

REVIEW ARTICLE

Sexuality in older adults: Clinical and psychosocial dilemmas

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ABSTRACT The present review aims to throw some light on the various aspects of sexuality in older adults and the challenges faced by medical professionals working in this area. Keyword searches using the terms “sexuality,” “sexual dysfunction,” “geriatric,” “old age,” and others in combination were carried out on PubMed, Google Scholar, and the Cochrane Database of Systematic Reviews. Relevant clinical trials, case studies, and review papers were selected. This was further supplemented with the clinical experience of the authors, who work with older patients in a psychiatric outpatient setting with a dedicated sexual disorders clinic. Sexuality is a lifelong phenomenon and its expression a basic human right across all ages. However, the construct of normalcy for sex in aging is blurred, with agism playing a distinct role. Older adults face much stigma when expressing sexual desires or concerns, both from their own families and the health-care system. Sexual dysfunctions due to comorbid medical illnesses and medications are often treatable. Evidence-based treatments for sexual dysfunction in the elderly, lesbian, gay, bisexual, transgender, and queer, and other orientations are especially underrepresented in research; available research has several limitations. Sexuality in people with dementia and sexual rights in nursing homes are gray areas. Medical training, treatment guidelines, and health-care facilities all need to be stepped up in terms of awareness and quality of care provided to the elderly with concerns related to sexuality.

Key words: Dementia, elderly, geriatric, lesbian, gay, bisexual, transgender, queer, sexual dysfunction, sexuality

INTRODUCTION

The term “sexuality” is explained as the capacity for sexual feelings and includes a person’s sexual orientation, gender identity, intimacy, eroticism, and the social aspects of sex.^[1,2] Historically, Eysenck correlated sexuality with personality, a theory that has been replicated over the years.^[3,4] The expression of sexuality is integral to every person is a basic human right^[5] and continues throughout life; this implies that older adults must be, and must enjoy being, sexually active.^[1,6] Globally, the demographic is aging, due to a downward trend in both fertility and mortality.^[7] The

geriatric population in India is projected to rise from the current 8%–19%, or 324 million, by 2050.^[8] This calls to attention the urgent need for an extensive upheaval of the health-care system for this burgeoning demographic. As physicians, we are responsible for providing care that ensures a good quality of life,^[9] in the pursuit of which, not surprisingly, sexuality plays a significant role.^[10,11] Further, there is a general lack of in-depth research into the subject of older sexuality, worldwide and more so in India, owing to difficulties such as interviewer and respondent biases, poor response rates, and hesitation

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to conduct detailed research into a deeply personal area already fraught with taboo.^[6] The present review addresses problems encountered both by the patient and health-care provider when dealing with sexuality and sexuality-related issues in the elderly. Rather than being a general review, it examines specific challenges of older sexuality.

METHOD OF CONDUCTING THE REVIEW

Keyword searches using the terms “sexuality,” “sexual dysfunction,” “geriatric,” “old age,” “erectile dysfunction,” “female sexual dysfunction,” “dementia,” “lesbian, gay, bisexual, transgender, and queer (LGBTQ),” and others alone or in combination were carried out on PubMed, Google Scholar, and the Cochrane Database of Systematic Reviews. Relevant clinical trials, case studies, and review papers were selected. This was further supplemented with the clinical experience of the authors, who regularly work with older patients in an outpatient psychiatry clinic with a dedicated sexual disorders unit.

AGISM AND SEXUALITY

Sexuality is widely considered taboo in India, let alone sexuality in older adults. This brings us to the concept of agism, a term first described by Butler that encompasses prejudicial attitudes and discriminatory practices against old people.^[12] Agism is rife globally, evidenced by the blanket association of old age with senility, dependency, ill health, disability, inability to relate to trends and technology, and the sidelining of older adults in health care, research, industry, advertising, and public policy. These attitudes are internalized and turn into self-fulfilling prophecies.^[13]

Many myths surround sexuality in older age, the most common being that older people are asexual and do not practice or desire sex. On the contrary, the majority of people ages 60 and older continue to engage in and most importantly, enjoy sexual activity.^[1,14-16] It is also erroneously believed that older people (especially older women) are unattractive that older sex is disgusting, risky, or “wrong,” aging entails sexual dysfunction and sex, as a rule, should be discouraged in old-age homes and other facilities.^[5] Such beliefs are internalized leading people to believe that old age and an active sex-life are mutually exclusive.^[13,14] The media, with its huge influence on popular culture, often neglects to depict older sexuality or portrays it in negative

light, especially in the case of older women, who have often been shown to “exist contentedly in a chaste sexual vacuum.”^[17] Older men may be portrayed as sexually attractive, but usually from the perspective of younger and not older women. Media portrayals of older people also tend not to depict their normalcy, virility, and intimacy, and older adults are often the subjects of humor directed at physical, cognitive, and sexual impotence.^[17,18] Elder LGBTQ sexuality is entirely absent from mainstream media. A recent Indian study on attitudes toward geriatric sexuality through a questionnaire interview of older adults revealed numerous myths among the study sample such as sexuality is meant only for reproductive purposes and sexuality in old age is wrong and amoral. The paper also reported a general sense of guilt, fear, and shame surrounding sex in anticipation of negative reactions from family members, especially children.^[19] As a result of this widespread stigmatization, medical professionals tend to neglect treatable sexual dysfunctions in older adults, who in turn are reluctant or even ashamed to seek professional help.^[20]

NORMAL SEXUALITY AND AGING

Older people are the same people who were once young, and therefore, it is unlikely that their sexual thoughts, desires, fantasies, abilities, and expressions would undergo a drastic shift. What do change, albeit not in every case, are general health, hormones, and the availability and quality of companionship.^[20] Again, these issues are not specific to this demographic - it is common for younger people to fall ill, suffer from endocrinal sexual changes, or lose their lover to death or discord. Yet, prejudicial beliefs lead practitioners to look at sexual dysfunction in younger people as “treatable,” while in old people, the same is viewed as “normal,” or part and parcel of the aging process. Hence, how should a clinician define normal sexuality in older people? Unfortunately, research is currently inadequate to truly answer this question. It is hard to disentangle sexual changes of normal aging from those related to illness and psychosocial problems.^[21,22] Further, there is a dearth of population-based studies aimed at assessing normal older sexuality; the bulk of currently available research tends to equate having sex with heterosexual vaginal intercourse, leaving out a host of other orientations and activities related to sexual expression, thus providing incomplete and misleading information.^[21] For instance, a study on sexuality in 80–102 year olds found touching and caressing to be the most common form of sexual expression beyond 80 years of age.^[1] Just like in younger

people, significant interindividual variations in sexual preferences and frequencies are seen in older adults.^[23] Available data suggest that both older men and women consider sexuality an important part of their lives, continue to possess sexual desires and wish to engage in intimate relationships and sexual activity (kissing, cuddling, foreplay, vaginal intercourse, oral sex, and masturbation) at similar frequencies as younger adults (18–59-year-old), despite the presence of sexual problems.^[24] Sexual activity may undergo adaptations or be less vigorous with age. Nevertheless, it has been shown to be as enjoyable and satisfying as in younger adults.^[1] Previous levels of sexual interest and function are strongly correlated with sexual activity later in life. Health-related issues, medical problems, marital status, and gender appear to have a consistent correlation with decline in sexual activity.^[1,16] Due to the limited data available on sexual activity in older adults, clinicians find it difficult to distinguish between the normal adaptations of sex with age and sexual dysfunctions in their older patients.

SEXUAL CHANGES WITH AGING

Men undergo a decline in testosterone levels with age though in many cases, this does not hamper sexual interest and activity, despite more time and greater stimulation being required for arousal and orgasm and a significantly longer refractory period.^[25] Currently, there are no conclusive data to suggest that hormonal changes significantly impact sexuality in healthy older men.^[26] A survey of 1031 veterans between 30 and 99 years of age found not a single respondent reporting a complete absence of sexual interest. Older men preferred intercourse to other forms of sexual activity despite reporting insufficient erectile frequency, duration, and rigidity.^[27] Importantly, erectile failure is not the norm among older men and when it does occur, it is often treatable.^[24] It has been postulated that only a certain minimal level of testosterone is required for adequate sexual functioning, as determined by the availability and sensitivity of testosterone receptors.^[16] This is supported by studies that show exogenous administration of androgens does not increase libido in middle-aged and older adults.^[16,28]

Women undergo changes in sexual function with age as well, starting around the time of menopause. They have decreased vaginal lubrication and thinning of the vaginal epithelium that lead to dyspareunia.^[29] This could be the underlying cause of the reported decline in sexual function in older women and is easily treatable

with vaginal lubricants or estrogen supplementation. Research into female sexuality in older age has long reported a severe decline in sexual interest and activity in women. However, studies often compare sexual activity of older women with men, rather than with their own previous level of sexual activity or with that of younger women. Other design flaws include equating sexual activity solely with vaginal intercourse and not accounting for those who have suffered the loss of partner. Women generally outlive men and marital status is correlated with continuing sexual activity in women.^[16] The Janus report, an extensive research project undertaken in the United States on a national scale over a period of 9 years, unravels many myths associated with sexuality and aging. In particular, it found that 74% of women above 65 years of age continue to engage in sexual activity at least once a week.^[16,30] There were no available data on the physiology of transgender aging.

MEDICAL DISORDERS AFFECTING SEXUALITY IN OLDER ADULTS

Concomitant medical disorders are an extremely prevalent confounding factor when considering sexuality across all age groups.^[31] Lack of careful segregation of aging from morbidity is a major contributor to the widespread false perception that older people are asexual. Some common medical issues encountered in old age that affect sexuality are hypertension and cardiovascular illnesses, diabetes, stroke, arthritis, depression, Parkinson's disease, multiple sclerosis, dementia, visual or hearing impairment, lower urinary tract symptoms (LUTS), and incontinence.^[5,32] Apart from these, abdominal and genitourinary surgery, reconstructive surgery, or malignancies and medical devices such as catheters may all affect self-image and impede sexual expression.^[5] The psychological correlates of illness and their effect on self-esteem and body image must also be taken into consideration.^[16]

Cardiovascular illness leads to erectile dysfunction due to vascular insufficiency and reduced endothelial integrity. Risk factors for cardiovascular illness such as pro-inflammatory molecules, increased body mass index, and an altered lipid profile are correlated with erectile dysfunction and hypogonadism.^[33] Stroke causes incoordination and sexual problems related to contractures.^[34] Diabetes mellitus leads to neurovascular insufficiency and may underlie frequent urinary tract infections and reduced vaginal lubrication. These patients may experience erectile dysfunction

and reduced intensity of orgasm and report fatigue and embarrassment about their disease.^[34,35] Benign prostatic hyperplasia and LUTS can cause erectile dysfunction, ejaculatory dysfunction, and hypoactive sexual desire.^[35] Urge incontinence, pelvic organ prolapse, and urinary tract infection in women are associated with psychological distress, avoidance of sexual activities, arousal disorders, painful sexual intercourse, orgasmic phase difficulties, and reduced sexual satisfaction.^[26,36] Arthritis is a common cause of reduced mobility, especially in women, impairing sexual activity due to pain and stiffness.^[33] Hearing or visual impairments can lead to a loss of familiar stimuli for sexual excitement.^[34]

Neuropsychiatric illnesses can impact sexual function in older adults. Depression and anxiety, common in older people, can affect sexual desire and arousal either directly as a disease or indirectly through the antidepressant medication used to treat them. Both these disorders have a complex, bidirectional relationship with sexual dysfunction, each adversely affecting the other.^[36] Chronic pain syndromes may cause reduced libido.^[34] Dementias of various etiologies may present with inappropriate sexual behavior. Dementia impacts sexuality both of the patient and their partner through reduced autonomy, declining ability to consent, reduced sexual interest or conversely, aggressive or insensitive sexual behavior.^[36] Sexuality in dementia also faces imposed restrictions on sexual expression, whether warranted or not, by caregivers. Parkinson's disease is associated with sexual disorders due to incoordination and other motor effects.^[34] There is a lack of research on sexual dysfunction in schizophrenia and bipolar disorder in older adults; available studies find no significant orgasmic impairment in people with bipolar mood disorder although those with schizophrenia are found to have lower rates of coital orgasm.^[36,37]

Personality disorders are also associated with erectile dysfunction later in life.^[38] Older adults are often multiple medications from multiple doctors. The propensity for drug–drug interactions and sexual side effects are high. The risk of drug side effects is higher in older people in general.^[39] Many commonly prescribed drugs in this population are notorious for their sexual side effects. These include diuretics, antihypertensives, antiarrhythmics, antidepressants, benzodiazepines, chemotherapeutics, and antacids. A list of these drugs and their adverse effects on sexual function is mentioned in Table 1.^[40-42]

SEXUAL DYSFUNCTION IN OLDER ADULTS

Many studies quantify geriatric sexual dysfunction, but few provide detailed accounts. In women, the most common perimenopausal complaints are dyspareunia and reduced sexual desire, often associated with decreased lubrication, prior hysterectomy, loss of a partner, depression, lack of physical activity, smoking, or financial problems.^[43,44] An Indian study on geriatric sexuality found that 20% of women reported reduced sexual activity due to the loss of a partner as opposed to 3.3% of the men. More women tended to report self-image as a reason for decline in sexual activity. The same study found that erectile dysfunction was reported significantly more frequently in those men with comorbid illnesses than in those without (26% vs. 9%).^[22] Another Indian study^[19] corroborated the higher prevalence of male sexual disorders in those with medical comorbidities than those without. The Massachusetts Male Aging Study showed that 34.8% of men aged 40–70 years had moderate to severe erectile dysfunction, which was strongly related to age, health status, and emotions.^[45,46] A majority of older adults believe that age hampers their sexuality. Increased

Table 1: Commonly used medications in older patients and their sexual side effects^[40-42]

Drug	Classification	Sexual side effects
Hydrochlorothiazide	Thiazide diuretic	Erectile dysfunction
Propranolol	Beta-adrenergic blocker	Decreased libido, erectile dysfunction, orgasmic dysfunction
Guanethidine	Peripherally acting sympatholytic antihypertensive	Erectile dysfunction, impaired ejaculation
Amiodarone	Antiarrhythmic	Testicular dysfunction
Imipramine, amitriptyline	Tricyclic antidepressants	Decreased libido, orgasmic dysfunction
Fluoxetine, sertraline, fluvoxamine, escitalopram, paroxetine	SSRIs	Reduced libido, reduced arousal, delayed ejaculation, absent or delayed orgasm
Clonazepam, lorazepam, alprazolam, diazepam, chlordiazepoxide	Benzodiazepines	Erectile dysfunction
Cyclophosphamide, busulfan	Chemotherapeutics	Erectile dysfunction, reduced libido
Ranitidine	Antacids (H2-receptor antagonists)	Erectile dysfunction

SSRIs: Selective serotonin reuptake inhibitors

time to sexual arousal is widely reported over the age of 60. However, this requires adapting sexual activity and is not to be equated with reduced sexual ability or pleasure.^[1,22] Cultural influences on sexuality are seen in the lack of masturbatory behavior and consistent preference of traditional sex roles (the male as the active partner) in Indian as compared to western research.

TREATMENT OF SEXUAL DYSFUNCTION IN OLDER ADULTS

There is a dearth of evidence-based data on the management of sexual dysfunction in older people. It is still not common in clinical practice to aggressively investigate and treat geriatric sexual dysfunction. A rational approach to the problem would involve an in-depth interview and investigation into the root cause.^[47] For instance, lack of sexual desire in older women is commonly due to dyspareunia^[44] which can be treated with water or silicone-based lubricants or estrogen supplementation. Chronic illnesses and medications causing sexual dysfunction, as discussed above, should be routinely investigated and managed.^[33] Differing etiologies of sexual dysfunction in different age groups, genders, and sexualities need to be researched to reach accurate diagnoses and provide effective treatment. One study found endocrine and vascular etiologies of erectile dysfunction to be common in older males while marital discord and depression were the common causes of erectile dysfunction in the younger age group.^[48] In older women with sexual dysfunction, the absence of a partner, a partner with sexual dysfunction, depression, and ongoing antidepressant medication should be looked for.^[49]

Drug trials for geriatric sexual dysfunction are extremely few, especially for women. Most clinical trials for erectile dysfunction exclude older adults, with the maximum age of participants being 60–62 years. Most of the drugs used to treat erectile dysfunction and premature ejaculation have thus not been investigated in older people. The authors believe that conducting drug trials for sexual dysfunction in old people is hampered by difficulties in recruiting study subjects due to stigma, reluctance from ethics committees, and lack of funding.

There is currently no Food and Drug Administration-approved treatment for hypoactive sexual desire disorder although the 5-HT_{1A} agonist gepirone shows some promise in this regard.^[50] Estrogen supplementation is known to alleviate the symptoms associated with

climacteric.^[51] Sildenafil has shown to be effective for older men with erectile dysfunction albeit with lower efficacy above the age of 80 years. The incidence of side effects and reported adverse events is no different than in younger males.^[52] It may also be used in the management of drug-induced erectile dysfunction.^[53] Testosterone replacement, although controversial in both men and women, is possibly efficacious for subthreshold depression in older men with hypogonadism.^[54]

Ideally, the approach to treating an older patient with sexual dysfunction should be multidisciplinary, with individually tailored biomedical and psychotherapeutic interventions following a detailed diagnostic workup. Please refer to the treatment algorithm in Figure 1. Nonpharmacological management including sex therapy (anxiety reduction and desensitization, cognitive behavioral interventions, increased sexual stimulation, and interpersonal assertiveness and couples' communication training, as described by Rosen^[55,56]) and the use of vacuum devices and penile prostheses for males have not been adequately explored in older adults. Psychotherapeutic interventions would also extend to any underlying amenable comorbid psychiatric condition such as depression.

PSYCHOSOCIAL BARRIERS TO SEXUAL EXPRESSION IN OLDER PEOPLE

Psychosocial factors affecting sexuality in older people are to a large extent similar to those affecting sexuality at any age. Marital satisfaction, life changes, self-esteem, body image, and misconceptions regarding sex and performance anxiety, especially in men, all play a role. Perhaps more specific to this demographic is the loss

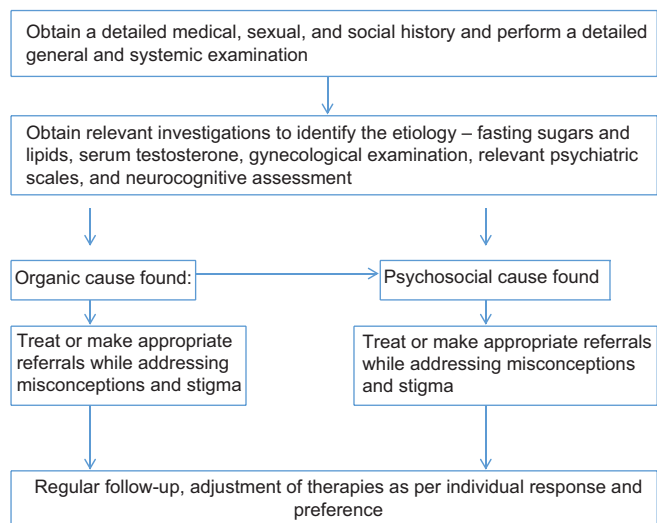


Figure 1: Management of geriatric sexual dysfunction

of a partner, especially in the case of women, who tend to outlive men.^[57] “Widower syndrome” refers to sexual difficulties in a new relationship after an interim period of abstinence due to the loss of a partner.^[16] Although the need for affection continues beyond the loss of a long-term partner or spouse, sexual relationships after the death of a spouse and remarriage in older age are still frowned upon and regarded with suspicion, by caregivers and society in general.^[58] Old people face shame and hesitancy when consulting health-care professionals for sexual problems due to the taboos surrounding sex, compounded by a lack of knowledge of older sexuality and agism in healthcare. Culture and societal attitudes are known to influence sexual activity in older people.^[19] The quality of self-perception of aging (whether positive or negative) differs significantly across cultures.^[59] Older women are especially likely to face difficulties acknowledging and expressing their sexuality because sexism does not suddenly end at the age of 60 years.^[60]

THE HEALTH-CARE SYSTEM AND SEXUALITY IN OLDER ADULTS

Agism, the sex taboo, and stereotypes regarding geriatric sexuality are distinctly prevalent among health-care professionals and researchers. Health-care professionals are reluctant to take a detailed sexual history, especially with their older patients.^[61-63] This may be an inherited reluctance, from lack of training during the formative years of medical education where the topic of sexual medicine is rather quiescent and geriatric sexuality quite unheard of.^[22] One study specifically found that sexual histories are avoided in the psychiatric workup and older men with complaints of sexual dysfunction are not adequately treated or referred.^[63] Other barriers to taking an adequate sexual history include the stereotype that sexual medicine is for younger patients, lack of knowledge and clinical experience in sexual medicine, lack of time or privacy, and gender.^[62] In fact, a study found that general practitioners’ beliefs and attitudes about geriatric sexuality were based largely on stereotypes, rather than on their own clinical experience.^[64] This discomfort is easily perceived by patients and sets forth a vicious cycle, or “we don’t ask and they don’t tell” attitude.^[2,65] This situation, compounded with a lack of comprehensive research on the subject, leaves us with major gaps in our knowledge of geriatric sexuality.

Sexuality in nursing homes and geriatric residential facilities is also a matter of debate. On the one hand, ethics demands sexual rights and autonomy for older

people, and on the other hand, the staff and family must negotiate the tightrope of consensual sex in older patients with cognitive impairment.^[66,67] There are often negative or even acrimonious reactions from the staff, fellow residents, and families when their parents and grandparents wish to engage in new, intimate relationships.^[68] An article that illustrates intimacy, love, and infatuation in old age attributes these reactions to protection from hurt or abuse, grieving over a lost parent, or denial of one’s parents’ sexuality.^[67] An account in the Indian setting tells of the author (AD), a psychiatrist, being called into a nursing home to counsel a man and woman in their 70s who had met at the facility and grown fond of each other. The management was of the opinion that this couple was disregarding “Indian social norms” after they, consenting, mature adults, requested to share a room. The author goes on to highlight the importance of education of the masses and staff at residential facilities regarding older sexuality and relationships.^[69]

SEXUALITY IN PATIENTS WITH DEMENTIA

Sexuality in patients with dementia is a gray area due to manifold legal and ethical concerns, especially in institutional settings. Stereotypes and misconceptions harbored by caregivers and others often blur the line between patients’ normal expressions of their sexual needs and inappropriate behavior. Differentiating between the two constitutes a gray area that needs careful scientific exploration.

Sexually inappropriate behavior can be seen in all stages and etiologies of dementia, with a prevalence of 1.8%. It occurs more commonly in patients with vascular dementia and in the community setting.^[70] One study noted the most common change in this population to be indifference. The same study establishes two kinds of altered sexual behavior – intimacy seeking and disinhibited – with different organic bases.^[71] Management strategies include pharmacotherapeutic and nonpharmacotherapeutic means as well as caregiver support and education. Selective serotonin reuptake inhibitors are considered as the first line of pharmacotherapy, followed by tricyclic antidepressants. Low-dose antipsychotics may also be used with caution. Other options are antiandrogens or estrogens or combination therapy.^[72] Nonpharmacotherapeutic means are considered to be safer and often superior to pharmacotherapy in this patient population although varied response is a concern.^[71]

SEXUALLY TRANSMITTED DISEASES AND OLDER ADULTS

Sexually active old people are at an equal risk of acquiring HIV and other sexually transmitted diseases (STDs) as their younger counterparts. However, they are less likely to take adequate precautions under the false impression that they are not susceptible to STDs.^[73] This is in part due to lack of information, from being brought up an era where sex education was not widespread, and only further emphasizes the need for health-care professionals to address sexuality with their patients. Furthermore, STDs may not be investigated for in this population and may go untreated for long periods of time or be mistaken for other illnesses that better fit the “age” paradigm.^[74]

GENDER AND SEXUAL MINORITIES

It is postulated that by 2030, there will be three million older LGBTQ and other gender and sexual minority adults, constituting around 4% of the geriatric population.^[2] In India, one of the few countries to officially recognize a third, nonmale, nonfemale gender, it is estimated that there are five to six million Hijras, who will of course age with the rest of the population.^[75] Sexuality in aging minority populations is grossly understudied although some data are available. Importantly, it has been found that older LGBTQ adults experience greater ill health and disability as compared to their heterosexual counterparts, which adversely affects their sexuality until treated.^[76] Older gay men may face additional concerns after prostate surgery owing to the loss of an organ of pleasure during anal sex, a reduction in semen production that may be associated with reduced sensuality and the loss of a firm enough erection for anal intercourse.^[77] LGBTQ seniors also express concerns regarding later-life care owing to strained relations with their biological families and the pervasive heteronormativity in residential facilities.^[78] Heteronormativity is overarching in the health-care system and society; our country is still to legalize homosexuality. To date, medical training, clinician mindsets, and even hospital forms have not been adapted to gender and sexual diversity. There is no training against homophobia for health-care personnel. Such environments preclude a sense of safety and freedom in members of these communities to speak about their sexuality and sexual issues.

RESEARCH NEEDS IN GERIATRIC SEXUALITY AND ITS DISORDERS

In general, there is a dearth of research on the subject and even more so in India although there has been a recent trend to remedy this. Available research does not provide us with a clear picture of the evolution of sexuality with normal aging. Studies tend to limit sexual activity to intercourse in heterosexual individuals and do not explore sexual dysfunction longitudinally, thus perpetuating mistaken beliefs surrounding geriatric sexuality. There is also a tendency to view the age of 60 and older as a single group. The effects of chronic medical illnesses such as diabetes and cardiovascular disease on sexuality are underresearched as well as there being a lack of drug trials for sexual dysfunction in older men and more so, women. Female sexual dysfunction is a neglected area both in the old and the young and needs serious consideration from research quarters.^[79] There are scant data on STDs in older people. There is a lack of research on older lesbian, gay, bisexual, and transgender (LGBT) and other sexualities. The available studies largely use nonsystematic sampling methods^[80] and consider LGBTQ people as a unit, which may be counterproductive given the degree of diversity within the acronym; individuals who identify with the gender binary are usually not clubbed together in scientific research. Clinicians working in geriatric psychiatry, geriatric medicine, and gerontology need to consider sexuality as a research priority.

CONCLUSIONS

Sexuality is a lifelong phenomenon and its expression a basic human right across all ages. Health care is currently naive in its understanding and acceptance of geriatric sexuality. Older women, LGBTQ, and other orientations are especially underrepresented in research on the subject, and the available research has several limitations. Medical training, treatment guidelines, and awareness among medical professionals and health-care facilities all need to be stepped up and oriented toward openness in their outlook toward geriatric sexuality and toward actively dispelling the myths and cultural conservatism surrounding it. Physicians of all specialties must routinely inquire about and address the sexual concerns of their older patients, doing so nonjudgmentally and understanding that many conditions are amenable to treatment and that sexuality in older people is the norm, not the exception.

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