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ORIGINAL ARTICLE

Sexual activity, satisfaction and quality of life in older adults

Atividade sexual, satisfação e qualidade de vida em pessoas idosas

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ABSTRACT

The objective of this study was to analyze the relationship between sexual satisfaction and demographic, social, and clinical variables as well as quality of life in older adults. This is a cross-sectional population-based study conducted as part of the Health, Well-Being, and Aging Study, in the city of São Paulo in 2010, with a sample of 1,129 older adults. Sexual satisfaction was measured by reporting sexual activity, satisfaction and quality of life using the SF-12 survey. Regarding sexual satisfaction, 45.1% reported being inactive and satisfied, 6.2% active and dissatisfied, 37.0% active and satisfied and 11.7% inactive and dissatisfied. The physical component of quality of life was associated with sexual satisfaction and the highest means of this component were found among the older adults who were active and satisfied. It was concluded that sexual practice is extremely important for quality of life in older adults, which reinforces the need to implement education and protection actions in relation to the vulnerability of sexuality in older adults.

Descriptors: Aging; Sexuality; Quality of Life.

RESUMO

Objetivou-se analisar a relação entre satisfação sexual e variáveis demográficas, sociais, clínicas e qualidade de vida em idosos. Estudo transversal de base populacional parte do Estudo Saúde, Bem-Estar e Envelhecimento, realizado no município de São Paulo em 2010, com uma amostra de 1.129 idosos. Avaliou-se a satisfação sexual pelo relato da atividade sexual e sua satisfação e a qualidade de vida pelo SF-12. Quanto à satisfação sexual, 45,1% afirmaram estar inativos satisfeitos, 6,2% ativos insatisfeitos, 37,0% ativos satisfeitos e 11,7% inativos insatisfeitos. O componente físico da qualidade de vida foi associado à satisfação sexual e as maiores médias deste componente foram encontradas entre os idosos ativos satisfeitos. Concluiu-se que a prática sexual é de extrema importância para a qualidade de vida do idoso, reforçando a necessidade de implantar ações de educação e proteção em relação à vulnerabilidade da sexualidade dos idosos.

Descritores: Envelhecimento; Sexualidade; Qualidade de Vida.

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INTRODUCTION

Despite the global growth of the older adult population, society still simplifies the aging process with negative stereotypes, including those related to sexuality, which is still a huge taboo in our culture and in the scope of health care[1-3]. In aging, sexuality varies as much as other behaviors and should be understood in a systemic manner as intrinsic to the whole individual, at any time in their life and considered unique to each person; moreover, sexuality is the fusion of symbolic and physical feelings, such as tenderness, respect, acceptance and pleasure and it is constructed progressively, thus not exclusively related to the genital apparatus[2,4].

The difficulties in accepting sexuality when aging can arise from the lack of adequate sex education, repressions suffered in the phase of discovery, shame of the body itself and by the notion that sexuality is restricted to genitality and procreation. These difficulties cause the individual to experience sexuality in an embarrassing way and to feel trapped in countless taboos, myths and prejudices that produce a pessimistic attitude[2,5-7].

Sexuality is present and can improve the quality of life of older adults[3]. Interpersonal relationships in older adults are fundamental for quality of life, and for them, at that stage of life, sex is not as important as the more satisfactory feelings resulting from companionship, complicity, and affection, which increase their satisfaction with life[3].

The lack of knowledge and devaluing of the real health and wellness needs of older adults[2-6] are linked to the lack of preparation of health professionals to deal with the sexual issues of this population, which are infantilized and/or underutilized, and to the fragile and scarce policies of care for the ignored active sex life of older adults and the impact sex has on their quality of life. Consequently, this paper aims to analyze the relationship between sexual satisfaction and demographic, social, clinical variables and quality of life in older adults.

METHOD

This is a cross-sectional household-based study conducted using the database of the Health, Wellness and Aging (SABE) study, in 2010. The SABE Study began in 2000 from a multicenter survey conducted in seven urban centers in Latin America and the Caribbean. In Brazil, it was conducted in São Paulo and, only in this city, since 2006, it became longitudinal and of multiple cohorts. In 2010, the older adults interviewed in 2006 were located and interviewed again, and a new cohort of individuals aged 60 and 64 years was added, totaling 1,345 older adults.

For this study, individuals who had incomplete answers to questions about sexuality and those who needed someone to answer the questionnaire were excluded. Of these older adults, 136 did not provide data or provided incomplete data on their sex lives and 80 had substitute or auxiliary respondents, since the presence of a third person could interfere in their responses. Thus, the final sample of the present study consisted of 1,129 older adults.

The dependent variable of this study was sexual satisfaction. Sexual satisfaction was considered as the reported practice of sexual activity according to level of satisfaction. Therefore, each older adult was classified as follows:

- active and satisfied;
- active and dissatisfied;
- inactive and satisfied;
- inactive and dissatisfied;

Sexual practice was evaluated for its frequency: two to three times a week, once a week, two to three times a month and once a month.

The analyzed independent variables were the following:

- Demographics: sex (female and male); age (60 to 69 years, 70 to 79 years, 80 or older; mean); race (white, mixed, black, East Asian, indigenous); religion (Catholic, Evangelical), other (Kardecist, Jewish and Buddhism), none;
- Socioeconomic: income (self-reported sufficiency); education (illiterate, one to three years of schooling, four to seven years of schooling, eight years and more of schooling); marital status (married, divorced, widowed, single); social engagement.

The variable "social engagement" was constructed according to the following activities:

- keeps in touch with others through letters, telephone or e-mail;
- visits family and friends; invites people to visit them at home;
- goes out with other people to public places;
- participates in organized activities.

The answers to the questions were 1 = always; 2 = often; 3 = occasionally; 4 = rarely; and 5 = never. Older adults who answered "1", "2" and "3" for at least one of the questions scored positively for social engagement.

- Clinical conditions: self-perceived health (very good or good; regular, bad or very bad); quality of life, reported chronic diseases (hypertension, diabetes, chronic lung disease, cardiovascular diseases, joint diseases, osteoporosis and sexually transmitted infection), multimorbidity (presence of two or more chronic diseases); polypharmacy (use of five or more medications), symptoms of depression (evaluated by the Geriatric Depression Scale, brief version with 15 items, whose cutoff point was higher than five

points) and medical consultation in the 12 months prior to the interview.

Quality of life was evaluated using the Short-Form Health Survey (SF-12), derived from the SF-36, a generic instrument for assessing health-related quality of life, which is easy to administer and understand. The SF-12 has 12 questions with scores that cover about 90% of the variance of the physical and mental components of the original instrument, and encompasses the dimensions of general health status, functional capacity, physical aspects, pain, vitality, mental health, emotional health and social life. The scores range from zero to 100 and higher scores represent a higher quality of life. The questions that assess physical function, physical condition, pain and general health have greater correlations with the physical component, while vitality, social function, and emotional and mental health are more correlated with the mental component.

The data were analyzed using Stata software version 14.0. To verify the association between categorical variables, a Chi-square test with Rao & Scott correction was used and the means were tested using the Wald test, with a significance level of 5%.

The SABE Study was submitted and approved by the Ethics and Research Committee of the Faculty of Public Health of the University of São Paulo, under opinion nº 23/10 for the year 2010. The research participants signed an informed consent form (ICF). The confidentiality of the information, anonymity and the right to withdraw from the study at any time was guaranteed.

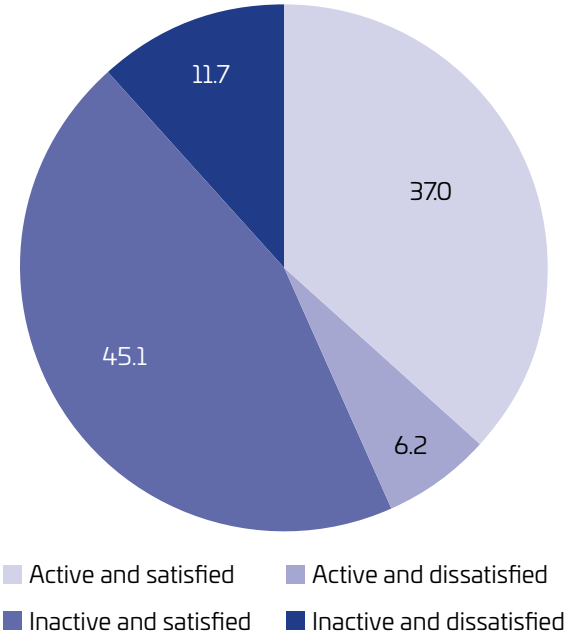
RESULTS

Most of the older adult participants were women (59.7%), aged between 60 and 69 years (57.5%), married (55.7%), with four to seven years of schooling (38.4%), sufficient income (57.2%), socially engaged (95.0%), self-declared white (59.8%) and Catholic (62.7%). Regarding health conditions, 50.4% of the older adults reported a very good and good perception of their health, 57.2% had multimorbidity with a prevalence of hypertension (66.6%), joint diseases (33.3%) and diabetes (24.9%). Furthermore, 51.4% used polypharmacy and 60.2% had been to three or more medical consultations.

Regarding sexual satisfaction, 45.1% of the older adults said they were inactive and satisfied, 6.2% reported they were active and dissatisfied, 37.0% reported being active and satisfied and 11.7% said they were inactive and dissatisfied (Graph 1).

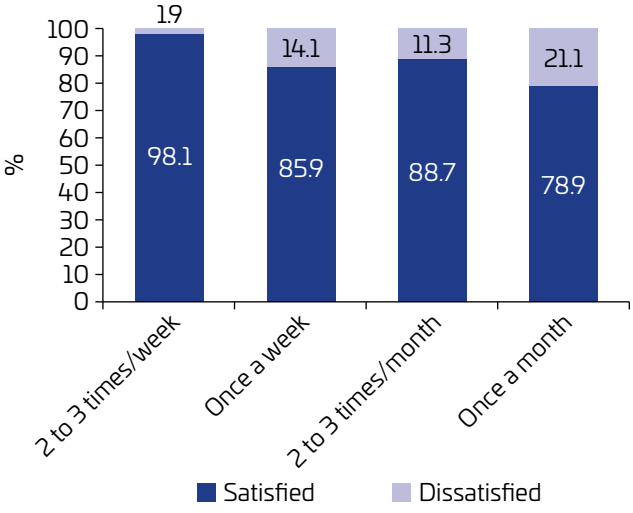
Regarding the frequency of sexual relations among the active older adults, 37.4% reported once a month, 27.5% reported once a week, 20.6% reported two to three times a month and 14.5% reported two to three times a week. Graph 2 shows a higher proportion of sexual dissatisfaction among those who reported having sexual relations once a month (21.1%).

The highest proportions of active and satisfied older adults were found among the men (58.5%), young old



Source: SABE Survey, 2010.

Graph 1. Distribution (%) of older adults according to sexual satisfaction (n=1,129). São Paulo, SP, 2010.



Source: SABE Study, 2010.

Graph 2. Distribution of the older adults with sexual relations according to frequency and satisfaction (n=410). São Paulo, SP, 2010.

adults (48.2%), without religion (55.9%), married (57.3%), with more years of schooling (47.8%) and socially engaged (32.8%), while most of the inactive dissatisfied older adults were women (64.5%), older old adults (78.3%), Catholic (46.0%), widowers (78.3%), illiterate (59.4%) and not socially engaged (63.1%) (Table 1).

An association was found between health status and sexual satisfaction, and the highest proportions of inactive and satisfied older adults were found in those who reported symptoms of depression (50.7%), stroke (60.0%), joint diseases (55.7%) osteoporosis (67.4%), multimorbidity (52.0%) and polypharmacy (53.4%). The older adults who

Table 1. Distribution of the older adults according to demographic and socioeconomic characteristics and sexual satisfaction (n=1,129). São Paulo, SP, 2010.

Variable	Satisfaction				p
	Active and satisfied (%)	Active and dissatisfied (%)	Inactive and satisfied (%)	Inactive and dissatisfied (%)	
Sex					
Men	58.5	11.0	16.4	14.1	<0.001
Women	22.5	2.9	64.6	10.0	
Age					
60 to 69	48.2	7.6	33.7	10.5	<0.001
70 to 79	27.1	5.4	54.1	13.4	
80 or older	7.6	1.0	78.3	13.1	
Race					
White	34.3	6.8	45.9	12.9	0.357
Mixed	39.7	6.4	43.4	10.5	
Black	40.7	2.2	47.9	9.1	
East Asian	56.0	2.2	40.0	1.8	
Indigenous	44.0	5.0	38.6	12.4	
Religion					
Catholic	37.2	5.8	47.0	10.0	0.041
Evangelical	32.5	4.7	45.5	17.3	
Other	40.7	10.7	39.7	8.9	
None	55.9	8.1	21.3	14.7	
Marital status					
Married	57.3	9.4	23.5	9.8	<0.001
Divorced	22.0	7.6	52.0	18.4	
Widowed	8.9	0.4	78.3	12.4	
Single	11.9	3.1	73.8	11.2	
Years of schooling					
Illiterate	23.7	4.3	59.4	12.6	<0.001
1 to 3 years	32.5	4.0	53.4	10.1	
4 to 7 years	34.9	4.5	46.9	13.7	
8 years or more	47.8	10.1	32.1	10.0	
Income sufficiency	39.5	5.3	44.7	10.9	0.206
Social engagement	38.5	5.7	44.4	11.4	<0.001
Total	37.0	6.2	45.1	11.7	

Source: SABE Study, 2010.

had an STI were the most representative among the active and dissatisfied (19.7%) and the inactive and dissatisfied (22.4%), although they were the most active and satisfied (35.4%) (Table 2).

An association was found between sexual satisfaction and quality of life for both the physical (p<0.001) and the mental (p<0.001) components. For both components, the sexually active and satisfied older adults had greater means for the quality of life score. In relation to the men, only the physical component was associated with sexual satisfaction (p<0.001). Among the women, both components were statistically associated with sexual satisfaction (Table 3).

Table 2. Distribution of the older adults according to sexual satisfaction (n=1,129). São Paulo, SP, 2010.

Variable	Sexual satisfaction				p
	Active and satisfied (%)	Active and dissatisfied (%)	Inactive and satisfied (%)	Inactive and dissatisfied (%)	
Symptoms of depression	18.1	9.9	50.7	21.3	<0.001
Diseases					
Hypertension	35.7	6.4	46.4	11.6	0.657
Diabetes	32.3	7.2	48.6	12.1	0.380
Cancer	31.1	2.1	49.5	17.4	0.135
COPD	27.5	9.4	47.8	15.2	0.132
Cardiovascular	32.7	6.8	46.0	14.5	0.296
Stroke	18.5	0.0	60.0	21.5	0.001
Joints	30.0	4.3	55.7	10.0	<0.001
Osteoporosis	20.8	1.9	67.4	9.9	<0.001
STI	35.4	19.7	22.5	22.4	<0.001
Multimorbidity	22.0	7.6	52.0	18.4	<0.001
Polypharmacy	32.5	4.0	53.4	10.1	0.007
Total	37.0	6.2	45.1	11.7	

COPD: chronic obstructive pulmonary disease; STI: sexually transmitted infections.
Source: SABE Study, 2010.

Table 3. Mean of quality of life of the older adults according to sexual satisfaction (n=1,129). São Paulo, SP, 2010.

Total	Mean	Standard Error	CI95%	
Physical component				
Active and satisfied	50.7	0.50	49.6 – 51.6	<0.001
Active and dissatisfied	47.7	1.49	44.7 – 50.6	
Inactive and satisfied	45.8	0.49	44.9 – 46.8	
Inactive and dissatisfied	46.6	0.78	45.0 – 48.0	
Mental component				
Active and satisfied	59.6	0.27	59.0 – 60.0	<0.001
Active and dissatisfied	56.8	1.03	54.7 – 58.9	
Inactive and satisfied	58.0	0.36	57.3 – 58.8	
Inactive and dissatisfied	57.0	0.82	55.5 – 58.8	

Continue...

Table 3. Continuation.

Total	Mean	Standard Error	CI95%	
Men				
Physical component				
Active and satisfied	51.5	0.56	50.0 – 52.7	<0.001
Active and dissatisfied	47.5	1.87	43.8 – 51.0	
Inactive and satisfied	47.0	1.10	45.0 – 49.6	
Inactive and dissatisfied	46.9	1.24	44.5 – 49.5	
Mental component				
Active and satisfied	59.9	0.27	59.0 – 60.0	0.125
Active and dissatisfied	57.5	1.21	55.0 – 60.0	
Inactive and satisfied	58.8	0.64	57.6 – 60.0	
Inactive and dissatisfied	58.6	1.05	56.5 – 60.6	
Women				
Physical component				
Active and satisfied	48.9	0.87	47.0 - 50.6	0.009
Active and dissatisfied	48.0	2.08	44.0 – 52.0	
Inactive and satisfied	45.5	0.51	44.5 – 46.5	
Inactive and dissatisfied	46.0	1.23	44.0 – 48.7	
Mental component				
Active and satisfied	59.0	0.60	58.0 – 60.0	0.044
Active and dissatisfied	55.0	2.02	51.0 – 59.0	
Inactive and satisfied	58.0	0.38	57.0 – 58.7	
Inactive and dissatisfied	55.7	1.17	53.4 – 58.0	

Source: SABE Study, 2010.

DISCUSSION

Almost half of the older adults reported being sexually active and more than 30% reported having sex once a month. A study conducted with older adults in England found that the prevalence of sexual activity (defined as sexual intercourse, masturbation, fondling or kisses) in the last year was higher in men (76.9%) than women (57.8%)[8].

Among the active older adults, it was also observed that the proportion of sexual dissatisfaction was higher in those who reported sexual activity once a month (21.1%). This relationship is explained by the fact that quality sex leads to the urge to have more sexual relations, which increases satisfaction, quality of life and sexual function and well-being, thus reactivating the cycle[9,10]. Nevertheless, the most satisfied were those who had sexual relations two to three times a week (98.1%), suggesting these older adults had a more intense adult sexual life and, therefore, remained sexually active older adults[3,11].

Women were the most prevalent in this sample, which reflects the feminization of the older adult population[4,8]. In relation to marital status, women after widowhood remained without a partner and tended not to remarry, while the opposite occurred among the men. This difference may justify the reason the studied women reported they were inactive and satisfied and the men reported they were active and satisfied. It is also the reflection of a sexist culture, in which women's sexuality is related to biological, procreative and family capacity, while for men, sexuality is associated with their social role as the family provider[12].

Most of the older adults who mentioned being married were more active and satisfied. Being married allows them to experience their sexuality and, consequently, interact with their spouse and strengthen affection, attachment, communication, companionship and mutual care[3,13]. Furthermore, satisfaction among married couples can be the result of prior knowledge of the partner's preferences, feelings

involved in the relationship and in the ease of having sexual relations when a person has a fixed partner[14].

Physiological changes, sociocultural aspects and health conditions are associated with sexuality; therefore, health workers to identify these factors during anamnesis and use educational activities to demystify the prejudice that permeates sexuality in old age[4].

Physiological changes and possible health complications evolve with advancing age, including the onset or worsening of sexual dysfunction, especially when associated with life-threatening habits. The factors that contribute to the acceleration of decreased libido, sexual capacity/frequency and general well-being suggest people believe they have passed the peak of their lives and consequently result in psychological, somatic and sexual disorders[1]. Given these conditions, the younger old adults in the present study were more active and satisfied than the older old adults.

A minority of older adults said they were dissatisfied with the absence of sexual practice. This may be a result of difficulties in accepting sexuality in one's own aging process, lack of adequate sex education, repressions suffered in the phase of discovery, shame of the body itself, as well as the notion that sexuality is restricted to genitality and procreation[2,5-7].

Regarding sociocultural factors, religion, schooling and social engagement were associated with sexual satisfaction in the present study. Most of the older Christian adults were inactive and satisfied, showing that Christian morals are still a strong factor in the life of the present generation of older adults[2]. Furthermore, this doctrine argues the sexual act should be associated with monogamous marriage, norms and morality, and, above all, the discourse of a single partner and sexual relations for procreation, thus linking sexuality with standardization and guilt and promoting a reduction of sexuality[15,16]. Consequently, the idea of sexual pleasure may seem repulsive to some individuals, especially women[6].

In contrast, the older adults who were atheists or devotees of Kardecism, Buddhism and Judaism were more active and experienced greater sexual satisfaction than the Christians. Judaism is more restrictive in terms of sexual activity during the menstrual period of the female spouse, although this barrier ends with menopause, a natural aging process of women. Kardecist sexual morality is based on the experience of love, affection and the existence of sexual energy and equal rights for men and women, thus characterized by values maintained and sometimes strengthened in the relationships between older adults. Buddhists, on the other hand, believe sexuality is a form of communication that goes beyond the physical relationship and has no restrictions regarding these experiences in old age[15].

Older adults who reported eight years or more of schooling had a higher prevalence of sexual activity and satisfaction since a better level of education is associated with higher quality of life scores, which include sex life, leading to better self-perception and experience of sexuality[17].

Socially engaged older adults were more active and satisfied than those who were not socially engaged. Social engagement, opportunities in the environment and personality are three of the factors associated with successful aging that influence relationships[18], as the other components of the group are a source of love, of security, and the feeling of belonging to a group, which makes the older adult feel loved and capable of triggering a range of feelings, including in sexuality[3].

The proportion of inactivity and sexual satisfaction was higher among the older adults who reported joint diseases, stroke and osteoporosis. According to Kazer[19], joint diseases affect sexual activity in a secondary manner because they chiefly create physical limitations and the movement restrictions associated with pain and joint dysfunction.

Approximately 60% of the older adults with STIs continued to be sexually active. Therefore, educational activities are needed to guide safe sexual practices and demystify prejudice related to STIs, mainly due to the increasing prevalence of these diseases resulting from the lack of knowledge and taboos regarding safe sex[9,20].

In a study conducted by Pereira et al.[13], individuals who had suffered vascular accidents also suffered from a decrease in erectile function and in the frequency of and desire to have sexual relations either due to sexual function limitations or physical and/or emotional problems. In addition, men are more sexually active and have less sexual decline than women. Sexual practice and satisfaction can also be influenced by osteoporosis since it can be caused by a deficiency of sex hormones despite the syndromic characteristic of the disease[21].

An integrative review indicated that the use of medicines for chronic diseases can primarily lead to disorders in sexual function because the side effects of the drugs are associated with aging and hinder the maintenance of a sexually active life[10].

Furthermore, the older adults with multiple chronic diseases were more inactive and dissatisfied than those who did not have multimorbidity. Studies argue that the sexuality of older adults can find unprecedented paths whereby desire, which does not die, finds other ways of expression, such as affection and tenderness[2,5-7,12]. Moreover, the literature has shown there are no physiological reasons that prevent older adults with satisfactory health from having an active sex life, especially considering the emotional and affective richness of such a practice[3,11].

For satisfactory sexual relations, physical and mental components are essential[3]. It was observed that the physical and mental components were associated with women since changes caused by aging, such as loss of lubrication and body alteration, as well as repression regarding their sexuality, are more intense. For men, an association was only found for the physical component because men tend to esteem their virility more highly.

Emphasis on the physical component can be justified by the present culture of valuing the young body, mainly due to the lack of adequate sexual education and the repressions suffered. This leads to sexuality being experienced with embarrassment, and the older adult frequently perceiving their body as unattractive and as being incompatible with the beauty standards stipulated by society[22].

Despite the culture of valuing the body, sexual activity can be satisfactory for older adults, since their bodies still function and can afford them pleasure[3,5,12]. In addition, quality of life is related to subjective well-being and self-esteem, and older adults should be guided regarding their bodies to better adapt and experience their sexuality[9].

However, the influence of a sexist culture is still evident when we observe that, for elderly men, only the physical component was associated with satisfactory sexual practice and quality of life. Similarly, according to a study, the sexuality of older men seemed permeated by a complex game in which intense sexual activity is stimulated/required and associated with an idea of "quality of life" while maintaining a game of moral orientations that restrict, control and standardize the practice of sex[23].

The mental component, although relevant only among women, is also important, as argued by authors who state that the presence of an emotional balance tends to improve the quality of sexuality, since a reduction in the frequency of sexual relations in older adults may be related to the onset of diseases caused by physical, psychological and social deterioration over the years[24].

One of the limitations of this study was the absence of variables to explain the justification of sexual satisfaction in older adults. Moreover, there was no control in the collection of data regarding the sex of the interviewers, that is, the interview was conducted by women, which may have influenced the answers provided by the elderly men for cultural reasons. One of the strong points of this study is the representativeness of the sample for the municipality of São Paulo.

CONCLUSION

This study showed that sexual practice is extremely important in the quality of life of older adults and that the physical component was more influential in a satisfactory practice than the mental component, which can help nursing professionals target their interventions. The changes caused by aging, due to disease, use of multiple medications, marital status and social engagement, as well as immutable factors such as sex, age and schooling, influence sexual practice and, consequently, sexual satisfaction.

Sexual education regarding physical and physiological aging and the culture that the older adult is an individual who is capable of sexual activity directly interfere with the sexuality of this population. Thus, nursing professionals should implement education and protection actions to emphasize the benefits and vulnerability of sexuality in older adults and, consequently, reinforce the health care network for this population.

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