CHAPTER 10

Assessment of Sexual Function and Dysfunction in Older Adults

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TWO OF US (Zeiss and Zeiss) have worked for 15 years as codirectors, with a physician, of a sexual dysfunction clinic that emphasizes assessment and treatment of older adults. One of the pleasures of working in this clinic derives from its role as an active training site for psychology interns and medical residents. Almost all of those receiving training in the clinic do so as part of broad geriatric training in multiple settings. The experience in this clinic is qualitatively different, and usually it is profoundly challenging to trainees' views of the lives of older adults. In learning to assess and treat sexual problems, they are also put in the position of confronting the vitality and sexuality of people at a stage in life that is usually desexualized in our culture. Hearing about the sexual desire and range of sexual activities of older adults is exhilarating for some, distressing for others, but memorable for all.

In this chapter we share a process for assessing sexual concerns of older adults and provide information on the range and variety of sexual expression in older adults. We hope that this will influence readers to assess sexuality in their older clients more frequently. This is a core issue for people of all ages and should be part of any thorough quality-of-life assessment, not just when the patient initiates discussion by describing a sexual complaint.

Discussion of treatment for sexual concerns is beyond the scope of this chapter, but excellent resources are available to learn about current medical, psychological, and combined approaches to treatment. For medical approaches, the most current summaries are Arthur Burnett (1998) and Barbara Sherwin (1991); soon there should be new summaries published that incor-

porate more information on the use of Viagra (sildenafil) in actual clinical settings. For psychological approaches to treatment with older adults, useful sources are Leslie Schover and Karen Jensen (1988) and Antonette Zeiss and Robert Zeiss (in press); in addition, Julia Heiman and Cindy Meston (1997) present a current review of empirically supported psychological treatments for sexual dysfunction across the adult life span, without special emphasis on the needs of older patients. Discussion of approaches to treatment for older adults that combine medical and psychological interventions are also available (Morrissette, Zeiss, & Zeiss, 1996; Zeiss, Zeiss, & Dornbrand, 1992).

Because our goal is to show the important role of assessing sexuality in any setting and in conjunction with any presenting problem, the chapter has been divided into three sections. In the first section, we discuss ways to bring up questions about sexuality and sexual problems, showing respect and sensitivity for the patient. In the second section, we present a protocol for obtaining a complete set of assessment information in a semistructured interview format. This kind of assessment should be done when the patient indicates that a sexual dysfunction should be considered as a focus of treatment. In the third section, we present special issues in assessing the sexual concerns and complaints of patients with dementia and their partners.

ASSESSMENT OF SEXUAL FUNCTION AS PART OF A STANDARD INTERVIEW IN ANY SETTING

Several research projects have confirmed what we consistently experience in our clinical work: Clients prefer health care providers to raise the issue of sexual function rather than having to initiate such discussion themselves (Davies, Zeiss, & Tinklenberg, 1992; Metz & Seifert, 1990; Moore & Goldstein, 1980; Mulligan, Retchin, Chinchilli, & Bettinger, 1988; Perez, Mulligan, & Wan, 1993). This seems counterintuitive to many health professionals, who fear being intrusive or insensitive in asking questions with clear sexual content. Nonetheless, it is the responsibility of the professional to become comfortable in assessing sexual issues and to learn to do so while conveying respect for clients' sensibilities. The number of undetected sexual problems in older adults is great (Mulligan et al., 1988), although it is hard to come up with precise estimates. The dramatic response to Viagra (sildenafil) when it emerged on the market in the spring of 1998 is a clear indicator of unmet need, at least among older men, for recognition of their sexual desire and need for a responsive health care system.

Setting the Stage

Raising sexual issues as part of a standard, broad psychological assessment is not as difficult as many clinicians fear. We recommend that all questions fol-

low the principles originally established by Alfred Kinsey (Kinsey, Pomeroy, & Martin, 1949): Don't ask yes/no questions; instead phrase questions so interviewee's are invited to share their experience. Thus, instead of saying "Are the two of you physically intimate?" the clinician would ask, "How do the two of you express intimacy physically?" This allows interviewees to respond in the negative: "We are not physically affectionate." It also leads naturally to a fuller description of current physically intimate behavior, if that is appropriate.

Another principle that guides this method of questioning is that it opens the door in a natural, potentially comfortable way for clients, without being coercive or pushing them too quickly. Not all clients will be comfortable or want to answer personal questions about sexuality, regardless of how skilled and comfortable therapists are. It is important to frame questions in a way that allows clients an "out." This strategy is the best one we know for accomplishing simultaneously the goals of giving permission to raise sexual concerns while allowing clients not to pursue that issue if they choose.

SPECIFIC QUESTIONS

Table 10.1 contains some sample questions that can be used in any mental health or primary care setting as part of a thorough assessment. They can break the ice and elicit helpful information. We prefer to ask such questions after we obtain basic information about the patient's life context, such as work and retirement issues, living situation, general health, and patterns of daily activity. In this context, it is natural to pursue more personal questions about relationships and sexuality. Here we provide examples first for the patient who is in a committed relationship and then for the patient who does not have a current intimate relationship.

Questioning a Patient in a Committed Relationship

For the patient in a committed relationship, it is natural to ask about affection in the relationship—in particular, how affection is displayed. It is important to point out here that the questions in Table 10.1 need to be adapted depending on the sexual orientation of the patient. Many clinicians slip into assuming that all clients are heterosexual, but the possibility of homosexual or bisexual orientations is just as high among older clients as in younger clients. Initial questions should try to determine the gender of the current partner without signaling an expectation that it must be the opposite of the patient. Clinicians can ask the name of the partner; if it is not clearly gender-identified, they can ask about the partner's gender in a way that expresses openness to any answer.

Once the partner relationship has been established, clinicians can invite clients to start by describing general verbal ways of showing affection, such as telling the partner about love or caring. General nonverbal expressions of

Table 10.1
Questions for Raising General Sexual Quality-of-Life Issues

For Clients in a Committed Relationship

- How do the two of you display affection?
- What are some ways you show affection nonverbally or physically?
- How do the two of you express physically intimacy?
- What changes in physical intimacy have you experienced as you've grown older? What positive changes have you noticed? Have there been any problems?
- Has menopause (for yourself or for a female partner) brought about any changes or concerns?
- What changes in quality of erections (for yourself or for a male partner) have you noticed, and how does that affect physical intimacy for the two of you?
- What health problems have affected your ability to be physically intimate? How do you cope with those health problems?

For Single Clients

- What are your wishes regarding having an intimate relationship in your life at this time?
- What are some obstacles to finding (or maintaining) an intimate relationship at this point in your life?
- What do you experience in regard to desire for sexual activity or sexual satisfaction?
- What are some of the ways you are able to express your sexual interests or to get sexual satisfaction?
- (If patient describes sex with a partner) What safe sex practices do you follow, to ensure that you will not put yourself at risk of developing a sexually transmitted disease?
- What changes have you experienced in your sexual desire or function as you've grown older? What positive changes have you noticed? Have there been any problems?
- Has menopause (for yourself or for any female partners) brought about any changes or concerns?
- (For male clients) What changes in quality of erections have you noticed, and how does that affect you?
- What health problems have affected your ability to have a gratifying sexual experience? How do you cope with those health problems?

affection also can be described, such as holding hands or kissing. If the patient initially describes only verbal signs of affection, we ask specifically about nonverbal, physical ways of showing affection. Once the patient has described some forms of physical affection, it is natural to ask about more intimate physical contact.

If the patient responds with information about sexual concerns, some additional questions can be added to gain a fuller perspective of those concerns.

For example, often it is helpful to ask about changes in physical intimacy experienced with increasing age. In this context, it is important to consider both problems that may have increased with age and positive changes related to aging. For example, men who ejaculated rapidly earlier in life may find that the problem no longer occurs with age. Or couples who had trouble finding private time for sex earlier in life may find that sex becomes more comfortable after retirement and after children leave home. Menopause can bring about sexual concerns, often because of the female partner's physical discomfort with vaginal stimulation. On the other hand, some women express increased interest in sex after menopause, as they no longer have to worry about pregnancy or birth control. It is important to ask about changes in quality of erections for older men, since age frequently does result in some decline in maximum and typical erection levels. For some couples, who think of sex as equivalent to intercourse, that may have major negative impact. For other couples, who are more flexible in sexual expression, change in erection may have less profound effect.

It also can be helpful to probe specifically about health problems that may affect physical intimacy. Particularly if the patient has a known health condition that frequently has a negative effect on sexual function, opening with a validation of that known relationship can be useful. For example, with a male patient who takes hypertensive medication, we might say: "Many men who take your medication find that they have more difficulty getting or keeping an erection. What have you noticed since you started taking this medication?" If a health-related sexual problem is described, it also can be useful to ask how the couple copes with the problem.

If problems have not been described by this point in the interview, it is probably unnecessary to continue pursuing questions about sexual activity, and clinicians can return to other issues. If a problem has been described, it should be pursued more completely, as described in the section on semistructured interviews for thorough assessment of sexual dysfunction. Clinicians can pursue the topic immediately or return to other issues after agreeing to set up a time for a more thorough assessment. The time available and the range of other issues that need to be covered will dictate when the issue can be discussed.

Questioning a Single Patient

The same general principles of assessment hold for clients who are not in a current relationship. Provide a comfortable way to open up discussion of sexuality as an aspect of quality of life, while leaving room for the patient to decline to explore sexual concerns. The specific strategies for opening up the topic, however, need to be altered. For one thing, it is less clear what the sexual orientation of the patient is, since there is not a specific partner to anchor

the discussion. Questions need to be sensitive to the possibility that the patient could be heterosexual, homosexual, or bisexual. In addition, while any patient (whether in a committed relationship or not) may use masturbation or sex with a noncommitted partner as an opportunity for sexual satisfaction, these activities are more likely with single clients. It is important for clinicians to signal early in the interview that they are open to discussion of masturbation, sex with multiple partners (including prostitutes), or other sexual activities, and that they will not be judgmental about consensual adult sexual behavior.

Without being judgmental, it is important to establish whether clients who have sex with various partners use safe sex practices. Many older adults are minimally knowledgeable about sexually transmitted diseases, particularly HIV. Many think of this as a younger person's disease, as only a gay disease, or as a disease they can avoid by choosing partners according to certain observable physical characteristics (e.g., nice looking, clean). Others are terrified but have no realistic information about risks and preventive practices. Education about safe sex practices and about the risks people take when engaging in sexual activity in nonmonogamous relationships is an important part of discussion of sexuality with older adults.

The questions in Table 10.1 begin with general queries about wishes for relationships and physical intimacy. These questions do not imply specific partner gender or the specific nature of sexual activity or level of commitment the patient might want for himself or herself, but they open up the area of sexuality explicitly. If the patient does express some desire for sexual activity, the additional questions explore the same issues presented for interviewing clients in committed relationships. As with such clients, if a problem is described, a more thorough assessment should follow, as described in the next section.

THOROUGH ASSESSMENT OF SEXUAL DYSFUNCTION

The approach to assessment of sexual dysfunction that follows is used in the setting described at the start of this chapte., the Andrology Clinic. Similar interviews could be done in any mental health or interdisciplinary medically-based setting where treatment of sexual concerns can be provided. The Andrology Clinic provides interprofessional assessment and treatment of sexual problems to clients of all ages, but with a particular emphasis on older adults. In this clinic, clients receive four kinds of assessment routinely: (1) a medical history and physical, with particular emphasis on genital function and identifying health problems or medications known to have a negative impact on sexuality; (2) a psychological semistructured interview; (3) an endocrine lab panel review, particularly emphasizing hormonal function; and (4) (for male patients) a simple nocturnal penile tumescence test, using a de-

vice called the Snap Gauge. Here we present in detail only the psychological semistructured interview, to provide guidance in the processes of clarifying the nature, extent, and history of sexual presenting problems. This interview format also describes techniques for probing for potential psychological factors that might have played an etiologic role in the sexual dysfunction or a role in maintaining problems originally caused by other factors, or that might be emotional or interpersonal consequences of a sexual problem. The goal of the interview is to be able to complete a multiaxial assessment of sexual dysfunction, as described by Leslie Schover and colleagues (1982).

Although we will not describe the specific procedures for doing the medical parts of the assessment, we are strong advocates of the interdisciplinary approach to assessment and treatment of sexual dysfunction in older adults. We have found repeatedly that small percentages of our patients have only medical or only psychological etiological or exacerbating factors; 80% of the patients have both significant medical and psychological factors; about 10% have only medical problems; and the other 10% have only psychological factors.

Articles occasionally appear in the medical literature (in particular) stating that 80% of erection problems in men are medically caused and contrasting this with earlier beliefs that 80% of erection problems were psychologically caused. A careful look at such claims revels that there was never a strong empirical basis for either claim and that what literature exists is based on one-sided evaluations. Thus, for example, the research ostensibly demonstrating that 80% of erection problems are medically caused usually focuses on patients coming to general medical clinics, with fairly high mean ages (Mulligan et al., 1988). Not surprisingly, in these populations at least 80% of the men with erection problems do have significant medical problems with known association to erectile dysfunction. Unfortunately, once a medical problem sufficient to cause loss of erection is established, there is no meaningful assessment of psychological factors. In clinics such as ours, which routinely evaluate both dimensions, almost all of those men also would be found to have significant intrapersonal or interpersonal issues that might be sufficient to create or maintain an erection problem.

The semistructured interview format that we use is based on two sources (Kinsey et al., 1949; LoPiccolo & Heiman, 1978) and has been refined over 15 years of experience in the clinic. The full interview outline appears in Table 10.2. Here we describe some of the rationale for the interview and general information about how it is utilized. It is important to note that we prefer to have both partners in a committed relationship present, if possible, but that the interview is designed to be used with either a couple or an individual patient. Not only do some patients not have a committed partner, but some patients are reluctant to bring in their partners. In such cases we initially accept that concern, but revisit it when the patient feels more comfortable with us, to see

Table 10.2
A Semistructured Interview for Thorough Assessment of Sexual Dysfunction

I. General Background
  A. Explanation of clinic procedures
  B. Request for explicit, specific information, while providing permission for patient to be uncomfortable
  C. Life situation
    1. Age
    2. Relationship—status, length, prior relationships, sexual orientation
    3. Family—kids, living situation
    4. Work—status, history
  D. Drug and alcohol status
    1. Current use of alcohol, cigarettes, other drugs
    2. Prior use
  E. Medical situation—very quick review
    1. Major medical problems
    2. Menopausal status, if female patient, or menopausal status of female partner, if relevant

II. Nature of Sexual Difficulty
  A. Description of problem(s) and current functioning
    1. Desire problems
      a. Sexual thoughts, fantasies, feelings, urges
      b. What percentage of time is this a problem?
    2. Excitement phase problems
      a. Erection problems
        - What percentage of time is this a problem?
        - Percent erection obtained typically and maximally
        - Frequency of attempts
        - When do problems occur—during which sexual activities? during foreplay? during intromission? prior to ejaculation? with which partner(s)?
        - Pain with erection, intromission, or ejaculation
        - Nocturnal or A.M. erections? Nocturnal emissions?
        - Erectile experience during masturbation
      b. Lubrication/vasocongestion problems
        - What percentage of time is this a problem?
        - Percent lubrication, labia engorgement obtained typically and maximally
        - Frequency of attempts
        - When do problems occur—during which sexual activities? during foreplay? during intromission? prior to ejaculation? with which partner(s)?

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Table 10.2 Continued

- Pain with intercourse
- Experience during masturbation

3. Orgasm phase problems
   a. Rapid ejaculation
      - Frequency of sexual activity; any changes in frequency?
      - Duration of erection until ejaculation
      - Duration of intercourse/sexual activity
      - Behavior after ejaculation (patient's and partner's)
      - Masturbation frequency and style
      - What influences latency until ejaculation
   b. Lack of orgasm
      - Aroused during foreplay? Intercourse? other sexual activity?
      - Percent of time orgasmic with partner and typical timing when orgasmic
      - Percent of time orgasmic in masturbation; typical timing when orgasmic
      - If uncertain regarding orgasm, ask if experience is pleasant. How would you describe your sensations during arousal? When you are having an orgasm?
      - How relationship with partner affects the problem

Note: Questions about any other sexual problems, such as vaginismus, dyspareunia, or sexual aversion, should follow the same pattern: describe current functioning in detail and examine what currently influences the occurrence of the problem.

B. History of the problem
   1. Baseline sexual functioning
      a. When was the last period of sexual function with no major problems?
      b. What was the pattern of activity at that time—frequency, partner(s), type of sexual activities, etc.?
   2. Pattern of onset
      a. Gradual vs. abrupt
      b. What aspect of the problem changed first (e.g., if erection, was percent of typical erection or percent of time able to get erection first affected?)
      c. Circumstances on first occasion(s)
      d. Other life changes associated with first occasion(s)
      e. If there are multiple problems, what was the sequence of onset, e.g., if erection or orgasm problems, did they precede or follow desire problems in onset?
      f. If erection or orgasm problems could be resolved, what is patient's expectation of likely desire level?
   3. How does the couple handle the problem?

Table 10.2 Continued

4. What have they tried to resolve the problem?
5. Any upsetting experiences caused by the problem (intrapsychic or between the couple; e.g., is the identified patient distressed/depressed as a consequence of the sexual problem)?

III. Causal beliefs and goals **(This section is vital; do not omit.)**

A. Patient's and partner's beliefs about causes of the problem

1. Primary hypotheses
2. Other possible contributing factors
3. Openness to a multifactorial explanation

B. Goals

1. Do not assume the goal is the opposite of the problem—ask what the patient's goals are. How much change in quality of life does the patient expect if sexual problems are resolved?
2. How do the patient's goals match the goals of his/her partner (if there is one)?

IV. Current Attitudes and Beliefs

A. The purpose of this section is to find out

1. Current sexual values and behaviors
2. The degree of integration or segregation of sex from other aspects of the patient's life
3. What areas might be particularly difficult for him/her/them to change

B. Current attitudes toward sex

1. General attitudes, concern re "normalcy"
2. Positive/negative/neutral feelings about: genital area, menstruation, vaginal/penile secretions, masturbation, oral-genital contact, foreplay, intercourse, manual stimulation to orgasm, sexual fantasy
3. Beliefs about partner's attitudes re 1 and 2 above
4. Beliefs about sex and aging
5. Should men and women have different roles in sexual activities? nonsexual activities? Patients' views on sex-specific roles compared to his/her current situation
6. Conflicts between attitudes about sex and those of peer groups, religion, partner(s)
7. Place of sex in patient's relationship; how important?

V. Current Behavior (Some of this is redundant. Pursue according to nature of problem and clarity of information already derived from other questions. Some repetition is useful to check reliability and to allow patients to share some information they may not have recalled earlier.)

A. Relationship with primary partner, if relevant

1. Feelings about the relationship: positives and negatives
2. Physical and nonphysical expression of affection in the relationship
3. Partner's health status

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Table 10.2 Continued

4. Is divorce or separation a possibility?
5. Impact of sexual problems on relationship
6. Communication: Generally; about difficult or conflictual topics; specifically about sex
7. Patterns of sexual initiation
8. Other problem areas
9. Use of contraception, if relevant
10. If partner not present, will he/she come in? Discuss in detail, emphasizing the importance of couples' interview as next step.

B. Sexual activity with partners other than a primary partner
1. Ground rules in the primary relationship, if relevant
2. Occurrences of intimacy and sexual activity
3. Experience of the presenting problem in relationships other than a primary relationship
4. Gender of other partners
5. Safe sex practices

C. Activity with partner of gender opposite from primary orientation, whether patient has a primary partner or not (i.e., same-sex sexual activity if patient presents as heterosexual; heterosexual activity if he/she presents as homosexual)
1. Sexual experiences with nonprimary gender: fantasies and behaviors
2. Feelings about these experiences
3. Safe sex practices

if he or she is then willing to invite the partner for the next phase of assessment and treatment. Our data have been clear over the years in confirming that outcomes are better, even for treatment with predominantly medical components, when a partner is involved (Zeiss, Delmonico, Zeiss, & Dornbrand, 1991; Zeiss et al., 1992).

SETTING THE STAGE FOR THE INTERVIEW

To open the interview, it is important to recognize that the level of candid detail that will be requested is high and that many patients will be uncomfortable, especially at first. Therefore, we start with a general overview of clinic procedures, reminding patients that the medical and psychological providers work as a team to obtain thorough information in order to provide the best possible treatment plan for each patient. We mention, in a validating way, that our requests for explicit, specific information may lead patients to be uncomfortable. We assure patients that we understand and that we will not push pa-

tients faster than they feel comfortable proceeding. We ask patients to indicate how they expect to feel during the interview and whether they have discussed sexual concerns candidly in any other situations. We invite them to let us know if they do feel uncomfortable at any point in the relationship and to check out our reasons for requesting certain information if they feel it is not relevant or too personal.

After establishing patients' agreement to proceed, we explore some general aspects of their life situation, partly in order to "break the ice" and partly to have a sense of the overall quality of life of patients. We also establish the use of various substances, such as alcohol, tobacco, or illegal substances. Most older adults are unaware that tobacco use has a decided negative impact on genital blood flow and, consequently, on erection for men and lubrication for women. Many older adults also believe that alcohol should enhance sexual function rather than having a deleterious effect.

We also do a quick review of major medical problems, largely to let patients know that we are aware of those problems and to assure them that we will not be ignoring those factors in our formulation of the causes of sexual dysfunction. Many older patients are concerned that seeing a psychologist means that the physician thought it was "all in their heads," so we assure patients that we think their medical problems are important. We use this as a first opportunity to mention the concept of multiple causes of sexual problems to each patient. This idea initially is difficult for some patients, who expect each problem to have a single cause and a single treatment. We return to this theme throughout the interview, helping patients recognize how factors they describe may interact with each other to initiate or maintain the sexual problems they bring to the clinic. In the initial review of medical problems, the psychologist doing the interview usually summarizes what he or she has learned from the physician, rather than reobtaining that information. We do invite patients to note if any of the information is incorrect and spend time to get greater clarity if there are corrections.

Obtaining a Description of Current Sexual Activity and Problems

Next we obtain a complete description of current sexual function, including what is going well in addition to what is problematic. We try to start by having patients describe information on sexual experience in the last month or two. Sometimes patients cannot follow this instruction; usually when this happens, patients feel a strong need to start with the period when the problem began and tell the story of declining function chronologically. In such cases it seems that patients have been mentally rehearsing for the appointment and need to be able to proceed in their own way in order to manage anxiety. If patients are more comfortable proceeding chronologically, we al-

ways allow them to do so. However, sometimes this extends the length of the assessment, since it is not always clear what historical information needs to be obtained when we do not yet know the nature of the current presenting problems. We speak of the interview as "semistructured" largely because of this need to allow patients some control over the pacing and sequence of providing information, given the very sensitive nature of the material and the discomfort patients often feel. We always emphasize to psychology trainees in the clinic that it is much more important to develop a bond with patients and to have them be willing to come back for a next appointment than it is to get every bit of information in the interview format on the first visit.

Desire Phase

To obtain an overview of current sexual function, we ask about every phase of the arousal cycle, beginning with sexual desire (Masters & Johnson, 1966). Describing desire is difficult for people, and patients can err in either direction. Sometimes they insist that they experience desire, while also indicating that they have not engaged in any sexual activity, including masturbation, or had any sexual dreams, thoughts, or fantasies, for a long time. Careful exploration in such instances usually reveals a "desire for desire" rather than the actual presence of sexual desire. That is, the patient remembers what it was like to have sexual thoughts and feelings and wishes fervently to have that state back; he or she may describe this as "having strong sexual desire." However, these same patients usually will agree that they have not felt any surges of sexual longing, and we would consider this a lack of sexual desire. On the other hand, some patients will describe a lack of desire yet report frequent attempts at sexual activity and frequent sexual thoughts and feelings. Sometimes these attempts are willed efforts and patients in fact do not spontaneously experience desire. In other cases, however, patients mean that they do not experience physiological arousal in response to feelings of desire—that is, if male, the patients do not get erections, or, if female, they do not lubricate or have other signs of genital vasocongestion. In such cases, patients do not have a problem with the desire phase but rather with the next phase of the arousal cycle, the excitement phase.

It is important to note that (as will be true for the other phases of the arousal cycle) establishing the presence or absence of a desire problem does not allow conclusions about other phases of the arousal cycle. Patients who report no desire may still report sexual activity with full physiological excitement and orgasm, or they may report no sexual activity and difficulty experiencing erection or lubrication. A fitting slogan in assessment of sexual dysfunction is "Never jump to conclusions."

Excitement Phase

Most typically, older patients coming for treatment of sexual dysfunction have an excitement phase problem. For men, most commonly this is difficulty obtaining and/or maintaining erections. For women, most commonly this is difficulty with full vasocongestion and lubrication, resulting in pain with any sexual activity that involves penetration of the vagina. These problems also can interact; when men have difficulty obtaining full erection but can get about 70% erection, intercourse is possible if a female partner's labia are fully elevated and her vagina is well lubricated. However, if her labia do not engorge, they will provide some barrier to intromission, and if she is not well lubricated, intromission will be difficult for him and painful for her. Under such circumstances, either individual might have successful intercourse with a partner showing no age-related problems (or problems due to other factors), but the couple may not be able to have intercourse together without some additional adaptations to their previous sexual patterns.

In pursuing excitement phase problems, we typically ask a broad array of questions, since experience may vary widely across a range of factors, including partner, time since last sexual activity, and time of day. In this section of the interview, patients who have been comfortable previously can get more anxious at the level of detail requested. Patients may wonder, for example, why it is necessary to know about their experience in masturbation, since they are only interested in changing what happens with partners. We encourage a collaborative stance, where patients' concerns can be expressed and honest answers are given about the rationale for each question. When it is explained to them, most patients understand that anxiety with a partner might have a negative impact on sexual excitement, whereas they may feel more confident and less "on the spot" when masturbating, resulting in a different pattern of excitement. Working with patients in this way also can begin the treatment process, pointing out the natural variability of excitement responses sometimes results in patients suggesting the very interventions that the therapist would have (e.g., working to reduce stress in a relationship, working to change patterns of thought during sexual activity).

Orgasm Phase

The presence of an excitement phase problem does not determine the presence or absence of an orgasm phase problem. Men who get no erection can have normal orgasm and ejaculation (in fact, such is the norm); men who are able to obtain and maintain erections may never reach orgasm. Parallel statements can be made about women. Thus it is important to ask specifically about the experience of orgasm, regardless of other information obtained in the interview. The most commonly diagnosed problems in orgasm phase

for younger adults are rapid ejaculation for men (Masters & Johnson, 1970) and absence of orgasm for women (Barbach, 1975). In older adults, these problems are less common, since aging reduces rapid ejaculation (Masters & Johnson, 1966), and years of sexual experience increase the likelihood of having learned to obtain orgasm for women (Kinsey, Pomeroy, Martin, & Gebhard, 1953).

Older adults generally report different problems. Men may report not coming to climax on every occasion of sexual activity, particularly if occasions are closely spaced. Many older men also have health problems or health-related events (i.e., a transurethral prostate resection) that result in retrograde ejaculation (ejaculate going up into the bladder during orgasm rather than being ejected through the penis). Women may report reduced orgasmic sensation or pain during intercourse, secondary to reduced lubrication; this may result in loss of excitement during intercourse rather than progress toward orgasm.

As with excitement phase problems, if there is a problem with orgasm it is important to ask about experience during various kinds of sexual activity, including response to manual or oral stimulation by a partner, with different partners, and during masturbation as well as about experience during intercourse. It is also important to check on the typical refractory period after orgasm for men and how it may have changed with age. With women, multiple orgasmic capacity typically does not seem to be age-related, but it is important to check about the personal experience of each patient.

Summarizing Current Function and Dysfunction

After completing the review of the arousal cycle, it is helpful to provide a summary before proceeding to history of the problem(s), to check on accurate understanding of the patient's experience. For example, we might say, "It sounds like you still experience sexual desire, because you have frequent sexual thoughts and dreams, and you express a real longing to have intercourse with your wife. You attempt to have sex with her less often these days, though, because you feel discouraged by your difficulty maintaining an erection. You can get up to 80% erection, especially in masturbation, and you can maintain erection during masturbation. However, you usually lose it when you attempt to penetrate. We've talked about the fact that your wife has been expressing some pain during intercourse, because of her arthritis and because she hasn't been lubricating as well since menopause. Her discomfort is upsetting to you, and you notice that losing your erection goes along with feeling less aroused at that point. We also wondered whether you might be worried about having another heart attack during intercourse. You and your wife have always used a position for intercourse with you on top of her, and you feel strained—like you're working hard—when you try to have intercourse. We know that position is, in fact, the most stressful for you, and it may also be the hardest posi-

tion for your wife because of her arthritis. How accurate does that summary sound to you? Am I missing anything important? Did I include anything that doesn't sound right to you?"

If a couple has been seen together, the summary would include problems each has individually as well as problems that occur for the couple and would recognize any discrepancies in their views of current sexual activity or function. After clarifying any misinformation, we reach a shared definition with the patient of the current problems in sexual function as well as of what functions well.

Establishing the History of the Problem

At that point, we shift to a discussion of the history of the problem(s). In establishing the history, we want to learn three things. First, we want to know about the baseline pattern of sexual activity; often this defines what the patient expects to have as an outcome of therapy. If that is an unrealistic expectation (e.g., if the patient hopes to reverse retrograde ejaculation), we work on establishing more realistic expectations for therapy outcomes, both by laying some groundwork here and, more thoroughly, in a later section of the interview. Second, we want to know about the pattern of onset of the problem and about any medical and psychological events that may have occurred in conjunction with the development of the problem. Here we ask whether the onset of the problem was sudden or gradual and about what life circumstances, medical or psychological, were present at the time of onset.

Third, if there are multiple problems, we want to learn about the sequence in which they developed—did desire problems occur first, followed by increasing difficulty getting erections, or did the patient start having difficulty getting erections and then begin to lose desire? Such questioning can lead naturally to the third goal of establishing what medical or psychological events may have exacerbated the problem or may have led to it being maintained, even after the original cause was corrected.

Sequential Patterns of Sexual Dysfunction

These questions are meaningful in providing clues to likely outcomes of different courses of treatment. For example, consider a male patient who describes reduced desire that followed a period of deteriorating ability to obtain and sustain erection, with the erection problem starting after the prescription of an antihypertensive medication. The medication likely was the initial cause of the erection problem. However, this man also seems to be describing the development of significant performance anxiety and an expectation of failure in sexual activity. In such cases, changing the medication to an antihypertensive with less risk of erectile dysfunction may not reverse the problem, since the learned anxiety and fear of failure may have become strong enough to sustain

the erection problem in their own right. Such cases are typical among older adults in our experience and call for a coordinated treatment plan that addresses both the medical and psychological factors present.

As another example, consider a woman who has been sexually inactive since the death of her husband ten years previously. During his last year of life, she provided significant physical care, as his prostate cancer progressed; they were not sexually active during that year, and in the prior two years he had difficulty with erections secondary to use of anti-androgens as part of his treatment regimen. She had assured him repeatedly that she did not mind this and that she was just glad to have him alive. However, sex became a source of disappointment and frustration for her. In the interim since his death, she has gone through menopause and is not using hormone replacement therapy.

Now, having fallen in love again with a man who is eager to be sexually active with her, she finds herself uncomfortable whenever he initiates sex. Intercourse is painful, and she does not experience orgasm. Very likely, her initial discomfort with sex in the new relationship had some psychological component, with likely contributors being a learned expectation of sex being frustrating and disappointing, with some possible additional contribution of lingering grief for her first husband and guilt about starting a new sexual relationship. However, the changes in her physical status are also important, both because of menopause and because of the long period of sexual inactivity. "Use it or lose it" does have some truth for older adults; women who continue to be sexually active through menopause and afterward typically show less loss of lubrication and genital responsiveness than women who are sexually inactive. While some of this responsiveness can be regained through renewed sexual activity, many women who have gone through this set of experiences are too physically uncomfortable for such renewal. In such cases, some medical intervention, either through hormone replacement therapy or use of vaginal creams and lubricants, is needed in addition to psychological interventions.

Impact of the Dysfunction(s)

While discussing the history of the problem, we also ask about how the couple has tried to deal with the problem and what negative impact it has had on either partner and/or on the relationship. Patients usually can describe their own internal sequelae: anxiety, depression, shame, and the like. In addition, some couples withdraw from any intimacy when the ability to complete a satisfying sexual interaction is lost. Among older couples, our experience is that this withdrawal is well intentioned but harmful.

Consider a woman who has pain during intercourse and whose husband consequently stops initiating sexual interaction out of concern for her well-being. Unfortunately, all too often we hear that he also stops touching her,

kissing her, and sometimes even sleeping in the same bed, with the rationale that he doesn't want to "tease" her—that is, create a situation where both become aroused and then cannot have intercourse. We hear about similar patterns with reverse genders, in which wives stop holding and cuddling their husbands because they fear the men will be upset about the fact that they do not get erections in situations that previously would have evoked them. Unfortunately, in such scenarios, the couple withdraws loving, intimate interaction from each other, just when they need it most to feel reassured of the partner's continued commitment and love.

Multiaxial Diagnosis of Dysfunction

After obtaining information up to this point, the interviewer can complete a multiaxial diagnosis of the patterns of sexual dysfunction presented by the individual patient or the couple. This approach to diagnosis, described thoroughly in Schover and associates (1982), captures all of the important information about current dysfunction. The interviewer must indicate whether any dysfunction occurs in each phase of the arousal cycle, and for each phase the diagnoses are defined so that a single diagnosis will be available that most specifically captures the problem(s) described. For example, in the excitement phase there are separate diagnostic categories for having difficulty only with obtaining erections, only with maintaining erections, or both with obtaining and maintaining erections. There are also separate orgasm phase diagnoses for women who reach climax only in certain circumstances.

After determining the category or categories of diagnosis to be used, the interviewer must make three additional ratings. For each diagnosis, the interviewer indicates first whether the problem is lifelong or developed after a period of effective sexual function. Second, the interviewer rates whether the problem occurs in all situations or whether it occurs more situationally, as only with certain partners or only in certain sexual activities. Finally, the interviewer indicates whether the problem is the concern that brought the patient to the assessment—in other words, the presenting problem—or whether it is an additional problem discovered during the course of the interview.

Clarifying the Patient's Causal Beliefs and Goals for Treatment

Although the data obtained thus far would be sufficient for diagnosis of sexual dysfunction(s), additional information is vital for planning treatment. Often this information has been obtained by this point, but if it has not been, it should be the next focus of the interview. Specifically, it is crucial to know what the patient or couple believe to be the causes of the presenting problems and to clarify the goals of treatment.

Causal Beliefs

In discussing the history of the problem, the important causal factors sometimes appear clear to the interviewer and to the patient or the couple. At other times, causal factors may not be clear, or the interviewer may have different hypotheses from the patient or couple. Patients carry their own personal beliefs about sexuality and sexual problems; interviewers must be sure to assess them. In particular, patients may expect, as with many medical problems, that there is one specific cause of the sexual dysfunction. It is harder for patients to grasp the idea that there may be multiple interacting causes or to understand that the original cause of a problem is not what is currently maintaining it. However, if the interviewer takes time to ask questions and respects patients' genuine attempts to understand the reasons they are having sexual problems, the collaborative rapport that develops between interviewer and patients will be strengthened. In this collaborative context patients will be more willing to listen to the interviewer's hypotheses, even if they differ from their own.

In addition, often we gain new, important information in this section of the interview. For example, consider a patient who first mentions that he always expected to stop getting erections when he turned 70 (and now he is 72), when asked about his hypotheses regarding the cause of his erection problem. While such information might be expected to come up when the interviewer asks questions about life circumstances at the time the dysfunction developed, sometimes the information does not seem relevant to the patient at that point, or he may not have been comfortable enough to tell you then.

Goals

Patients' or couples' goals frequently come up earlier in the interview, for example, when discussing baseline patterns of sexual activity before the onset of the sexual dysfunction. However, if they have not been clarified by the end of the interview, it is crucial to address them. It is easy to assume the goal is the opposite of the problem (e.g., to reach orgasm instead of not reaching orgasm, to obtain and maintain erections instead of not being able to get an erection), but this is not always the goal, and it is almost always not the only goal. For example, sometimes patients tell us at this point that they actually have no goal to change their current function; instead, the goal is to be able to tell a partner that there is no treatment available and thus to stop the partner from pressing for change. Obviously this fact is important to know before embarking on intervention.

More commonly, patients do want the problem reversed, but not only for its own sake. For example, we see women with sexual problems who have other very serious problems in their committed relationships but who believe that the other problems would not matter if they could only have orgasm during intercourse. In other cases, men without partners believe that they cannot even speak to a potentially appealing partner unless they have the capacity

for erection and sexual activity to orgasm. As a result, they have become isolated, lonely, and depressed, but they expect that it suddenly will be easy to date and find a permanent partner if the erection problem is treated successfully. In other couples, the husband's goal may be to have intercourse six times a week after treatment of his erection problem, whereas the wife feels that once a week would be plenty. These goals, in our experience, need to be asked about specifically, by asking patients what they hope will happen and how life will be different if the presenting problem is treated successfully.

There are several possible outcomes of clarifying goals. In some cases, it is a straightforward process, where therapists and patients agree on the desired outcome, and clear markers of the success or failure of treatment can be defined. In other cases, patients may desire goals that cannot be accomplished, and it is important to deal with that issue right away. For example, one patient was not able to get erections, largely as a result of diabetes, and had retrograde ejaculation due to prostate surgery. On questioning, he initially felt that he would not want the erection problem treated unless we could also change his ejaculatory pattern, which we cannot do. In some such cases, working with the patient may result in changed goals that are likely to be accomplished.

In other cases, patients may choose not to pursue treatment, because the achievable outcomes are not worth the effort of treatment. While it can be disappointing to have a patient decline intervention, it is certainly important to have determined this at the start of the process, rather than having the patient become frustrated and upset by the failure to achieve goals that he or she assumed were the purpose of treatment.

Finally, when a couple's goals conflict, we believe it is vital, both ethically and for accomplishing a useful outcome, to find a shared goal before beginning treatment. For example, we have had older women take us aside to tell us that they don't want a husband's erection problem treated because sex has been much better since he developed the problem. Now he provides manual and oral stimulation and attends to her experience, whereas previously he would penetrate as soon as he had full erection, and sex was over as soon as he ejaculated. In such cases, helping the couple communicate more openly about sex and working toward a shared definition of the kind of sex they want to have is time well spent before beginning intervention on the presenting problem.

Additional Information

The final section of the semistructured interview format provides a mental checklist. Usually, by the time interviewers reach this point, most of the remaining information listed in Table 10.2 has been obtained. However, it is helpful to review the list before feeling completely finished. Patients' beliefs and attitudes about sexuality may have an impact on their hypotheses about the sexual dysfunction or goals for treatment. In addition, if patients come in

without their committed partner, the interviewer may, by learning about patients' beliefs and attitudes about sex, understand why patients think partner participation is unimportant. The interviewer may then be able to devise a strategy to persuade patients to involve the partner. Asking questions about other problems in the relationship also may clarify reluctance to involve a partner.

Some of the information may be important in gauging the likely acceptability of various treatment approaches. For example, patients who believe that sex should always be "spontaneous" have difficulty accepting all of the currently available interventions for erectile dysfunction, since they all require planning and specific action prior to obtaining an erection. In such cases, treatment will need to include interventions to expand patients' attitudes about acceptable sexual activity as well as providing specific means to obtain an erection.

Finally, if it has not already been discussed, it is important to clarify patients' range of partners. Even if there is a primary, committed partner, ask about other partners, including those of either gender. For patients without committed relationships, find out who current partners are and who patients see as potential partners if the presenting problem is treated successfully. For any patient who is having sex with more than one partner, who might have sex with more than one partner, or who has sex with a single partner who might have other partners (i.e., *everyone* not in a stable, monogamous relationship), it is important to review safe sex practices. As discussed earlier, many older patients have limited knowledge about HIV and other sexually transmitted diseases, and they may believe that what they know about sexually transmitted diseases (STDs) more prevalent in their own youth is true of current STDs (e.g., that antibiotics can treat any STD).

Discussing the potential for STDs can raise ethical issues as well as opportunities for psychoeducational intervention. Consider, for example, an older male patient who cannot currently get erections sufficient for intercourse and consequently is celibate. Imagine that he states that, if successfully treated, his plan is to find partners in bars and to have sex with any partner interested in him. Further, he states that he does not like condoms and cannot imagine agreeing to wear one. If the therapist, or the referral setting that provides treatment is successful, it is fully expected that he will act on his stated intentions. In so doing, he will put himself at risk, likely high risk, for developing an STD, possibly HIV. That may be his choice, and as treatment providers we may believe that he has the right to make choices, even ones that seem to us unwise. However, in addition, he will put others at risk, and the therapist will be the means of having allowed him to engage in behavior that could lead to a life-threatening illness for another partner. Obviously we cannot tell readers how to resolve such an ethical dilemma, but we believe that it must be faced by those who are working with sexual dysfunctions in older adults (or those of any age). We would not offer treatment in this scenario, but we strug-

gle with every such case, and we work hard to remain collaborative with the patient and to help him or her understand the reasons why we refuse treatment and the conditions under which we would gladly provide it.

SEXUALITY IN OLDER ADULTS WITH DEMENTING ILLNESS

Up to this point, we have assumed implicitly that neither the patient nor the partner have an advanced dementing process. The interview and diagnostic processes described can be used when there are normal age-related changes in cognitive function, and sometimes when there is even greater cognitive loss, as after a traumatic brain injury or early in a dementing process. However, assessing sexual function when a dementing process is present has specific challenges of its own.

Assessment with Couples When One Partner Has a Dementing Illness

In the last ten years, two of us (A. Zeiss and H. Davies) have conducted research on the impact of Alzheimer's disease, in particular, on sexuality. We also have offered clinical interventions for couples who wanted to remain sexually active in the presence of a dementing illness for one partner. Finally, we have offered a group intervention for caregivers of demented partners; the group offered an opportunity to examine sexuality in their lives and to obtain support from other caregivers regarding sexual choices they were making.

Current Knowledge

Knowledge has accumulated slowly, but currently some general conclusions can be drawn. First, although many people fear that a patient with Alzheimer's disease will become sexually disinhibited and display inappropriate or sexually demanding behavior, there is little evidence that this occurs with much frequency (Zeiss, Davies, & Tinklenberg, 1996). In fact, sexually inappropriate behavior seems to be a rare event in patients with Alzheimer's disease, even at advanced stages. Patients with some other dementing processes, such as Korsakoff's syndrome or post-stroke dementia, may display sexually inappropriate behavior with somewhat greater frequency, probably depending on the specific locus of brain damage, but even in these patients, such behavior is uncommon. Second, Alzheimer's disease is associated with a higher than expected rate of erection problems in male patients, even very early in the disease process (Zeiss, Davies, Wood, & Tinklenberg, 1990). The reasons for this are not yet clear, and the problem seems to be reversible in some, but not all, cases. Third, women with Alzheimer's disease do not show any obvious sexual dysfunctions, but in some couples, the male partner becomes very concerned about continuing sexual activity (Litz, Zeiss, & Davies, 1990). Such husbands often express the fear that they might be, in essence, "raping" their

wives, since the wife can no longer verbally express consent for sexual activity. Thus a source of closeness and pleasure for the couple may be dropped unnecessarily. Finally, some female caregivers express concern about continuing to have sex with a husband who has Alzheimer's disease; concerns are associated most commonly with one of two factors: (1) responsibility for intensive physical care of the patient, including toileting, and/or (2) the patient no longer recognizing the caregiver and being able to call her by name consistently (Davies et al., 1992).

Interview Strategies

In our current research, we are interviewing a broader sample of couples in which one partner has Alzheimer's disease, in order to learn more about patterns of sexual activity and the sexual concerns, pleasures, and frustrations experienced by such couples. Whenever possible, we interview both partners, each one individually. Certainly there are cases where only the partner without Alzheimer's disease can be interviewed.

Components of the interview were chosen with several factors in mind. First, we want to get more information about how much change couples perceive to be a result of the dementing illness and what changes they emphasize before we probe specific problems. The first sections of the interview cover this content, with additional emphasis on the natural flow of a sexual encounter. Further, we have hypothesized that a patient with Alzheimer's disease may have trouble remembering the sequence of sexual activities involved in a satisfying encounter, the kinds of stimulation his or her partner especially likes, and how long each phase of a sexual encounter might go on before making a transition to the next (e.g., when does initial cuddling become foreplay and when does foreplay become intercourse?). We have called this problems with the "orchestration" of sex—with weaving together the multiple components of sexual activity into a harmonious whole. Many questions in the interview are designed to obtain information relevant to this question.

We also are interested in how the pre-Alzheimer's disease sexual relationship influences sexuality after disease onset. Initially we hypothesized that couples who had more satisfying predisease sexual relationships would be more motivated to make modifications in behavior and seek help for problems after disease onset. However, in early data analyses, the opposite pattern has emerged: Couples with the most rewarding sex lives before illness were reporting the most dissatisfaction. These couples also report that sex has been the most disrupted by Alzheimer's disease (Redinbaugh, Zeiss, Davies, & Tinklenberg, 1997; Zeiss, Redinbaugh, & Davies, 1996). Examining all the data, it appears that their sexual activity patterns before illness were the most complex and varied. Subsequent to illness, memory problems have had major impact in trying to sustain this complex orchestration of sex, and the couples experience failure and frustration. Couples whose sex lives were pleasurable

but not highly rewarding before illness seemed to follow a more scripted, predictable sexual pattern, which presumably became overlearned. Such couples find it easier to continue sexual activity, albeit at a continued level of moderate satisfaction. Needless to say, we find these data concerning and emphasize that (although significant with a small sample), they are based on preliminary analyses.

Finally, we remain interested in the kinds of sexual counseling that would be acceptable and helpful to couples facing the dementia of one partner. Many couples state that they would like to be able to remain intimate and give each other pleasure for as long as possible, but that help in seeking this goal is hard to find. In other couples, the nondemented partner may want help to reduce the sexual initiation attempts of the partner with Alzheimer's disease. We have tried to be clear that we do not have a position about what couples should want and that we are interested in learning more about how they perceive their own needs.

While we have focused on couples, there also has been useful work examining the sexual concerns and desires of patients in nursing home settings, particularly those with a dementing condition (Lichtenberg & Strzepek, 1990). People living in nursing homes are typically urged by staff to think of themselves as "residents" rather than patients, with rights to set up a comfortable and personal environment, within the constraints of institutional living space and daily activity patterns. Nonetheless, there is limited freedom in most nursing homes when it comes to sexual activity.

Peter Lichtenberg and Deborah Strzepek (1990) have advocated greater freedom for nursing home residents to have the opportunity to maintain sexuality as a part of their lives, whether currently in a committed relationship or not. They have offered guidelines for staff to use in deciding when it is appropriate for residents to be allowed to continue sexual activity or to begin sexual activity with a new partner. These guidelines thus become a template for assessment of the resident's understanding of sexual activity and competence to make informed decisions in this part of their lives. Key steps in the assessment process include obtaining a Folstein Mini-Mental State score, clarifying the patient's ability to avoid exploitation, the patient's awareness of the nature of the relationship, and the patient's awareness of potential risks involved in any particular sexual relationship. These criteria are organized in a decision tree for assessing competency to participate in an intimate relationship; this decision process appears in detail in the original article (Lichtenberg & Strzepek, 1990) and in Lichtenberg (1994).

CONCLUSION

We believe that sexuality can be rewarding and vital throughout the life span. With age, the likelihood of sexual problems developing increases, in part because of physical health changes. These physical changes are not the only

cause of sexual problems in later life, however; changes in relationships, self-perception, and overreaction to minor age-related changes in function play a dominant role as well. In most older adults with sexual problems, there are intertwined medical and psychological reasons for the problems, and both must be assessed fully to design effective intervention. This chapter has provided specific strategies for obtaining basic information about sexuality as a part of any sexual encounter, thus showing respect for the older adult as a sexual being and for the importance of recognizing sexuality as core quality of life issue. We also have provided a strategy for a thorough assessment of sexual problems, when they become a focus of treatment. The assessment is related to and results in the ability to make a multiaxial diagnosis, which captures the complete set of sexual concerns for each patient or couple being assessed. Finally, we have reviewed some special issues in the assessment of sexuality in the lives of older adults with dementing illness and their partners.

Our goal has been to influence readers to assess sexuality in older clients routinely and to provide a validating health care environment in which older adults can express sexual concerns openly and with an expectation that they will be taken seriously. As we stated at the outset, sexuality is a core issue for people of all ages, and it should be part of any thorough quality-of-life assessment. Although we have not discussed treatment in this chapter, effective treatments for most sexual problems of older adults are available. The purposes of assessment should be to determine the full range of problems experienced, the full range of etiological and maintaining factors, and the goals the patient will bring to treatment, so that treatment that is responsive to both the medical and psychological concerns of each patient or couple can be provided.

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