

Senior Sexual Health: The Effects of Aging on Sexuality

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By the year 2030, nearly 20% of people in the United States will be 65 years of age or older. This group will consist of an estimated 71 million individuals, 19.5 million of whom will exceed the age of 80 (Centers for Disease Control and Prevention [CDC], 2003). This trend is not restricted to Americans; worldwide, adults aged 60 and older comprise the most rapidly growing segment of the population (World Health Organization, 2002). Increasing longevity is partly responsible for this demographic shift, suggesting a need for focus on sustaining health and quality of life into old age. The maintenance of good health and general well-being in later life has meaningful implications for sexual relationships and behaviors. Although the average adult age is clearly on the rise, sexuality in older adults is often misunderstood, misrepresented, or simply invisible. The purpose of this contribution is to provide an overview of the influence of aging on the sexual lives of men and women and to describe potentially important aspects of assessment and treatment of older adults with sexual concerns.

SEXUALITY ACROSS THE LIFE SPAN: WHAT IS "NORMAL"?

Normative information about sexuality can be both educational and therapeutic to clients who are concerned about their own sexual lives as they grow older (Leiblum & Segraves, 2000). Although information on sexuality in midlife and old age has been limited compared to the available data on younger adults, the growth of the older adult population has contributed to recent interest in the scientific study of sexual feelings and behaviors in this age group. The precedent for including mature adults in studies of sexual behavior extends back a number of decades (e.g., Kinsey, Pomeroy, & Martin, 1948), but many of the most comprehensive examinations of sexuality in this population have been conducted more recently (e.g., American Association of Retired Persons [AARP], 2005; Laumann et al., 2005; National Council on Aging [NCOA], 2005).

A consistent finding from multiple studies is that sexuality continues to be an important aspect of life for many adults throughout midlife and into old age. The American Association of Retired Persons reported that 62% of men and 51% of women between ages 60 and 69 believed sexual activity is an important component of a good relationship; these figures declined slightly after age 70 (AARP, 2005). The National Council on Aging (2005) reported that 71% of men in their 60s and 57% of men in their 70s engaged in sexual activity at least once per month. These percentages were somewhat lower for women (51% and 30%, respectively).

Less is known about sexuality in very old age (e.g., 80 years of age or older), but the available data suggest that sexuality is significant for many people in this age range as well. Bretschneider and McCoy's (1988) survey of 202 men and women over the age of 80 concluded that the majority of these individuals continued to fantasize about intimate contact with a partner. The NCOA (2005) study reported that 27% of men and 18% of women in their 80s engaged in sexual activity at least once a month.

Men

Although erectile functioning tends to decline progressively beginning in midlife (Araujo, Mohr, & McKinlay, 2004; Laumann, Paik, & Rosen, 1999), it should not be inferred that erectile failure is an inevitable consequence of aging. Although some degree of change in sexual response is normal for middle-aged and older men, there is considerable variability in the extent to which these changes affect the ability to engage in satisfying sexual activity. Typical changes in erectile function include a lengthier delay in attaining a full erection, less distension or rigidity of the erect penis, fewer erections during sleep, and a decline in penile sensitivity (Rowland, 1998; Schiavi, 1999; Wespes, 2002). Adapting to these changes may require some variation from the sexual routines of years past, including, for example, the addition or prolonging of foreplay, greater emphasis on direct physical stimulation of the penis, and adjustment to sexual intercourse positions that are more feasible when some rigidity of the erection is lost.

Men may also experience change in orgasmic responses with age. Latency to ejaculation may be increased, and consequently the amount of time and stimulation required to reach orgasm may be greater. Typically the orgasmic response itself is shorter in older men, with a less forceful ejaculation and a lower volume of semen expelled at each ejaculation. The refractory period following ejaculation is also lengthened; whereas a young man may be able to become aroused to orgasm within minutes of a previous ejaculation, in older men this delay can be considerably longer, spanning as long as a few days (Masters & Johnson, 1966; Schiavi, 1999).

Androgen production gradually wanes in men beginning around age 50 and is often implicated in the decline of libido and sexual responsiveness. In a longitudinal study of aging men, nearly half of men aged 80 and older could be classified as "hypogonadal" on the basis of norms for testosterone levels in younger men (Harman et al., 2001). However, testosterone treatment for sexual problems and the concept of a "testosterone deficiency" or "andropause" syndrome in older men are controversial. The available clinical evidence to date suggests that the benefits of testosterone for sexual function are limited to those men whose natural testosterone levels fall below a relatively low "threshold" value that seems to be necessary to maintain adequate sexual function. Thus, men who are near or within a normal range of androgen production are unlikely to enjoy substantial benefit from the use of testosterone (Isidori et al., 2005).

Women

Unlike men, whose capacities for sexual responsiveness generally peak in early adulthood and slowly change over time, women's sexual responding does not show such a consistent pattern over the life span. The incidence of some sexual problems in women may actually decrease after early adulthood (Laumann et al., 1999). However, women experience a steeper decline in sexual interest than men in later life (DeLamater & Sill, 2005). Interestingly, this trend does not parallel sexual satisfaction among older women, which may remain somewhat higher in women than in men (AARP, 2005).

Menopause typically occurs in midlife around the age of 50 and is marked by a dramatic reduction in estrogen, progesterone, and androgen levels. Menopause, more so than age *per*

se, seems to be critically associated with sexual changes in women (Dennerstein, Alexander, & Kotz, 2003). Following menopause, a number of physiological changes secondary to the loss of estrogen affect the appearance and functioning of the genitals. The lining of the vaginal wall thins, and vaginal secretions are reduced. The vagina also shortens and loses flexibility (Masters & Johnson, 1966). Atrophy of the genital tissues and vaginal dryness may lead to painful sexual intercourse. An increased risk of urethral irritation, urogenital infections, and urinary incontinence also accompanies postmenopausal changes in genital tissue (Butler et al., 1994; Masters & Johnson, 1966; Society of Obstetricians and Gynaecologists of Canada, 2004).

Age-related changes in women's sexual responses somewhat mirror those that occur in men. Vaginal lubrication is not only reduced but also takes longer to appear following the onset of sexual stimulation. Likewise, engorgement of the clitoral and vaginal tissue is slower and less robust. As in men, orgasm tends to be briefer and associated with fewer muscular contractions, although the capacity for multiple orgasms is not necessarily compromised. These declines in responsiveness may be attenuated somewhat by engaging in regular sexual activity, although the mechanism is not understood (Masters & Johnson, 1966).

Despite abundant interest in the effects of sex hormones on women's sexual desire, responsiveness, and satisfaction, the clinical efficacy of systemic hormone replacement therapy for sexual problems is unclear. The effects of estrogen treatment on the integrity of genital tissue are the best established. Speculation about the influence of androgens on sexual desire, on the other hand, has yielded numerous studies with clinically ambiguous outcomes (Alexander et al., 2004; Davis et al., 2005). The long-term safety of estrogen and androgen supplementation in women has also been called into question (e.g., Basaria & Dobs, 2004; Hickey, Davis, & Sturdee, 2005), and thus at present there is insufficient data to inform a clear risk-benefit calculation. Among women who cannot or choose not to take systemic estrogen, localized estrogen preparations (e.g., creams, vaginal suppositories) can be effective alternatives for treating vaginal dryness and irritation (for recommendations, see Society of Obstetricians and Gynaecologists of Canada, 2004). Although the loss of estrogen during menopause inevitably brings about physical changes, it should be noted that women's psychological and relational adjustment during the menopausal transition and beyond have a greater influence on sexuality than genital structure and function alone (Hartmann et al., 2004).

SEXUALITY AS AN ASPECT OF HEALTHY AGING

A number of chronic medical conditions are more prevalent in older adults, and the impact of poorer health on sexuality can be substantial. Clinical reports suggest that many elderly couples discontinue sexual activity due to illness, especially in the male partner (Leiblum & Segraves, 2000). Some of the most common chronic medical conditions among middle-aged and older adults, including cardiovascular disease, hypertension, and diabetes mellitus, are associated with various sexual problems in men and women (M. Burchardt et al., 2002; DeLamater & Sill, 2005; Doruk et al., 2005; Laumann et al., 2005). The impact of degenerative neurological disorders, such as multiple sclerosis (McCabe, 2004) and Parkinson's disease (Bronner et al., 2004), is also associated with a greater incidence of sexual problems and lower levels of sexual activity than in people without these conditions. In women, sexual problems can arise from pelvic pain and bleeding resulting from gynecological conditions such as uterine fibroids and endometriosis. Unfortunately, conventional treatment of these conditions with hysterectomy may not always result in improved sexual outcomes (Meston & Bradford, 2004).

Cancers involving the reproductive organs can be particularly devastating to sexual function due to the effects of treatment on overall health status, self-image, and psychological well-

being. In addition, nerve damage following surgical procedures or radiation therapy can markedly alter genital function and sexual responses. In men, treatment of testicular and prostate cancer is frequently associated with erectile dysfunction (Kao, Jani, & Vijayakumar, 2002; Nazareth, Lewin, & King, 2001). Adverse sexual outcomes are also common after pelvic radiation and radical hysterectomy for cancers of the female reproductive organs (Andersen, Woods, & Copeland, 1997; Bergmark et al., 1999). Sexual problems in patients recovering from nonpelvic organ cancers are also common, but, with the exception of breast cancer in women (see Henson, 2002), are less emphasized in the clinical literature (Monga, 2002).

In addition to physical health complaints, psychiatric disorders can negatively affect sexual well-being. Depression and anxiety are notable risk factors for sexual problems (Dunn, Croft, & Hackett, 1999), although there are few indications that adults become more vulnerable to these disorders as they age (Henderson et al., 1998). The prevalence of cognitive impairment and dementia does increase with age, however (Graham et al., 1997), and this can present unique challenges for maintaining sexual health. Dementia can significantly change the dynamic of a sexual relationship, and concerns about the cognitively impaired partner's ability to consent to sexual activity are common. If the degree of cognitive impairment necessitates the use of residential care, maintaining a sexual relationship becomes especially difficult. Inappropriate sexual behavior occurs in some individuals with dementia, but this is relatively atypical (Benbow & Jagus, 2002; Jagus & Benbow, 2002).

Several types of drugs are commonly associated with sexual dysfunction in men and women. Selective serotonin reuptake inhibitors (SSRIs), used for the treatment of depression and related conditions, have a host of well-documented side effects, including decreased sexual interest, sexual arousal difficulties, and inhibited orgasm. Tricyclic antidepressants may have sexual side effects as well (Meston & Gorzalka, 1992). Other psychiatric drugs, including antipsychotics (Wirshing et al., 2002) and benzodiazepines (Segraves, 1988), are also associated with an increased risk of sexual problems. Other classes of drugs frequently associated with sexual problems include beta blockers and some diuretics (Leiblum & Segraves, 2000). Finally, the long-term use of recreational drugs (including alcohol and nicotine as well as many illicit drugs) can interfere with sexual function (for review see Huws & Sampson, 1993). Although these are some of the most commonly reported drugs involved in sexual complaints, other drugs may have similar effects as well. The effects of current medication use, therefore, should be considered in the sexual health assessment.

There is a growing body of evidence that suggests that lifestyle factors, particularly physical activity, may offer some protection against sexual problems that are frequently associated with health concerns. Several studies have investigated the benefit of physical activity on erectile function and other aspects of sexual response among older men. Derby et al. (2000) followed a cohort of men between the ages of 40 and 70 over a period of about a decade. Their findings indicated that smoking, obesity, alcohol use, and a sedentary lifestyle were all associated with an increased risk of erectile dysfunction. However, the effects of inactivity on erectile function appeared to be somewhat reversible with the adoption of regular exercise during the course of the study. In another study, middle-aged chronic heart failure patients who received 8 weeks of exercise training showed significant improvement on a questionnaire assessing the quality of their sexual relationships and erectile responses. This effect was attributed in part to improved endothelial function as a result of training (Belardinelli et al., 2005). Studies examining the contribution of physical activity to sexual function in women have been less comprehensive, but have so far been promising. Physical activity in menopausal women has been linked to frequency of sexual intercourse, overall sexual responsiveness (Dennerstein & Leher, 2004), sexual satisfaction (Gerber et al., 2005), and orgasmic functioning (Penteado et al., 2003). The extent to which these effects are attributable to the impact of activity on physical or mental health remains to be seen.

SEXUALITY AND AGING IN A PSYCHOSOCIAL CONTEXT

Across age groups, men and women are more likely to be sexually active if they have access to a regular sexual partner (i.e., married or otherwise in a long-term partnership). Because women tend to live longer than men, and often marry men who are older than themselves, they are more likely than men to be widowed and live alone in old age. This trend has important implications for understanding statistics on sexuality in older women, which often suggest a rapid deterioration of women's sexual function in old age. For women in midlife and old age, not only is the presence of a partner associated with levels of sexual desire, but sexual desire appears to be more dependent on the availability of a partner in women than in men (Baumeister, 2000; DeLamater & Sill, 2005). Indeed, it is not unheard of for women to express a loss of interest in sex coinciding with the disability or death of a spouse, suggesting that some older people, especially women, transition into a state of "sexual retirement" (Gott, 2005). This is compounded by the fact that the male-female ratio progressively decreases with advanced age; thus, finding a new partner seems a more viable option from the outset for older (heterosexual) men than for women. However, the urgency with which individuals seek a new sexual partner – if they do so at all – is highly variable. Voluntary celibacy should therefore be carefully distinguished from *problematic* deficits in sexual desire; this may be challenging if guilt or negative attitudes toward sexuality conflict with continued sexual interest after the loss of a partner.

A plausible and quite different reaction to the loss of a long-term partner is a sense of renewed sexual curiosity or "reawakening" of sexual desire. This may be particularly significant for individuals coming out of partnerships in which sexual expression was restricted due to the other partner's illness, disability, or lack of interest. However, older people who wish to seek out new sexual partners may understandably have some difficulty adjusting to dating. Concerns about the adequacy of one's own sexual performance may be activated with the prospect of a new and unfamiliar partner. In addition, unresolved feelings toward a previous partner (e.g., grief, guilt) may interfere with the development of new sexual relationships.

A potentially strong barrier to sexual expression among older people is a lack of broad social recognition and support for sexual relationships after midlife. This is fueled by myths and misperceptions about aging and sexuality (Hodson & Skeen, 1994). Although there is some evidence to suggest that attitudes toward sexuality in later life have improved over the past several decades (Gott, 2005), there remains little representation of later-life sexuality in popular culture and media. What is depicted often conveys the message that older people are or *should* be asexual. Walz (2002) noted that, among the relatively few representations of older adults' sexual lives in film or literature, a negative subtext is often present (e.g., the predatory conquests of a "dirty old man"). Some of these negative images are instantly recognizable character types from popular media, television, and film: the man in midlife crisis desperately clinging to the "glory days" of his youth; the promiscuous older woman dressed unflatteringly in provocative clothing. Perhaps more prominent, however, are images of chastity or sexual indifference among elders – their sexuality is invisible or nonexistent.

Lesbian, gay, bisexual, and transgender (LGBT) adults face unique challenges associated with aging. Heterosexuality is often assumed by society and caregivers, leaving many nonheterosexual elders with little social support for intimate relationships. Adults who live openly as gay, lesbian, or bisexual risk discrimination by health care providers (Brotman, Ryan, & Cormier, 2003; Gott, 2005), exposure to violence or neglect, and economic inequalities in countries that lack legal recognition of same-sex unions. Supplementary social services for LGBT persons may be limited or absent in many areas. Moreover, even within some sexual minority communities, older people may be marginalized. A study by Schope (2005) suggested

that ageist attitudes pose a greater perceived threat to gay men than to lesbians. Although resources for sexual minority populations are not uniformly available, many LGBT community organizations offer special services and programming to older people.

Some stereotypes about sexuality in old age are based on the belief that older people are more conservative in their sexual behavior. This perception is not entirely inaccurate; older adults tend to report less permissive attitudes about sex, often having grown up in more restrictive environments than their children or grandchildren (Hartmann et al., 2004; Leiblum & Segraves, 2000). However, AARP's (2005) survey of adults over 45 indicated that approximately half of respondents were receptive to trying new sex-related activities (e.g., watching erotic films, role playing, using sex toys) with their partners, although men and younger adults were generally more willing to consider these activities. Differences in sexual attitudes and behaviors between older and younger adults are most likely due to generational differences rather than actual changes related to age *per se*, and within generations there exists considerable variability in sexual attitudes and mores. Negative attitudes toward sex are, not surprisingly, associated with lower levels of sexual desire and a greater risk of problems related to sexual arousal and orgasm (DeLamater & Sill, 2005; Laumann et al., 2005). However, sexuality education may be useful in challenging and modifying negative attitudes toward sexuality in older adults (White & Catania, 1982).

ASSESSMENT OF SEXUAL CONCERNS IN OLDER PERSONS

In evaluating the sexual well-being of older persons, the clinician is charged with the delicate task of *acknowledging* the client's advanced age while resisting assumptions about what that may entail for the individual's sexuality. On one hand, approaching the assessment of an 80-year-old client as one would a 30-year-old can appear disingenuous and may be perceived as insulting. Moreover, the "age-blind" approach may neglect information that is particularly relevant to people in later stages of life (e.g., health concerns, changes in living arrangement, ill health or death of sexual partners). On the other hand, clinicians are not immune to the belief that older peoples' sexual lives are less active, varied, or satisfying than those of their younger counterparts. This belief may manifest itself not only in the content of interactions with the client, but perhaps most often in what is *not* addressed during the assessment. For example, the assumption that an older client won't engage in casual sex may lead the clinician to entirely neglect the topic of protection against sexually transmitted infections (STIs). The clinician's negative attitudes toward sexuality in later life can subtly reinforce existing shame, discomfort, or self-doubt in a client who is reluctant to discuss sexual topics. Organizations that provide education about sexuality in old age and support for lifelong sexual health can help correct misinformed beliefs and may be appreciated by clinicians and clients alike; see Table 1 (p. 41) for a list of resources.

In addition to addressing one's own biases, the clinician should be sensitive to the possibility that clients may have internalized negative attitudes about sexuality in old age. For instance, the older client who dismisses the idea of sex at her age may be tacitly expressing shame, embarrassment, or hopelessness about her sexual life. Acquiescing to the client's dismissal of sexuality may neglect an opportunity to discuss ways in which her sexual situation might be changed. Regardless of whether sexual topics are discussed in depth, the clinician should be careful to avoid inadvertently confirming ageist attitudes by failing to inquire about sexuality at all. Because many older people hesitate to initiate conversations with health care providers about sexual topics (Gott, 2005), a sensitive but proactive approach is warranted.

TABLE 1: Recommended Organizations and Internet Resources for Clinicians and Clients

Title/Organization	Description	Contact Information	Website*
General Information			
American Association of Retired Persons	Major nonprofit organization devoted to advocacy and services for adults over the age of 50	201 E Street, N.W. Washington, DC 20049 (888) 687-2277	http://www.aarp.org
Sexuality Information and Education Council of the United States	Provides sexuality education on a wide range of topics; website offers comprehensive bibliographies of resources for older people	130 W. 42nd Street, Suite 350 New York, NY 10036-7802 (212) 819-9770	http://www.siecus.org
American Psychological Association, Aging and Human Sexuality Resource Guide	An online guide to books, articles, and other media on the topic of aging and sexuality; especially appropriate for professionals	American Psychological Association 750 First Street, N.E. Washington, DC 20002-4242 (202) 336-5500	http://www.apa.org/pi/aging/sexuality.html
Elder Abuse			
National Center on Elder Abuse	Organization devoted to education, research, and advocacy related to elder abuse and neglect	1201 15th Street, N.W., Suite 350 Washington, DC 20005-2800 (202) 898-2586	http://www.elderabusecenter.org
Disability and Illness			
Sexual Health Network	An Internet resource for general sexuality information and information targeted to people with disabilities and chronic illnesses	3 Mayflower Lane Shelton, CT 06484	http://www.sexualhealth.org
Disability Resources Monthly WebWatcher	Provides a list of Internet sites related to sexual topics of interest to people with disabilities	Disability Resources, Inc. 4 Glatler Lane Centereach, NY 11720-1032 (631) 585-0290	http://www.disabilityresources.org
Association of Cancer Online Resources	Guide to online cancer support resources; also hosts a mailing list dedicated to discussion of sexuality after cancer diagnosis	173 Duane Street, Suite 3A New York, NY 10013-3334 (212) 226-5525	http://www.acor.org
Menopause			
North American Menopause Society	Scientific organization promoting menopause research and education for professionals and consumers	P.O. Box 94527 Cleveland, OH 44101 (440) 442-7550	http://www.menopause.org
Lesbian, Gay, Bisexual, and Transgender Issues			
American Society on Aging: Lesbian and Gay Aging Issues Network	Organization devoted to education and advocacy in support of LGBT elders; professional development is a major focus	833 Market Street, Suite 511 San Francisco, CA 94103 (415) 974-0300	http://www.asaging.org/lgain
Transgender Aging Network	Promotes awareness and support of issues relevant to older transgender adults; also offers a mailing list	6990 N. Rockledge Avenue Glendale, WI 53209 (414) 540-6456	http://www.forge-forward.org/tan

* Although all contact information and websites in this contribution were correct at the time of publication, they are subject to change at any time.

Beyond the details of the presenting problem, the assessment of sexual concerns in an older client should include a sexual history, or a discussion of how sexuality has been experienced over time. Past experience, enjoyment, and perceived importance of sex are natural antecedents to sexuality in later life. Similarly, sexual disturbances due to primary sexual dysfunction, relationship maladjustment, sexual abuse history, health conditions, or other factors may have long-lasting implications for sexual function even after their acute impact has passed. Other important considerations include current or recent life stress, physical and mental health status, relationship satisfaction, sexual risk behaviors, and the partner's sexual functioning. If the client is not able to live independently, his or her living environment should also be assessed to determine whether he or she is able to pursue sexual activities with privacy and dignity, and whether he or she may be at risk of abuse or neglect.

TREATMENT STRATEGIES FOR OLDER ADULTS

The differentiation of a sexual problem and a "dysfunction" in need of treatment (i.e., an attempt to change) should be approached with caution and with respect to the client's appraisal of the problem. Sexual dysfunctions as defined by the *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR)* (American Psychiatric Association, 2000) are diagnosed only when sexual functioning is a source of interpersonal difficulty or personal distress. Sexual problems and sexual distress are not inherently linked. For example, Bancroft, Loftus, and Long (2003) reported that even as older women tended to report less frequent sexual interest than younger women, younger women were more likely to endorse distress about low sexual interest. At times it may be appropriate to help a client appreciate the impact of a sexual problem on his or her life, but in other circumstances it may be to the client's benefit to normalize rather than pathologize a change in sexuality.

There is some evidence to suggest that knowledge of sexuality in later life is associated with more positive attitudes about sexuality among older people (for review, see Hillman & Stricker, 1994); thus it is worthwhile to consider the potential usefulness of sexuality education in modifying clients' attitudes toward sex. Educating clients about typical age-related bodily changes may help to normalize their experiences and reduce distress about the meaning of their symptoms. Suggesting alternative sexual techniques (e.g., sexual positions or activities that maximize direct genital stimulation) or sexual aids (e.g., lubricants for women with vaginal dryness) may also be an appropriate aspect of education.

Understandably, changes in health and body functions with advancing age may not always be met with full acceptance. How the individual interprets and copes with these changes, however, may transform a relatively benign event into a significant sexual dysfunction. For example, a man who experiences erectile failure during sexual intercourse with his partner may interpret the event as a signal of impending sexual impotence and react catastrophically, creating expectations of future disappointing sexual experiences. Performance anxiety can lead to avoidance of sex as well as arousal difficulties during sexual activity (Barlow, 1986). Thus, expectations of failure can have a powerful effect on future sexual encounters, especially when combined with an "all-or-nothing" attitude toward sexual performance. Cognitive restructuring may be useful in modifying pessimistic or overly rigid beliefs about sexuality that hinder adjustment to normal aging (Schiavi, 1999).

Advances in medical treatments for sexual problems, particularly for men, may be of interest to older clients who present with sexual dysfunction. The availability of phosphodiesterase type 5 (PDE-5) inhibitors such as sildenafil (Viagra) for erectile dysfunction

may be especially appealing. However, medical treatments for sexual dysfunction entail some degree of risk and may not be appropriate for all clients. A thorough assessment that includes screening for physical and psychiatric health problems should inform appropriate referrals for medical management when a medical condition is a suspected etiological factor in sexual problems. Targets for medical intervention may include sexual problems that co-occur with changes in health status, persistent sexual problems that develop in the absence of relational or psychosocial changes, changes in genital function that occur despite sexual interest and desire for sexual activity, and sexual changes that arise with medication use. Even when medical treatments for sexual problems are not indicated, counseling about lifestyle modification may be worthwhile. Adopting or increasing regular physical activity may be beneficial to sexuality by improving fatigue, mood, self-image, and cardiovascular fitness, and it may also help prevent future sexual dysfunctions.

CONCLUSION

Aging typically entails some degree of change in men's and women's capacities for sexual "performance" from a strictly physiological standpoint, yet research data suggest that a large proportion of people find sex in later life equally satisfying, if not more so, than in their youth. Their "secret" seems to lie not in the pursuit of a sexuality left behind in early adulthood, but in a positive, adaptive attitude toward aging that includes entitlement to sexual well-being. Continued sexual enjoyment into later life requires a degree of adjustment to changes in the body, the mind, relationships, and life circumstances. This does not preclude, and may even enhance, continued sexual expression and pleasure late into life.

There is no mysterious threshold separating the sexual concerns and difficulties of older people from those of younger people, and it is reasonable to conclude that there is no one event or quality that characterizes "old-age sexuality." On the other hand, it is important to recognize that older people are at risk for several health-related, psychosocial, and environmental circumstances that can hinder sexual expression and functioning. Although some of these barriers cannot be prevented entirely, education, advocacy, and adaptive coping strategies can soften their impact considerably. Clinicians who work with older clients should be aware of the ageist context in which many of their clients' social interactions take place and take action, when possible, to counter cultural and societal myths about sexuality in old age.

CONTRIBUTORS

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