Living in hostile environments has been shown to be associated with worse health outcomes. A 2019 study by Grabovac et al. [42] analyzed cross-sectional data from the nationally representative English Longitudinal Study of Aging and reported that lesbian, gay, and bisexual older adults in England had lower quality of life scores and lower levels of sexual satisfaction compared to their heterosexual counterparts. Given the lack of data, however, no analyses were possible for transgender, nonbinary, or intersex individuals. Overall, some studies also report that gay men experience more ageism, and LGBTIQ+ people may be more at risk for loneliness and isolation due to their inability to live in legally recognized unions in most parts of the world. The ability to live in a legally recognized union has indeed been associated with less psychiatric morbidity and psychological distress [43–45]. In 2020, a cross-sectional study by Fleischmann et al. [46] reported that men and women aged 60–75 living in same-sex relationships showed high levels of relationship satisfaction and resilience, moderate levels of sexual satisfaction, and low levels of internalized homophobia. No other studies focusing on sexual activity or sexual satisfaction/dysfunction in older lesbian gay or bisexual individuals could be identified.

Older transgender individuals are even less present in the literature, with no studies at all available on aspects of sexual health in transgender older adults. However, a 2022 study using data from 325 participants of the ENIGI (European Network for the Investigation of Gender Incongruence) study did report, using the Amsterdam Sexual Pleasure Index, that younger age (as well as current happiness and genital body satisfaction) was associated with more sexual experiences of sexual pleasure, indicating that older adults experience less sexual pleasure [47]. Additionally, in a 2014 study by Friedriksen-Goldsen et al. [48] transgender older adults were found to be at a significantly higher risk for poor physical health, disability, depression, and stress compared to their cisgender counterparts. We may hypothesize that given the data indicating overall poorer health in transgender older adults, there is also a significant prevalence of sexual health issues and low sexual satisfaction. Finally, nonbinary and intersex people are virtually invisible in the literature concerning sexual health. With their experiences in the healthcare system being reportedly mostly unsatisfactory and problematic (high levels or stigmatization and discrimination), it is highly likely that the levels of dissatisfaction and poor health outcomes for intersex and nonbinary people are similarly high.

Beyond gender and sexual orientation, the relationship of physical disability and sexual health is significantly understudied. As levels of physical disability rise with age and multimorbidity, it is crucial to investigate the experiences of non-ablebodied

older adults, and to create environments and techniques that would allow for satisfactory sexual activities. In a 2003 study by McCabe and Taleporos [49], 1196 people aged 18–69 were interviewed (60% having a physical disability). The authors report that people with more severe physical impairments experienced much lower levels of sexual self-esteem and satisfaction compared to those with milder forms of disability or no disability at all. A study on the use of aids for sexual activity in middle-aged adults with long-term physical disability did show that use of aids was generally associated with better sexual function, but this result varied by type of disability. Overall, the lowest levels of sexual satisfaction were found in men with spinal cord injury [50]. In 2003, Onder et al. [51] analyzed data from 980 women with moderate to severe disabilities aged 65 and older, using data from the 1992/1995 Women's Health and Aging Study. Their report showed that around 50% of women who lived with a spouse describe being satisfied with their sexual activity. Older age, being Caucasian, and having higher levels of physical functioning were shown to be associated with more sexual satisfaction. It is important to note that disability does not reduce desires for intimacy. However, due to harmful portrayals in the media and overall underrepresentation in research, stereotypes are created which often infantilize people with disability and propagate views of them as "asexual" [52]. Such stereotypes and biases need to be challenged by increasing, both in media and in research, the presence of people with disability. Only such, safe environments can be created where topics of sexual functioning and activity can be discussed with healthcare providers and the evidence is there to provide adequate care.

13.6 Making Sexual Health of Older People a Health Policy Priority

The demographic shift and rise of older adults as a subgroup within the world population have already incentivized international policy change that voices the needs of healthy aging. However, sexual health remains a "topic of minimal interest" for both researchers and practitioners. Where there is interest, it is usually focused on experiences of heterosexual and cisgender older men—less so, but also on women—and focuses mostly on medical issues and dysfunctions connected to penetrative sexual intercourse. This means that older adults rarely get the type of help they need from a healthcare system not designed for their sexual health needs and concerns.

The introduction of the Millennium Development Goals and Sustainable Development Goals, which both aim to ensure healthy lives and promote well-being of all ages, provided opportunity for the promotion of age-inclusive health and social systems that would provide a holistic view of older adults as patients [53, 54]. Ideally, this would include the sexual health needs of older adults, especially as they were recognized as significantly excluded from accessing appropriate sexual health services. However, little has changed so far [55].

To achieve change, effective strategies for large-scale epidemiological studies need to be created, with questions on both sexual health and practices routinely assessed. Beyond that, more qualitative work still needs to be done on the meaning

of sex and sexuality, and so as to investigate both facilitators and barriers experienced by older adults. Furthermore, researchers, practitioners, and policy makers alike need to actively work to diminish the cultural stereotyping of older adults as being “asexual” or “celibate,” and to promote healthy and positive views of sexuality in older age. This societal shift dovetails recent research showing that older adults today are much more open on topics of sex and sexual activity than the generations before them. Such changes might be expedited if researchers, practitioners, and policy makers took a clear stance.

13.7 Final Remarks

There is much work to be done in research on the sexual health of older adults. More attention needs to be afforded to the life experiences of older adults, and how sexuality and sexual activity fit into them. This means both the experiences of sex and sexuality of older adults with multimorbidity and chronic illness, but also an understanding of older adults as a very diverse group. Older adults are people of various gender identities and expressions, sexual orientations, ethnicities, socioeconomic status, religious beliefs, and more. All of it affects sexual activity and sexual health. More research should result in more advocacy work and policy change to reflect the needs of older adults, provide appropriate access, and assure that they get the help they need from their healthcare providers. The sexual health of older adults must therefore be included as a key topic in the training of future healthcare professionals and in courses for the continuous education of practitioners already working.

The above list is neither exhaustive nor complete and presents only the opinion of its author and his limited research experience. The list should be viewed as signposts to highlight the areas where more work is desperately needed, while keeping in mind that the sexual health of older adults is, as a whole, still underresearched or not properly understood.

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