Sexual health and the new ageing

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Whilst later-life sexual health issues have typically been afforded low priority in policy, practice and research, a sociocultural shift in attitudes to sexuality and ageing is challenging the traditional stereotype of the ‘sexual old age’. Indeed, the contemporary view of celibacy as the ‘new deviancy’ [1] has extended into later life to the extent that ‘life-long sexual function...has come to be seen as’ a primary component of achieving successful ageing in general’ [2, 3]. Key factors underpinning this shift include the increasing medicalisation of sexuality and a cohort change in later-life sexual attitudes and behaviours.

It has been argued that the baby-boomer generation who are now entering later life are confounding expectations of what it means to be ‘old’ [4], and this is particularly apparent in relation to sexuality. For example, later-life divorce and remarriage rates are increasing steadily [5], and there is a growing trend of intimate but non-cohabiting relationships amongst older people [6]. Greater social and legal recognition has been afforded to non-heterosexual lifestyles [7], and older lesbians and gay men are more open about their sexual identity. A new industry is being built up around providing dating services for older people and advice on forming new intimate relationships in later life is now being given by organisations such as Age Concern (http://www.ageconcern.org.uk). Even more tellingly, rates of sexually transmitted infections, including HIV/AIDS, are rising rapidly amongst people over 50 years of age, with 6% of female AIDS diagnoses and 12% of male AIDS diagnoses now in this age group [8].

A further influence upon how later-life sexuality is both understood and experienced is the growing medicalisation of sexuality. Indeed, medicine now extends into the realms of sexual performance and sexual pleasure to the extent that the sexual fulfilment of a population has come to be viewed as a major ‘public health’ concern [9]. This trend has particular implications for older people who are less likely to have sexual intercourse, the perceived ‘gold standard’ of sexual expression, for many reasons often attributed to health status and partnership availability [5]. Both older men and older women have also been identified at increased risk of sexual ‘dysfunctions’, including erectile dysfunction and ‘female sexual dysfunction’.

However, what is interesting is that, whilst many older people do perceive sex to be an important quality of life issue [3], older age appears to facilitate coping when barriers to sex are experienced. For example, whilst older men are more likely to experience erectile dysfunction than younger men, they are less likely to report that it impacts negatively either on their quality of life or on their relationship [10]. Qualitative research indicates that this is likely to be because erectile problems are an expected part of old age and are accepted as such [11]. However, the advent of new pharmaceuticals, and in particular Viagra, is challenging this view. Indeed, research from New Zealand indicates that Viagra has helped create a situation where ‘opting out’ of sex, at any age, is not considered acceptable [12].

The commercial success of Viagra prompted pharmaceutical companies to begin searching for a female alternative, although this did not prove as straightforward as was originally anticipated. However, ‘female sexual dysfunction’ is still enshrined within the DSM-IV despite considerable opposition [13] and is claimed to affect 42% of the US population [9] and be ‘age-related and progressive’ [14]. Notwithstanding the obvious difficulties of a classification system that deems nearly half of all women sexually ‘abnormal’, there is little evidence that older women are more affected by sexual problems than younger women. However, the view that older women do experience more sexual problems fits with the emergent belief that ‘normal ageing’ can, but need not, cause ‘sexual dysfunction’ [2]. Within this context, any loss of sexual desire or suboptimal performance of sexual intercourse, at any age, is deemed abnormal and in need of a medical ‘treatment’ response.

Whilst this may raise concerns about an over-medicalisation of sex, the tendency to view sexuality through a biomedical lens is one that is set to continue. This is the context within which people have come to understand and experience sexual difficulties and, as such, the context within which they seek and expect help for these. The trends outlined above indicate an increase in demand for advice and treatment for sexual problems amongst older people. How well-equipped health professionals working in this area will be to meet this demand is less certain.

Indeed, recent research has identified that, whilst older people do experience sexual concerns which they would like to discuss with a health care professional, most will not do so, often because they are worried about the appropriateness...
of being seen as sexual ‘at their age’ [15]. On the other hand, health professionals fear that raising a sexual issue with an older person may cause offence or that such issues are simply not of relevance within this context [16]. It is likely that the trends outlined above will result in older people being more vocal about their sexual health concerns in interactions with health care professionals which may help overcome this communication impasse. However, those working with older people must increasingly expect to be involved in sexual health management in the future and may require additional training in this area. Failing to acknowledge later-life sexuality will no longer be an option.

References

8. Health Protection Agency (HIV/STI Department, Communicable Disease Surveillance Centre) and the Scottish Centre for Infection and Environmental Health, Table 6.1: UK AIDS cases and HIV infection for individuals aged 50 and over at diagnosis, by sex: to end December 2003, 2004.