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## **How do older people discuss their own sexuality? A systematic review of qualitative research studies**

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## **Abstract**

This study captured older people's attitudes and concerns about sex and sexuality in later life by synthesising the qualitative research published on this issue. The systematic review was conducted between November 2015 and June 2016 based on a pre-determined protocol. Key words were used to ensure a precise search strategy. Empirically-based, qualitative literature from 18 databases was found. Twenty studies met the inclusion criteria. Thomas and Harden's thematic synthesis was used to generate 'analytical themes' which summarise this body of literature. Three main themes were identified: a) social legitimacy for sexuality in later life; b) health, not age, is what truly impacts sexuality, and c) the hegemony of penetrative sex. The themes illustrate the complex and delicate relation between aging and sexuality. Older adults facing health issues that affect sexual function adopt broader definitions of sexuality and sexual activity.

**Keywords:** sex; intimacy; aging; thematic synthesis

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## **Introduction**

Sexuality is a broad concept. The World Health Organization's, (2006, p.5) definition encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction. It stresses the importance of how sexuality is experienced, expressed and influenced through the interaction of biological, psychological, social, economic, political, cultural, ethical, legal, historical, religious and spiritual factors.

Research into the contribution of sexuality and remaining sexually active to the quality of life and wellbeing of older people is increasing (Kontula and Haavio-Mannila 2009; Katz and Marshall 2003; Hinchliff and Gott 2011). Some studies have focused on biological aspects, such as hormonal and other physical changes (e.g., Dennerstein, Randolph, et al. 2002) or through the lens of difficulties and dysfunctions (Lindau, Schumm, et al. 2007). The knowledge and attitudes of healthcare professionals towards sexuality in later life (Haesler, Bauer and Fetherstonhaugh 2016) has also been examined, with a focus on physicians (Dogan, Demir, et al. 2008; Langer-Most and Langer 2010; Gott, Hinchliff, and Galena 2004) and residential care (Bauer, McAuliffe, et al. 2013; Di Napoli, Breland, and Allen 2013).

Our initial review of empirical literature identified that rather less research about sexuality and aging from the subjective perspectives of older people was available. Studies examining older adults' sexuality have mainly focused on sexual behaviour, sexual health and sexual dysfunction, through quantitative analyses (e.g. Twenge, Sherman and Wells 2015; Laumann, Nicolosi, et al. 2005; Lee, Nazroo, et al. 2016; Lindau, Schumm, et al. 2007). Other research has tended to focus on the perspectives of health professionals and family members regarding later life sexuality, rather than those of older people (e.g. Villar and Serrat 2016; Roach 2004; Bauer, Nay, et al. 2014). Given that there is less research about sexuality and aging from the perspective of older people themselves, placing older people's voices at the centre of any analysis provides an opportunity to understand their views about their own sexuality and how these perspectives might meet their needs and shape services and support (Gott and Hinchliff 2003). Our aim in this study was to review and synthesise qualitative research on older people's sexuality from their own perspectives, attitudes, perceptions and personal sexual experiences.

## **Methods**

### ***Conducting the search***

The review was based on the *SCIE Systematic Research Reviews: Guidelines* (Rutter, Francis, et al. 2010) Key words were: ("older adult\*" OR senior\* OR elder\*) AND (sex OR sexual\* OR intimacy) AND (image\* OR perception\* OR attitude\* OR expectation\* OR stigma OR belief\* OR knowledge\* OR stereotype\* OR desire\* OR need\*). The following databases were searched, given the cross-disciplinary topic: CINAHL, SCOPUS, PsycINFO, PsychARTICLES, Web of Knowledge, Open Grey, PubMed, Web of Science, Sociological Abstracts and

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German datasets (PubPsych, which includes PSYINDEX; PASCAL; ISOC-Psicología; MEDLINE®; ERIC; NARCIS; NORART; PsychOpen; and PsychData). A snowball search was subsequently conducted via Google Scholar using the function 'cited by' and 'related articles' to capture any further studies not initially identified. The search in databases was conducted in November 2015.

### ***Inclusion and exclusion criteria***

Inclusion criteria were 1) articles written in English, German, or Hebrew (languages of study co-authors), 2) qualitative research design with findings based on empirical data, 3) samples with individuals 60 years and older, and 4) studies based on older people's own attitudes or perceptions about their sexuality and personal sexual experiences. We excluded studies that 1) focused exclusively on sexual behaviours or practices (as we were particularly interested in capturing older people's voices and perceptions about their sexuality, rather than sexual behaviours, 2) included participants younger than 60 years, 3) were based on quantitative methods, 4) were opinion or review studies and those where the full texts were not obtainable, and 5) studies not written in English, German or Hebrew. There were no restrictions related to the location or date of the study. The search process complied with the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) flow diagram (Moher, Liberati, et al. 2010), as illustrated in Figure 1.

The initial search yielded 19,548 records, further screening of titles, abstracts and removal of duplicates resulted in a total of 181 full texts, of which 15 met the study criteria. The Google Scholar snowball search resulted in 24 studies, of which 5 were included (see Figure 1). A total of 20 papers met all the inclusion criteria.

Figure 1 about here

### ***Review process***

All titles and abstracts were reviewed independently for relevance by at least two reviewers and disagreements were resolved through consensus or by involving a third reviewer. Each full-text study (n=205) was read first by one reviewer and another reviewer then reread, filtered and re-evaluated the papers for inclusion. The Critical Appraisal Skills Programme tool, developed for screening and appraising qualitative research ([www.casp-uk.net](http://www.casp-uk.net)), was adapted to inform a protocol for systematically assessing studies based on the inclusion criteria.

### ***Data analysis***

Thematic synthesis was used to analyse data in primary qualitative research to bring together and integrate the findings of multiple qualitative studies (Thomas and Harden 2008). It followed three stages. First, open coding of the text 'line-by-line' was undertaken by two reviewers independently in order to generate 'descriptive themes' about what older people said about their sexuality. This was followed by the generation of 'analytical themes'. Whilst the descriptive themes (see Table 2 for more detail of how the eight descriptive

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themes (A-H) were generated from the data) remained close to those of the primary studies, the analytical themes were initially developed by the first two authors who examined the descriptive themes in order to synthesise primary studies and findings across the studies. All authors then commented on these themes until a final version was agreed upon. This detailed process enabled us to produce new concepts and hypotheses about older people's attitudes towards their own sexuality transparently and facilitated the production of three main themes, as presented below.

Table 2 about here

Context was preserved by providing aims, methods, settings and samples as outlined in Table 1 and by checking during synthesis whether emerging findings were transferable across different study contexts.

## **Findings**

### ***Overview of the studies***

Table 1 summarises the 20 studies included in the review. They utilised a range of qualitative research methodologies, illustrating that there is no single way of engaging older people in discussing their own sexuality. Most papers noted the challenges of data collection and difficulties participants had had discussing the topic. The studies spanned 27 years (1987-2015); most were published in the last 10. The views of 437 older adults were captured from ten countries: Australia 3 (n=31), Brazil 2 (n=30), Canada 2 (n=36), China 1 (n=20), Germany 3 (n=125), Iran 1 (n=15), Korea 2 (n=34), Sweden 1 (n=22), the USA 4 (n=80) and Uganda 1 (n=44).

### ***Themes***

The first theme generated was the social legitimacy for sexuality in later life, which addressed the feelings of older people about the tensions experienced between the desire to express their sexuality and social conventions that inhibited them from doing so. The second theme involved health issues affecting sexuality that challenged expression and desires. The third theme addressed the hegemony of penetrative sex and how this narrow perception minimises the diversity of sexual activities and the sense of meaning sexuality has for people who are growing older.

#### ***Social legitimacy of sexuality in later life***

This theme concerned the impact of socialisation and social legitimacy on how people viewed their sexual selves in later life. Across studies, older individuals reported that other people presumed that they were asexual (de Oliveira Silva et al. 2015) and were sexually invisible (Bayler-Levaro 2011). Women discussed the social silence regarding their sexuality and intimacy, which made raising these issues with friends, family or service providers uncomfortable (Drummond et al. 2013). The invisibility of older people as sexual beings reflects the Western orientation toward youthfulness and beauty (Rowntree 2014).

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Internalising this orientation made people feel less inhibited by personal sexual expression and more inhibited by social norms and perceived social legitimacy (Rowntree 2014). Negative attitudes toward expressing sexuality in later life compelled people to conceal their sexuality. These attitudes were reinforced by expectations of more modest sexual dress and by insulting terms such as *cougar* (Rowntree 2014, 151) to describe “older” women who assertively pursued younger sexual partners (Montemurro and Siefken 2014; Alarie and Carmichael 2015). Social norms and delegitimation were not direct barriers to sexual expression in later life but accepting these norms tended to inhibit older people’s sexual expression. Yun, Kim and Chung (2014) found that sexual desire in later life was mediated by concerns of societal opinions of older people engaging in sexual activities or new romantic relationships. However, it is more socially accepted that men should still engage in penetrative sex, while women should be satisfied with “cuddling” (Fournier 2000, 100).

Older men attributed this difference to the availability of phosphodiesterase type 5 inhibitor drugs such as, Viagra™, Cialis™, Levitra™, which made their sexual lives more visible, legitimate and accepted by society (Loe 2004). Older women tended to observe how manifestations of female sexuality are closely monitored by society and thus, controlled by it. To prevent social exclusion, they adopted sexual attitudes and behaviours that complied with social expectations and avoided some situations to avert judgmental comments such as ‘nasty old woman’ (Baldissera, Bueno and Hoga 2012, 965; Nyanzi 2011). Yet, other women saw expectations of diminished sexual interest with age as a welcome relief and as a legitimate means of escaping this ‘oppressive’ aspect of their lives (Rowntree 2014).

Despite these constraining messages, some did not view age as a factor that prevented them from enjoying satisfying sexual experiences (de Oliveira Silva et al. 2015). Older people noted that social norms inhibit younger adults’ sexual expression as well, as they are socialised to meet expectations that are sometimes very difficult (Menard et al. 2015). In a way, freedom from *these* expectations in later life allowed some older people to re-evaluate their understanding of sex and sexuality, to attempt new sexual techniques and to enjoy a better sex life than was experienced when they were younger (Menard et al. 2015). Yet, engaging in sexual activities or expressing sexuality still caused many to feel shame and guilt (Menard et al. 2015). These social norms perceived to demand secrecy between generations about sexual matters, made sex a very private matter (Nyanzi 2011) requiring modest behaviour (Yan et al. 2011). Hence, some older people turned to online communication (e.g. cybersex) to express their sexuality (Malta 2007). Other studies revealed that older people who wanted to establish new romantic relationships would try to adapt to social norms by acting younger and distancing themselves from the use of the term *old* (Bayler-Levaro 2011) or by finding a partner younger than themselves (Loe 2004). These actions facilitated greater social legitimacy for expressions of sexuality.

#### *Health, not age, is what truly affects sexuality*

Older people also emphasised how the ageing process affected their sexual lives. Maintaining a sex life was seen as an integral part of healthy and positive aging (Bayler-Levaro 2011; Gledhill and Schweitzer 2014; Loe 2004; Yan et al. 2011; Menard et al. 2015) and perceived as a symbol of vitality and longevity (Yan et al. 2011), but was dependent on physical health and well-being (Sandberg 2013; de Oliveira Silva et al. 2015). Older people

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described how remaining sexually active promoted psychological health (Ravanipour, Gharibi and Gharibi 2013). Higher levels of sexual desire were reported among women who were physically active, reported the fewest medical conditions and took little or no medication (Malta 2007).

Across studies, participants identified various health conditions, physical limitations, or illnesses that limited their ability or willingness to engage in sex (Bauer, Fetherstonhaugh et al. 2013; Roney and Kazer 2015). Poor physical health accounted for low levels of sexual activity, sexual intimacy and sexual desire (Roney and Kazer 2015; Yan et al. 2011). Declining physical functioning of a partner or concerns over their partner's medical condition constituted a primary reason to stop having sex (Roney and Kazer 2015; Drummond et al. 2013).

One study explored the intersecting realities of caregiving and gender, in which women's role as caregivers challenges their self-perceptions of being sexual or desirable (Drummond et al. 2013). Losing control over bodily functions, such as the incontinence that can be associated with prostate surgery, can alter relationships and day-to-day functioning (Loe 2004). Among women, declining oestrogen levels can result in lower levels of sexual desire, vaginal dryness and atrophy, and painful intercourse (Fournier 2000; Ravanipour, Gharibi et al. 2013). Among men, prostatic hypertrophy, peripheral vascular disease or medication for blood pressure can also contribute to erectile dysfunction (Fournier 2000).

Many of the sexual issues and physical changes associated with age and/or deteriorating health are treatable and older people wanted their own or partner's physicians to enquire about or discuss their sexual needs with them (Roney and Kazer 2015; Drummond et al. 2013). However, healthcare providers were shown to have stereotypical views of older people as asexual (Bauer, McAuliffe et al. 2013), which limited their ability to respond appropriately to older people's sexual needs and realities (Drummond et al. 2013). Older people reported that this lack of discussion about health-related sexual issues negatively affected their ability to have a satisfying sex life, to cope with changes in sexual function and identity, and their expectations for a diminished sexual life (Bauer, McAuliffe et al. 2013; Drummond et al. 2013).

Across studies, this emergent theme captured how despite being highly correlated with health, the bio-medicalisation of sex can be a disappointing experience for older people using sexual enhancement medicine. This was particularly true when changes in sexual function as a result of medical conditions or aging were conceptualised via biomedical terms and related to hormones or pathology (Gledhill and Schweitzer 2014). Many study participants were familiar with medications for sexual dysfunction and enhancing performance (Fournier 2000), but these often created anxiety as they were perceived as interfering with health as if by 'putting up a brand-new flagpole on a condemned building' (Fournier 2000, 898). Whether or not older people chose to use pharmaceuticals, they were frequently offered (in various forms of pills, pumps and injections) instead of other interventions (Fournier 2000; Gledhill and Schweitzer 2014).

### *Hegemony of penetrative sex*

The third theme, the hegemony of penetrative sex describes the narrowed definition for sexual activity: sex means intercourse; intercourse means vaginal penetration; and vaginal penetration requires penile erection (Malta 2007). This ideology accompanied by continued

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sexual desire, but the loss of sexual function was found to give rise to feelings of distress, disappointment, frustration, shock and fear of failure, which could lead to despair, devastation and a sense of hopelessness (Loe 2004). Erectile dysfunction strikes deep into the *heart of masculinity* (Gledhill and Schweitzer 2014, 899), making men feel they have lost their vitality (Fournier 2000). Older people were challenged by the heterosexual norms rooted in Western cultural expectations and the media, which emphasise and focus on penetrative sex (Loe 2004). Older men able to sustain an erection are promoted to 'hero' status (Gledhill and Schweitzer 2014, 900) as they have preserved a 'normal' sexual life (Menard et al. 2015).

There was very little reference to masturbation as a means of pleasure. Most participants in the studies spoke of the significance of romantic relationships, which included penetrative intercourse as normative, definitive, important and desirable (Malta 2007). Older women also expressed intercourse is the "gold-standard" within sexual activity (Loe 2004). Those seeking new partners lamented the short supply of healthy men who could perform adequately (Loe 2004). One study documented the impact of physical limitations in new relationships that led to disappointment and sorrow when sex was attempted (Gledhill and Schweitzer 2014). Men unable to achieve an erection were considered suitable as friends but not romantic partners. Some women expected everything in their sexual partner to work and wanted to be satisfied with penetration rather than by other forms of sexual pleasuring, such as oral sex (Loe 2004). For men, penetration was an essential aspect of manhood (de Oliveira Silva et al. 2015; Loe 2004). Other forms of physical contact such as kissing, hugging and caressing were not considered 'sexual', but romantic or expressions of love (Yan et al. 2011).

However, discourse about drugs for treating erectile dysfunction which help men gain and maintain an erection sufficient for penetrative sex when sexual stimulation occurs, also emerged as a significant issue in several studies where older people discussed their sexual practices (Gledhill and Schweitzer 2014; Yan et al. 2011; Loe 2004). For women, the availability of PDE5i medications was seen as an opportunity to open new conversations about their feelings or about wanting sex (Loe 2004). Women found themselves having to balance their partner's needs for sexual potency against the health risks and negotiation involved (Loe 2004). Possible side effects associated with PDE5i, such as heart complications and sudden death, presented a narrative of mortal danger alongside a miracle (Loe 2004).

Drugs for treating erectile dysfunction were not always welcomed by women. Loe's participants (2004) were petrified of having their sexual lives reactivated by the availability of drugs for treating erectile dysfunction. This PDE5i-driven threat of heterosexual penetrative sex constituted an invasion of an emotional safe space after some women decided they no longer needed or wanted sex, and one woman spoke of having '*paid my dues*' (Loe 2004, 314). Wonder drugs that turned men into sexual beings and left *wives worn out* (p. 315) reinforced the emphasis given to penetrative sex and ejaculation as essential to fulfilling male physical drives. This discourse reinforced rigid definitions of what sex is or is expected to be (Yan et al. 2011).

The voices of older adults described their sexuality in two ways. While penetration remained the gold-standard, alternative ways of viewing sex and sexuality emphasised relationships beyond genital functionality and penetration (Loe 2004). Some men and women spoke openly about achieving sexual satisfaction through the alternate sexual skills



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they had learned without the need for erections and penetration (Sandberg 2013). By including physical contact, such as hugging, kissing, cuddling and holding hands in the equation, many older people experienced a satisfactory sense of sexuality and men were able to successfully reconstruct their sexual identity despite erectile dysfunction (Brandenburg, Attermeyer et al. 2000; Sandberg 2013).

## Discussion

This review aimed to capture older people's attitudes and feelings about sex and sexuality in later life and to synthesise themes from which we might learn from and reflect upon our current understanding and knowledge, as well as identify additional research objectives. The scope of the studies reviewed allowed us to consider the wider influence of factors, such as the Internet, gender norms and availability of drugs for treating erectile dysfunction on older people's own perspectives.

While older people experience sexuality from a broader and richer point of view, its social expression can be delegitimised. Myths and stereotypes that deny their unique sense of sexual well-being and the right to express it (McAuliffe, Bauer and Nay 2007; Kirkman, Dickson-Swift and Fox 2015) are compounded in ageism, irrational fears, stereotypical thinking and lack of knowledge. Resultant attitudes and behaviours constitute significant barriers to older people's sexual expression, enjoying sexuality and achieving a sense of self (Snyder and Zweig 2010), which is reinforced by the bio-medicalisation of sexuality and the dominant role of pharmaceuticals in sexual discourse (Wentzell 2013; Marshall 2012; Marshall 2006).

Older people need to re-evaluate and redefine sexuality to liberate themselves from the sexual norms set by society and the media, and to achieve a broader perspective of sexuality and to enjoy a variety of sexual activities. The challenges of ageing can enable older people to explore and experiment with their sexuality. Cognitive and psychological changes can result in a greater sense of entitlement for pleasure, various sorts of reappraisals, loosened inhibitions, and a better understanding of both one's self and others (Yun, Kim and Chung 2014). Sex in later life was described by some as '*greater*' (Menard et al. 2015, 84), perhaps due to the growing knowledge of one's own body, the ability to derive pleasure from it (alone or partnered), feeling more comfortable with partners, with changing sexual practices and with less attention to fertility (Loe 2004; Yun, Kim and Chung 2014). Relationship quality may mediate the experience of the ageing body, as a recent study found that while older women were frequently unhappy with their appearance, this was less important to them in relationships (Thorpe et al. 2015).

This review captured the idea that sexuality in later life consists of more than penetrative sex, although sex remains a popular discourse linked to the bio-medical view of sexuality in old age. Disability, illness, sexual dysfunction or simply life experiences facilitate an appreciation for other aspects of sexuality, such as coexistence, affection and companionship. Across studies, older people specified that sexuality in later years produced richer and deeper feelings than those experienced earlier in life and reported more pleasure from varied aspects of sexuality such as cuddling, foreplay, masturbation, and so on. A recent study has confirmed these changes (Fileborn, Hinchliff et al. 2017). When answering

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the question “What is sex?” older men were found to hold broader definitions and, rejected discourses which described penetrative intercourse as “real” sex.

Our findings also reveal the importance of giving attention to health and physical impairments when discussing sexuality. Sexual dysfunction is more prevalent in the presence of comorbidities and increasing age (Corona et al. 2010). For example, in a sample of 12,815 men over 50 years-of-age, the presence and severity of lower urinary tract symptoms was found to be an independent risk factor for sexual dysfunction (Rosen et al. 2003). However, many of the studies reviewed addressed specific populations of older people with various medical conditions, such as prostate cancer, dementia, diabetes, cancer, cardiovascular problems, chronic obstructive pulmonary disease, multiple sclerosis, epilepsy, HIV and iatrogenic disorders among others (Gledhill and Schweitzer 2014; Bauer, Fetherstonhaugh et al. 2013; Bayler-Levaro 2011; Menard et al. 2015). Descriptive themes therefore focused on sexuality in the light of deteriorating health. They also suggested that researchers often equate problems related to sexuality with more general health status issues among older individuals.

Taken together, the three themes outlined here illustrate the complex and delicate relationship between aging and sexuality. As older people encounter health issues that affect their sexual function, many adopt a wider definition of sexual activity. Social constraints and the delegitimation of their sexuality affects their sense of autonomy and wellbeing and narrows their indicators of how successful they are in remaining sexual and/or expressing their sexuality.

Overall, this review provided rich insights from older people on their own sexuality by drawing upon a range of studies. Thematic synthesis enabled us to paint a richer, more complex picture of the manner in which older men and women are “forging their own pathways to intimacy” (Marshall 2012, 341); “elicit[ing] the emotional side of this important issue” (Doll 2013, 36), and making space for the views and concerns of a population that otherwise, might not be heard.

### ***Limitations***

Like all reviews this one is not without its limitations. We elicited studies with a focus on heterosexual and heteronormative populations. The search terms did not explicitly facilitate the inclusion of Lesbian, Gay, Bisexual, Transgender, Queer or Questioning, and Intersex (LGBTQI) literature. There may be a dearth of research on sexuality focused on the views of the aging LGBTQI population given that its focus may be on concepts of discrimination and cultural issues in this community rather than on sex itself. This would provide an interesting platform for further research.

The papers reviewed suggest a distinct lack of direct consultation with older adults living in long-term care facilities and assisted living settings. Only one study (Bauer, Fetherstonhaugh, et al. 2013) was conducted in a care facility, which constitutes another gap in our knowledge base. This is important for debates about how permissive or encouraging care facilities should be regarding older people’s sexuality (see Hafford-Letchfield 2008; Simpson et al. 2017).

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Finally, the literature search was conducted in 2015 and did not include potentially important qualitative papers published afterward; as is often the case in systematic reviews, where at some point the search has to be concluded. As with every systematic review, it is possible that we missed relevant articles that would have met our inclusion criteria. It was certainly not possible to fully present the richness of the research findings within the limitations of this paper.

### ***Implications***

The findings of this review have much to offer administrators, clinicians, family caregivers and care professionals to enable deeper understanding and more considerate and person-centred responses to combat ageism. Review findings suggest that later life sexuality should be addressed within social policy, sex education and aging policies (Gledhill and Schweitzer 2014). Sexuality needs to be made more integral to healthcare assessment and provision by giving attention to older people's wishes to maintain a healthy sexual life as one of their human rights. Sexuality should be viewed and treated from a broad perspective, addressing its biological, psychological and social aspects, as well as the diverse sexualities of older people. Those living in long-term care facilities are likely to be influenced at least in part by wider social attitudes, as well as by the context of the long-term care environment. It is important to ensure that the residents' rights to intimacy and to express their sexuality are not neglected (Frankowski and Clark 2009).

In moving forwards, it is important for carers, health professionals, family members and others to familiarise themselves with the sexual health issues encountered by older people, to examine their own values with respect to this otherwise 'taboo' topic, and to ensure they are open to consultation and discussion when appropriate. Older people deserve sensitive, trained support to avoid concealing sexual problems and to ensure that deep-rooted cultural and gender issues are accepted and addressed (Yan et al. 2011). Positive responses from healthcare providers can facilitate improved access to sexual healthcare (Fileborn, Lyons et al. 2017). There is a need for more positive perceptions of older adults' sexuality in our culture, recognising the diversity of late-life sexualities and legitimising other avenues in which older adults can or may express their sexuality. Care providers should be aware of the limitations of their personal definitions of sexuality the danger of a *one-size-fits-all* approach to any form of response (Marshall 2012; Southard and Keller 2008).

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**Table 1: Papers included in thematic synthesis after systematic review**

<b>Study</b>	<b>Study location</b>	<b>Target population</b>	<b>Samples' ages</b>	<b>Sample size and gender</b>	<b>Data collection method</b>
Baldissera, Bueno and Hoga (2012)	Brazil	Older women in a community group session on health education	62-73	20 F	Face-to-face in-depth interviews
Bauer, Fetherstonhaugh et al. (2013)	Australia	Older people living in care facilities	79-101	9 M 7 F	Semi-structured interviews
Bayler-Levaro (2011)	USA	Older people	70-92	13 M 11 F	Semi-structured interviews
Brandenburg, Attermeyer and Saß (2000)	Germany	Older women in the community	60-89	52 F	Individual interviews
de Oliveira Silva et al. (2015)	Brazil	Attending a community resource centre	60-79	7 F 3 M	Semi-structured interviews
Drummond et al. (2013)	Canada	Community residing women caring for an ill spouse in the home	60-80	6 F	Individual semi-structured /open-ended interviews
Ebberfeld (1990)	Germany	Case study with one woman	78	1 F	Case study, narrative

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Fournier (2000)	USA	Men and women living independently	60-82	18 M 22 F	In-depth interviews
Gledhill and Schweitzer (2014)	Australia	Men who had experienced erectile dysfunction and used pharmaceuticals for sexual enhancement and partners of men with ED	65-84	6 M 2 F	In-depth interviews
Loe (2004)	USA	Women in senior citizen organisations	67-86	8 F	In-depth telephone interviews
Malta (2007)	Australia	Older Adults	61-85	6 F 1 M	Semi-structured qualitative interviews conducted via synchronous computer-mediated-communication (private chat).
Menard et al. (2015)	Canada	Participants in partnered relationships at least 25 years	60-82	30 M & F	Semi-structured online interviews via private chat, and Semi-structured face-to-face interviews
Nyanzi (2011)	Uganda	Widows and widowers	62+	9 M 35 F	Individual interviews

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Ravanipour, Gharibi, and Gharibi (2013)	Iran	Healthy women living with their husbands	60+	15 F	Individual interviews
Roney and Kazer (2015)	USA	Older adults from a senior centre	62-95	2 M 6 F	Individual interviews
Sandberg (2013)	Sweden	White, heterosexual men	67-87	22 M	Qualitative in-depth interviews and 'body diaries'
Westenberger (1987)	Germany	Community dwelling older adults	65+	33 M 39 F	Individual interviews
Yan et al. (2011)	China	Older Chinese people of varying backgrounds	61-85	7 M 13 W	Individual interviews
Youn (2009)	Korea	Married, Korean women and men	65-79	12 W 12 M	Semi-structured, open-ended interviews
Yun, Kim and Chung (2014)	Korea	Widowed, elderly, city-dwelling women registered with a community senior centre	65-75	10 W	In-depth interviews

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**Table A: Descriptive and analytical themes**

Descriptive themes	Analytical themes
<p>A) <i>Complexities of sexuality and sexual desire in later life</i></p> <ul style="list-style-type: none"> <li>• Descriptions: combination of love, communication, self-gratification, body image, individuality, imagination, physical closeness</li> <li>• Influencing factors; sexual partnerships and quality of spousal relationships, psychological, cultural and physical health</li> <li>• Impact of life history: moral values and behaviours</li> <li>• Psychosocial narratives</li> <li>• Lifecourse experiences of sexual activity; a process;</li> </ul> <p>B) <i>Diversity of models of sexuality in later life</i></p> <ul style="list-style-type: none"> <li>• Wide spectrum of what is considered sexuality,</li> <li>• Post reproduction, post coitus</li> <li>• Variability across gender, age, regarding meaning of sexuality</li> <li>• Psychological (impact of feelings); ageism used as rationalisation or justification for one’s own sexual inactivity.</li> <li>• Impact of illness; physical limitations</li> <li>• Impact of cultural and religious influences and attitudes</li> <li>• Role of community emancipatory education</li> <li>• Use of narrative inquiry; social constructivist frameworks of ageing sexuality and gender in later life</li> </ul> <p>C) <i>The impact of socialisation on forming new sexual relationships.</i></p> <ul style="list-style-type: none"> <li>• Changes in sexuality impacting on autonomy</li> <li>• Gender roles and ambivalence</li> <li>• Views of children and presumption of asexuality, overprotectiveness; fear of outsiders; property rights; cringe factors</li> <li>• Embarrassment; privacy; when seeking new partner</li> <li>• Challenges of sex related communication online and stereotypes about internet use.</li> <li>• Self-censorship (prudish/ normal) behaving ‘modestly’</li> <li>• Impact of harmful messages about sex, age and body image</li> </ul>	<p>Theme 1: Social legitimacy for sexuality in later life</p>

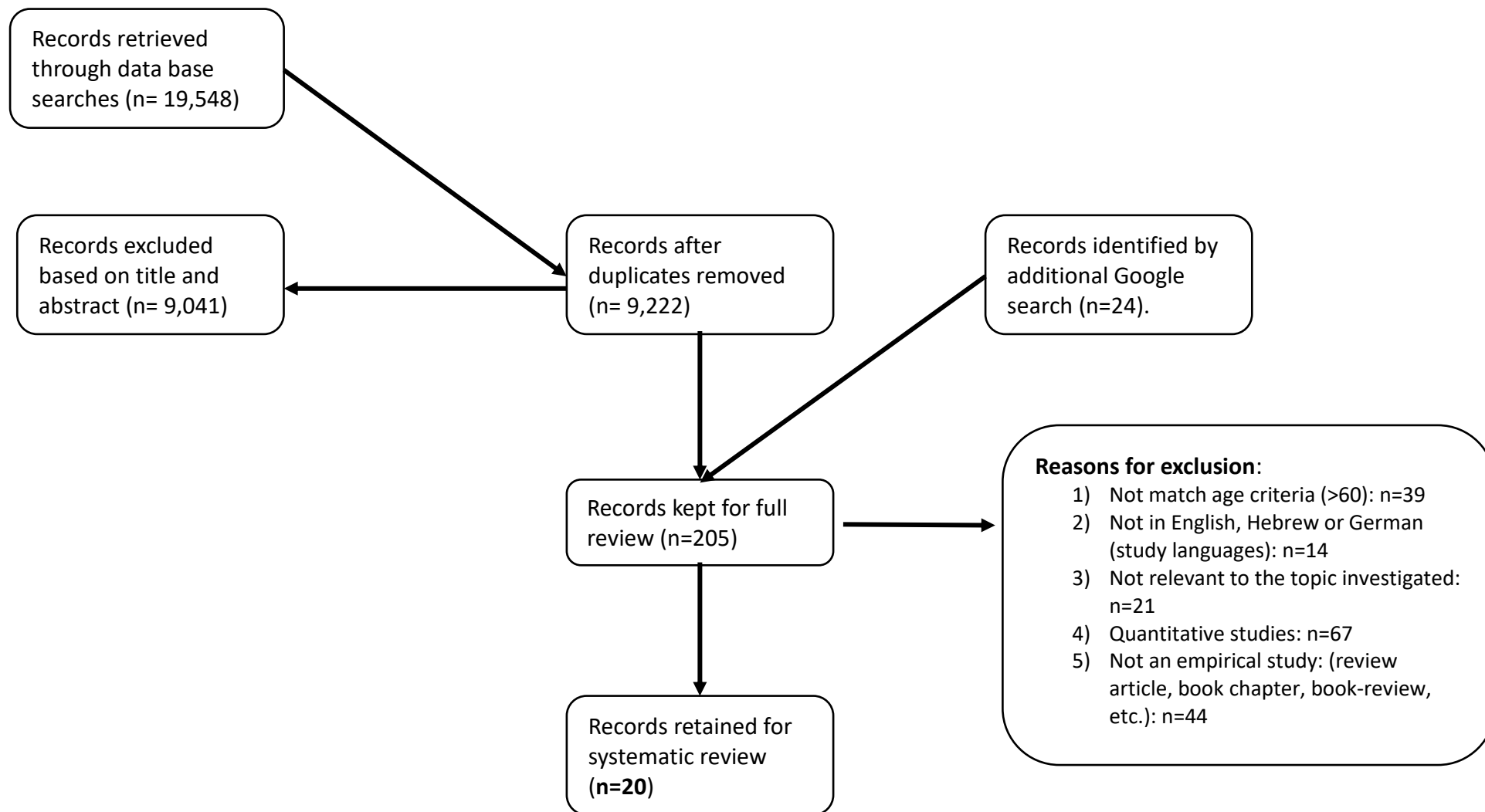
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<ul style="list-style-type: none"> <li>• Motivation for sexual relationships – loyalties to past partners; intimacies; gender differences</li> <li>• Performativity (in new relationships).</li> <li>• Reappraisal of sexual pleasure and rights, overcoming inhibitions and learning, tolerance and acceptance of others</li> </ul>	
<p>D) Physical manifestations</p> <ul style="list-style-type: none"> <li>• The realities of physical limitations on sexual intimacy and activities (desire and frequency)</li> <li>• Adapting sexual behaviour to changing needs and abilities/ compensation and substituting acts</li> <li>• Psychosexual needs of older men with erectile dysfunction (impact of prostate cancer/masculinity, potency, and control)</li> <li>• Psychosocial needs eclipsed by the need to survive/ sick role and associated dependence on physical and emotional issues on sex</li> <li>• Being sexual seen as relevant to health and well-being</li> <li>• Hazards of HIV associated with new partnerships in later life.</li> <li>• Physical benefits; Burns calories; masturbation</li> <li>• Loss of control over bodily function such as incontinence on relationships and day-to-day functioning</li> <li>• Mental skills for successful sex seen as important</li> </ul> <p>(E) Behavioural manifestations</p> <ul style="list-style-type: none"> <li>• Differences between those in long term married and ‘other’ relationships</li> <li>• Sexual satisfaction related to relationship satisfaction (arranged/happy marriages) including abuse</li> <li>• Women’s acceptance of friendship and companionship due to sexual dissatisfaction and men’s inability to perform</li> <li>• Women’s frustration by sexual impotency of men</li> <li>• Meaning of sexual desire and importance of relationship where erectile dysfunction implications for health educators</li> <li>• Implications for health educators where there are problems</li> </ul> <p>J) Narratives about intimacy</p> <ul style="list-style-type: none"> <li>• Role of time, feelings of comfort, security, seen equal to coitus</li> <li>• Notion of sexual activity being elongated</li> </ul>	<p>Theme 2: Health, not age, is what truly affects sexuality</p>

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<ul style="list-style-type: none"> <li>• Preferred use of language 'romantic' rather than 'intimate'</li> <li>• Optimal sexual experiences enhanced by common values, a good fit, growth, fluidity, maturing of the relationship and knowledge of a partners body/desires/feelings/erotic wishes and depth</li> </ul>	
<p>G) <i>Discourses on Viagra</i></p> <ul style="list-style-type: none"> <li>• wonder drug turning men into sexualised beings and invasion of safe spaces for women (6)</li> <li>- Availability opening new conversations for women</li> <li>• Promotion of sexualised youthful masculinity.</li> <li>• Balancing health risks with potency needs and negotiation involved</li> <li>• Shift in values about sexual roles and functions.</li> <li>• Shock and stress involved with erectile dysfunction</li> </ul> <p>H) <i>Dominance of heterosexual penetrative sex</i></p> <ul style="list-style-type: none"> <li>• Gendered dimension</li> <li>• Linked to procreation, masculinity, ejaculation and drive</li> <li>• Cultural differences</li> <li>• Impact on male mental health, supporting partners</li> <li>• Masturbation and shame</li> <li>• 'Fiery sex' replaced by intimacy</li> <li>• Male peer support/ group work/ often characterised by notions of vaginal-penile penetration</li> <li>• Dating activities – strong Viagra culture which could lead women to look for younger partners, language used to reinforce penetrative sex as expected</li> </ul>	<p>Theme 3: Hegemony of penetrative sex</p>

**Figure 1. PRISMA flowchart detailing primary study selection.**



**Fig. 1. PRISMA review flow**