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ELDER CARE

A Resource for Interprofessional Providers

Sexual Health: Tips for Taking a Geriatric Sexual History

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Some clinicians find it challenging to talk to patients about sex, sexual health, and sexual intimacy. Studies suggest that only 50% of primary care clinicians have documented such discussions with their patients, and the percentage is even lower for the geriatric population. In one study, only about 38% of men and 20% of women over age 50 stated that they had talked to their physician about sex. Yet, over 50% of patients wished that their physician had asked them about sex.

A substantial proportion of older adults are sexually active. Even among those over age 80, about 30% are still sexually active. A variety of sex-related issues are pertinent to individuals and can and should be discussed in a sexual history. They include “social” and medical issues along with age-related physiologic changes.

Social and Medical Issues

Some older patients may be returning to sexual intimacy for the first time in years, following divorce or death of a spouse or partner; having sex with a new partner may seem intimidating. They may also be unaware of the concept of “safe sex” and not realize that like younger adults, older adults are also at risk for acquiring sexually transmitted infections including HIV. Others may experience difficulty with sexual activity due to medical conditions that affect movement (e.g., arthritis) or stamina (e.g., heart failure).

Age-Related Physiologic Changes

Older women may experience vaginal atrophy, thinning of the vaginal epithelium, and vaginal dryness and stenosis due to decreased estrogen levels. Contrary to popular belief, however, lower estrogen levels in older women do not lead to diminished sexual desire or interest.

In aging men, decreasing testosterone levels can lead to greater time and stimulation needed for arousal and ejaculation, as well as a longer refractory period. Similar to women, however, decreasing testosterone levels do not decrease libido and exogenous testosterone replacement does not increase libido.

Keys to a Geriatric Sexual History

As noted above, many patients want to talk to their clinicians about sex and sexual health, but, they may be unwilling or unsure how to bring up the topic themselves. An estimated 75% of adults think that sexual dysfunction is part of the normal aging process and further, that there is no treatment for sexual dysfunction. So, a first step is for clinicians to simply be willing to talk about sex with their patients, as patients may not bring up the issue.

When taking a sexual history, a key part should be an assessment of what sex means to the patient. While some patients might have a desire for penetrative intercourse, others may not. Some patients might consider cuddling as adequate physical intimacy. At minimum, sex should be “pleasurable and safe, free from coercion, discrimination, violence, and disease.” Unless clinicians ask about patients’ goals for physical intimacy and sexual health, or what sex means to patients, they cannot adequately address those issues, nor provide guidance or treatment to their patients.

Every clinician should develop a way in which they and their patients feel comfortable and safe talking about sexual health and physical intimacy. Some resources recommend waiting until the end of the interview after some rapport has been built. Additionally, it is recommended that you ask open-ended questions to allow the patient to express in their words what sex means to them and what issues or concerns they may have.

Some clinicians use mnemonic models to help with taking sexual histories. One commonly used model is the PLISSIT (Permission, Limited Information, Specific Suggestions, Intensive Therapy). Examples of items in PLISSIT are shown in Table 1. Another such model is the 5Ps model (Partners, Practices, Pregnancy prevention, Protection from sexually transmitted infections (STIs), and Previous STIs), shown in Table 2. While the 5Ps model has one question about pregnancy, which does not pertain to geriatrics and is not shown in Table 2, other questions modeled can be a useful place to start taking a sexual history.

Some clinicians develop sayings or phrases rather than relying on mnemonic models. One example is “As a health professional I’m here to provide you with the right kind of guidance, prevention, and treatment, regardless of your sexual habits or preferences.” Such statements can open the door and relax patients into feeling that they can be open and honest.

There are also questionnaires available to aid in taking a sexual history. The instrument most widely used by behavioral health clinicians is the Arizona Sexual Experiences Scale (ASEX); a link to the scale is on the references and resources list.

Another important component of the sexual history is asking about medical conditions or use of medications that can impair sexual function. It may also be appropriate to discuss the use of medications that can enhance sexual function, such as topical/vaginal estrogen to relieve vaginal dryness in older women.

TIPS FOR TAKING A SEXUAL HISTORY FROM OLDER ADULTS

- Patients want to talk about sex, they just might not know how to bring it up.
- It’s important to find out what “sex” means to your patients.
- Try a couple different strategies for collecting comprehensive sexual histories for your patients.

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Table 1. The PLISSIT Model

Permission	Give permission for patients to share details about their sexual history or ask for permission to continue with more questions. Example: “Sex and intimacy can be a sensitive topic but it is an important part of health and well-being. Can I ask you more questions about your sexual health?”
Limited Information	Normalize the process by providing basic information. Dispel misconceptions about sexuality. Consider general handouts for common symptoms such as vaginal dryness or erectile dysfunction.
Specific Suggestions	Once specific concerns are raised, engage in shared decision-making about treatment options. Example: “How have your sexual relationships or intimacy changed as you have aged? What symptoms worry you?”
Intensive Therapy	Referral for behavioral health or marriage counseling. Also consider medical interventions.

Table 2. The Ps Model

Partners	When you have sex, is it with men, women or both? How many partners have you had in the past 12 months? Have you had any new partners in recent weeks?
Practices	Do you have vaginal sex, meaning “penis in vagina” sex? Do you have anal sex, meaning “penis in anus/rectum”? If the response is yes to either vaginal or anal sex: how often do you use condoms: never, sometimes, or always? Do you have oral sex, meaning “mouth on penis or vagina”?
Protection from STIs	What are you doing to protect yourself from STIs?
Previous STIs	Have you had a STI in the past? Have any of your partners had a STI? To identify patients at higher risk for HIV and hepatitis: Have you or your partners ever injected drugs? Have you or your partners ever exchanged money or drugs for sex?

Current Barriers and Limitations of Research

Regardless of how one takes a sexual history, it is important that it is done in a comprehensive and non-judgmental manner. Additionally, it is important that clinicians pick an approach that works for them and their patients. This may take some trial and error to start creating comfortable and natural conversations about sexual health.

While it is important to discuss sexual issues with patients, it is also important to recognize current barriers to providing evidence-based care once the conversation begins. First, studies done on sexual health tend to focus on heterosexual couples, providing limited guidance on how to approach issues with same-sex couples. Similarly, many studies compare women to men and vice versa, rather than to same-sex cohorts. Third, trials of pharmaceutical agents

typically exclude patients over the age of 60, making it sometimes difficult to assess safety and efficacy in older adults. Clinicians must keep these barriers and limitations in mind when discussing sexual health with patients.

Conclusion

Clinicians don't always do a good job of taking and documenting sexual histories. Additionally, there is a lot of misinformation regarding sexual dysfunction and what is “normal.” As the population continues to age and clinicians see more and more older adults who are sexually active, taking sexual histories is important. Clinicians are encouraged to start taking comprehensive sexual histories in whatever way is best for their patients to feel that they are in a safe and nonjudgmental space.

References and Resources

- 2015 Sexually Transmitted Diseases Treatment Guidelines. Centers for Disease Control and Prevention. <https://www.cdc.gov/std/tg2015/clinical.htm>
- Arizona Sexual Experiences Scale. https://www.mirecc.va.gov/visn22/Arizona_Sexual_Experiences_Scale.pdf
- Gruta C, Goldschmidt R. HIV/AIDS: Implications for Older Adults. *Elder Care*. 2017. <https://www.uofazcenteronaging.com/care-sheet/providers/hiv-aids-implications-older-adult-patients>
- Inelmen Em, et al. The importance of sexual health in the elderly: breaking down barriers and taboos. *Aging Clin Exp Res*. 2012;24(3 Suppl):31-4
- Sex After 50. American Sexual Health Association. 2019. <http://www.ashsexualhealth.org/sexual-health/sex-after-50/>
- Sexual Rights for Seniors. American Sexual Health Association. 2019. <http://www.ashsexualhealth.org/sexual-rights-for-seniors/>
- Sexuality in Later Life. National Institute for Aging. 2019. <https://www.nia.nih.gov/health/sexuality-later-life>

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