Sexual and Relationship Therapy
Publication details, including instructions for authors and subscription information:
http://www.tandfonline.com/loi/csmt20

Relationships and sexual expression in later life: a biopsychosocial perspective
John DeLamater & Erica Koepsel

Department of Sociology, University of Wisconsin-Madison, Madison, WI, USA
Department of Gender and Women's Studies, University of Wisconsin-Madison, Madison, WI, USA

Published online: 08 Aug 2014.

To cite this article: John DeLamater & Erica Koepsel (2014): Relationships and sexual expression in later life: a biopsychosocial perspective, Sexual and Relationship Therapy, DOI: 10.1080/14681994.2014.939506

To link to this article: http://dx.doi.org/10.1080/14681994.2014.939506

PLEASE SCROLL DOWN FOR ARTICLE

Taylor & Francis makes every effort to ensure the accuracy of all the information (the “Content”) contained in the publications on our platform. However, Taylor & Francis, our agents, and our licensors make no representations or warranties whatsoever as to the accuracy, completeness, or suitability for any purpose of the Content. Any opinions and views expressed in this publication are the opinions and views of the authors, and are not the views of or endorsed by Taylor & Francis. The accuracy of the Content should not be relied upon and should be independently verified with primary sources of information. Taylor and Francis shall not be liable for any losses, actions, claims, proceedings, demands, costs, expenses, damages, and other liabilities whatsoever or howsoever caused arising directly or indirectly in connection with, in relation to or arising out of the use of the Content.

This article may be used for research, teaching, and private study purposes. Any substantial or systematic reproduction, redistribution, reselling, loan, sub-licensing, systematic supply, or distribution in any form to anyone is expressly forbidden. Terms & Conditions of access and use can be found at http://www.tandfonline.com/page/terms-and-conditions
Relationships and sexual expression in later life: a biopsychosocial perspective

John DeLamater*a and Erica Koepselb

aDepartment of Sociology, University of Wisconsin-Madison, Madison, WI, USA; bDepartment of Gender and Women’s Studies, University of Wisconsin-Madison, Madison, WI, USA

(Received 13 April 2014; accepted 23 June 2014)

The literature on sexual activity and ageing has grown substantially in the past 20 years. Until recently, a medicalized perspective dominated. In the past decade research based on a social-relational perspective has emerged. We summarize recent work from both perspectives. In addition to the effects of disease on sexual functioning of men and women over the age of 50, this review emphasizes sexual expression among older couples, newly emerging topics such as human immunodeficiency virus (HIV) in the older adult, and older lesbian and gay sexuality. Sexual functioning in both males and females continues in later life, while sexual satisfaction within their relationships is dependent upon individual responses to age-related changes. As the life course continues, some older married couples begin to desire emotional intimacy, stability, and continuity in addition to or instead of penetrative sex. This also appears to be characteristic of relationships involving two (older) women. As the world’s population over 50 continues to grow there is an increasing interest in older adult’s sexuality. This signals progress toward understanding healthy sexual relationships.

Keywords: ageing; long-term relationships; sexual behavior; sexual desire; masturbation; oral sex; HIV; lesbian; gay

Introduction

Until recently, the research literature on later life sexual activity has been dominated by studies identifying physical and mental health barriers. The sexual expression of typical, healthy older persons is a relatively neglected topic of research, which makes it difficult to develop generalizable models of sexual relationships in later life. We cannot provide accurate information and support for older persons who wish to remain sexually active, or provide evidence-based advice to individuals and couples seeking counseling. There are little data on the potential benefits of sexual activity for quality of life. Data on which to base policy decisions regarding housing, sexual health care, and related programs for this age group are also limited.

We begin this review with a brief discussion of measures of sexuality. Next we summarize the data consistent with the medical model, focusing on ageing, physical health, mental health and medications as influences on sexual activity. In this context, we review the literature on sexual dysfunctions. Then we turn to research based on the alternative biopsychosocial model, focusing on attitudes, relationship status, and quality of relationship as important influences. We will review the limited literature on two new topics of research, the impact of human immunodeficiency virus (HIV) on sexual functioning and

*Corresponding author. Email: delamate@ssc.wisc.edu

© 2014 College of Sexual and Relationship Therapists
later life, and sexual expression of lesbian, gay, and bisexual (LGB) individuals and couples as they age.

An understanding of the realities and potential of sexual function at older ages is important for many reasons. First, there are a large number of older adults in the USA. In 2012, there were 41.5 million persons 65 and older, comprising 13.4% of the population (U.S. Census Bureau, 2012b). This group will double in size to 83.7 million in 2050, when one in five Americans will be 65 or older (U.S. Census Bureau, 2012c). Second, men and women in the United States are living longer. Life expectancy at birth increased from 70.8 in 1970 to 77.7 in 2006, and is expected to increase to 79.5 by 2020 (U.S. Census Bureau, 2012a). Even more significantly, active life expectancy at age 65 (years with no health-related difficulty performing instrumental activities of daily living) is estimated to increase by 2.5 years by 2022 (Manton, Gu, & Lamb, 2006). The number of years of potential sexual activity in later life will increase significantly as a result of these changes. Third, as families are smaller, and men and women are living longer, they no longer spend most of their adult years bearing and raising children. New stages of the later life course are emerging, including “empty nest” and “retirement” phases (Burgess, 2004). Individuals and couples may experience greater solitude and privacy during these years with more opportunity to engage in sexual activity. All of these changes have been observed globally.

Most importantly, regular (consensual) sexual expression contributes to physical and psychological well-being, and may reduce physical and mental health problems associated with ageing (Burgess, 2004; Edwards & Booth, 1994). Brody (2010), reviewing the literature, reports that engaging in penile—vaginal intercourse is correlated with higher quality of intimate relationships, lower rates of depressive symptoms, and improved cardiovascular health in both men and women. A study in South Korea also noted, “those who were maintaining a sexual life had significantly higher self-esteem than those who were not” (Choi, Jang, & Kim, 2011).

There are two fundamental perspectives in the research literature on sexuality beyond age 60. One is a medical perspective, which focuses on physical and mental health concomitants of ageing and their effect on sexual behavior. These studies generally consider the effects of various illnesses and treatments on sexual behavior, leading to a focus on dysfunctions.

In the past 15 years, research based on an alternative perspective has appeared with increasing frequency. In their analysis of sexuality across the life course, Carpenter and DeLamater (2012) develop and illustrate a biopsychosocial perspective, in which biology (health and illness) is only one of three influences on sexual functioning. Psychological influences (knowledge, attitudes) and relationship characteristics (quality, satisfaction) are also important. Increasingly, research on community samples of older adults has been published which reflects this more inclusive perspective.

**Sexuality in later life**

**Sexual functioning**

Until recently, the published literature on sexuality and age ing has concentrated on sexual interest or desire, capacity for sexual intercourse, and erectile dysfunction, particularly among older men. This reflects the medicalization of sexual functioning (Tiefer, 1996). However, in order to appreciate the role of sexuality in later life, we need to consider a
range of sexual activities, including solo and partnered masturbation and oral sex. Moreover, the definition should include both objective and subjective components (Araujo, Mohr, & McKinlay, 2004). “Subjective sexual well-being” refers to the perceived quality of or satisfaction with the person’s sexual life and relationships (Laumann et al., 2006).

**Sexual behavior**

Data on frequency of sexual behavior among older persons in the USA are available from three recent surveys: the American Association of Retired Persons survey conducted in 2009 (AARP, 2010), the National Social Life, Health and Aging Project (NSHAP) survey conducted in 2005–2006 (Waite, Laumann, Das, & Schumm, 2009), and the National Survey of Sexual Health and Behavior (2010), or NSSHB, conducted in 2009. The latter is a cross sectional survey of persons aged 14–94 years, and therefore covers the broadest age range. The sampling frame was constructed via a complex process, described by Herbenick et al. (2010). Persons in the frame were invited to complete an Internet survey, yielding 950 male and 958 female participants over the age of 50.

Table 1 presents data on the sexual activity reported by persons over 50 years of age in the year prior to the survey. The data include all respondents, whether partnered or not. Solo masturbation is common among older American men and women; 46% of the oldest men (over 70) and 33% of the oldest women report engaging in the behavior. The data clearly indicate the extent of continuing sexual expression in this population. Men are somewhat more likely to report giving and receiving oral sex with a female partner (48% and 44%, respectively, for men aged 50–59), than women are to report these behaviors with a male partner (34% and 36% among those aged 50–59), and annual incidence declines with age among both. Vaginal intercourse is reported by 58% of men and 51% of women aged 50–59. The incidence declines to 43% among men aged over 70, and to 22% among women aged between 70 and older. Analyses of these data indicate that the decline among women is primarily related to relationship status, i.e., loss of a male partner (Schick et al., 2010).

Table 1. Sexual behaviors in the past year by gender and age.

<table>
<thead>
<tr>
<th>Male</th>
<th></th>
<th>Female</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>50–59</td>
<td>60–69</td>
<td>70+</td>
</tr>
<tr>
<td>masturbation alone</td>
<td>72.1%</td>
<td>61.2%</td>
<td>46.4%</td>
</tr>
<tr>
<td>Masturbated with partner</td>
<td>27.9%</td>
<td>17.0%</td>
<td>12.9%</td>
</tr>
<tr>
<td>Received oral from female</td>
<td>48.5%</td>
<td>37.5%</td>
<td>19.2%</td>
</tr>
<tr>
<td>Received oral from male</td>
<td>8.4%</td>
<td>2.6%</td>
<td>2.4%</td>
</tr>
<tr>
<td>Gave oral to female</td>
<td>44.1%</td>
<td>34.3%</td>
<td>24.3%</td>
</tr>
<tr>
<td>Gave oral to male</td>
<td>8.0%</td>
<td>2.6%</td>
<td>3.0%</td>
</tr>
<tr>
<td>Vaginal intercourse</td>
<td>57.9%</td>
<td>53.5%</td>
<td>42.9%</td>
</tr>
<tr>
<td>Inserted penis into anus</td>
<td>11.3%</td>
<td>5.8%</td>
<td>1.7%</td>
</tr>
<tr>
<td>Received penis in anus</td>
<td>4.6%</td>
<td>6.0%</td>
<td>1.7%</td>
</tr>
</tbody>
</table>

Note: Data taken from National Survey of Sexual Health and Behavior (NSSHB).
These results are consistent with those reported by the NSHAP (Waite et al., 2009). A survey of 2341 German men and women aged 18–93 also found that engaging in sexual activity was primarily related to having a partner (Beutel, Stobel-Richter, & Brahler, 2007). Research on large samples of adults conducted in Great Britain (Mercer et al., 2013), Finland (Kontula, 2009), and Australia (Hyde et al., 2010) reports similar frequencies of and declines in sexual behavior in later life.

Thus, sexual activity remains a significant component of life and relationships well into the 70s. Having a sexual partner and being in good health are the primary influences or mechanisms for continued sexual activity (Karraker, DeLamater, & Schwartz, 2011). As noted earlier, maintaining sexual activity will likely increase in importance as more people live longer, and live more years in good health.

The medical perspective

Recently, the advent of Viagra and other forms of treatment have stimulated a substantial literature on the prevalence and pharmaceutical treatment of various sexual dysfunctions in later life. As noted by Tiefer (2007), much of this research is based on a biomedical perspective and assumes declining individual sexual functioning in later life, though there are exceptions (e.g., Laumann, Das, & Waite, 2008).

Research from a medical, rather than social scientific perspective, suffers from reliance on limited samples. Most of these studies involve small samples of older persons who have been diagnosed or treated for accident or illness, or who were taking a specific medication. Although informative, such research provides a little indication of typical patterns of sexual expression among healthy older adults who form the majority of people aged 50 and over.

In this section, we summarize the data consistent with the medical model, focusing on ageing, physical health, mental health, and medications as influences on sexual activity. We will review the limited medical literature on a new topic of research, the impact of HIV on sexual functioning, and later life. Then we turn to research based on the biopsychosocial model, focusing on attitudes, relationship status, and quality of relationship as important influences. We introduce recent research on sexual expression of LGB individuals and couples as they age.

Health and sexual activity

Physical changes associated with ageing

Ageing is associated with physical changes in women and men that may affect sexual functioning. The most noticeable changes in women are related to a decline of function of the ovaries during the climacteric. Due to the gradual decline in levels of estrogen in the body, women may experience vaginal dryness and atrophy. As many as 60% of post-menopausal women experience these conditions (Krychman, 2007), but there is little consistent evidence of the effect of such conditions/symptoms on the sexual activity. Some women report a less frequent sexual activity, possibly associated with negative feelings, others report no change, and some may experience greater excitement and desire after the menopause (Dillaway, 2012; Hinchcliff & Gott, 2008; Koch, Mansfield, Thurau, & Carey, 2005). Consequences associated with changes in estrogen levels vary considerably. Serious symptoms include aches and itching in the vulva and vagina, burning and dyspareunia. Obviously, these may lead to a reduced frequency or cessation of sexual
activity. The experience of serious symptoms does not appear to be common. A study of a random sample of urban women aged 40–79 in Australia found that vaginal dryness was reported as always present by only 11.5% and never present by 35.8% (Howard, O’Neill, & Travers, 2006). Dyspareunia was experienced half of the time or more by only 14.6% of the women. The incidence of vaginal dryness and of dyspareunia did not differ significantly by age.

The analogous change in men is a slow decline in testosterone production. This is much more gradual than the decline in estrogen production in women, and so its consequences may take much longer to appear and may be subtle. Consequences for sexual functioning may include slower erections, less firm erections, decreased likelihood of orgasm, and a longer refractory period (Aubin & Heiman, 2004).

In short, there is little evidence that the normal physical changes that accompany aging necessarily or irreversibly affect sexual functioning.

Cognitive perspectives suggest that it is the meaning of these changes, not the changes themselves that may determine their impact on sexual functioning. These meanings are derived from social values. Many people experience age-related changes in physical appearance, including changes in skin tone and firmness, and amount and coloring of hair. Physical vitality may also be affected. These changes are reminders of biological aging and may be stressful for those who live in an ageist society (Slevin & Mowery, 2012). In a Western society surrounded by youthful media images, ageing means movement away from that youthful status, and may have negative effects on self-esteem and body image. Ageing men and women may feel that they are no longer physically or sexually attractive, undermining their sexual desire even though their physical capacity has not declined. Koch et al. (2005) found that women aged 39–56 who reported declining sexual desire and frequency of activity also reported that they felt less physically attractive than 10 years earlier, regardless of age.

Another influence on women’s interest in and desire for sexual activity is pronatalism (Baker, 2005). Some men and women define womanhood in terms of motherhood. An inability to reproduce following menopause may result in the belief that there is no longer any reason to engage in sexual activity. Thus, social values may result in cessation of sexual activity by some (older) people.

Physical health

Lindau and Gavrilova (2010) calculated sexually active life expectancy “defined as the average number of years remaining spent as sexually active” (p. 3). Their estimates take into account the likelihood of having a partner and of being institutionalized at specific ages. At age 55, they estimate sexually active life expectancy for men at 15 years and for women at 10.6 years. Men in excellent or good health are estimated to gain 5–7 additional years of sexual activity compared to men in fair or poor health. Women in excellent or good health are estimated to gain 3–6 years.

Research on health often relies on a measure of self-reported health. Older men and women who report their health as excellent or good are more likely to be sexually active than those who report their health as fair or poor (Lindau & Gavrilova, 2010). In the AARP (2010) results, there is a strong positive association between the rating of one’s health and reports of engaging in sexual intercourse at least once per week. Similar results were found in two nationally representative surveys in Finland in the 1990s (Kontula & Haavio-Mannila, 2009). Hence, good health is related to continuing sexual activity, and self-reported health does not inevitably decline with age.
We noted earlier the substantial literature on the impact of chronic conditions and illness on sexual functioning. AARP (1999) conducted a questionnaire survey of 1384 respondents aged 45 and older. The results indicated that less than 16% of the men and 6% of the women reported restrictions in their sexual activity due to serious medical conditions. At the same time, one-third of men and women had been diagnosed with high-blood pressure, 19% of men and 31% of women with arthritis, 15.6% of men with enlarged prostate, and 14% of men and 12% of women with diabetes mellitus (Table 2).

Lindau et al. (2007) reported results from NSHAP, based on face-to-face interviews with a national probability sample of 3005 adults aged 57–85. Respondents who reported that their health was fair or poor were less likely to be sexually active and reported a higher incidence of sexual problems. The results indicate that diabetes mellitus and hypertension are associated with sexual dysfunction among older men and women (Lindau et al., 2010). The AARP results indicate that the incidence of these diseases is less than 12%.

Howard et al. (2006) studied sexual functioning in a sample of 474 Australian women aged 40–79. These women reported a variety of medical conditions including breast cancer, diabetes mellitus, hypertension, and osteoarthritis. Howard and his colleagues conclude, “Overall, women with medical conditions showed no increase in sexual distress compared with women without medical conditions” (p. 363). Similarly, Kontula and Haavio-Manilla (2009), basing their conclusion on an analysis of the Finnish survey data, claimed that illness seldom causes sexual problems.

The evidence does not support the argument that medical illness is a major influence on declining sexual desire or behavior in later life. The literature does suggest that improvements in the health of a population will increase rates of sexual activity in later life.

Mental health

Mental health also influences sexual functioning in later life. Laumann et al. (2008), analyzing data from NSHAP, reported that scores on an anxiety scale were related to sexual difficulties among both men and women. Increased anxiety was associated with a lack of sexual interest in both women and men, with increased anorgasmia and lack of pleasure.

<table>
<thead>
<tr>
<th>Conditions that respondents think restrict sexual activity</th>
<th>Men</th>
<th>Women</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Base)</td>
<td>45–59</td>
<td>60–74</td>
</tr>
<tr>
<td>Have conditions that restrict sexual activity</td>
<td>(341)</td>
<td>(205)</td>
</tr>
<tr>
<td>High blood pressure</td>
<td>18.2%</td>
<td>39.0%</td>
</tr>
<tr>
<td>Arthritis or Rheumatism</td>
<td>8.2%</td>
<td>15.6%</td>
</tr>
<tr>
<td>Diabetes</td>
<td>4.4%</td>
<td>4.9%</td>
</tr>
<tr>
<td>Depression</td>
<td>3.5%</td>
<td>10.7%</td>
</tr>
<tr>
<td>Enlarged or swollen prostate</td>
<td>4.1%</td>
<td>0.5%</td>
</tr>
<tr>
<td>Enlarged or swollen prostate</td>
<td>2.1%</td>
<td>9.3%</td>
</tr>
<tr>
<td>Prostate cancer</td>
<td>0.3%</td>
<td>4.4%</td>
</tr>
</tbody>
</table>

from sex among women (e.g., Moreira, Glasser, King, Duarte, & Gingell, 2008). Symptoms of depression were associated with anorgasmia and erectile problems among men. There was a correlation between self-rating of mental health as fair or poor and reports of problems in sexual functioning amongst women (e.g., Brody, 2010). Laumann and colleagues concluded that stress, a major contributor to anxiety and depression, may be a primary cause of reduced sexual functioning in later life.

There is a positive relationship between mental health and sexual functioning in later life.

**Medications**

Significant numbers of older adults take various medications, some of which are known to affect sexual functioning. The impression is created that increasing use of multiple medications, with the exception of drugs for erectile dysfunction, is a major reason why older people stop engaging in sexual activity. Therefore, it is important to assess this relationship in large samples of typical adults.

The AARP (2010) survey asked respondents aged 50 and above to identify the prescription drugs they took. Overall, 47% of men and women reported taking blood pressure medication, and 41% of men and 36% of women reported taking medication to lower cholesterol. Medication to relieve pain was being taken by 39% of men and by 43% of women. The frequency of use of all three prescribed drugs increased with age in both men and women. Three medications were reportedly taken by more than one-third of the respondents (Table 3).

<table>
<thead>
<tr>
<th></th>
<th>Males</th>
<th>Females</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>45–49</td>
<td>50–59</td>
</tr>
<tr>
<td>(Base)</td>
<td>82</td>
<td>198</td>
</tr>
<tr>
<td>Blood pressure pills</td>
<td>30%</td>
<td>36%</td>
</tr>
<tr>
<td>Medications for cholesterol</td>
<td>23%</td>
<td>28%</td>
</tr>
<tr>
<td>Pain killers</td>
<td>29%</td>
<td>32%</td>
</tr>
<tr>
<td>Pills or other med. to thin blood</td>
<td>11%</td>
<td>11%</td>
</tr>
<tr>
<td>Pills/paste patches or anything for heart or heart beat</td>
<td>4%</td>
<td>7%</td>
</tr>
<tr>
<td>Medications for depression</td>
<td>12%</td>
<td>8%</td>
</tr>
<tr>
<td>Sleeping pills of other meds to help you sleep</td>
<td>13%</td>
<td>13%</td>
</tr>
<tr>
<td>Medications for a nervous condition, such as tranquilizers</td>
<td>3%</td>
<td>5%</td>
</tr>
<tr>
<td>Medications to improve sexual functioning</td>
<td>6%</td>
<td>10%</td>
</tr>
<tr>
<td>Any androgens, testoderm, or bromocriptine</td>
<td>1%</td>
<td>2%</td>
</tr>
</tbody>
</table>

DeLamater and Sill (2005) conducted extensive analyses of the AARP (1999) data related to influences on sexual desire. A two-item index of desire was related negatively to regular use of anticoagulants, cardiovascular medications, medications to control cholesterol, and drugs to reduce hypertension among women. It was related negatively to taking anticoagulants and medications for hypertension among men. These correlations were significant and uniformly small; the largest was \(-.19\). In multivariate analyses, the total number of drugs being taken regularly was significantly related to desire, but the coefficients were small. DeLamater and Moorman (2007) conducted regression analyses of the 1999 AARP data focused on influences on frequency of sexual behavior. Diagnosed illnesses and medication use were generally unrelated to frequency of sexual activity.

Sexual functioning

Sexual desire

Much of the literature on sexual functioning presumes, implicitly or explicitly, that sexual desire is important. Desire is thought to index motivation for sexual activity and gratification. Reported sexual desire declines sharply with age, although there is some variation across studies. In the AARP (1999) data, 76.5% of men aged 45–59 reported desire a few times per week, declining to 43% among men aged 60–74, and 17% among men aged over 75. Among women, the comparable percentages were 36%, 11%, and 4%, respectively. Ergo, women were much less likely to report frequent sexual desire than men. Kontula and Haavio-Mannila (2009) reported data from two surveys in Finland with data from 705 men aged 45–74. They asked whether lack of sexual desire had caused problems very often or quite often in the past year. Thirteen percent of respondents aged 45–54, 12% aged 55–64, and 30% aged 65–74 replied affirmatively. In contrast, Moreira et al. (2008) found that 18% of 750 Australian men aged 40–80 reported lack of sexual interest with no variation by age. Similarly, lack of sexual interest was reported by 33% of 750 Australian women aged 40–80 with no variation by age. Huang et al. (2009) assessed sexual desire/interest among an ethnically diverse group of US women participating in the Kaiser Permanente Medical Program using items from the Female Sexual Function Index. Scores indicating at least moderate sexual desire were obtained by 56% of women aged 45–54, 35% of women aged 55–64, and 29% of women aged over 65, indicating a less substantial decline than other studies. Of the female respondents 50% Black, 46% Latina, 41% White, and 39% Asian women reported at least moderate desire.

Lindau and Gavrilova (2010) analyzed data from two surveys, MIDUS (the national survey of Midlife Development in the USA) with 3032 respondents aged 25–74 and NSHAP. Both surveys assessed sexual interest. The results indicated that among men sexual interest was stable across age groups and did not vary by partner status. For women interest declined significantly after the age of 60 and was much lower among women without a partner.

The relationship between age and reported sexual desire varies across studies. Clearly, desire does not always decline as men and women age, suggesting that other variables such as partner status and health/stress are influential.

While reported desire varies, several studies indicate a link between sexual desire and sexual activity. In a study of healthy older women there was a positive association between sexual desire and frequency of arousal, lubrication, and orgasm (Trompeter,
Two surveys of adults in Finland reported that frequency of desire predicted frequency of sexual intercourse (Kontula & Haavio-Manilla, 2009). The AARP data indicate, along with more frequent sexual activity, that there is an association between desire and increased masturbation (DeLamater & Moorman, 2007). It appears that desire is significantly associated with frequency of sexual activity in later life.

**Sexual dysfunctions**

As noted earlier, much of the recent literature on sexuality among older adults is focused on sexual dysfunctions, contributing to the stereotype that later life is a time of diminished or no sexual activity. The following discussion considers issues related to desire, arousal, orgasm, and sexual pain/use of lubricants.

**Hypoactive sexual desire.** Hypoactive sexual desire disorder (HSDD) is defined as “the persistent or recurrent deficiency (or absence) of sexual fantasies/thoughts, and/or desires for, or receptivity to, sexual activity, which causes personal distress” (Aubin & Heiman, 2004, p. 481). This is considered a serious disorder. Hayes et al. (2007) measured HSDD by combining their measure of desire from the Profile of Female Sexual Function with a validated measure of sexual distress. They found that while lack of desire increased with age, especially in the European sample, the percentage of women distressed by their lack of desire declined from two-thirds of women aged 20–29 to 37% of women aged 60–70 in the USA and 22% of women of the same age in Europe. They conclude that HSDD among women is not associated with age.

**Problems of sexual arousal.** The occurrence of vaginal lubrication is an indicator of physiological arousal. The percentage of women reporting that lubrication was difficult, very difficult, or impossible increased from 17% among women aged 45–54 to 28% among women aged 55–64 and 27% among women over the age of 65 (Huang et al., 2009). While this age trend was not significant, Kontula and Haavio-Manilla (2009) reported a significant age trend among Finnish women, 13% of those aged 45–54, 36% of women aged 55–64, and 31% of women aged 65–74 reported lubrication difficulties quite often in the past year. Similar results were found in a survey of 750 Australian women (Moreira et al., 2008).

The most common disorder among men aged from 57 to 85 years is erectile dysfunction (Laumann et al. 2008, Table 2). Laumann, Paik, and Rosen (1999), analyzing National Health and Social Life Survey data, found that men aged 50–59 were three times more likely (17%) than those aged 18–29 to experience erectile difficulties in the past year. Results from NSHAP (Laumann et al., 2008) and the study of Australian men (Moreira et al., 2008) indicate that the incidence of erectile problems was significantly related to age. The AARP (1999) questioned men about impotence, defining the condition as “being unable to get and keep an erection that is rigid enough for sexual activity.” Among men aged 45–59, only 2.5% rated themselves “completely impotent,” increasing to 16% among men aged 60–74, and 38% among men aged over 75. Frequencies reported in the 2010 online survey are similar. However, in response to an open question about what conditions restricted their sexual activity, only 2%–4% of the men wrote “impotence.” It appears as though many men with difficulties maintaining erections may be engaging in sexual activities other than those involving penile penetration. This issue should be investigated in future research.
**Problems associated with orgasm.** Among men, in the NHSLS, with respondents aged 18–59, only 7%–9% of men reported “inability to climax or achieve orgasm” in the past year (Laumann, Paik, & Rosen, 1999). In the NSHAP data, inability to climax was reported by 16%, 23%, and 33% of men aged 57–64, 65–75, and 75–85, respectively. The age trend is highly significant (Waite et al., 2009).

Among women aged between 18 and 59, inability to climax or achieve orgasm was reported in the past year by 22%–26% of the respondents (Laumann et al., 1999). Among the older women in NSHAP, there is no significant age trend (Waite et al., 2009). In response to the AARP question regarding frequency of orgasm, the percentage saying “never” was 4% among women aged 45–49, 13% among women aged 50–59, 5% of women aged 60–69, and 7% among women aged 70 and over. In a survey of almost 2000 women aged 45–80, Huang et al. (2009) reported the percentage of women stating that achieving orgasm was difficult, very difficult, or impossible did not increase significantly with age from 45 to over 65. Thus, in all four of these studies, there is little evidence that orgasmic disorder increases with age among women, although the precise measure varies across studies.

**Pain during intercourse.** Among male respondents in NSHAP, reports of experiencing pain during intercourse in the past year were very infrequent, less than 4%, and did not vary with age (Laumann et al., 2008). Similar results were found in the AARP (1999) questionnaire, indicating pain associated with sex appears to be a very uncommon experience among older men.

Among women, the NSHAP data indicates that 12%–19% experienced pain during intercourse in the preceding year. The incidence did not vary with age. Hispanic women were significantly more likely to report this experience (31%) than Black (9%) or White (17%) women. In three other studies, there are no differences with age in the frequency of reports of pain during intercourse (AARP, 1999; Huang et al., 2009; Leiblum, Hayes, Wanser, & Nelson, 2009). The experience of pain during intercourse appears to be unrelated to age among women.

**Treatment.** With regard to treatment, the Associated Press-LifeGoesStrong (Knowledge Networks, 2010) poll asked respondents whether they have ever sought treatment from a medical professional for problems related to sexual functioning. Forty-six percent of people aged 45–65 said they had. Twelve percent of people aged 45–65 and 14% aged 66 and older reported taking medication or receiving treatment for such a problem.

Moreira et al. (2008) found that only 22% of Australian men and women who had reported at least one sexual difficulty had sought help from a medical professional, typically a medical doctor. Men experiencing erectile difficulties, women experiencing problems with lubrication, and those who believed sex is a very or extremely important part of life were more likely to have sought medical help.

The AARP (1999) survey indicates that 28% of the men and 13% of women had sought treatment for problems related to sexual functioning. About half of these participants consulted their primary care physician and half consulted a specialist physician. This clearly indicates the need for medical personnel to be trained in the assessment and management of sexual function in older people. About 6% of the men and 4% of the women reported using medication, hormone replacement therapy, or other treatments to improve sexual functioning at the time of the survey. Five percent of the men and 3% of the women reported using these in the past. Of the men who had ever received a treatment, one-half used Viagra. Among women, one-half reported using hormone
replacement therapy. Those who received/accepted treatments did not report a significant increase in frequency of intercourse following treatment, but 60% of the men and women who were treated reported an increase in their satisfaction with sex.

**HIV in the older adult**

While HIV has been identified in populations of adults aged 55 years and older for the past decade, the literature has only recently recognized that this population is at risk of HIV infection. The *National HIV/AIDS Strategy for the United States* indicates a continual rise in the number of individuals aged 50 and over who contract HIV each year (White House Office of National AIDS Policy, 2010). The Centers for Disease Control and Prevention (CDC) estimates that by 2015 over half of HIV cases in the United States will be adults in this age range, with the majority being new cases (CDC, 2008). Of the older adults currently infected with HIV approximately 60% of males were infected due to sex with other males. In contrast, 80% of infected females contracted HIV from heterosexual contact (CDC, 2013).

The rise in HIV infection among older populations has been attributed to four main factors (Emanuel, 2014). First, as stated earlier, older adults are living longer and staying healthier. As a result older people are able to remain sexually active for longer than in the past. Second, even individuals who experience problems in sexual functioning have the assistance of Viagra or other drugs that enable enjoyment of penetrative sex for longer than was possible in previous generations. Third, retirement communities, where large numbers of people of similar aged live together and interact daily, provide a greater opportunity for older people to engage in sexual partnership. Finally, it appears that older, sexually active people may not have received safer sex information earlier in life. They also may have minimal information on condom use.

Not surprisingly, older individuals with HIV have similar reactions to the virus and medication as younger adults. It is common for HIV drugs to affect sexual functioning, by preventing arousal and erection, in ways similar to anti-depressant medication (Gay Men’s Health Crises Inc., 2010). Other studies have identified HIV as a hindrance to sexual activity. HIV may also lead to loss of libido due to the emotional stress related to contracting a serious and stigmatizing illness (Sadeghi-Nejad, Wasserman, Weidner, Richardson, & Goldmeier, 2010). As HIV progresses it can be responsible for low testosterone levels and nerve damage, which in turn may cause erectile problems in men (Mayr & Bredeek, 2007; State of New York Department of Health, 2012). Women who may already have low postmenopausal estrogen levels are at a higher risk of contracting HIV due to the thinning of the vaginal walls (Brennan, Emlet, & Eady, 2011; Rural Center for AIDS/STI Prevention, 2013). A woman who is HIV positive may also experience altered production of progesterone and estrogen which may affect female sexual enjoyment by causing vaginal dryness, thrush, and pain (Carter, 2011). Unfortunately, these symptoms can be more intense or can escalate more quickly in older bodies due to the typical decline of the immune system.

Another factor affecting HIV rates in the older population is the social stigma surrounding the sexuality of older people (Brennan et al., 2011; CDC, 2013; Miller, 1996). Because it is typically assumed that older adults are sexually inactive, health care providers are less likely to inquire about older patients sexual habits, so rarely consider their risk of HIV and other STIs (CDC, 2013). Older patients may be embarrassed or uncomfortable and avoid discussing sexual activity with their health
care providers. This may result in late diagnosis, which is often accompanied by a quicker progression of HIV/AIDS disease and more rapid bodily deterioration (Brennan et al., 2011). Because older individuals are expected to have bodily ailments in later life, many who experience symptoms of HIV fail to identify them as HIV related. They may also be misdiagnosed by doctors who attribute symptoms to ageing (CDC, 2008, 2013). In addition, the ability for more individuals to perform sexually into later life can lead to more sexual activity, which includes more risky sexual behaviors (Carter, 2011; Maes & Louis, 2003). This misunderstanding of older sexuality and failure of both older adults and care providers to discuss sexual health behaviors with one another results in an increased incidence of HIV infection in the older community.

Many older adults do not perceive themselves at risk for HIV. As a result single, older individuals are less likely to take necessary precautions to protect themselves from HIV and other STIs. Moreover, many women have already gone through the menopause and therefore are unconcerned about using contraception (Maes & Louis, 2003). The NSSHB indicated that older men are more likely to use condoms than older women, but rates of condom use decline significantly in older age (Reece et al., 2010; Schick et al., 2010). It appears that Black and Hispanic adults aged over 50 are more likely to use condoms and get tested for STIs than other adults (Dodge et al., 2010). Even if older adults are aware of the risks, they are often under-educated on the modes of transmission as well as proper condom use (Scudder, 2012). Organizations are trying to combat this knowledge gap with educational series in New York City, and books featuring lesson plans for sex education with older adults, e.g., Older, Wiser, Sexually Smarter are being published. However, it is unclear how these resources are being used (Brick, Lunquist, Sandak, & Taverner, 2009; Kilgannon, 2007). Research indicates that loneliness among single, older adults can lead to riskier sexual behavior, such as unprotected vaginal or anal sex and multiple or anonymous partners, especially when combined with drug and alcohol use (Golub et al., 2010). As part of a vicious cycle, lack of a support system and loneliness often have detrimental effects on the mental health of older individuals who have already contracted HIV.

Clearly current research on HIV in older individuals illustrates an interaction between biological and social influences that affect the sexual functioning and sexual health of older adults.

**A biopsychosocial perspective**

The variables employed in the medical perspective — ageing, health, medications, and sexual functioning — explain relatively little of the variation in reported sexual expression in older couples. Carpenter and DeLamater (2012) develop and illustrate a biopsychosocial perspective, in which biology is only one of three types of influence on sexual functioning.

Research based on the biopsychosocial perspective has been facilitated by the publication of articles and the release of data from several large studies of older populations. The samples include larger numbers of “well persons” and measure a broad range of variables. The vast majority of participants in research using community-based or representative samples are heterosexual, due to their predominance in populations. The data reviewed in this section are about partnered heterosexual activity and masturbation. A short review on the limited published research on typical patterns of sexual expression among older LGB persons follows.
Psychological factors

Attitudes about sex

Attitudes about sexuality are an important influence on frequency of partnered sexual behavior. The AARP (1999) survey included three measures of the importance of sex to a relationship, e.g., “Sexual activity is a critical part of a good relationship.” One-third to one-half of men and women agreed with each item. Three additional items measured the importance of sex to the person, e.g., “Sexual activity is important to my overall quality of life,” and “I would be quite happy never having sex again.” Fifty-nine percent of the men agreed or strongly agreed with the first item, compared to 35% of the women. Conversely, 3% of the men agreed with the second item, compared to 20% of the women (DeLamater & Moorman, 2007). Therefore, men were more likely to rate sex as important than women. Results from the AARP (2010) online survey conducted 10 years later found similar results.

The AP-LifeGoesStrong (Knowledge Networks, 2010) surveyed 945 adults 45–75 years of age. Asked to choose between “Sexual activity is a critical part of a strong relationship,” and “Couples can have a strong relationship without sexual activity,” 45% of people aged 45–65 chose the former, compared to 29% of the people aged 65 and older. With regard to attitudes about sex as people age, 51% of respondents aged 45–65 endorsed the statement “Sex becomes less important to most people as they get older,” as did 76% of those aged over 65.

The NSHAP survey included the attitude statement “sexual ability decreases with age.” Among men, 68% of those aged 57–64 agreed, as did 72% of those aged 65–74 and 78.5% of men aged 75–85. Among women, the comparable percentages were 71%, 83%, and 89%, respectively (Waite et al., 2009).

Substantial percentages of older people believe that sex declines in importance as they age. The results of two surveys in Finland indicate that men and women (of all ages) who rated sex as important reported more frequent sexual activity (Kontula, 2009). DeLamater and Sill (2005), analyzing the 1999 AARP data, constructed three-item indices of attitudes about the importance of sex for the self, and of sex for relationships. Men and women who agreed that sex was important to them reported significantly greater desire (r = .31 and .19, respectively). Men and women who agreed they would be happy never having sex again reported significantly lower sexual desire (r = −.47 and −.57, respectively). In regression analyses with desire as the outcome variable, attitudes were associated with the largest beta coefficients after age.

This research demonstrates the importance of positive attitudes to continuing sexual activity.

Information about sexuality

It is plausible that information about sexuality and especially sexuality in later life influences sexual activity. There is almost no systematic empirical research on this issue. One exception is a survey of 844 adults over 65 years of age living in Melbourne (Minichiello, Plummer, & Loxton, 2004). Higher scores on a six-item sexual knowledge scale were associated with being in a sexual relationship, for both men and women. There are many anecdotal reports of older persons ceasing to engage in partnered sexual activity because they mistakenly believe that one should not do so following major health events, e.g., a heart attack, or fears about negative health consequences for self or partner. “Older adults are misinformed about normative patterns of ageing and often rely on stereotypes in order
to understand sexuality and older adults” (Burgess, 2004, p. 439). This misinformation demonstrates the need for accurate sex education for older adults.

**Relationships /social well-being**

Most sexual activity is coupled (Gagnon, Giami, Michaels, & de Colomby, 2001). The foundation of couple relationships or partnering is a desire for sexual and emotional intimacy (Sassler, 2010). The research summarized above indicates that couple relationships are typically beneficial for physical and mental health. Couple relationships provide instrumental and emotional support, social support, and meaningful activity (Blieszner, 2006). As people age, their partner(s) may become more important as one, or perhaps the only, source of these rewards.

**Relationship status**

Table 4 describes the marital status of men and women aged over 45 years in the United States (U.S. Census Bureau, 2010). Among men, 67%–72% are married. Among women aged 45–64, about 63% are married. The percentage declines sharply to 40% among women aged over 65. This reflects two demographic characteristics. Women in the USA marry men who are on average 2.6 years older (England & McClintock, 2009). Typically women live 5–6 years longer than men. Therefore, many older women are widowed.

Married men and women report more frequent partnered sexual activity (once a week or more) than single individuals, including those who were formerly married and are divorced or widowed, particularly at older ages (Lindau & Gavrilova, 2010). This reflects cultural norms limiting intimate sexual activity to persons in committed relationships. The incidence of sexual activity (sexually active in the past six months) declines with age, in the age range 57–85 years of age, especially among women (Lindau et al., 2007) (see Table 1). The most significant contributor to the decline in frequency among women is the increase in percentage of widowed women (Delamater & Moorman, 2007), as reflected in Table 4.

Across the range of statuses, frequency of sexual activity is highest among the currently married, intermediate among never married and divorced persons, and lowest

<table>
<thead>
<tr>
<th>Age and sex</th>
<th>Total</th>
<th>Married</th>
<th>Widowed</th>
<th>Divorced</th>
<th>Separated</th>
<th>Never married</th>
</tr>
</thead>
<tbody>
<tr>
<td>Males</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>45–54</td>
<td>21,493,896</td>
<td>66.80%</td>
<td>1.00%</td>
<td>15.60%</td>
<td>2.60%</td>
<td>14.00%</td>
</tr>
<tr>
<td>55–64</td>
<td>15,712,993</td>
<td>72.40%</td>
<td>2.50%</td>
<td>15.20%</td>
<td>2.00%</td>
<td>7.90%</td>
</tr>
<tr>
<td>65 and older</td>
<td>16,027,330</td>
<td>71.40%</td>
<td>13.80%</td>
<td>8.90%</td>
<td>1.30%</td>
<td>4.60%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Females</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>45–54</td>
<td>22,152,876</td>
<td>64.10%</td>
<td>3.20%</td>
<td>18.40%</td>
<td>3.60%</td>
<td>10.80%</td>
</tr>
<tr>
<td>55–64</td>
<td>16,888,360</td>
<td>62.30%</td>
<td>9.10%</td>
<td>19.20%</td>
<td>2.40%</td>
<td>7.00%</td>
</tr>
<tr>
<td>65 and older</td>
<td>21,973,540</td>
<td>43.40%</td>
<td>43.40%</td>
<td>10.60%</td>
<td>1.00%</td>
<td>4.60%</td>
</tr>
</tbody>
</table>

Source: 2005—2009 American Community Survey, Table S1201.
among widowed persons (Smith, 2006). Smith attributes this variation primarily to availability of partners, recognizing that health becomes a factor as people age.

Population level changes in types or frequency of relationships may affect rates of sexual activity (Karraker et al., 2011). New relationship forms have emerged in the United States in the past two decades. Manning and Brown (2009) estimate that in 2009, 2% of older Americans were cohabiting. They suggest that one reason these couples do not marry is a desire to maintain financial autonomy. Part of this may be related to the disincentives of remarriage for older adults in the USA. Remarriage may result in higher American taxes due to combined income or loss of survivor benefits from social security, thus encouraging cohabitation and autonomy (Kahler, 2014). Research on sexual activity in a national representative sample indicates that cohabiters report more frequent partnered sexual activity than married couples (Yabiku & Gager, 2009), 12 times per month and 6 times per month, respectively. In contrast, when older adults live in separate residences, known as living apart together, there may be an associated decline in the frequency of sexual activity (Blieszner, 2006; Manning & Brown, 2009).

Between 9% and 19% of men and women aged over 45 in the USA are divorced (Table 4). As noted, frequency of sexual activity in this group is intermediate between married and widowed individuals. Research using the NHLS data on people aged 18–59 found that resuming sexual activity following divorce or dissolution of a cohabiting relationship was related to how recently the event had taken place. There was a significant positive relationship between having left a relationship within the past year and more frequent sexual activity (Wade & DeLamater, 2002). Stack and Gundlach (1992), analyzing older General Social Survey data, reported that men were more likely to be sexually active following divorce than women, and that likelihood of being sexually active declined with age. Qualitative research (Lichtenstein, 2012) suggests that whether divorced women re-enter the dating scene and become sexually active depends partly on whether they are financially independent. Data from the AP-LifeGoesStrong (Knowledge Networks, 2010) poll indicate that one in three divorced women aged between 45 and 65 is dating, compared to only one in ten aged over 65. Poor adjustment to the stresses of divorce or the breakdown of a long-term relationship reduces the chance of forming a new romantic relationship (Coleman, Ganong, & Leon, 2006). As they age, women face the challenge of an increasingly lopsided sex ratio when attempting to form new relationships (England & McClintock, 2009). These data indicate that relationship or marital status is perhaps the major influence on the frequency of heterosexual sexual activity in later life.

Relationship satisfaction

The quality of, or satisfaction with, committed relationships is a major influence on sexual activity. Spousal support and relationship happiness were associated with more frequent and satisfying sexual episodes (McFarland, Uecker, & Regnerus, 2011). Smith (2006) also reported that rating one’s marriage as happier is associated with more frequent sexual intercourse. In the AARP (1999) survey, 60% of the men and women aged between 45 and 59 were satisfied with their sex lives. By the age of 75 this had fallen to 35%. Satisfaction was associated significantly with frequency of partnered sexual activity. Greater satisfaction was associated with more frequent hugging and kissing, oral sex, and vaginal intercourse (DeLamater & Moorman, 2007). Satisfaction was also associated with less frequent reports of reduced sexual interest, lack of pleasure, and anorgasmia in women (Laumann et al., 2008).
Yabiku and Gager (2009) used the National Survey of Families and Households data to examine the relationship between frequency of sexual activity and separation. Using reported sexual frequency in 1987–1988, they looked at whether unions were intact in 1992–1994. The data include 5440 marriages and 462 cohabiting unions. Forty-seven percent of the cohabiting unions compared with 10% of the marriages dissolved in the interim. The results indicate that there is a significant association between low sexual frequency and dissolution, and the relationship was stronger among cohabiters. Infrequent sexual activity will create dissatisfaction which may lead to the breakdown of some relationships.

Huang et al. (2009) report data on an ethnically diverse sample of 1971 women aged 45–80. Overall, there was an age-related decline of just 7% in women who claimed to be moderately or very sexually satisfied (61% of those aged 45–50 and 54% for those aged over 65). The same trend was observed among sexually active women. In multivariate analyses, sexually active Latina women were more likely to report being sexually satisfied than sexually active White women. It should be noted that 29–45% of woman who were not sexually active still reported being satisfied. A similar trend was noted by Trompeter et al. (2012). The evidence suggests an overall increase in sexual satisfaction, independent of sexual activity, among community dwelling women.

Research has recently expanded to include the sexual satisfaction of married couples. For a variety of reasons most couples report less sexual activity as they age. Many indicate that this “loss” of sexual activity, while mourned by a few, is replaced with emotional attachment and alternative expressions of affection such as holding hands, hugging, and cuddling (Lodge & Umberson, 2012). Some older, sexually active women feel this emotional closeness results in more frequent arousal, lubrication, and orgasm (Trompeter et al., 2012). Similarly, some married couples experience the decrease in sexual activity as an increase in quality of sex. However, in heterosexual married couples where reports of quality were inconsistent between the two parties, women expressed satisfaction while men did not (Lodge & Umberson, 2012). None of the research focuses on the sexual satisfaction of single individuals outside a committed relationship.

However, to say individuals enjoy the sex they do have in older age does not mean it comes without occasional distress. It is common for older men to express distress at the inability to get or maintain an erection, while women often fault themselves, rather than their partners, for this obstacle. Many also seem to hold to societal notions about who should initiate sex, so many women feel uncomfortable with this new role of pursuer (Lodge & Umberson, 2012; Mitchell et al., 2013). Often, couples who have ceased all forms of sexual activity have done so due to erectile dysfunction, and show no interest in replacing penile—vaginal intercourse with other types of sex (Lodge & Umberson, 2012). This indicates a rather strict definition of sex, which may be limiting possible healthy expressions of sexuality.

Lesbian and gay older adults

As research on the sexuality of older adults expands to include topics within a psychosocial perspective, a new focus has developed on the sexual and emotional relationships of older lesbian and gay (LG) individuals. Little to no research has been done in other sexual minority groups. Similarities in sexuality between the general population of ageing adults and LG older people include more frequent sex with a life partner as opposed to a new partner, concerns of isolation, and a shifting focus from sex to intimate acts such as hand holding, hugging, and sleeping together. While there are many similar narratives in the
experiences of ageing heterosexual adults and older LG individuals, researchers have indicated a major difference in the ability of older LG adults to express their sexuality throughout old age.

Older LG adults may have experienced a lifetime of victimization specifically related to their sexual identity. Although there is little research to indicate a compounded stigma of ageism and homophobia during later life, it is likely that experiences of violence and discrimination earlier in life may impede disclosure of information about sexuality to new friends, caretakers, or medical professionals. However, some researchers believe that the lifelong victimization experienced by these older adults may mean that they cope better with the transition to old age in an ageist society (D’Augelli & Grossman, 2001). Nevertheless, LG individuals are still confronted with societal standards of beauty. They react quite differently from one another and from their heterosexual counterparts. Lesbians may be more accepting of the changes to their ageing bodies than straight women due to a lack of interest in and pressure from the “male gaze.” In contrast, older gay males may fare less well due to the continued emphasis on youth in the gay community. However, there are indications that LG individuals try to reject the ageing process as much as the general population does by controlling their ageing bodies through dieting, exercise, and cosmetic surgery (Slevin & Mowery, 2012).

For independent LG older adults, there seem to be distinct but varying changes in sexual behavior. Some consider themselves to be “sexually smarter” after a lifetime of sexual activity and so are able to enjoy stress-free sexual encounters (Slevin & Mowery, 2012). Those in primary relationships seem to benefit from this more relaxed attitude towards sexual behavior, as this is the population most likely to engage in frequent sexual activity (Averett, Yoon & Jenkins, 2012). On the other hand, lesbian older adults, like many ageing persons, notice a greater emphasis on affection rather than sex (Averett et al., 2012; Slevin & Mowery, 2012). However, the opportunity for LG adults to engage with a community of similarly identified individuals is limited when compared to those of heterosexual older adults. This may result in isolation and less sexual activity than is desired or in high-risk sexual behavior (Gay and Grey in Dorset, 2006; Kuyper & Fokkema, 2010).

Often, the isolation and loneliness experienced by LG individuals are the result of being confined to home care or long-term care (LTC) facilities. Furthermore, a move to LTC facilities may affect more LG older people, as many of these individuals have no children to help care for them (Bloomberg & Quinn, 2009). A recent study of staff perceptions and acceptance of sexual activity in LTC facilities discovered that staff members of one LTC facility were much more accepting of heterosexual pairings than same-sex pairings. They were least tolerant of male-to-male sexual contact (Hinrichs & Vacha-Haase, 2010). Another study emphasized that housebound LG individuals may feel alienated from their former queer communities (Cronin, Ward, Pugh, King, & Price, 2011). It is reasonable to believe that residents in LTC facilities without many other LG individuals may feel the same. Interviews with older LG persons in care facilities indicated disappointment with their inability to disclose information about long-term partners when other residents can freely talk about their spouses (Cronin et al., 2011). There is no question that these individuals experience stigma due to their sexual orientation. There is a fear that resistance, from unaccepting caregivers, to older LG sexual expression may cause a retreat back into the “closet” and a suppression of sexual desire and identity (Bloomberg & Quinn, 2009; Cronin et al., 2011; Gay and Grey cited in Dorset, 2006; Hinrichs & Vacha-Haase, 2010). While this stigma may certainly change based on the location of the older adult and their dependence on caretakers, there is certainly a question to be asked about how these facilities can become gay friendly places.
It appears that regardless of sexual identity, older adults are in need of an accepting community that allows them to express their sexuality, and engage in healthy sexual activity.

**Summary: sexual expression in later life**

Research indicates that men and women remain sexually active into their 80s. Men report greater incidence and frequency of sexual activity, including sexual intercourse than women. The differences increase with age due to differential loss of partners, and variations in health (Karraker et al., 2011).

We reviewed research based on a medical perspective. There is little evidence that physical changes associated with ageing necessarily lead to reduced sexual activity. Hormonal changes may affect sexual functioning negatively in some men and women, but these effects are often treatable. Men are more likely to report difficulties with sexual arousal and erection as they age; women are more likely to report at least occasional orgasmic difficulty as they age.

There is a positive relationship between good physical and mental health and frequency of sexual activity in both men and women. Diabetes mellitus and depression are associated with reduced sexual activity for both sexes, but are reported by relatively small percentages of the participants in recent large-scale surveys. These associations between physical and mental health and sexual activity are found across several Western societies.

Turning to the research based on a biopsychosocial model, positive attitudes about the importance of sexual expression for oneself and in one’s relationships are associated with more frequent sexual activity. Men, particularly older men, are more likely to rate sex as important to themselves. Loss of a sexual partner may explain why older women do not rate sexual activity as highly as younger women. It may also reflect the impact of ageist and pronatalist attitudes.

Relationship status is a major influence on whether a person engages in partnered sexual activity. Differences in relationship status — married, cohabiting, single, divorced, and widowed — are related to differences in frequency of sexual activity among persons over 50 years of age. For persons within relationships, satisfaction is an important correlate of frequent sexual activity.

Newer studies on the sexuality of LG older adults indicate some unique challenges the older LG individual may face. Standards of appearance seem to differ between the LG communities and result in more potential for acceptance of ageing among older lesbians and more pressure to appear young for older gay men. Older LG individuals may also experience LTC facilities much differently than their heterosexual peers and may find it more difficult to develop new sexual relationships in old age due to social stigma and silence surrounding homosexuality.

**Limitations**

The scope of this review is constrained by the limits of the literature.

First, the research is overwhelmingly descriptive. There has been little effort to develop a theoretical model that encompasses all of the major influences and outcomes studied. Clearly, an interdisciplinary or biopsychosocial framework would be beneficial. Although HIV risks among older people are being studied, there is little clear information suggesting how medical experts and community leaders are dealing with the issue.
Further research should work to identify successful interventions and educational programs for older adults at risk of contracting HIV.

It is also important that future research further explores the sexual satisfaction of individuals who are not in committed relationships. Those who are sexually active and those who only engage in masturbation must also be the focus of future studies.

The nature of samples studied is a continuing problem, and much of the available data reflects white, heterosexual, and primarily middle-class patterns of behavior. Most of the research involving sexual and racial/ethnic minorities in the United States is focused around HIV risk behavior. We need research on all aspects of older adult sexuality that is inclusive of racial/ethnic minority groups, and facilitates the study of intersectionality that undoubtedly influences sexual expression. While the research includes more information on LG individuals, it is necessary to expand this information beyond HIV prevention behaviors to include information about sexual desire and sexual satisfaction. It is also vital to continue expanding this research to emerging sexualities.

In the last 20 years we have learned much about sexuality beyond the age of 50 but there is more to do. This review provides a map indicating some of the routes we need to take.

**Notes on contributors**

John DeLamater (PhD) is Conway-Bascom Professor of sociology at the University of Wisconsin-Madison. The focus of his research is sexuality across the life course. He teaches human sexuality at College level and is the co-author of *Understanding Human Sexuality* (12th ed.), New York: McGraw-Hill, 2014.

Erica Koepsel is a master’s candidate in Gender and Women’s Studies at the University of Wisconsin-Madison. Her research focus is on pleasure and sex education, and healthy sexual expression throughout life.

**References**


