

MORE ABOUT...KEEPING THE ELDERLY HEALTHY

LOVE IN LATER LIFE

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He was 80 years old.

I gave him Viagra.

He returned glowing.

'It's like putting up a new flag pole on a condemned building.....'

Today it has become commonplace for many individuals to far exceed the antique three score and ten years allotted to mankind. Modern medicine, improved nutrition and lifestyles have all contributed to create a growing population of energetic and enthusiastic senior citizens. The Pfizer Global Study on Attitudes to Sex in Later Life interviewed 27 000 individuals in 29 countries including South Africa. The ages ranged from 40 to 80 years. This study began in 2001 and ended early in 2003. A surprise finding was the universal interest in loving and a universal concern for possibly not satisfying one's partner in all the individuals questioned. When asked if loving was still pleasurable the global response among men was 52% saying yes it was, compared with 58% of South African men. More than half of the men questioned were still enjoying sex.

Over the age of 50, some 52% of men struggle to consistently maintain an erection adequate for full penetration. This is not an index of ageing, but rather the consequence of lifestyle, illness, operation or injuries, and the multitude of medications taken by the average individual. Age plays a secondary role. The responses of

both partners may be slower. The male may take longer to reach a full erection. His partner may take longer to lubricate. There is a slight shrinking of the clitoral hood in older women, exposing the clitoris for more stimulation and a tightening of the vagina which could provide more friction to the penis. Men may last longer and generally perform better than younger vigorous men. In a recent Japanese study young women were asked to state their preference for either a young Olympic sexual athlete with a great variation of positions and great orgasms, or an older male, gentle, slow, more loving and caring. The older man won....

Mary

Mary calls for help. She is 60 years old. She has spent her entire working life as a librarian. This has been an extension of her personal lifestyle where everything is always in the right place. She is neatly dressed, formal and controlled. I take my usual history. I ask about her marriage, her sexual life. She tells me she has lost all desire for loving.

If I am only looking for clues to complete a puzzle, this is a major piece. It fits in with a sleep disturbance, and an overwhelming sense of unworthiness. She has a deep morbid preoccupation. We have a diagnosis. Mary is in the throes of a depression. The enquiry might stop at this point. It so often does. We have made a viable diagnosis. From this point on many doctors have begun writing a prescription in their minds. And listening with one ear....

Having opened the door, it seems easy and logical to step in. I am listening. She slowly takes me beyond

her present loss of desire, to her entire married life. In the beginning sex was good. It was frequent and energetic. It easily took the place of any need for communication. It was their meeting place. It was their only meeting place. They had little to say to each other. Little to share. The children in time, provided them with a focus. Making love was the only intimacy. He was caring and affectionate only as an invitation for sex. For the rest they ran busy parallel lives. Marriage was a narrow river. They were flowing sedately down the centre. Lonely but together. When sex became less frequent, an invisible empty space appeared between them. She was suffering from malnutrition of her emotional life... Now at 60 she was more aware of this gap and her lifelong need. She was hungry for touch, for an intimate companionship, for a more meaningful sharing. Mary took me into the very core of her loss. She was also describing the marriages of almost every woman in my practice.

There are women who may have been happy with sex providing the only intimacy. The thought that there could be any other way of sharing never occurs to them. Like their husbands they too have never learned or needed to be affectionate and enjoy touch. After all, the need to feel and to always share feelings is a comparatively recent invention. In later life there is, for so many women, a subtle shift. A focus on companionship and closeness. This is the core of their loss.

Richard

Richard calls for help. He is 65 years old. He complains of an erectile problem. His entire working life has been desk-bound in the corporate world. He has been retired for 15 years. He

looks extremely fit. Both he and his wife enjoy an active social life. He says: 'I'm never sure if it will work. Sometimes it's great. Mostly it's catastrophic. Nothing, no matter what we do, it's just dead.'

Richard's life has been amazingly predictable and stable. Happiness is knowing what tomorrow will bring and knowing that there are no unforeseen problems. Loving was an enjoyable routine, totally predictable and uneventfully satisfying. Retirement was a major blow. The routine was shaken. He felt too young at 50 to stop working. All the wisdom and the mythology of his working life was there — safe in his head. The bewildering realisation that this was of no consequence shook his confidence badly. A change of status. And the discomfort of the breakdown of years of routine and predictability. Failing to achieve an erection is a confirmation of his inability to control this new hopelessly erratic life. A downsizing of his masculinity.

Helen and Harry

Helen enters my consulting room. She is 65 years old. A large strong, woman. She has worked hard all her life. She has an open honest face, she sits squarely in the chair and confronts me. Many years ago she and her husband Harry involved themselves in a massage programme. It was a great adventure for them. They incorporated this massage into their loving and into their lives. For the past few years she has developed arthritis and is unable to reciprocate her husband's caring massage. This is a great distress for her. I wonder why she brings this up so early in the interview. I cannot believe it's the reason she is calling for help. Was she actually seeking help to find a way of massaging her husband? Or was this the opening gambit to test and check out my listening capacity. So much happens in the first interview. The patients are examining us as closely as we examine them...she could have started her story determined to explore a desperate sexual problem, became sidetracked by a fear of embarrassing me

or herself and settled for a treatment plan for the arthritis in her fingers....I listen more intently than ever. I say to her with my entire body: 'Yes that's interesting but there is much more...'

There is also pain as they attempt to make love. Arthritic changes in her hip joints restrict the opening of her legs. She is avoiding loving because of the pain and the embarrassment.

Harry joined us in the next meeting. We discussed the problems of finding a comfortable position for penetration. Any position with him on top necessitates the opening of her legs with excruciating pain. Her knees were too painful for her to adopt any position that required her to sit astride him. We discussed the possibility of vaginal penetration from behind. She should lie on her side with her back to him, then place her upper leg forward. He then penetrates with her lower leg between his legs. They are both lying on their sides facing the same direction. This position is called the Cuissade posture. Since immobility is usually worse on waking, we discussed the possibility of making love in the evening after a warm bath and after a massage.

Pain generally must always be addressed. In the young the act of loving can blanket pain or discomfort. In the elderly, pain may make it impossible to contemplate loving.

A major difficulty in loving in later life is patients' lifelong attitude to sex, their expectations and the expectations of their cultural group.

Cultural beliefs

Heather and her husband Charles called for help. Charles is 76 years old. Heather is a young woman of 65. He has struggled with erections since a prostatectomy for benign hyperplasia. Heather feels it's unnecessary to call for help.

They sat before me stiffly formal, immaculate and painfully polite. She was not wearing white gloves, but she might have... 'Dear doctor, I think it's unseem-

ly for people of our age to indulge in sex. Surely that time has passed?'

This was her attitude and a reflection of her cultural beliefs. This is very powerful. Young men and women in their 20s cannot believe that sex exists at all beyond 50. Sex is only for the young. Few individuals can imagine their parents making love. How could they have wanted to.... These attitudes dominate so many lives. This is reinforced by a culture that relentlessly diminishes the status and worth of the older citizens. These beliefs surface at so many levels. So many men believe that the removal of the prostate heralds the end of sex. Women frequently believe the removal of the uterus will do the same. The belief itself is the problem.

An irate man phones me late one evening. His elderly father is having an affair with a woman in the home for the aged. Would I speak to the superintendent and stop it. 'Why,' I asked 'Surely it could harm him?!' 'Well I guess getting out of a warm bed and shuffling back to one's room could harm anyone. Can I arrange for them to be in one room?' I cannot express his rage at my naiveté.

Conclusion

For anyone, loving creates a powerful sense of worth and self-esteem from the wellbeing that always follows being loved and needed. I have encountered many elderly couples who for one reason or another are completely unable to have adequate penetrative sex. However there still is the joy of loving, the touch, the holding, the warm companionship and the intimate sharing. This is the magic of loving.

The cultural binds often make calling for help difficult. The real problem may in fact be the medical consultant and of course the family. They all conspire to reinforce the cultural beliefs. Doctors don't ask about sex. It could be too embarrassing. It might offend the patient. Yet how often such a

question could be gratefully received and how willing they may be to share their fears and bewilderment. In our black cultures where age confers an increase in status, it's far easier to call for help.

Again the concern is attitudes. These must be respected. We have to treat our patients in the confines of their own religious and cultural beliefs. Patients may benefit from the permission they experience when discovering that loving is normal and possible at any age. It may be important to understand their need to blame age for their loss of desire. It is certainly important to understand the social pressures that exist in their lives.

Every human being has a right to love and to be loved throughout their entire life. This is a special time for maturity and wisdom. A time of deep fulfilment and satisfaction. It's not for the faint at heart.

SLEEP PROBLEMS IN THE ELDERLY

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One of the commonly ignored problems in the elderly patient is that of sleep disorders. On the one hand, the patient often feels that this is not an 'important' problem and is embarrassed about taking up the doctor's time to discuss it. On the other hand, the doctor is often not completely aware of the circumstances and situations which may give rise to such problems.

A very common problem is that of bad sleep habits. The patient is frequently put to bed very early — in some residences for the elderly as early as 18h00, and then only helped out of bed at 07h00 or 08h00. This would imply a sleep need of 13 hours, which is obviously not physiological and results in the patient being awake for

a large part of the night. Elderly patients may need less sleep than when they were younger, and confining them to bed is unnecessary and even cruel in some circumstances.

Unfortunately, the response to reports of 'poor sleep' is often to give the patient a sedative which, in the elderly, may result in confusion the next day and in rapid habituation. There is a long list of problems resulting in sleep disorders in the elderly, which is summarised below.

- **Dementia.** The dementing patient frequently demonstrates 'sundowning'. Towards the end of the day he/she becomes more confused, which is thought to be related to diurnal changes in the body. These patients are frequently excessively sleepy during the day and awake at night, wandering through the house (day/night reversal). Sunlight exposure during the day, rigid daily schedules and appropriate sedation at night are usually beneficial.
- **Cerebral degenerative disorders.** Sleep problems, especially insomnia but also hypersomnolence, as well as sleep-wake cycle problems, are frequently associated with degenerative disorders such as Huntington's disease, Olivopontocerebellar degeneration and progressive supranuclear palsy.
- **Pre-existing sleep disorders.** These may or may not have been appropriately addressed. Many of these are life-long conditions and require management into old age. Conditions such as obstructive sleep apnoea are common and do not disappear spontaneously. Periodic limb movement disorder may also appear for the first time at a later age, sometimes in association with a mild peripheral neuropathy. This may present as either a complaint of insomnia or excessive daytime sleepiness.
- Parkinson's disease is notorious for associated sleep problems. These are difficult to manage, and frequently require small nocturnal doses of L-DOPA or one of the newer DOPA agonists.
- **Medication.** Older patients are often on a number of different medications, many of which can affect sleep, especially when used in combination. The treating doctor must

be alert to this possibility and try to minimise polypharmacy. Adverse effects of one drug should not be treated by adding a second drug.

- **Alcohol.** In the same vein, it is important to realise that older people may have an alcohol problem, possibly carried over from younger days, also potentially the cause of sleep problems. Equally, a perceived insomnia may exacerbate alcohol use, which the patient may use to relieve boredom or even to try to fall asleep.
- **Anxiety and depression.** Both are common in the elderly, and frequent causes of insomnia. Counselling or even the judicious use of antidepressant or anxiolytic medication may be necessary.
- **Cardiac and lung disorders.** Especially those that cause a decrease in blood oxygen saturation overnight may lead to sleep problems. This may cause a severely disturbed sleep pattern with daytime hypersomnolence and increasing confusion.
- **Gastrointestinal and renal disorders.** These may also at times be associated with sleep disturbances.
- **Pain.** Any pain syndrome will adversely affect the quality of sleep. It may also require pain control, which may cause confusion. The patient may not complain about the nocturnal pain — the elderly frequently regard pain as an unavoidable consequence of age, and may not ask for help. The treating doctor needs to be proactive in the management of a nocturnal pain problem.

In summary, sleep disorders are important contributors to a general reduction in the quality of life of the elderly. These disorders are generally not very difficult to manage or to ameliorate, but are often overlooked by both the patient and the treating doctor.

Further reading

Kryger MH, Roth T, Dement WC. *Principles and Practice of Sleep Medicine*. Philadelphia: WB Saunders, 2000.
www.Medlink.com