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Older Adults and Sexual Health: A Review of Current Literature

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Abstract The sexual health of older adults is part of their overall health but significantly under researched and often unaddressed. Health care practitioners (HCPs) and mental health counselors admit they are not trained to address sexual health and frequently ignore or underestimate older adults' sexual health concerns. This article summarizes the barriers to sexual health care for older adults and the current literature understanding effects of aging on sexual function and dysfunction. Areas for further research are discussed.

Keywords Older adults · Aging · Seniors · Sexual health · Sexual activity · Sexual functioning · Sex · Sex therapy · Sexuality counseling · Medical professional sexuality education

Overview

Older adults are the fastest growing segment of the population in the USA. In 2000, one in ten persons was over 65, and in 2030, one in five will be over 65. Currently, 14.1 % of the US population is 65 or older [1]. With increased age comes a greater possibility for chronic illness and disability and a disproportionately greater use of health and public health care services compared to those under 65. Although sexual health is a vital part of general health, health care practitioners and mental health counselors are ill prepared in understanding and addressing the sexual problems faced by older adults.

This article provides an overview of terminology for sexual health and sexual activity, addresses barriers to effective education and treatment regarding sexual health concerns for older adults, and reviews current literature addressing sexual health and activity.

A literature search of PsycINFO and PubMed databases was performed with an emphasis on articles published in the last 3 years (search terms included older adults, aging, sex therapy, sexual medicine, sexual health, sexual problems, sexual dysfunction, sexual activity, sexuality education). Articles of importance and of major importance are noted in citations.

Several key survey research studies addressing sexuality and aging are discussed to highlight the discrepancy between a growing and increasingly significant literature surveying older adult attitudes about sex and an almost nonexistent literature on provider education. There is also a scarcity of research discussing models for understanding sexual responsivity and treating sexual problems for older adults. Treatment interventions will be covered in a separate article.

Sexual Activity and Sexual Interaction Over 60: Definitions and Models

Sexuality is defined by the World Health Organization (WHO) as a biopsychosocial phenomenon comprised of physiologic functioning, psychological factors specific for each person, and sociologic/interpersonal/cultural environment contributors to personal sexual health and well-being. The WHO further defines sexuality as not only safe but also including the "possibility of sexual experiences that are pleasurable" [2]. The WHO includes no age limit for healthy sexual experiences.

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The inclusion of *pleasure* is important. Sexual satisfaction and pleasure are rated highly by older adults, especially those in good health [3, 4••]. Many, including the National Social Life, Health, and Aging Project (NSHAP) surveys, have looked closely at sexual health for older adults in the last two decades [5–7]. These studies place the span of older age variously (57–85, 40–80, 57–85). Others' research includes those in their 90s [8•]. Sex matters to older adults, but there is no other time in life when vitality, health, sexual interest, and activity are as variable from person to person as in older age.

Definitions of Older Age and Sexuality Activity

Age There is no common agreement about when older age actually begins. In this article, 65 years—the onset in the USA for Medicare health coverage—will be used to demarcate the socially defined beginning of older age.

Sexual Functioning DeLameter defines sexual functioning as, "… one's ability to engage in sexual expression and sexual relationships that are rewarding, and the state of one's physical, mental, and social well-being in relation to his or her sexuality" [9•].

Sexual Activity In research, sexual activity remains a commonly used but little understood term, often used as a synonym for "sexual intercourse," "sexual functioning," or "intimate relations" [10–12].

For NSHAP surveys, it is "any mutually voluntary activity with another person that involves sexual contact, whether or not intercourse or orgasm occurs" [5].

"Sex" is commonly defined as "the sphere of interpersonal behavior especially between male and female most directly associated with, leading up to, substituting for, or resulting from genital union" [13].

These definitions are problematic because they do not capture the changes in older adult sexual activity as discussed herein. The author therefore proposes that sexual activity be defined herein as the "sphere of behavior and pleasurable thought most directly associated with, leading up to, or resulting in sexual arousal, excitement, satisfaction, and/or pleasure with oneself and/or others."

Viable Human Sexual Response Models for Older Adults

The human sexual response cycle has been reconfigured to directly reflect the experiences of many. Historically, the Masters and Johnson (excitement, plateau, orgasm, resolution) or triphasic (desire, arousal, orgasm) models were considered normative [14].

Women More recently, Rosemary Basson and colleagues have introduced a nonlinear model of the female sexual response cycle that includes physical and emotional satisfaction and sexual pleasure. The Basson model is well researched and represents an accurate understanding of sexual arousal and responsivity for many women [15–17]. The model emphasizes willingness, motivation, intentionality, and individual sexual satisfaction rather than a performance model. Although the triphasic model continues to be endorsed by some, the Basson model calls into question the need for "desire" to exist as a separate distinct category prior to arousal. By indicating that interest/desire and arousal are neither distinctly separate nor exactly the same for all, Basson's model supports individual variances in sexual response and also endorses the biopsychosocial nature of sexual response [16].

Men AARP conducts semi-decennial research on "Sex, Romance, and Relationships: AARP Survey of Midlife and Older Adults." The 2009 survey employs a representative sample of the US population aged 45 and older. Thirty percent of men report that they "never" or "just sometimes" are able to maintain erections sufficient for penetrative sex, indicating a high correlation with illness and medication related problems [18]. Despite promising integrative treatments for erectile dysfunction (ED), older men will continue to have treatment resistant ED due to confounding factors [19••].

Interestingly, many men in the AARP study continue to report sexual satisfaction even if they are not able to have penetrative sex [18]. Newer sexual response models need to be developed reflecting older men's experience of sexual satisfaction and pleasure. The more "performance" or "erection focused" male models simply do not reflect all older men's experiences of continued sexual satisfaction even if erection does not occur [9•, 20, 21•]. Wittmann describes such a model for survivors of prostate cancer and their partners, a model that could well be adapted to the experience of many older adult men [22•, 23••].

Diagnostic and Statistical Manual of Mental Disorders (DSM) IV and DSM 5 Sexual Disorder Classifications The recent transition from DSM IV to DSM 5 classification of sexual dysfunctions is confusing to many. Although the DSM 5 no longer recognizes women's Hypoactive Sexual Desire Disorder (HSDD) as a separate category, the FDA continues to invite research on this topic [24] and it is subsumed under Female Sexual Interest-Arousal Disorder (FSIAD).

Aging, chronic illnesses/treatments, medications, and substance abuse contribute to sexual problems. Sexual dysfunctions affecting older adults include:

Male	Desire disorders
	Erectile disorders
	Premature (early) ejaculation
	Inhibited/retrograde ejaculation
	Genitopelvic pain
Female	Female Sexual Interest Arousal Disorder (FSIAD), includes Hypoactive Sexual Desire Disorder (HSDD)
	Orgasmic disorders–anorgasmia
	Genito-pelvic pain disorder including dyspareunia and vaginismus

Cultural Problems Affecting Sexual Health for Older Adults

Myths and Misconceptions

Cultural ignorance creates misinformation and stereotypes about older adult sexuality [25, 26]. A "sexy grandmother" is not an oxymoron [27] and education about sexual health and medications is changing social beliefs about aging and sex [28–30, 31•, 32•]. Older adults themselves have been denied developmentally important sexual health information and legitimization of sexual interest. Many have internalized these negative messages and report disinterest in sexual activity for themselves and/or dislike of their partners' interest in sex [33, 34, 18]. In fact, an important aspect of asking about their sexual health concerns is to reduce invisibility and normalize sexual concerns as part of older adult general health [35•].

Patients and providers benefit from an understanding of the holistic attributes associated with sexual activity such as remaining physically active, partner availability, prior sexual activity, good health, low stress, financial stability, positive self-esteem, and a good outlook about life [4••, 18, 36].

Many people have a need for sexual health information and optimal sexual experience regardless of their age [37]. Yet challenges of physical frailty, chronic illnesses, lack of privacy, safety, and consent are often neglected by health care providers [38, 39, 40•]. This is particularly evident for older gay, lesbian, bisexual, or transgender (GLBT) adults. Indicating a strong need for social support and knowledgeable caregivers, they would prefer residential care facilities specifically designed for older GLBT adults [41] thereby reducing discrimination and stigma [42].

Older Adults and Health Care Providers: Training Deficits, Missed Opportunities

Health care providers are susceptible to these same cultural biases [43] and avoid asking older adults questions about their sexual health due to discomfort addressing explicit sexual information with individuals older than themselves. Providers may also lack confidence that they have anything beyond Viagra to offer a patient [11, 12, 35•, 44•].

Medical school education and residency training in sexual health has been described as being in a "state of crisis" regarding a sexual health curriculum [45•] and in need of a serious overhaul [44•]. Providers simply do not get enough training in sexual health [9•, 46•, 47]; learning less about the patient's sexual health needs, the farther the patient is from childbearing/rearing age [35•]. Sadly, this lack of information can translate into silence about high rates of unprotected sex—older adults being the least likely cohort to use condoms in partnered sexual activity—and the increasing risk for sexually transmitted infections [48]. In this current environment, sexual health education makes good common sense and good patient care.

Finally, a persistent myth is that older adults are not comfortable talking about sex or won't respond to referrals for counseling or mental health interventions. In fact, in an analysis of psychological problems and treatments, the evidence supported that older adults are comfortable talking, follow up on referrals, and respond well to psychological interventions [49]. Health and mental health care providers are the key for older adult access to sexual health information [50, 51], but poor training and the reluctance of a provider to ask about "it," prevents the flow of information to older adults about their sexual health [25, 35•, 44•].

There is worry about being overly optimistic or overselling sex [3, 44•, 47] and offending those who do not want to be "cured" of their lack of interest in sex [18]. Relationships play a key role in much sexual activity, making it important not to neglect the couple or over-medicalize treatment options [52, 53•]. Additionally, many patients refrain from asking questions because they do not think their providers will know the answers or they are concerned that they will be judged as being "sex crazed" [54, 55, 25].

Older Adult Sexual Health: Survey Research

General Studies

North America The highly respected National Social Life, Health, and Aging Project (NSHAP)—an enduring contribution to our understanding of sexual attitudes and behaviors for older adults in the USA—reports increases in most sexual dysfunctions. Decline in sexual function is more affected by physical health for men and by marital status for women [56]. Using NSHAP data, Stroope found that marital sexual activity is more frequent in longer-duration first marriages—contradicting the prevailing bromide that there is less sex in long-married couples. However, physical satisfaction and

emotional pleasure in sex are not linked to frequency of sexual activity for couples in either first or subsequent marriages [57].

International International studies support these findings [58•]. Heiman compared sexual satisfaction and relationship happiness for midlife and older couples across five countries (Brazil, Germany, Japan, Spain, and the USA) finding that for men, relationship satisfaction was influenced by overall health, physical intimacy, and sexual functioning, while women's relationship satisfaction was predicted by sexual functioning. For both sexes, "significant" physical intimacy and sexual functioning predicted sexual satisfaction [59]. Couples sexual health and self-esteem (Taiwan [20]), sexual desire and activity (South Korea [26]), and sexual problems for men aged 75–95 (Australia [8•]) were similar to those reported in North America [5–7, 51]. Overall, sexual functioning, relationship satisfaction, and general well-being are intertwined.

Testosterone, Postmenopausal, and Erection Studies

Testosterone—Older Men The results of the REDUCE (REduction by DUtasteride of prostate Cancer Events) study investigated several physiological markers to determine if they were related to sexual dysfunction (including erectile dysfunction, ejaculatory disorders, and low libido). Body mass index (BMI) was a significant predictor of lower libido in men, while lower urinary tract infections (LUTS, previously known as prostatism) and an International Prostate Symptom Score (IPSS—a screening tool to manage symptoms of benign prostatic hyperplasia or "enlarged prostate") in the moderate to severe range were predictive of sexual dysfunction [60•]. Lower serum testosterone levels were not independent risk factors for sexual dysfunction, with only 4 % of older men having lower serum testosterone levels correlating with sexual dysfunction. "Age, IPSS, BMI and diabetes/glucose intolerance, but not serum testosterone or TPV [total prostatic volume], were significant independent predictors of sexual dysfunction in the REDUCE study population" [60•]. Hyde found that lower testosterone levels were associated with less interest in sex but not associated with erectile functioning [8•]. Complicating matters, a higher association of medical problems (cardiovascular disease, diabetes, depression, insomnia) co-occurring with sexual problems makes causality difficult to establish.

The question of "male andropause" has been described [61]. Symptoms include lowered interest/desire in sex, sexual functioning problems, lowered energy and sleep changes, psychological changes including depression, physical changes including hair loss, weight gain, and decreased muscle mass and strength. Aging men can be at greater risk for chronic illness-related problems such as mood disorders, diabetes, and cardiovascular problems [61–64]. In some instances, testosterone replacement may be helpful and should be managed by an endocrinologist [62, 63].

Testosterone—Menopausal Women Basson and colleagues studied the role of androgens in post-menopausal women's hypoactive sexual desire disorder (HSDD) finding that androgen deficiency in women with HSDD could not be confirmed. They advise that women seeking testosterone replacement therapy should be counseled that the long-term effects on women taking testosterone replacement are not known and that currently, a link between testosterone deficiency and HSDD has not been established [29]. Some studies suggest a beneficial effect of testosterone in women who are "eugonadal" [65].

Menopause—Sexual Problems At menopause, some women experience a decrease in arousal when masturbating or engaging in partnered sex. Many remark that the pleasant sense of "fullness, tingling, and swelling" in and around the vulva is only vaguely represented [66].

Several valuable studies reflect the growing interest in understanding and treating postmenopausal changes for older women, especially those associated with vaginal atrophy (VA) and vulvar vaginal atrophy (VVA) [31•, 67••, 68••, 69].

REVIVE (REal Women's VIews of Treatment Options for Menopausal Vaginal ChangEs) survey [67••] offers well-designed research addressing women's experience of their VVA symptoms, interactions with health care providers (HCPs), and understanding of treatments. It is geographically, economically/educationally, ethnically, and racially diverse. VVA symptoms negatively affected sexual enjoyment (59 %), including problems with spontaneity, intimacy, and partner relationship. Loss of sexual intimacy was of "concern" for 47 % of women with a partner, with 85 % stating "some problems" related to loss of intimacy due to VVA. Most common concerns were dryness (55 %), dyspareunia (44 %), and irritation (33 %). Education for the general population about VVA is low, with most women lacking familiarity with VVA before it occurred and only 24 % of all women attributing VVA to menopause.

Half of women with VVA (56 %) had discussed symptoms with their HCP. Notably, the HCP had initiated discussion of VVA concerns only 13 % of the time. Hispanic women had the highest number of discussions (66 %), followed by African-American women (56 %) and Caucasian women (55 %). Of women identifying as "other ethnicity," 53 % had conversations with HCPs about VVA. Higher incomes and educational levels predicted more conversations and there were no regional differences [67••].

In an excellent review of seven studies, Parish and colleagues (2013) summarize results from national and international studies regarding the impact on vulvovaginal health on postmenopausal women [68••]. Despite some small

differences in describing VVA, there is general concordance that symptoms include vaginal dryness, pain during penetration, involuntary urination, soreness, itching, burning, and pain when touching the vagina, resulting in negative effects on sexual activity, self-esteem, and confidence in psychosexual interactions.

Sexual problems included pain with penetration, difficulties with interest and arousal, and orgasm difficulties, with 32 % of women not discussing these with their HCP. Use of oral or topical supplements or medications for lubrication or moisturizing was variable. Parish and colleagues note most women do not know or are not comfortable with terms like "vaginal atrophy," "vaginal dysfunction," or "poor vaginal health" and recommend using language directed toward specific symptoms like "vaginal dryness." A barrier to effective treatment of VVA appears to be discussing sexual health and vaginal dryness during medical visits [69].

The CLOSER (Clarifying Vaginal Atrophy's Impact On Sex and Relationship) survey (Nappi et al., 2013) addressed postmenopausal vaginal atrophy (VA) especially vaginal discomfort. Communication with partners and health care providers was addressed. In Europe and North America, women with VA and male partners of women with VA (4100 in each group) participated in an online survey to determine importance of communication and psychosocial components like self-esteem and embarrassment on sexual intimacy. Although many women had the indication of VA, not all were symptomatic or bothered by VA. Study limitations were present (Internet access required, no control for variables like smoking or frequency of sexual activity), but results suggest "that a dialogue about vaginal discomfort does take place between the couples, with men more likely than women to discuss the issue" [31•].

These studies underscore that vulvovaginal changes—and, for some, decreased sensitivity and increased dryness and thinning of vaginal walls—are associated with vaginal pain, negatively affecting sexual activity, with decreases in desire, arousal, and pleasure.

HSDD/FSIAD/Pain For older women, there are vulvovaginal changes and, for some, decreased sensitivity and increased dryness and thinning of vaginal walls, with associated vaginal pain. The associated discomfort results in avoidance of sexual thought or activity—both penetration and vulvar stimulation—leading to decreases in desire arousal and pleasure.

Erectile Dysfunction and Medical Treatment Erectile dysfunction (ED) increases with age. In the USA, older men's sexual activity declines from 87 % sexually active (57–64 years) to 38.5 % of men (75–85 years) [7]. Although phosphodiesterase-5 inhibitors (PDE5I) are publicized as highly effective "pro-erection" drugs, one third of men with ED who try these drugs do not respond to them. This figure increases as men age due to an increase in co-occurring health problems affecting erectile functioning [70•]. Relationship factors are often overlooked in the treatment of ED. Writing a prescription for a pill does not guarantee that it will be taken and co-occurring problems with partners can include postmenopausal symptoms, low interest/arousal, a partner's ED (in same sex couples), and for any couple, a range of problems related to communication, friendship, general intimacy, and unresolved hurts. Resuming dating after divorce or widowhood [57] may be avoided due to these concerns. Barnett observes that the absence of research on social and psychological aspects of treatment for ED is a significant barrier in addressing ED [28]. Finally, the medications affect men differently and medication dose and characteristics must be tailored to the individual [30], with clear and repeated instructions.

Peyronie's Disease Peyronie's disease (PD) is under researched and most likely underreported. Tapscott and Hakim (2013) provide a review of the literature, stating, "an ideal, reliable, and effective nonsurgical therapy still eludes the practicing urologist." They observe that no standardized treatments can be studied because "standardized assessments and objective measures of deformity, including curvature and circumference are lacking." Medically, they recommend avoiding surgery (for above reasons). Remarking that "some combination of intralesional injection with traction therapy may provide a synergy between the chemical effects of the drugs and the mechanical effects of traction" to help to possibly decrease curvature and increase erectile pliability [71•].

Both ED and PD are examples of the need for integrative treatments for older adults and a move away from hyper-focus on simplistic medical interventions [3, 52, 56, 61]. The "good enough sex" model proposed by Michael Metz and Barry McCarthy [72] suggests sex therapy, communication skill building, and expanding couple's sexual repertoire.

Dementia, Mild Memory Impairment and Mild Cognitive Impairment Studies

Memory problems remain under researched. Davies and colleagues (2010) report that caregiver burden increases with a partner with dementia, including disruption in communication, perceptions of burden, and marital cohesion. Decreases in sexual expression due to physical limitations occur and some couples substitute touching including hand-holding, massaging, and hugging. Current hardships and uncertain future increased the difficulties [73]. Within residential facilities, dementia, mild memory impairment (MMI), and mild cognitive impairment (MCI) present challenges to staff who wish to encourage autonomy but worry about inappropriate sexual expression [39]. Review of extant literature points to deficits

in staff training; setting policies regarding consent, privacy and safety; and grappling with complexities for these populations [39, 73, 74], including development of measures to assess capacity for consent for persons with dementia [75].

Other Sexual Problems Although older adult sexual research focuses on problems of arousal, pain, and sexual stimulation, other sexual problems do present. Delayed ejaculation, delayed orgasm, changes in the experience of orgasm and/or ejaculation, changes in proprioception, physical positioning problems, anxiety about performance or body image, and out of control sexual behavior (including impulsive/compulsive sexual behavior) may also present [7, 51, 59, 76]. In addition, individuals with a history of trauma may develop increased panic or anxiety. Sexual problems like pain or erectile difficulties can lead to secondary sexual problems and avoidance of sex altogether [36, 58•, 77].

In general, sexuality education and counseling follows these axioms: sexual health is lifelong so provide lifelong education. Sexual problems are biopsychosocial so it requires biopsychosocial solutions. Sex therapy for sexual problems can be adapted for older adults, taking into consideration the severity of the problem and the current potential for resilience in the individual or couple. Several bibliographies and books are recommended for further education about sexuality counseling and sex therapy [78, 79].

Older GLBT Adult Sexual Health

There is limited research on this topic and much of it was done toward the end of the twentieth century [80]. Existing research suffers from small sample sizes [51], making it difficult to get a sense of older GLBT sexual activity [80]. The picture that does emerge is that older GLBT adults face the same sexual problems as straight adults, but with the added burden of stigma [80]. Grossman and colleagues (2007) researched caregiving and care receiving among older GLBT adults and found that the process of forming identity and community in GLBT experiences helped to develop strengths that are valuable in aging, including resilience and adaptability [81].

Illness, Injury, and Sexual Health in Older Age

As a group, older adults have more problems with injury and chronic illness, leading to an increase in sexual problems and a decrease in sexual satisfaction [82]. Among others, sexual problems occurring with illness include cardiovascular [21•], cancer [83, 84] arthritis [10], kidney disease [85], mental health problems [86], diabetes [87–89], and dementia [90, 91] as well as mild memory impairment (MMI) and mild cognitive impairment (MCI) [73].

Medication side effects and cross-effects are often a source of sexual problems for patients including older adults [92] and require careful monitoring and ongoing dialogue between the person and her or his HCP [93–96].

What Does Sexual Satisfaction Look Like?

Trompeter and colleagues addressed sexual function rather than dysfunction [4••]. In a study of sexual activity and satisfaction in healthy community-dwelling older women, 806 respondents were divided into four equally divided quartiles. Consistent with other research [7], those with chronic pain or mental or physical illness reported lower levels of sexual activity and satisfaction. And in accordance with other research, sexual activity (as defined as interaction with a partner) was higher for those with a partner but declined with age: 83 % of women aged 40–55.13 were sexually active, 64 % of women aged 55.14–68.02, 40 % of women aged 68.03–79.91, and 13 % of women aged 79.92–100 [4••]. Differences from other studies were identified; less than 5 % of sexually active women reported high levels of discomfort or pain during or after sexual activity.

> Among the oldest women, 71.4 % reported their degree of discomfort or pain as low, very low, or none during or following vaginal penetration. There was no significant association between current hormone replacement therapy use and pain with vaginal penetration [4••].

Highest frequency of both arousal and lubrication was reported by youngest (40–55.13) women, but one in five women over 80 reported consistent arousal, lubrication, and orgasm always or almost always. The majority of women reported frequent arousal, lubrication, and orgasm with the youngest and oldest reporting the greatest satisfaction with orgasm. There was no correlation between hormone use and orgasm.

Women were either moderately (24 %) or very satisfied (54 %) with the level of emotional closeness during sexual activity with their partner. Those satisfied with the level of closeness had more frequent arousal, lubrication, and orgasm. Age, current use of hormones, and the individual's educational level were not related to the experience of emotional closeness during sexual activity.

Finally, 39.87 % of all women reported that they never or almost never felt sexual desire and 33 % of all sexually active women described their sexual desire as low, very low, or none at all.

> Despite a correlation between sexual desire and other sexual function domains, only 1 of 5 sexually active women across all age groups reported high sexual desire. Approximately half of women aged 80 years or more reported arousal, lubrication, and orgasm most of the time but rarely reported sexual desire. In contrast with the traditional linear model in which desire

precedes sex, these results support a nonlinear model of sexuality in older women because sexual desire did not precede sexual arousal in most women, suggesting women engage in sexual activity for multiple reasons, which may include nurture, affirmation, or sustenance of a relationship [4••].

Although the study's limitations include homogeneity socioeconomically and the possibility that only those with the best emotional and physical well-being would take the time to complete the questionnaire (response rate bias), still, the study indicates that for many women, sexual satisfaction increased with age and was not associated with partnered sexual activity.

Senior Coolness Contributing to sexual satisfaction in older age may be some very "non-sexy" factors—socioeconomic security, a sense of well-being about one's life, friendships, meaningful social contexts, and a positive sense of one's self. This last has been described by Zimmermann and Grebe as "senior coolness." Whereas the "third age" of life between 65 and 80 is seen as still vigorous, it is the "fourth age"—80 and beyond—that is viewed with fears about loss of independence, decrepitude, being over the hill, and a burden on others [97]. It is this fourth age that seems most striking in the Trompeter study because women, even without the presence of sexual partners, continued to think about sex, masturbate, and enjoy arousal and orgasm [4••].

Zimmerman and Grebe observe that regardless of economics, gender or lifestyle, and accepting of limitations, individuals who do not succumb to these fourth age stereotypes but engage in "resistance and rejection" of these negative views of aging—expressing indifference to labels—refuse to allow difficulties to spoil their lives.

In some cases, individuals are even able to distance themselves from psychological and physical limitations—not fighting or fleeing them, but *flowing* with them, to maintain a distance from disparaging remarks.

They ascribe value to what they have: "If I never get to travel to the mountains again, so what! I will make the most of what is here." The approach may be considered intellectualizing, but it focuses on the present and allows older adults to preserve energy for what they want. Recognizing that they are near the end of their life, this existential condition does not have to paralyze one psychologically. Senior coolness involves caring for the self, facing indignities with reserve, distance, intellectualism, perspective, and focusing on the art of living well in the present [97].

Optimal Sexuality Kleinplatz's research about optimal sexuality for older adult couples is a rich qualitative study detailing eight different aspects of "what works" for older adults experiencing satisfying and pleasurable sexual activity. In line with Trompeter's and Zimmermann's observations, she finds that these individuals work on their relationships and deepen them with time. These couples identify focusing their time, devotion, and intentionality in their relationship, finding *both* exploration of new experience and the comfort of familiarity advantageous. One individual described sexual interaction as "always a dance… with different steps." The couple's safety and trust were also seen as contributing to sexual satisfaction. Within this context, intriguingly, aging, chronic illness, and disability "were not necessarily obstacles to optimal sexuality" [98].

Conclusion

Even though the frequency of sexual activity declines from one's 50s into one's 80s, it by no means disappears. Overall, for men in their 70s, 26 % were still extremely to somewhat satisfied with their sex lives and for women over 70, 28 % were extremely to somewhat satisfied with their sex lives [18]. For a certain percentage of older adults, sex remains important and a source of pleasure in their lives. These studies show us that sexual health is alive, that it differs by decades and is influenced by life's vicissitudes, and whether one is "young old," "mid old," or "old old." Since older adults currently in their 70s or 80s were raised with little or no information regarding healthy sexuality in general but especially in older age, the stubborn persistence and vitality of sexual activity is quite remarkable.

Research Limitations

There are significant limitations in the research. With a few notable exceptions (e.g., Kingsberg et al. 2013), most studies are homogenous socioeconomically, racially, and ethnically. There is a paucity of research for older GLBT adults. The effects of relationship—long or short term—are not adequately studied. Since older adults are often partnered with other older adults, it is probable that both will be challenged by effects of aging, chronic illness, or challenges representative of the aging cohort (i.e., widowhood, lower socioeconomic status, living in residential facilities lacking privacy). Most sexual health professionals working with older adults know that sexual dysfunctions increase in older age, but far fewer can discuss the nonmedical and relationship interventions for these problems [99]. We are better at gathering numbers for what is wrong than providing treatment outcome studies for these problems.

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Compliance with Ethics Guidelines

Conflict of Interest Sallie Foley declares a financial relationship with Guilford Press, publisher of a book she co-authored, *Sex Matters for Women*: *A Complete Guide To Taking Care Of Your Sexual Self*.

Human and Animal Rights and Informed Consent This article does not contain any studies with human or animal subjects performed by the author.

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- • Of importance
- •• Of major importance

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