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AFFECTIVITY AND SEXUALITY IN THE ELDERLY: OFTEN NEGLECTED ASPECTS

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SUMMARY

Sexuality and affectivity constitute a complex phenomenon involving many spheres: biological, psychological and social. To investigate these aspects, we distributed a dedicated questionnaire, followed by an interview, to 130 elderly residents in Milan and 100 in Monza. The answers indicated that the elderly communicate their emotions regarding the affective and sexual sphere, with different levels of desire for physical contact. The main variables were sex, age, marital status, co-morbidity and poly-pharmacotherapy, the perception of health status and of oneself, past experiences, cultural conditioning and social factors.

Keywords: sexuality in elderly, affectivity in elderly

INTRODUCTION

The health of the elderly depends on many factors: co-morbidities, functional autonomy, social conditions and relationships. The emotional-affective sphere and the approach to sexuality play an important and largely underestimated role. Studies to date suggest that as the individual gets older the "sentimental universe" remains substantially vital, in spite of physiological changes in sexual behavior (Malatesta et al., 1987; Lewis, 2000; Di Iusto, 2003). Sexuality and affectivity are complex phenomena involving many spheres (biological, psychological and social) and inevitably various aspects seem involved; these include anatomic condition, feeling of wellbeing and perception of illness (Mulligan et al., 1988), history (Kalunger and Kalunger, 1979, White, 1982), social factors (Skoog, 1996; Matthias et al., 1997), cultural conditioning (Scortegnana, 1999), psycho-logical conditions, and functional autonomy (Matthias et al., 1997; Dello Buono et al., 1998).

SUBJECTS AND METHODS

To investigate these aspects, we distributed a questionnaire (Table I), followed by an interview, to 130 elderly outpatients (58 males, 72 females), resident in Milan, and 100 elderly outpatients (31 males, 69 females), resident in Monza, with no cognitive deficits, as measured by the mini mental state examination (MMSE) >24, or depression established by using the geriatric depression scale (GDS) <14. The variables considered were: sex, age, schooling/education, job, marital status, cognitive sphere, functional condition, emotional and affective sphere, physical pathologies, pharmacological history, motivation and desire, affective and sexual satisfaction, history, perception of health status, demand for closer medical attention. The results were analyzed using the t-test, χ^2 and Mann-Whitney-tests.

Table I
THE QUESTIONNAIRE USED, WITH THE POSSIBLE ANSWERS

1. Do you feel any desire for physical contact with a partner?
   NO, it doesn't interest me YES
2. If yes, what is you desire?
   Sexual intercourse other type of contact (e.g., touching, embracing....)
3. Do you derive satisfaction from your physical contact?
   YES NO
4. If not, why not?
   I'm not able because of physical problems.
   I'm not able because of psychological problems.
   My partner is ill.
   My partner is not interested.
   Lack of partner.
5. What was the importance of physical contact with your partner in the past?
   (rated from 1 to 10)
6. How do you consider your health status?
   (rated from 1 to 10)
7. Do you think your doctor pays enough attention to this topic?
   YES NO

RESULTS

There were several differences between the two samples (Table II). Both samples expressed a desire to maintain emotional-affective and physical relations, but with differences. In Milan the desire was expressed by more than 60% of the subjects, with a difference between the sexes (86.2% males, 38.9% females). As regards marital status, the desire was almost the same in married subjects (90.7% males, 88.9% females), and lower among widow/ers (29.4%). What seemed to be desired most was complete sexual

intercourse (92% males, 64.3% females), and the subjects were not content with other forms of physical contact.

In Monza the desire was expressed by only 36% of the population, with a difference between the sexes (54.8% males, 27.5% females). In this sample too marital status had an important influence, married people expressing more desire (60.9% males, 53.3% females) than widow/ers (28.6% males, 19.6% females). There was a different demand for physical contact too: only 58.8% of men and 21.1% of women desired complete sexual intercourse. Analyzing satisfaction with the present situation, in Milan dissatisfaction prevailed in both genders (66.0% males, 71.4% females), whereas in Monza dissatisfaction prevailed only in women (57.9%) but not in men (41.2%).

Table II
DEMOGRAPHIC AND CLINICAL CHARACTERISTICS OF THE TWO SAMPLES

		Milan (%)			Monza (%)		
		Total	Men	Women	Total	Men	Women
Sex distribution			44.6	55.4		31.0	69.0
Age[1]	65-75	30.8	41.4	22.2	33	35.5	31.9
(years)	75-85	66.2	55.2	75.0	46	48.4	44.9
	>85	3.1	3.4	2.8	21	16.1	23.2
Education[2]	0-5	24.6	17.2	30.6	64	48.4	71.0
(years)	6-8	41.5	51.7	33.3	22	25.8	20.3
	9-13	21.5	10.3	30.6	9	12.9	7.2
	>13	12.3	20.7	5.6	5	12.9	1.4
Employment	Retired	90.8	79.3	100	100		
	Self-empl.	9.2	20.7				
	Employee						
Marital status[3]							
Married		47.7	75.9	25.0	38.0	74.2	21.7
Widows + P		4.6	6.9	2.8	1	0	1.4
Widows - P		26.2		47.2	53	22.6	66.7
Separated + P		3.1	6.9		0	0	
Separated - P		10.8	6.9	13.9	0	0	0
Unmarried + P		1.5		2.8	1		1.4
Unmarried - P		6.2	3.4	8.3	7	3.2	8.7
Psychometric test scores (means)							
MMSE[4]		29.09	29.1	29.08	27.99	27.7	28.1
ADL[5]		5.88	5.83	5.92	5.19	5.5	5.2
IADL			4.8	7.81		4.3	5.7
GDS		7.28	6.28	8.28	9.17	8.7	9.3

Notes: [1]younger subjects in Milan, than in Monza ($p < 0.001$). [2]lower level of education in Monza, than in Milan ($p < 0.002$), [3]more widows in Monza, than in Milan ($p < 0.017$), [4]higher MMSE score ($p < 0.001$) in Milan, than in Monza, [5]higher ADL score ($p < 0.002$) in Milan, than in Monza. +P, -P indicate the presence or absence of partner, respectively.

As far as the motivation was concerned, physical problems were more important for men, relationship and couple problems for women, without differences between the two samples. MMSE, ADL, IADL, GDS, education and employment on desire did not appear to have substantial weight in either sample.

There was an association between the importance of affectivity and sexuality in the past and persistence of desire. In Milan there was a significant association in men (χ^2-test, 95%, $p = 0.008$) and women (χ^2-test, 95%, $p = 0.015$); in Monza men with persistent desire attributed more importance to this in the past (χ^2 not significant) than men without desire. Perception of one's own state of health also appeared important in relation to present desire. In Milan there was an association between a good perception of one's own health and desire in men (χ^2-test, 95%, $p < 0.0001$); in Monza men and women with a better perception of health appeared to feel more desire (Mann-Whitney-test, 95%, $p < 0.040$), although there was no significant association with the χ^2-test.

We found an association between co-morbidity and absence of desire in Milan (χ^2-test, 95%, $p < 0.045$) and in Monza (χ^2-test, 95%, $p < 0.05$). There were associations between lack of desire and the following diseases: depression (Milan $p < 0.003$, Monza $p < 0.014$), benign prostatic hypertrophy (Milan $p < 0.012$), hypertension (Monza $p < 0.014$). Only the Milan sample showed an association between poly-pharmacotherapy and absence of desire among men ($p < 0.017$). The following drugs appeared to have most effect on the lack of desire: sedatives (Milan $p < 0.031$), beta-blockers (Milan $p < 0.03$), angiotensin converting enzyme (ACE) inhibitors (Monza $p < 0.045$), H_2 blockers (Monza $p < 0.024$). The people in both samples asked for closer attention to this subject. Finally, the interviews showed innumerable cultural conditionings in both samples (e.g., difficulties for widow/ers and single people to commit themselves to new love affairs and new sexual relationships on account of memories of the past and the idea that sexual activity should decline with aging.

DISCUSSION

The elderly showed a desire to communicate and transfer their emotions through the affective and sexual sphere, but with different levels of desire for physical contact. The persistence of the desire to maintain emotional-affective and physical relations differed in the two samples examined here, with more desire and demand for physical contact in Milan than Monza. Besides the baseline differences between the two samples, what seems important is the social context which creates differences between city dwellers and those in

the provincial town, so we found more taboos arising from religion, and difficulties in talking about personal and private topics in Monza than in Milan. Often the needs expressed are not met in their present situation, giving rise to differences in satisfaction in the two contexts. Sex, marital status, co-morbidity and poly-pharmacotherapy, perception of the health status and of oneself, and past experiences are all important. Cultural conditioning, social setting, satisfaction and willingness to commit oneself to a new relationship are also major factors in the persistence of desire. In spite of cultural conditionings and the differences between the samples, however, the majority of people interviewed expressed a desire for greater attention to this subject, underlining the importance of emotional communication with other people in one's own social context, including doctors.

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