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Sexual Aging: A Systematic Review of Qualitative Research on the Sexuality and Sexual Health of Older Adults

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Abstract

Negative stereotypes regarding the sex lives of older adults persist, despite sexuality being an important factor that influences the quality of life. We conducted a systematic review of the qualitative literature on the sexuality and sexual health of older adults to address which topics have been researched and the quality of research within this field. We searched PsycINFO, SocINDEX, MEDLINE, and CINAHL for qualitative articles investigating the sexuality of adults aged 60+ years. We analyzed 69 articles using thematic analysis to synthesize their findings. We identified two overarching thematic categories: psychological and relational aspects of sexuality (personal meanings and understandings of sex, couplehood aspects, and sociocultural aspects) and health and sexuality (effects of illness and/or treatment on sexuality, and help-seeking behaviors). Research is needed into male sexual desire and pleasure, culture-specific and sexual/gender identities and their effect on outcomes such as help-seeking behavior and sexual satisfaction, and sexual risk-taking in older adults.

Keywords

older people; aging; sexuality; sexual health; research evaluation; qualitative systematic review; thematic analysis

Introduction

Although sexuality is often thought of as absent from the lives of older adults, research shows that sex and sexuality still hold importance as people move into later life (Bauer, McAuliffe, & Nay, 2007; DeLamater, 2012; Gott, 2005). Stereotypes about old age and sexuality persist, however, despite new generations of older adults becoming increasingly more liberal than previous generations in their attitudes toward sex and sexual behavior (Syme, 2014).

Sexuality is a socially mediated and multidimensional phenomenon that includes biological, psychological, and social influences (Simpson et al., 2017). Sexuality is reflected in specific individual behaviors, fantasies, desires, beliefs, attitudes, values, practices, roles, and relationships perceived as sexual (World Health Organization, 2006), that is, sexual intercourse, kissing, hugging, touching, flirting, and acts of bodily and/or emotional intimacy. While this perspective focuses on activity/behavior of actors, it recognizes that different individual perceptions of what is sexual are based on complex social, economical, and political factors.

This is especially important when studying the sexuality of older adults. Changes in sexual and bodily practices are affected by both age-related physical constraints and social norms regulating sexuality. Thus, what does not seem sexual for someone at one stage of life might be for someone else of different age and social circumstances (Oppenheimer, 2002). In this context, sexual health relates not only to medical issues related to human sexuality but also to social, mental, and emotional factors that affect possibilities of sexual expression in older age (World Association for Sexual Health, 2014; World Health Organization, 2006).

Sex and sexuality is increasingly seen as an important part of older adults' lives, which influences their perceived quality of life and the quality of their partnerships (Fisher, 2010). Data from the Midlife in the United States (MIDUS) project suggest that a person's experience of sex in later life is predicted by both their subjective age and their views toward aging (Estill, Mock, Schryer, & Eibach, 2017). Individuals who felt older and held more negative opinions of aging reported less interest in sex and lower quality sexual experiences than those who felt

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more positively about themselves and the aging process. Being in better health also predicted higher quality of sex and interest in sex (Estill et al., 2017).

A shift in views toward the end of the 20th century which emphasized the importance of sexual activity in older adulthood for a person's health and well-being has made sex in later life an indicator of "successful" aging (Marshall, 2011). Hinchliff and Gott (2016) suggested that an emerging stereotype now sits alongside negative stereotypes of sex and aging: the "sexy oldie" (Gott, 2005). A potentially negative consequence is that sex in older age is now being promoted as integral to physical and emotional health in older age. Sex is consequently being framed as a personal responsibility, and celibate older adults may be regarded as unconcerned with preserving their personal health (Hinchliff & Gott, 2016). This new stereotype, although more positive toward the idea of active sexual life of older adults, creates new barriers for those whose body image, physical capabilities, and partner status do not conform to the "sexy oldie" model.

The aging process and related health conditions can undoubtedly affect older people's sexual functioning. The population of older adults in Western countries is growing (DeLamater & Karraker, 2009), and the need for appropriate health care provisions and accurate information on sexual issues for older adults is increasing. Rates of sexually transmitted infection (STI) diagnoses have also been rising in the older adult population (Minichiello, Rahman, Hawkes, & Pitts, 2012; Public Health England, 2016). A recent qualitative study of adults older than 60 years old carried out in Australia reported that factors such as erectile difficulties, stigma, and a lack of safer sex culture reduced safer sex behavior (Fileborn et al., 2018). Thus, the topic of sexual health in later life is becoming increasingly important for both older adults themselves and for their health care practitioners. The challenges these changes present are typically unmet (Hinchliff, 2016).

As the issues related to older adulthood become ever more important due to demographic changes and aging populations, research on sexual health in this population has also increased. A growing body of literature has emerged on the topic, including several literature reviews regarding aging and sexuality. The latest and arguably the most comprehensive review by Træen and associates (Træen, Carvalheira, et al., 2017; Træen, Hald, et al., 2017) covered a plethora of topics, including sexual function, sexual difficulties, sexual satisfaction, and body image in older adults. Other reviews, including several systematic reviews, focused on narrower topics within this research area. These include sexuality in institutionalized care (Mahieu & Gastmans, 2012, 2014); HIV/AIDS prevention (Milaszewski, Greto, Klochkov, & Fuller-Thomson, 2012); sexual issues experienced by aging lesbian, gay, and bisexual people and the lack of health care provisions for this population (McParland & Camic, 2016); and sexual health care in old age (Foley, 2015; Hinchliff & Gott, 2011).

Although these reviews included qualitative studies, none of them provided the overview of the qualitative research specifically, nor appraised the quality of qualitative studies. In this review, we explore the qualitative research on the sexuality and sexual health of older adults, with the aim to determine which topics are researched and with what conclusions, and to determine the overall quality of the research in this area. The research questions are as follows:

Research Question 1: Which topics, related to the sexual health and sexuality of older adults, have been researched by qualitative methods?
Research Question 2: What is the overall quality of the qualitative research in this field?
Research Question 3: What are particularly underresearched topics in this area?

Method

Selection Criteria

The goal of the database search was to identify qualitative research done on the sexuality and sexual health of older adults (aged 60 or older) and published in English language in peer-reviewed journals between 1990 and 2016. The age limit was set at 60 years as this is one of the thresholds for old age (Hinchliff, 2016). However, as aging is a long-term process, a minimum mean age of 55 was set as an additional criterion to include mixed age samples from studies taking a broader perspective of older age. Reviews and theoretical articles were excluded because they already provide secondhand interpretations of empirical data and would thus bias our synthesis. The focus of this review is on the research conducted on older adults, thus research including only health care professionals has been excluded. Likewise, research on body image or sexual orientation that was not focused on sexuality, sexual practices, and activities was excluded to keep a more focused perspective. The full inclusion and exclusion criteria are presented in Table 1.

Search Strategy

A search was conducted on three databases, PsycINFO, SocINDEX, and MEDLINE, covering psychological and related disciplines, sociological and anthropological research, medical, public health, and related disciplines relevant to the topics of sexuality, health, and aging. The

Table 1. Inclusion and Exclusion Criteria.

	Inclusion Criteria	Exclusion Criteria
Sample	Adults aged over 60 years If mixed age samples, mean age > 55	Adults under 60 years Mean age < 55 Sample comprises only health care professionals
Design	Empirical research using either qualitative or mixed methods methodology	Anything other than specified in inclusion criteria Review articles Theoretical articles
Publication	Peer-reviewed journals	Anything other than specified in inclusion criteria
Language	English	Any other language
Focus	Sexual health of older adults Sexuality of older adults Sexual practices of older adults Barriers to sexual functioning Body image and sexuality	Body image not related to sexuality Sexual orientation not related to sexual activity/practices

search terms define the target population as older adults, and sexuality and sexual health as target topics of the studies. In addition, search terms or limiters were added to the syntax, depending on the database, to limit the search to qualitative or mixed method articles. Search syntax was created by the first author with the help from a university librarian. For each database, syntax was supplemented using the limiters and expanders available for the given database. All three databases were searched through the EBSCOhost interface. Complete search syntax for each database is available as online supplementary material.

Procedure

Articles were assessed for relevance according to their titles and abstracts (in some cases, it was necessary to read the full-text article).[1] Those that did not meet the inclusion criteria were omitted from further analysis and duplicates were detected using Mendeley. Thematic analysis (Braun & Clarke, 2006) was used for identifying the main topics in each of selected articles. We approached the analysis from a contextualist perspective, taking the view that knowledge emerges from context (Braun & Clarke, 2006; Henwood & Pigeon, 1994; Tebes, 2005). To this end, we attempted to pay close attention to situations where experiences and values may contrast, such as cultural differences, sexual orientation, and health status. An inductive approach to data analysis was taken. First, we extracted the main findings and subtopics for each article. Based on the extracted data, we coded the main topics for each article resulting in one or two main topics per article. After comparing codings of the main topics for each article and resolving differences, each author grouped them in higher level themes independently. We discussed the results and reached consensus over themes and overarching thematic categories (Table 3). Main analytical points were agreed upon and each author analyzed one of the two overarching thematic categories in detail. Analysis of each thematic category was double-checked by the other author and discussed.

Quality assessment of selected articles was conducted using the National Institute for Health and Care Excellence's (NICE; 2012) checklist. Quality was assessed using 13 questions from the checklist.[2] Each question assessed a specific dimension of quality with three descriptive grades. Only one of these grades was positive, while the other two indicated that either the information provided was insufficient or unclear, or that there were methodological issues. An overall grade was assigned to each of the articles (++, +, or –). For the highest (++) grade, an article needed positive grades for at least 10 of the 13 criteria, and at least six for the middle grade (+). Only the lowest overall grade meant an article was assessed as "inadequate."

Results

Our database search initially identified 527 articles. Of these, 458 were excluded because they did not meet the inclusion criteria or because they were duplicates. Most of the articles were excluded during titles and abstracts screening, but 47 articles were excluded during full-text reading and initial stages of quality assessment. For example, they dealt with sexual orientation and other variables not related to sexual activity (e.g., socioeconomic status of older gay men), nonsexual aspects of body image, or mixed-methods articles where the qualitative data were insufficient to warrant an analysis (e.g., one open-ended question in a survey with average answers of 50 words). In the end, 69 articles were analyzed (for PRISMA flow-chart, see online supplement; Moher, Liberati, Tetzlaff, Altman, & The PRISMA Group, 2009). The majority of the articles were published after 2010 (median year 2013), and most of the research was done in English-speaking countries (46 articles). The most widespread method for data collection was interviewing (used in 57 articles), while thematic analysis (22 cases) and grounded theory (17 cases) were the most common methods/approaches used for analysis. For more details of the reviewed articles, see online supplementary material.

Table 2. The Number of Inadequate Articles ($N = 69$) for Each NICE Quality Assessment Item.

NICE Checklist Items	Number of Articles by Item Characterized as Unclear or Inadequate[a]
1. Is a qualitative approach appropriate?	2
2. Is the study clear in what it seeks to do?	14
3. How defensible/rigorous is the research design/methodology?	18
4. How well was the data collection carried out?	26
5. Is the role of the researcher clearly described?	53
6. Is the context clearly described?	32
7. Were the methods reliable?	28
8. Is the data analysis sufficiently rigorous?	30
9. Is the data "rich"?	39
10. Is the analysis reliable?	32
11. Are the findings convincing?	16
12. Conclusions	13
13. How clear and coherent is the reporting of ethics?	32
14. As far as can be ascertained from the article, how well was the study conducted? *(Overall assessment)*	11[b]

Note. NICE = National Institute for Health and Care Excellence.
[a]Number of articles with one of the two descriptive grades indicating lack of quality.
[b]Number of articles with the lowest (–) overall grade.

Quality Assessment

When discussing the quality assessment, it is important to note that it was the quality of the report that was being assessed and not of the research itself. Overall, the quality of the selected articles was relatively high; only 11 of the articles were assessed as of inadequate quality (Table 2) and 23 articles were assigned the highest grade. If the overall grade of the articles was substituted with a 1 to 3 numerical scale (with 3 denoting the highest quality), the average grade of the selected articles would be 2.42 ($SD = 0.67$). The highest graded items from the checklist were those assessing the appropriateness of a qualitative approach (only two articles assessed as inadequate or unclear) and the conclusions drawn from a study (13 articles assessed as inadequate or unclear).

Despite the relatively high overall assessment of the quality of the articles, more than half were assessed as inadequate or unclear on two items, "Is the role of the researcher clearly described?" and "Is the data 'rich'?" while almost half of the articles were assessed the same for reporting of ethics (Table 2). The role of the researcher, their relation to the participants and the research process, and their characteristics were in most cases not dealt with at all and in some cases addressed only superficially. Although research ethics were usually reported in some form, this was mostly limited to stating that ethical approval was obtained. Important details regarding anonymity of the participants, confidentiality of data, and/or obtaining informed consent were rarely described.

Providing rich descriptions of data in the limited space of a journal article proved challenging for researchers. In the majority of the articles, raw data (quotes) were used in a very limited manner, with the quotes often lacking background information (e.g., participant characteristics). In other cases, quotes were used but without in-depth analysis.

Also, considering that more than a third of the articles were evaluated as lacking in regard to description of data collection, the context of the study, reliability of methods used, rigor and reliability of data analysis, and reporting of ethics, the overall positive assessment of selected articles should be interpreted with caution.

Table 3. Sexuality and Sexual Health of Older Adults: Thematic Organization.

Thematic Categories	Themes	Subthemes[a]
Psychological and relational aspects	Personal meanings and understandings of sex	Male sexuality (11) Female sexuality (19) Meanings and experiences of sex in the old age (9)
	Couplehood aspects	Search for partners/ relationship (6) Caregiving and sexuality (3)
	Sociocultural aspects	Stereotypes and prejudices (5) Gender dynamics (6) Sexuality in retirement homes (5)
Health and sexuality	Effects of illnesses and/or treatments on sexuality	Cancer (5) HIV-related issues (9) Other health conditions (9)
	Help-seeking behaviors	Barriers to help-seeking (7) Facilitators to communication with health care providers (9)

[a]Number of articles contributing to subthemes in the brackets.

Thematic Analysis

From the analyzed articles, 81 main topics were extracted and organized (Table 3) in two main overarching thematic categories: *psychological and relational aspects of sexuality*

and *health and sexuality.* In the first thematic category, themes of personal meanings and understandings of sex (male sexuality, female sexuality, meanings, and experiences of sex in the old age), couplehood aspects (relationship search, caregiving, and sexuality), and sociocultural aspects (stereotypes, gender dynamics, and sexuality in retirement homes) are grouped. In the second thematic category, themes of effects of illnesses/treatments on sexuality (cancer, HIV, erectile dysfunction, and other health conditions) and help-seeking (help-seeking barriers, communication with health care providers) are grouped.

Psychological and relational aspects

Personal meanings and understandings of sex

Male sexuality. With 13 topics from 11 articles that focused on men exclusively, male sexuality is less researched compared with female sexuality. Erection is central to the theme of male sexuality, most common are discussion of erectile difficulties (Low, Ng, Choo, & Tan, 2006; Lyons, Croy, Barrett, & Whyte, 2015; Potts, Grace, Vares, & Gavey, 2006), use of sildenafil (Viagra) (Potts et al., 2006), effects of cancer and urological issues (Chapple, Prinjha, & Salisbury, 2014; Gilbert et al., 2013; O'Brien et al., 2011), and masculine stereotypes (Low et al., 2006). Loss of erection is mainly reported as having dire effects on men: negatively affecting their self-confidence, family and professional life, prospect of having a relationship (Gilbert et al., 2013; Low et al., 2006), and being related to the loss of manhood (Low et al., 2006). Still, a British study reported that the majority of men cope with erectile difficulties by accepting them as part of the natural course of aging, and that relationship context determined whether sexual problems had an impact on well-being (Hinchliff & Gott, 2004).

Interestingly, erection issues are also sometimes reported to have positive effects. These include increased intimacy between partners, and the development of alternative sexual practices less focused on the penis, which resulted in greater sexual satisfaction (Potts et al., 2006; Sandberg, 2013). All of the studies that focused on the positive consequences of erectile problems were conducted in Western societies. Two studies investigated older gay men's sexuality: one explored dating among older single gay men (Suen, 2015) and the other explored sexual changes in the lives of the "gay liberation generation" (Lyons et al., 2015). These studies indicated both positive (more sexual freedoms, more acceptance of gay men) and negative (ageism, youth-oriented gay culture, lack of emotional intimacy) changes that occurred during the aging process. Finally, one study researched risky sexual behavior among both heterosexual and gay men, and one sexual desire of older men, reporting changes in desire related to aging and how common narratives of desire establish heterosexual masculine identity (Sandberg, 2016).

Female sexuality. Female sexuality was the largest subtheme in our review with 21 topics from 19 articles. It was also the most complex and diverse one, but mainly focused on heterosexual women. Despite the fact that some of the studies had lesbian or bisexual participants, no significant insight on their sexuality was provided. In the majority of articles, women's sexual behavior and attitudes toward sexuality varied from inactive and conservative to frequently sexually active and open toward sexual experiences in older age. The overall impression that can be derived from these studies is that sexual activity, but not necessarily sexual interest, decreases with age. This is often a result of the lack of a partner or a partner's health problems. The reported incidence of sexual activity appears to be influenced by social norms that inhibit sexual expression, and cause underreporting of sexual activity (Fileborn, Thorpe, Hawkes, Minichiello, Pitts & Dune, 2015). This inhibition in the discourse around sexuality is reflected in another finding that was prevalent in this subtheme: women's position in sexual relationships with men is usually passive and subordinated, particularly in more traditional societies such as Mexico, Iran, Brazil, and Korea. Men's sexual satisfaction is often viewed as women's obligation (Baldissera, Bueno, & Hoga, 2012; de Araújo, Queiroz, Moura, & Penna, 2013; Ravanipour, Gharibi, & Gharibi, 2013) and women take a passive role and leave initiating sex to men (Lagana & Maciel, 2010; Yun, Kim, & Chung, 2014).

Similar findings, but contrasted with more emancipated views, are also reported in studies conducted in less conservative societies. For example, in a U.K.-based study of aging women, Hinchliff and Gott (2008) noted that participants positioned their sexuality as responsive to men's sexual desire, although they rejected the stereotype of asexuality in older age and claimed that sexuality remained an important part of their lives. Several studies reported some form of fear of men or male sexuality. When talking about Viagra, women emphasized danger rather than pleasure. Viagra was seen as setting dangerous masculine standards in sexuality encouraging "expectations of sexually unrestrained men" and a lack of emotional and romantic intimacy (Loe, 2004). Other studies reported sexuality as a "risky business" for women (Hinchliff & Gott, 2008) and fear of negotiating condom use with their male partners (Morton, Kim, & Treise, 2011).

These contrasting findings that reflect both traditional and more permissive values are reported in other studies as well. Sex is reported as important in old age, but something which should only happen within a relationship (Fileborn, Thorpe, Hawkes, Minichiello, & Pitts, 2015). Women reported not only greater sexual freedom in old age but also lack of control over their understanding and experience of sexuality (Fileborn, Thorpe, Hawkes, Minichiello, Pitts, &

Dune, 2015). Financial dependence on men also affects older women's sexual relationships (Yun et al., 2014).

Postmenopausal women not only reported increased sexual desire but also expressed a perceived obligation to please their male partners and follow their lead (de Araújo et al., 2013; Loe, 2004). In a study on aesthetic surgery, women's narratives reflected either "the feminine imperative" (i.e., the perceived responsibility of women to look as sexually attractive as they can) or that they tried to redefine beauty to include age-related changes, nonappearance characteristics, and capabilities (Brooks, 2010).

These discrepancies reflect the interplay of different social and cultural contexts with individual life circumstances which affect sexuality (Fileborn, Thorpe, Hawkes, Minichiello, Pitts, & Dune, 2015; Hinchliff & Gott, 2008). Articles on sexual desire reflect this. A study of older Mexican American women reported that sociocultural factors not only restricted women's abilities to act upon their desires and fantasies, but also affected if desires and fantasies would occur at all (Lagana & Maciel, 2010). Religion, gender, and family norms determined if, and in what form, sexual desire manifested (Lagana & Maciel, 2010; Ravanipour et al., 2013). Other factors reported to affect sexual desire in women are relationship quality, family obligations, health (both their own and their partners), medications, and general wellbeing (Fileborn, Thorpe, Hawkes, Minichiello, Pitts, & Dune, 2015), as well as diverse social and emotional support, availability of sexual partner, and history of partner abuse (Lagana & Maciel, 2010).

Meanings and experiences of sex in old age. Studies grouped under this most general subtheme mainly reflect positive stance toward sexuality in older age. Aging is often connected with self-growth and better quality of sex due to a more relaxed attitude toward it, freedom from family responsibilities, and greater self-confidence (Gott & Hinchliff, 2003b; Kleinplatz, Ménard, Paradis, Campbell, & Dalgleish, 2013). Australian studies of the "baby boomer generation" reported increased sexual agency in older age which reflected positively on sexual expression (Rowntree, 2014, 2015). In contrast, they reported a negative effect of aging on open public expression of sexuality unless participants were youthful looking.

One of the major influences on quality of sex life was a change of partners in old age. Whether it was because of divorce or widowhood, this "second couplehood" had positive effects on both quality and frequency of sexual intercourse (Koren, 2011, 2014; Rowntree, 2014). Feelings of freedom, associated with both older age and new relationships, resulted in more sexual experimentation, openness, and questioning of participants' sexual orientation, preferences, and other unfulfilled desires (Rowntree, 2015).

It is important to notice that in all of the articles, some participants expressed negative sexual experiences, such as loss of sexual desire and decline in sexual activity. Health, whether personal or a partner's, was often reported as the main deterrent of an active sexual life, rather than age itself (Freeman & Coast, 2014; Gott & Hinchliff, 2003b; Roney & Kazer, 2015). In some cases, this resulted in sexual frustration, especially if previous desire was strong and regarded as "innate" (Freeman & Coast, 2014). On the contrary, aging was seen as an explanation for reduced sexual interest and activity (Gott & Hinchliff, 2003b; Roney & Kazer, 2015). Such a rationalization is explained as a way of coping with sexual decline.

Couplehood aspects

Search for partners/relationships. It seems that the search for a new relationship in old age is confronted with age-related barriers regardless of sexual orientation. Still, we found no qualitative research on this topic among heterosexual men and lesbian women, so more research is needed. Despite the positive influence of a "second couplehood" described above, an Australian study reported that many women choose to stay single both because of unwillingness to sacrifice their independence and because of social obstacles to finding a suitable partner. Women reported that men look for more traditional relationships, men are typically interested in younger women, and online dating is deemed inappropriate because of this gendered ageism toward women (Fileborn, Thorpe, Hawkes, Minichiello, Pitts, & Dune, 2015). A desire for intimate partnership was also expressed among HIV positive women, who face double stigma, as older women and because of their HIV status (Psaros et al., 2012).

Older gay men reported both positive and negative attitudes toward entering a relationship. Being single leaves sexual needs unfulfilled for some, but for others, a relationship would restrain opportunities for sexual exploration (Suen, 2015). When actively looking for an intimate relationship, older gay men are faced with age discrimination in the gay community and may believe that advanced age makes them less attractive (Kushner, Neville, & Adams, 2013; Suen, 2015).

Caregiving and sexuality. In studies that researched caregiving in older age, carers were predominantly female partners, reflecting the gendered dimension of caregiving. Three studies focused on issues of intimacy, and findings were diverse. In the shift of roles from partner (wife, husband) to caregiver, sexual intimacy often suffered, although emotional intimacy may strengthen through care for some (Drummond et al., 2013; Harris, Adams, Zubatsky, & White, 2011; Youell, Callaghan, & Buchanan, 2016). For others, emotional intimacy decreased due to the stress of

caregiving (Harris et al., 2011). One article reported that lack of intimacy was coped with by participants replacing their sexual identity with a caregiving identity (Drummond et al., 2013). However, the same article reported women's acts of intimacy with a partner, someone else, or alone. This reflects ambiguity regarding sexuality in caregiving relationships which is also reported in other articles (Harris et al., 2011; Youell et al., 2016). All of the articles above highlighted the importance of better health care support for caregiving partners and communication from health workers on topics of sexuality.

Sociocultural aspects

Stereotypes and prejudices. Among the articles with a strong focus on stereotypes and prejudices in Western cultures, all of them were focused on stereotypes and prejudices toward women. Ageism affects older peoples' sexuality, as sex is usually linked with youth and older age with being asexual. This especially targets older women who report being judged and disrespected when expressing their sexuality. Health care workers, when avoiding discussion of sexual health topics with older women, have an impact in perpetuating these stereotypes (Bradway & Beard, 2015). As mentioned above, women face a double burden of ageism and sexism. Still, women from these studies, being from a generation affected by the feminist movement, take an active role toward stereotypes positioning sexual liberation against ageism (Fileborn, Thorpe, Hawkes, Minichiello, Pitts, & Dune, 2015; Rowntree, 2014).

Two studies conducted in non-Western cultures (Korea, Malawi) were characterized by a focus on traditional cultural beliefs and myths regarding sex and sexuality. None of the studies in Western cultures had this "ethnographic" characteristic. A Korean article on sexual conflicts in marriage reported beliefs that sexual intercourse "prevents senility and maintains virility," legitimizing married men's dominance and insistence on sexual intercourse (Youn, 2009). In a Malawian study, sex in old age was depicted as a matter of strength and life force, which depletes with aging. Thus, old bodies are defined as unhealthy, and loss of desire as reflecting illness and the path toward death (Freeman & Coast, 2014). Interestingly, this study reported equal importance of sexuality for men's and women's health, unlike the Korean study and Chinese studies discussed in the next section.

Gender dynamics. The theme of gender dynamics can be divided into studies of Western and non-Western cultures. In narratives from non-Western cultures, a dominant theme is one of patriarchal order and male sexual and gendered dominance, often combined with various sexuality myths (see above). Gender differences in sexual desire are the focus of the majority of these articles. It is reported that women have less sexual desire than men (Ravanipour et al., 2013), and that they openly dislike sex (Youn, 2009). One Chinese study reported a belief among both men and women that sex is not enjoyable for women (Yan, Wu, Ho, & Pearson, 2011). Rigid gendered sexual order and beliefs were especially evident in the above-mentioned Chinese and Korean studies, where this sometimes also led to marital conflict, and sometimes to violence toward women who did not fulfill their husbands' sexual demands (Youn, 2009). On the contrary, an Iranian study reported women withholding sex as a tool for management of relations within the family (Ravanipour et al., 2013).

Although all of the findings reported in the themes of male and female sexuality reflect gender dynamics in some way, some of them illustrate this more explicitly. Studies on Viagra, mentioned earlier, most clearly reflect gender dynamics. Women reported that Viagra enhances unrestrained male sexuality. Sexualization of old age by means of Viagra reinforces patriarchal ideas about sexuality in which manhood and male desire are at the center, while women feel increased pressure to "please her men" and "go along with it" (Loe, 2004). On the contrary, some research provides different narratives to those of "unrestrained male sexuality" and desire. A minority of men provided counter-stories to the use of Viagra and resistance to cultural pressure for men to sexually perform, even in old age (Potts et al., 2006). Gender stereotypes that govern sexual behavior of men and women are also reported in other studies. Men are expected to look for younger women, while women's sexuality in old age is policed by others and assumed to be either contained within a relationship or nonexistent (Fileborn, Thorpe, Hawkes, Minichiello, Pitts, & Dune, 2015). The stereotype of asexual old age applied more to women than men (Bradway & Beard, 2015).

Sexuality in retirement homes. Studies on older adults' sexuality in retirement homes provide a consistent picture. Sex happens, but staff and other residents do not always welcome it. Interest in sex not only depends on the interest of other residents and peer pressure, but is also regulated by what staff and family judge to be appropriate (Frankowski & Clark, 2009; Hungwee, 2010; Villar, Celdrán, Fabà, & Serrat, 2014). Some types of sexual behavior such as masturbation (Villar, Serrat, Celdrán, & Fabà, 2016) and same-sex sexual behavior (Frankowski & Clark, 2009) are especially judged. Beside family and other residents' attitude toward sexuality, the main barrier to sexual expression is a lack of privacy and imbalanced gender ratio (Frankowski & Clark, 2009; Villar et al., 2014). Dementia is also reported as a serious issue because of the potential victimization of other residents and female staff (Frankowski & Clark, 2009; Tzeng, Lin, Shyr, & Wen, 2009).

Health and sexuality

Effects of illness and/or treatment on sexuality

Cancer. Five articles explored the effects of cancer and its treatment on sexuality in older age. These span a range of issues, including physiological, psychosocial, and relational effects. For men, erectile difficulties were the most common sexual change associated with cancer treatments (Gilbert et al., 2013; Korfage, Hak, de Koning, & Essink-Bot, 2006; O'Brien et al., 2011; Pinnock, O'Brien, & Marshall, 1998). These psychosexual changes are not limited to men whose cancer is located in a sexual site of the body (Gilbert et al., 2013), and can manifest some time after their condition has stabilized, suggesting that proper evaluation of psychosexual needs should be undertaken throughout the follow-up period, and not only at the time of treatment (O'Brien et al., 2011). Men identified a lack of information regarding the impact of cancer treatments on sexual functioning, and lack of support regarding these effects from health care providers (O'Brien et al., 2011; Pinnock et al., 1998). However, men who had a cancer diagnosis seemed to minimize sexual dysfunction issues as a natural part of aging. Acceptance of sexual dysfunction as unrelated to cancer treatments and positioning it as "the norm" for older men was identified as a coping mechanism to reduce distress in those experiencing these issues (Gilbert et al., 2013; Korfage et al., 2006; O'Brien et al., 2011; Pinnock et al., 1998).

Partner support (or lack thereof) was identified as another important factor that influenced the impact of psychosexual problems emerging from cancer diagnosis and its treatment. Generally, older men identified that an understanding approach from their partner and lack of sexual pressure meant that sexual issues had little impact on intimacy and relationship stability (Gilbert et al., 2013). However, feelings of blame and fear over partner commitment meant that the relationship went "downhill" for some (Gilbert et al., 2013; Sawin, 2012). Older women in nonsupportive partnerships identified various relational issues following breast cancer and mastectomy, including reduced sexual contact and changes in how their partners viewed their bodies, but the extent to which these issues were caused by the cancer and not general aging and/or relationship issues is unclear. This research indicated that these women's sex lives changed regardless of cancer, due to a stagnant relationship, partner illness, or the aging process in general (Sawin, 2012).

Still, older women seemed to cope with cancer and its treatment despite lack of partner support. Congruent with the findings for men with cancer, attributing psychosexual changes to the aging process and being accepting of this seems to be a method of coping with the changes and reducing distress (Sawin, 2012). However, this was the only article that focused on the impact of cancer on sexuality for older women. More qualitative research is needed to elucidate the role of partner support for those who *did* have a supportive partner, how these women might compare with those who did not receive support, and the impact of cancer on women's sexuality in general.

HIV-related issues. Articles concerned with HIV focused on two areas: prevention interventions and the effect of HIV diagnoses on intimacy and partnerships. Despite there being a lack of awareness over the risk of HIV and AIDS among the elderly and their relatives (da Silva Santos, Arduini, Carvalho Silva, & da Silva Fonseca, 2014), older adults are willing to receive education and participate in strategies regarding HIV prevention, highlighting that safe sex strategies are still personally relevant to them despite social expectations of celibacy. Older adults feel that HIV prevention messages are generally not targeted toward their age group, despite feeling that they are at risk of HIV infection through unprotected sex (Klein et al., 2001). Furthermore, many older adults still occupy a caregiving role to children and grandchildren, indicating that prevention strategies that ignore the older generation may miss the chance to further their reach within the younger generation (Altschuler & Katz, 2015; Jobson, 2010). In South Africa, an intervention strategy which was sensitive to masculine ideologies within this culture allowed men to create a "safe-space" in which to discuss and receive information about sexual health (Jobson, 2010). In doing so, the men's role as the information provider within the family was maintained, meaning that information about HIV reached spouses and children in a way that was seen as appropriate and culturally sensitive. Older gay men living in the United Kingdom reflected this emphasis on the need for a supportive community. These HIV-positive men faced challenges in adjusting to old age, reporting that they lacked adequate social support as they aged and that care services for older adults were not sensitive enough to gay sexual identities (Owen & Catalan, 2012). These findings highlight the need to be sensitive toward cultural and sexual identities when providing health care and education regarding sexual issues to older adults. The lack of attention on the experiences of older lesbian and bisexual women also points to a lack of sensitivity toward sexual identities within the research itself.

Research into the impact of living with an HIV diagnosis indicates that the constraints the disease places on sexuality, intimacy, and relationships were among the most profound burdens of the disease. Even when older men and women had been living with an HIV diagnosis for many years, they still felt that the disease was an enduring constraint on their sexuality and intimate relationships (Lyons et al., 2015; Neveda & Sankar, 2016; Psaros et al., 2012). Witnessing the HIV/AIDS epidemic has led the older generation of gay men to perceive sex as "dangerous" (Lyons et al., 2015). Unpartnered women

with HIV particularly felt a sense of hopelessness regarding their need for satisfying intimate partnerships (Psaros et al., 2012). These studies support the idea that sexuality and intimacy are still important expectations throughout adulthood, despite age and health status (Neveda & Sankar, 2016).

Other health conditions. The literature concerning the effects of other health conditions on sexual health and sexuality covers conditions such as benign prostatic hyperplasia (BPH), traumatic brain injury (TBI), diabetes, menopause, incontinence, dementia, and general fatigue. Once again, the importance placed on sexual functioning is diverse. Research into treatment selection for BPH indicated that sexual dysfunction was a key concern for almost half of the men in one study, with comments focusing on the impact of treatments on their ability to physically perform sex (Kelly-Blake et al., 2006).

However, Hinchliff and Gott (2004) found that majority of men and women felt that psychological factors affected their sense of well-being over physiological factors, with relationship context determining whether sexual problems had an impact on well-being. Those with conditions such as myocardial infarction (MI), TBI, and diabetes reported that sex was no longer an important part of their lives partly due to their age and partly due to their condition (Abramsohn et al., 2013; Chapple et al., 2014; Layman, Dijkers, & Ashman, 2005; Rutte et al., 2016). In one study, indifference toward sexual intercourse was common among women following MI (Abramsohn et al., 2013). Despite this indifference, many women reported increased sexual satisfaction and nonsexual physical contact with their partners after the MI.

There is some support for the idea that acceptance of sexual problems is influenced by the attribution of these problems to aging, rather than to a health condition. Older adults with TBI reported being less sexually satisfied than their same-age cohorts, but tended to attribute the reduced satisfaction to the aging process (Layman et al., 2005). Those who did attribute changes in sexuality to their condition reported that their condition caused discomfort during sexual activity, and affected their self-esteem and their feelings of masculinity/femininity (Chapple et al., 2014; Roe & May, 1999; Rutte et al., 2016). In summary, although reported levels of sexual satisfaction post health condition vary, the acceptance of sexual problems as part of the aging process (and therefore, "normal") seems to shield older adults from some of the negative psychosocial effects of sexual problems.

Help-seeking behaviors

Barriers to help-seeking. As previously discussed, men and women seem to cope with sexual problems by positioning them as "normal" effects of aging, thereby reducing feelings of distress (Gilbert et al., 2013; Hinchliff & Gott, 2004; Korfage et al., 2006; Low et al., 2006; O'Brien et al., 2011; Pinnock et al., 1998; Sawin, 2012). This acceptance may prevent older men from seeking treatment for sexual problems (O'Brien et al., 2011; Pinnock et al., 1998). Similarly, women who were caregivers to their spouses felt that sexuality was no longer relevant to their daily lives, so they refused to discuss sexual problems with friends or health care providers (Drummond et al., 2013). Some may not address sexual issues with doctors because sexual dysfunction can be seen as separate to health. Men who had received treatment for prostate cancer felt that sexual dysfunctions did not have an impact on their view of their health status or quality of life because they attributed sexual dysfunction to the aging process, and not as a health issue worth to talking to a doctor about (Korfage et al., 2006). For some couples, sexual function is a key determinant of a person's quality of life, for others it is not, further highlighting the diversity of importance and meaning placed on sexuality in later life (Pinnock et al., 1998).

Lack of available information about sexual issues and lack of rapport with health care providers prevented older men and women from seeking help. Many older people felt that health care providers were not forthcoming with information regarding sexual issues, were too embarrassed to discuss the issue, or were not knowledgeable enough to assist with sexual problems (Abramsohn et al., 2013; Drummond et al., 2013; Gott & Hinchliff, 2003a; O'Brien et al., 2011; Pinnock et al., 1998; Roe & May, 1999; Slinkard & Kazer, 2011). In particular, those whose sexual problems were a result of health conditions (such as cancer and diabetes) were not aware that these problems might be related to their condition. They indicated that they would have initiated discussion with their health care provider if they had been made aware of this (Rutte et al., 2016). Feelings of shame and embarrassment in this group were prevalent, as well as the perception that there is a social expectation to be sexually inactive during older age (Gott & Hinchliff, 2003b; Hughes & Lewinson, 2015; Morton et al., 2011; O'Brien et al., 2011). This social expectation particularly discouraged women from discussing sexual issues with young male health care providers (Abramsohn et al., 2013; Gott & Hinchliff, 2003b; Morton et al., 2011). Similarly, in some studies, the traditional masculine ideals of stoicism affected respondents' willingness to discuss sexual issues with health care providers and spouses (O'Brien et al., 2011; Pinnock et al., 1998).

Facilitators to communication with health care providers. Building rapport with health care professionals was seen as an important facilitator to the discussion of sexual health issues with health care providers, and having long-standing, continuous contact with one health care provider

was seen as essential to building that rapport (Abramsohn et al., 2013; Gott & Hinchliff, 2003a; Hughes & Lewinson, 2015; O'Brien et al., 2011; Rutte et al., 2016). Positive attitudes toward sexuality and feelings of self-efficacy appeared to be relevant to women's intention to communicate with a health care provider about their sexual health (Hughes & Lewinson, 2015). Older adults indicated that health care providers should be more open to discussing sexual issues, and discussion should be integrated into standard health care as opposed to treating sexuality as separate to health (Rutte et al., 2016). A holistic, "whole person" approach to health care appears to be central to facilitating discussion of sexual health (Abramsohn et al., 2013; Hughes & Lewinson, 2015; Rutte et al., 2016).

The literature suggests that showing awareness of cultural ideals of masculinity and gender norms within interventions and health consultations can empower older men to discuss sexual issues openly with health care providers, family, and peers (Jobson, 2010). Overall, older men and women seem likely to seek medical advice and discuss sexuality with health care providers when they feel a personal connection with them, when they feel confident and empowered to talk about sexuality, and when communication about sex and sexuality has been normalized by health care providers.

Discussion

The current review investigated the following questions: which topics concerned with the sexuality and sexual health of older adults have been researched by qualitative methods, what is the quality of the qualitative research in this field, and which areas are currently underresearched. We identified two overarching thematic categories: *psychological and relational aspects of sexuality* and *health and sexuality.* Within the first category, we identified three main themes (personal meanings and understandings of sex, couplehood aspects, and sociocultural aspects), while within the second category, we identified two main themes (effects of illnesses/treatments on sexuality and help-seeking behaviors).

The number of qualitative studies is relatively low when compared to the number of quantitative studies. If we compare the number of studies before abstract screening[3] from this review (305) with Træen, Hald, et al. (2017) (4,214), which analyzed both quantitative and qualitative studies using a similar search syntax, it is clear that qualitative methodology is underused in the research of older people's sexuality and sexual health. Also, the number of articles which contributed to each of the themes we have built through our analysis is relatively small (Table 3) and covers diverse, loosely connected subtopics. Therefore, we cannot say that any of the identified themes have been given enough research attention within qualitative paradigm. However, we found that several research areas are particularly lacking in qualitative research.

Risky Sexual Behaviors

First, there has been surprisingly little qualitative research on risky sexual behaviors in this population. Quantitative research has shown that older adults generally have limited knowledge of STIs and safe sex practices, and STIs are on the rise in this population (Lyons et al., 2017; Minichiello et al., 2012; Public Health England, 2016). Thus, qualitative research in this area would be crucial for understanding the patterns of sexual behavior of older adults and formulating public health interventions. Studies included in this review (Altschuler & Katz, 2015; Jobson, 2010) show that older adults not only lack information on STIs but are also willing to learn if given the opportunity.

The Gender Gap

There is a substantial gender gap in research on older adults' sexuality, with more research focusing on female sexuality. This is especially evident in the lack of the qualitative research on male desire and pleasure. As the findings of quantitative research on the relationship between age and sexual interest both in men and women are inconsistent (Graham et al., 2017), more qualitative research on sexual desire might shed light on these inconsistencies. For example, a recent qualitative study on a mid-aged cohort of Canadian men (M age = 42.83) reported that male desire was influenced by emotional intimacy and connectedness with the partner, indicating that there might be fewer differences in how men and women experience desire than previously thought (Murray, Milhausen, Graham, & Kuczynski, 2017). An exception to the gender gap is the lack of the research focused on older lesbians and bisexual women. Although some studies included nonheterosexual female participants, limited insight was provided on this population, and more focused research is needed.

On the contrary, qualitative research on cancer and related sexual problems is male oriented: we found only one study focused on older women (on breast cancer). The highest rates of new diagnoses of breast cancer in women occur in the population aged 65 to 69, and age-specific incidence rates continue to rise until age 90 (Cancer Research UK, 2018). Thus, this review highlights that the impact of cancer on sexual functioning of older women is not currently being investigated qualitatively. This is consistent with the conclusions of the Træen, Hald, et al. (2017) review that research has focused on the impact of illness on sexual functioning in

older men. Future qualitative research should focus on how health problems, especially breast cancer and cancer of reproductive organs, affect women's sexuality.

Sexual Problems Are a "Natural" Part of Aging

An interesting finding that recurred frequently across the articles included in this review was the acceptance of sexual problems as a "natural" part of aging. This appeared to modulate the impact of sexual problems on an older person's sense of well-being, and older adults who held this view typically reported low levels of distress about changes in their sexual life (Gilbert et al., 2013; Hinchliff & Gott, 2004; Korfage et al., 2006; Low et al., 2006; O'Brien et al., 2011; Pinnock et al., 1998; Sawin, 2012). With this in mind, the medicalization of sexual functioning may inadvertently serve to stigmatize lower levels of sexual functioning. As Hinchliff and Gott (2016) pointed out, celibate older adults may be seen as unconcerned with preserving their health and well-being.

However, this acceptance of sexual problems as a part of normal aging could also act as a barrier to seeking help from health care providers for those who may benefit from it (Drummond et al., 2013; O'Brien et al., 2011; Pinnock et al., 1998). This raises the following question: Are these older adults truly accepting of sexual changes, or do they simply feel that they have no other options? It could be that remaining stigma around sexuality in later life and the medicalization of sexual problems prevents some older adults from acknowledging that sexual problems may be having some impact on their well-being. Future research should explore this in more detail, to enable health care providers to identify which patients may need greater encouragement to seek help. While sexual problems in later life should be normalized, this should be done in a holistic way that does not focus on pharmacological treatment and sexual function only, and in a way that reflects the diversity of individual importance placed on sexuality in later life.

Cultural Influences on Sexuality in Older Age

Discrepant views on sexuality in older age, ranging from traditional to liberal values, prompt more research to foster better understanding of culture-specific influences on attitudes toward and experiences of sexual well-being in older adults. In a recent British National Survey of Sexual Attitudes and Lifestyles (NATSAL-3), men who endorsed traditional gender views regarding male sex drive were less likely to report lack of interest in sex, whereas the reverse was true for women (Graham et al., 2017). This is congruent with the findings from this review that cultural and sexual identities are diverse, and that these play an important role in the sexual health outcomes of older adults (Jobson, 2010; Low et al., 2006; O'Brien et al., 2011; Owen & Catalan, 2012; Pinnock et al., 1998). Exploring those factors cross-culturally would improve our understanding of older adults' sexuality. Træen, Carvalheira, et al. (2017) found a lack of systematic research on sociocultural factors, especially societal norms, affecting sexual satisfaction in older adults. The qualitative research analyzed in this review contributes to a better understanding of these factors, but more cross-cultural research is needed. Finally, we found no studies that focused on the views and experiences of older gay women. Of those that featured lesbian and bisexual women within their sample, very little attention was paid to this population specifically within the analyses (Bradway & Beard, 2015; Fileborn et al., 2018). Research is needed within this population to ensure that their voices are represented and their needs are met within social policy and health care provisioning, as well as within the research literature itself.

Quality Assessment

Regarding the quality assessment of the qualitative research that has been conducted in this field, we found that the majority of articles were of at least adequate quality. Only 11 of the 69 included articles were judged to be of inadequate quality. In the context of this review, assessing a certain aspect of a study as inadequate or unclear means that it is either not reported adequately or that it is reported but it does not meet NICE's methodological standards. Inadequate reporting was the reason for low quality assessment scores in the majority of articles in this review. Because of the limited space provided by the journals (especially within public health and medicine), authors were likely to omit details of their research. Some aspects, like the role of the researcher or ethical considerations, seem to have been judged less important and were usually omitted or only briefly mentioned. Most importantly, richness of data description was often compromised. Articles would often clearly describe study design and analytical procedures but presentation of the findings would lack depth and richness. In some cases, data only appeared rich because of unusual, exotic quotes, while lacking the context and comparative quality which characterizes rich description. As the NICE assessment items were also heavily weighted toward methodological quality, these articles may have scored higher than an article featuring a very rich analysis but with some details omitted from the description of methodology.

We recommend that future qualitative research reports focus on providing rich description while providing a more balanced level of detail in the methodology sections. We suggest use of online supplementary materials should be more commonplace, which could be utilized by researchers for more detailed descriptions of methodological procedures, preferably in a table format. This

would enable authors to both report on neglected methodological and ethical issues, and provide space to explore the richness of their data in the body of the article.

Strengths and Limitations

To our knowledge, this review is the first to synthesize the qualitative literature on the sexuality and sexual health of older adults, identifying both the scope of the field and the gaps in the research. Drawing focus to the quality of the research within this field, and the methods with which the quality is assessed, may serve to influence how findings are reported in future research. Regarding limitations, the current review included only literature published in the English language and we did not include books nor gray literature. Future reviews should seek to access the knowledge cumulating in other languages by utilizing a multilingual research team.

In addition, we analyzed only studies with older adults as participants. Future reviews, particularly those that seek to investigate barriers to help-seeking behaviors, may benefit from including articles that focus on health care professionals and/or policy makers, further. It is worth noting that the aims of this review were broad. Due to its large scope, our analysis could not feature every finding of each article in equal detail. As such, the analysis will not have captured some of the nuances and intricacies found in some qualitative articles. However, we identified that a review of this scope was necessary as the task had yet to be undertaken. Also, a review of this type will be of particular use to health care practitioners and public health policy makers.

Conclusion

Although the qualitative research into older adults' sexuality and sexual health covers a wide range of topics, the qualitative approach is still underutilized in this field. More qualitative exploration is particularly needed on the topics of male sexual desire and pleasure, sexual risk–taking in older adults, culture-specific influences on outcomes such as help-seeking behavior and sexual satisfaction, and the impact of health problems on older women's sexuality. The quality of reporting of qualitative research on sexual aging should be improved by focusing on a rich description of the data, while online supplements should be utilized for a detailed description of methodological procedures (and the related validity issues), including ethical issues.

Regarding sexual health issues, the results from this review show that older adults are willing to learn about sexual health and prevention strategies (including safe sex and HIV prevention), but the biggest barrier is feeling that health care providers are not approachable enough to talk about sexual issues. Building rapport with health care providers is reported as crucial for overcoming this barrier.

Findings from this review show an increase in women's emancipation, but older women's position in sexual relationships is still mostly described as passive and subordinated, while perceived expectation of sexual inactivity in older age affects women more than men. Among older men, the most common sexual issues are erectile difficulties, although these can also result in positive changes in partner intimacy and development of alternative sexual practices. This latter finding is consistent with reports of better quality sexual relationships in old age due to self-growth, greater self-confidence, and more relaxed attitudes toward sexuality.

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Notes

1. M.S. was responsible for searching the databases and assessing the relevance of the resulting articles. M.S. and L.T. conducted the quality assessment and thematic analysis for the first five articles independently, and compared their results to check consistency. The remaining articles were divided equally between M.S. and L.T. and analyzed separately. The authors cross-checked the findings for consistency and discussed discrepancies in approach and coding on several occasions.
2. One question, assessing the relevance of the findings, was omitted as only relevant articles were included in the review and quality assessment was not used for the exclusion of articles.
3. Træen, Hald, et al. (2017) do not specify the final number of reviewed studies.

Supplemental Material

Supplemental Material for this article is available online at journals.sagepub.com/home/qhr. Please enter the article's DOI, located at the top right hand corner of this article in the search bar, and click on the file folder icon to view.

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