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Biopsychosocial Assessment and Treatment of Sexual Problems in Older Age

Sallie Foley[1]

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Abstract Treating the sexual problems of older adults begins with education of the healthcare practitioner (HCP) and sex therapist. For older adults, emphasis on what does not work sexually must be balanced with a curiosity about "what does"—the resiliencies and capabilities of the individual and couple in a broader context than that based solely on "sexual performance." This article summarizes assessment and therapeutic interventions emphasizing pleasure and satisfaction as well as functionality within a biopsychosocial framework. Using an algorithm designed specifically for older adults with sexual concerns, several sexual problems accompanying chronic illness will be highlighted. Areas for further research are discussed.

Keywords Older adults · Aging · Seniors · Sexual health · Sexual activity · Sexual functioning · Sex · Sex therapy · Sexuality counseling · Assessment · Treatment · Medical education · Provider education

Sexual Satisfaction in Older Adults

If healthcare providers (HCPs) can get beyond the myths, misperceptions, and internalized distaste for discussing sex with older adults, they uncover the truth—that sexual interest and activity is an important part of life for many [1–3]. Sexual function and activity are shaped by a person's age, gender, availability of a partner, quality of the relationship with the partner, and overall health and healthy lifestyle for both [2]. While the biopsychosocial nature of sex and curiosity about improving one's sex life are constants, sexually active older adults have more gender role flexibility and interest in adaptation than younger people [4]. If health and security are stable, history is a good predictor: if adults enjoyed sex earlier in life, they continue to enjoy it.

Sexual problems can be addressed within medical or mental health settings, adapting approaches useful to each setting and accounting for sexual problems within the framework of aging-related changes, illness, and disability. It is not only possible but responsible for HCPs and sex therapists to provide assessment, education, and clinical interventions useful in treating many sexual problems.

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✉ Sallie Foley
smfoley@umich.edu

[1] University of Michigan School of Social Work, 1080 S. University, Ann Arbor, MI 48109-1106, USA

Integrative and Resiliency-Based Assessment and Treatments

Assessment of Sexual Problems

Many older adults have a need for sexual health information that can address concerns and educate about treatment. Medical and mental health care providers can open the conversation by including questions about sexual health in the general review of systems (ROS) or early in the interview:

- Ask: "We've been talking about your general health and your sexual health is part of your general health. Do you have any questions about your sexual health?"
  "We've been talking about your general concerns and often sexual concerns are part of general concerns. Do you have any sexual concerns or need for more information?"

- Some individuals may answer "No" but others will welcome this opportunity. Many will say "No" and bring up their questions later. They may have difficulty describing their concern.
- Some professionals don't ask about sex for fear of looking stupid when they don't know the answer. Research indicates that older adults don't expect professionals to know everything; rather, they value the discourse. Providers can model collaboration: "That's a good question. I don't know the answer, but will check and get back to you."

- Ask: "Do you have a spouse or partner?" rather than asking, "Do you have a wife?" Use of inclusive questioning shows respect for all patients/partner relationships. Pronoun sensitivity empowers the patient to more comfortably disclose the nature of his/her sexual orientation and relationship status, providing more accurate information about sexual activity. Sadly, because providers so commonly use assumptive pronouns, GLBTs, regardless of age, are faced with "constantly coming out" every time they see a new provider.

DOUPE—an Assessment Algorithm A standard interview assessment called "DOUPE" was developed by the author to allow professionals to gain information quickly and concisely. Useful in any assessment, it is especially helpful when weaving sexual health assessment into a more general interview. It follows the lines of routine medical history-taking such as the OPQRST (onset, provocation, quality, radiation, severity, time).

- **D**escription—What is the concern? or What is a typical situation when this happens?
- **O**nset—Lifelong or more recent? Paired with any other change? Every time or just in one situation or with one person.
- **U**nderstanding—"What's your understanding of why this is happening?" allows HCP to understand level of distress and the person's reasoning. "God is punishing me." is a different interview than "I think it happens a lot to older women."
- **P**ast—"What's your experience trying to fix the problem?" Almost everyone has thought of or tried something. This also elucidates the "why now" of seeking help.
- **E**xpectations—How motivated and how realistic is the person?

Once DOUPE is established, further questions usually "deepen the conversation" and include discussion of pain or discomfort, changes in amount of stimulation needed for arousal, and other challenges. Because older adults do not define quality in sex solely by performance, asking "How satisfied overall are you with your sex life?" sheds light on presence or absence of satisfaction and pleasure in spite of functionality challenges. Use real language rather than euphemisms (i.e., "intercourse" or "masturbation/manual stimulation" rather than vague references to "having relations" and "taking care of yourself") [5]. Finally, model an affirmative outlook on sexuality by taking a permission-giving stance.

Assessment Questionnaires Use of assessment tools also allows the HCP to gain a picture of the problem and the person's thinking about it. There are many excellent questionnaires that are available, some developed specifically for chronic illness [6] and the following [7]:

All:

- Depression scale (PHQ9)
- Alcohol use disorders identification test (AUDIT)
- Drug abuse screening test (DART)
- Personal beliefs about illness questionnaire (PBIQ-R)

Couples:

- Dyadic adjustment scale (DAS)
- Protective buffering scale

Women:

- Female sexual functioning index (FSFI)
- Female genital self image scale (FGSI)

Men:

- Mulhall sexual experience questionnaire (SEX-Q)
- Expanded prostate cancer index composite (EPIC)

General Areas of Functioning

Assessment of sexual problems for older adults will include a detailed history of current health issues as well as chronic problems. Both physical and mental health histories are important. Substance use and medications should be addressed. Sleep, nutrition, physical exercise, and regular routines are important factors in sexual health. Self-regulation and healthy self-soothing (friends, interests, community engagement, and meaningful pursuits) are important in every adult's life, no matter the age and are predictive of better mental health.

Memory Older adults fear memory loss. Functional independence is often calculated not only by what one can "do" but what one can remember. Aging, chronic illness, stroke, traumatic brain injury, and treatments for some illnesses can contribute to memory and cognitive impairment.

Not only is dementia feared, but mild memory impairment (MMI) and mild cognitive impairment (MCI) [8]. To assess, most HCPs use the Short Test of Mental Status (STMS), which is often used in research (above the Mini-Mental Status exam), because of its ease of use and ability to pick up mild cognitive impairment [9].

Stress Stress is a significant factor in many older adults lives and accompanies health, socioeconomic, and personal challenges. Grief, mental rumination, depression, and anxiety create stress and contribute to sexual problems.

Isolative, Repetitive Behaviors Isolation, repetitive isolative activities that can "look" interactive (i.e., gambling, strip clubs, excessive shopping) and overuse of all screen activities (TV, web surfing, Internet, pornography) can contribute to sexual problems. Dissociation and out-of-control or problematic sexual behavior—both challenging for sexual satisfaction—can often be addressed if the HCP is willing to ask questions about frequency, time and money spent, and disruption of activities of daily living (ADLs).

Partners If a person is partnered, it is important to include the partner in part of the interview. Satisfaction, frequency, perceived changes, and previous functioning are important areas of concern. Partners will have their own feelings about the sexual concern(s) and their involvement in assessment assures a better outcome for treatment. If a partner is unwilling to meet with the HCP, it is predictive of a more complicated picture that may require more intensive couples counseling to address the concerns.

Sexual Dysfunctions and Aging and Illness-Related Problems

Aging, chronic illnesses/treatments, medications, and substance abuse contribute to sexual problems. Sexual dysfunctions affecting older adults include:

Male	Desire disorders (male hypoactive sexual desire disorder (MHSDD))
	Erectile disorders (ED)
	Premature (early) ejaculation (PE)
	Inhibited/retrograde ejaculation (delayed ejaculation (DE))
	Genitopelvic pain
	Peyronie's disease (PD)
Female	Female sexual interest arousal disorder (FSIAD), includes Hypoactive sexual desire disorder (HSDD)
	Orgasmic disorders (anorgasmia)
	Genitopelvic pain disorder including DSM IV categories of dyspareunia and vaginismus

Assessing for sexual problems can lead to earlier treatment with better outcome and also to earlier diagnosis of some chronic or life threatening illnesses. One sexual dysfunction can contribute to another; a man frustrated by ED or PE may lose interest and desire for sex (MHSDD). A woman frustrated by FHSDD or FSIAD may develop anorgasmia. Illnesses like depression, cardiovascular problems, and type 2 diabetes (T2DM) in men have high prevalence's of ED, DE, and MHSDD. Both physiological and psychological factors contribute [10].

Treatment Interventions

Many older adults erroneously believe that there is nothing that can help their sexual problem. Currently, integrated treatments of medical and educational/counseling interventions are considered best [11••]. Treatment should give permission to talk about sex, establish comfort, attend to specific concerns, teach distress tolerance and communication, address necessary accommodations in functioning, and encourage broader definitions of success that are not only about performance but more importantly emphasize pleasure and satisfaction. Metz and McCarthy's "good enough sex" model and self-help books are examples of this approach [1–10, 11••, 12, 13]. Treatment interventions frequently include the following:

Authenticity Authenticity is sometimes referred to as believability and reflects the professional's positive intention to respect and educate. Authenticity is modeled by showing curiosity about patient concerns and being real. For North Americans, eye contact is considered a sign of respect and engagement. If professionals write or type during interviews, then explaining this early in the interview creates rapport.

Normalizing Often referred to as the "use of ubiquity" ("Many people experience this…"), it reduces anxiety and isolation, creates safety and furthers the relationship with the professional. It opens dialog to provide useful information. Reminding older adults about the human needs for socializing and touch, as well as the normalcy of concerns and questions about sexual problems is important.

Education Education about sexual health is a powerful intervention that legitimates concerns.

- Maintain descriptive lists of specific information: lubrications, definitions of different PDE5 inhibitors, good sexual health websites, and the following Internet advice: never search "sex" as a subject, instead search using the phrase "sexual health and [insert specific topic]".
- Maintain handouts of frequently given recommendations, with space below to write in specific suggestions.

- Maintain resource lists of books, websites for purchase of dilators, vibrators and other sex toys (lists available at salliefoley.com), sex therapists (aasect.org), and pelvic pain specialists (apta.org). Note that there are reliable sites that do not sell their mailing lists, don't create "cookies" or "popups" on computers, and mail all items in neutral wrapping/neutral return address (lists available at salliefoley.com). These lists and follow-up instructions can be kept at checkout with directives to staff to give these lists to patients when checking out.

Education about the impact of general mental and physical health on sexual health is important. Some older adults who are no longer working in structured jobs lead irregular schedules without routines, good sleep, adequate nutrition, or regular physical activity. Physically active older adults report less sexual dysfunction [14].

Assume the Person Needs to Know Some professionals worry that they are disrespecting older adults by going over basic sexual health information. A maxim for all caregivers: assume patients have tried or thought about trying more sexual activities than they report, but know far less than expected. If worried about offending the already-knowledgeable, use the phrase, "As you perhaps already know…" at the beginning of explanations.

Office Personnel Attitudes Start "at home" and address negative perceptions about older adult sexuality held by staff. The disdainful demeanor of office staff can derail even the best discussions between the professional and an older adult. Educate everyone, especially scheduling and checkout personnel, about the importance of treating all older adult sexual health concerns with respect. Consider inviting a local sex therapist (located via www.aasect.org) to present about sex therapy treatment to staff.

General Sexual Counseling Interventions An informed health care professional can treat many sexual problems within a clinical practice. Treatment often begins with the recognition and treatment of underlying medical problems, encouraging the inclusion of the partner, and comfort with addressing both partners' concerns. The professional listens carefully, encourages couples to openly discuss concerns and enhance their skills in communication [15, 16]. Interventions frequently useful in addressing sexual problems include asking permission to proceed with discussion, explaining the causes and physiology of the problem, regularly checking in with the individual or couple to make sure they are "following" the discussion, recommending patients read sexual problem-specific self-help books [17, 18], addressing co-occurring problems like anxiety or sleep apnea, and integrating medical (including pharmacologic) and physical therapy as needed.

If the individual and partner are comfortable, recommending sensory touch and non-demand sexual interaction help build confidence and interest for both. In some circumstances, masturbation may be recommended. Sensate focus (graduated mutual touch) is often a valuable sex therapy intervention [19].

If problems persist, if individuals have a history of trauma affecting their sexual lives, if the couple is unable to work collaboratively, or if mental health or substance abuse problems predominate, it is best to refer to a sex therapist. Sex therapists have extensive training in treatment of complex sexual problems as well as couples therapy [20–22]. Couples and individuals may need the HCPs assurance that trying out new things with curiosity and non-judgment is good. Use of ubiquity ("Many individuals think about use of a vibrator but wonder if it's okay to try something like that if you are over 80. Lots of people of all ages and sex explore new options for sexual pleasure. Focusing in and trying new things may take some work, but it is a good work to do.") is affirming.

Taking Care of Vulvovaginal Health—Counseling Older Women Older women need very specific counseling and education about taking care of their vulva and vagina. Some older women do not experience decreased lubrication, dryness, thinning of the vaginal walls, pain on genital touch or penetration, or atrophy. They report comfortable sexual activity and lubrication throughout their lives. But most women need to learn to moisturize tissue with estrogen or non-estrogen topical applications as well as use lubrication when engaging in partnered sexual activity or masturbation. Moreover, women who are not currently engaging in regular (i.e., once weekly) vaginal penetration may also need information about routine "stretching" of the vaginal introitus and vagina. Stretching is brief—taking 30 seconds or less—and can be accomplished using fingers, a dilator, a conically shaped vibrator or a dildo. This can be accomplished at the same time a woman is using vaginal moisturizer and is considered part of routine health care for older women.

The approach to taking care of vulvovaginal health is often described as "moisturize, lubricate, and stretch" [3]. Framed as part of general health, taking care of one's sexual health involves routinely moisturizing the vulva and vagina, using lubrication, and stretching both the opening (introitus) of the vagina and the vagina itself [3, 7].

Some older women remark that they do not need to worry about vaginal stretching because they are not partnered and do not plan to be sexually active with a partner again. Although inconceivable to them at the time, some of these women may later become interested in penetrative sexual activity and wish they had engaged in routine stretching. Furthermore, vaginal atrophy can impede routine gynecologic care. HCPs can advise women that stretching helps to avoid irreversible vaginal atrophy.

The use of localized estrogen replacement (ET) for postmenopausal care of the vulva and vagina is an important consideration for many older women with vaginal discomfort, pain, itching, and dryness. Estrogen cream in small amounts may also be applied to the vulvar vestibule including the inner labia, clitoris, urethra and vaginal introitus. ET is also referred to as moisturizing to reduce vulvar and vaginal problems, and women report decrease in pain, dryness, itching, pain, and general discomfort with regular use. Some women also report slightly increased sensation during arousal and most report an increase in comfort during any stimulation or penetration [3]. Finally, some women find that vulvar and vaginal tissue feels more supple and springy. Administered in small, localized doses, there is no endometrial stimulation and administration of opposing progesterone is not necessary [23•]. The use of estrogen cream in caring for urinary tract concerns including urinary incontinence and urinary tract infections is helpful to many [24].

Non-hormonal moisturizers can provide topical relief for some women diagnosed with cancer that is estrogen receptor positive. In cases of severe vulvar and vaginal atrophy, some women report such physical discomfort and sexual problems that there is concern they cannot complete cancer treatment, especially aromatase inhibitors (AI). In a study by Biglia and colleagues, they find that ET may be useful for women with significantly reduced quality of life. However, they caution that further study is necessary to determine long-term risks [25]. Careful consideration must be given to the use of localized estrogens for women with a history of estrogen positive breast cancer.

Overall, the quality of life for postmenopausal women can be greatly improved with good communication and education about ET, especially before vaginal atrophic changes are irreversible [23•].

When women have painful sex, some may be helped by referral to a physical therapist trained in pelvic floor muscle relaxation and rehabilitation (Visit www.apta.org) as well as self-help books addressing their concerns [26]. The use of Osphena® (ospemifene) a medication developed as an estrogen receptor modulator for reduction of vaginal atrophy and pain for postmenopausal women was reviewed by Cui and colleagues (2013). Six studies were evaluated in meta-analysis and the conclusion was that ospemifene was a safe and effective treatment for vulvar and vaginal atrophy postmenopause [27].

Urinary Incontinence Problems with urinary incontinence continue to be associated with lowered frequency of sexual activity for postmenopausal women—especially urgency symptoms [28]—highlighting again the need for HCPs to initiate conversations with women about all their postmenopausal symptoms. Women with UI may be helped by referral to a physical therapist with a specialty in pelvic floor muscle rehabilitation (Visit www.apta.org) as well as by self-help literature [29].

In sum, sexual function for older women includes the passage through menopause and, for most, changes in sensation and some decreased sensitivity as well as vulvovaginal changes with increased dryness and thinning of vaginal walls. There may be increases in vaginal pain associated with drying thinning tissues. The associated discomfort often results in increased avoidance of sexual thought or activity—both penetration and vulvar stimulation—since it is no longer pleasurable and pain free.

Sexual Problems of Desire/Interest, Delayed or Absent Orgasm, and Pain for Women Several self-help books are especially helpful in addressing these problems and can be recommended with confidence: desire/interest [3, 30, 31] orgasm [32, 33], and pain [34, 35].

Taking Care of Sexual Health—Counseling Older Men Many men admit that they know very little about how sex works for them *now*, other than that it is different from *before*. Many men report a need for increasing manual stimulation when aroused, and many men do not know they will need to continue genital stimulation even when taking a PDE5 inhibitor. Men need education about the ways in which too much weight, alcohol, lack of routine and too little physical exercise can affect sexual functioning. They are often unaware that "sleeping" is not the same thing as "sleep hygiene" [36]. Their lifestyle and physical health contribute directly to sexual health. Older men's experience of sexual response and pleasure is not accurately represented in a performance-based model that emphasizes sexual arousal ending in orgasm [37].

The "seeking behavior" of focused interest, play, or being "in the zone" can be a problem for many men when it comes to screen activities. Pornography (commonly referred to as porn) as *play* is different from porn as *dissociation*. Dissociation predictive of out-of-control sexual behavior may interfere with daily living, relationships, and realistic sexual practice and interactions. Assume that amount of time spent on screen activities, especially porn, may be greatly underreported by men and women. Sexuality educators and counselors encourage HCPs to refer individuals for sex therapy treatment (visit aasect.org for reliable professional referrals) when the HCP suspects out-of-control or problematic sexual behavior. Treatment is beyond the scope of a general medical or mental health practice and requires specialist referral.

Delayed Orgasm (DE), Rapid or Premature Ejaculation (PE), and Pain—Including Peyronie's Disease (PD)

Integrated biopsychosocial treatment combining medical and psychological interventions remains the gold standard. Either a primary (occurring without other sexual problem) or secondary (resulting from or co-occurring with another sexual difficulty), MHSDD responds to a combination of medical and

psychological interventions [38, 39]. Problems with delayed orgasm DE) may increase with aging [3]. These can be exacerbated by health challenges, fatigue, medications, or alcohol as well as other physical or circumstantial challenges. Anxiety can worsen DE. Currently, DE responds best to a combined treatment of sex therapy and possible medications for anxiety, or use of PDE5 inhibitors. Some men report the use of a vibrator as helpful in treatment [3].

Erectile Dysfunction, Assessment, and Treatment Just as older women's experience of vaginal atrophy is variable, so too is older men's experience of ED. For some, it is transient and associated with fatigue or poor sleep. Some diseases like cancer, depression, and diabetes mellitus type 2 are highly associated with both MHSDD and ED [10, 40••]. Weight gain, depression, overuse of alcohol or other drugs, generally poor health, and a loss of sexual desire can all contribute to ED. Psychologically, ED can be affected by stress, performance anxiety, general anxiety, anger, and negative self image.

If possible, it is helpful to involve the man's partner in the assessment phase, since some men have difficulty fully acknowledging the impact of ED on their sexual life. Men may have experienced cultural expectations to deny help, go it alone, or ignore any problem because men "should" be able to fix things and "take care of everything", including problems with sexual functioning.

Treatments for ED include counseling to address the psychological aspects of ED—including reducing shame or avoidance and attending to performance anxiety, while utilizing strategies to decrease self-criticism and "spectatoring" (worrying and over-attending to penile function) during sex. Psychosexual education about erectile functioning and normalizing treatments for ED are useful.

An effective treatment for ED is the combined use of PDE5 inhibitors with sexuality counseling for the individual or, when possible, the couple. Use of medication alone is not as effective. Counseling includes the "fix and foster' principle described by Metz and McCarthy [18], addressing—"fixing"—the problem with medication and psychoeducation to enhance treatment, and then helping the couple "foster" greater intimacy and sexual pleasure. The experiences and attitude of the partner has a significant impact on the positive outcome with ED treatment and, in fact, in all sex therapy [40••].

Other treatments for ED include the vacuum erectile device (VED), penile injections (shots) of alprostadil into the shaft near the base of the penis, or the urethral insertion of alprostadil suppository into the penis (MUSE). All three methods have drawbacks. Men report the VED creates penile tumescence but that that penis "hinges" at the groin and is not rigid enough. The shot provides a more familiar-feeling erection with rigidity but the experience of giving the shots can be anxiety producing or feel clinical. MUSE causes irritability at the urethral site and an "uneven" erection with more penile pain, irritation of the penis, and burning [18].

In some "last resort" situations, men may choose surgery for the insertion of a penile prosthesis—surgically implanted rods that use different mechanisms to create a rigid penis. The surgery requires the removal of cavernosal tissue (the spongy tissue inside the penis) and is irreversible. Once this surgery takes place, no other medical treatments for ED are possible.

Accommodating ED Psychological treatment of ED is undervalued. Individuals and couples can address grief about ED and utilize sex therapy to "relearn" touch [41] and reprioritize what matters sexually. The focus shifts to increasing sensual touch and manual and oral stimulation, minimizing the expectations that an erect penis must "carry the day" sexually. For older men and women, performance-based models of sex with strict "orgasm required" expectations are not accurate representations of their sexual experiences. For some, firm erections with predictable orgasms may continue to be the norm. For many, pleasure and satisfaction replace performance-based outcomes. Interest, arousal, and eroticism based on "what works" is both creative and passionate.

Premature ejaculation (also known as early ejaculation) requires professionals address the man's self-awareness and motivation to make behavioral changes. Additionally, some medical providers prescribe SSRIs (selective serotonin reuptake inhibitors) off-label to treat PE [17, 39, 40••, 41, 42]. Psychological interventions include cognitive behavioral therapy, self-help books, enhancing ability to self-regulate, and increasing couple's communication skills and mutual pleasure [17].

Peyronie's Disease (PD) and all forms of pain also require steady professional encouragement to seek the least invasive paths toward the relief of pain and the increase of function, satisfaction, and pleasure. Pelvic floor muscle physical therapy—long a substantial part of women's treatment for genitourinary pain problems—is helpful for men as well [43] and should be recommended by the HCP or sex therapist. This usually requires a prescription and connection with a pelvic floor muscle specialist (contact apta.org).

Books addressing the sexual problems of men and women are excellent resources. Respected sex therapists and authors Michael Metz and Barry McCarthy have written valuable books on coping with ED [18, 44], overcoming PE (a balanced approach) [17], and low desire or desire discrepancy between two partners [1]. A recent McCarthy book, dealing directly with therapy for men after 60, addresses an unmet need [45]. Self-help books, however, are not magic and the HCP or therapist should remain engaged, offer guidance, and provide referrals as needed.

Special Considerations

The Special Circumstance of Trauma Trauma represents special challenges because of post-traumatic stress disorder (PTSD) and the unconscious brain patterning that maintains dissociation (checking out), structural dissociation (over reacting in an angry or anxious way) and hypervigilence (flashbacks, panic). Contributions by Daniel Siegel [46–48] and Besel van der Kolk [49] recommend that trauma-based responses be specifically addressed by creating safety, providing calm reassurance, being willing to teach simple breathing techniques and meditation (specifically "mindfulness meditation"), and acknowledging to the patient that his or her symptoms support further evaluation and treatment for PTSD by a skilled psychotherapist.

Grieving Sexual problems may not be "fixable". North American expectations assume that sexual problems have easy solutions. Older adults and their partners will benefit from sexuality counseling and education about the importance of grieving—recognizing that they are facing a loss and have to adjust to a "new normal"—when faced with the diagnosis of a sexual problem. Counseling to realistically adapt to new circumstances and accommodate the changes in sexual expression and activity will be more successful if grieving about what "no longer works" is part of the discussion. Successful adaptation is predicated on realistic assessment of what is possible [39, 50•, 51]. If the person is partnered, the HCP or sex therapist will need to include the partner to be successful in counseling about grief, change and accommodation. If the person is not partnered, then counseling will follow similar lines but focus on self-stimulation.

Ongoing Connection Shame is a social emotion and a universal reaction to feelings of helplessness, rejection, humiliation, and profound disconnection from other people. It is a state of unbearable self-consciousness and cannot be relieved simply by being hugged or any physical means. Instead it requires a sense of relational connection [52]. As a person feels more connected, their sense of shame dissipates. Diagnosis of sexual problems often creates feelings of helplessness and shame. Treatment should include the promise of continued availability and support to address sexual problems. Rather than stating that the HCP or a special medicine can fix the problem, it validates that the problem exists and that the HCP will continue to help sort through alternatives with the person.

Mindfulness Meditation, Breathing, and Yoga The usefulness of these techniques is now well-established in mental health, pain, and chronic illness literature. The benefits of mindfulness meditation and breathing practices appear noteworthy in the treatment of sexual problems and may be of even greater help to those with a history of trauma or anxiety [53]. Educating about their usefulness for enhanced comfort, focus, and adaptation can include referral to books that teach mindfulness meditation and breathing [54] as well as local groups that teach and practice these techniques. Yoga may be helpful in the treatment of some sexual disorders [55].

Therapeutic Weaving Interventions for sexual health problems require sound knowledge of psychoeducation principles and flexibility in therapeutic approaches [56]. Utilizing the resiliencies of the individual and couple is key in offering effective interventions for the problems faced by older adults.

Referral Many sexual problems require referral for specific treatments like pelvic floor physical therapy or couples sex therapy. The interventions may include those mentioned above and continue with more specific, focused, and in-depth interventions. The treatment of sexual problems is interdisciplinary.

Conclusion

Older adult sexual health is multidimensional. Further research about all aspects of assessment and treatment of sexual problems is critical. Training is necessary for HCPs to feel comfortable and competent discussing sexual activity with older adults. Sex therapy, sexuality counseling, and education require baseline expertise about general trends in sexual health and aging as well openness to the unique presentation of each individual and couple.

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Compliance with Ethics Guidelines

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Human and Animal Rights and Informed Consent This article does not contain any studies with human or animal subjects performed by the author.

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- •• Of major importance

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