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Older Adults' Experiences of Sexual Difficulties: Qualitative Findings From the English Longitudinal Study on Ageing (ELSA)

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There is a growing body of evidence demonstrating that sexual activity is important to the quality of life of older adults, and that it can be influenced by physical, psychological, and social factors. However, older adults' experiences of sexual difficulties remain relatively unexplored. This article draws on qualitative data collected as part of the English Longitudinal Study of Ageing (ELSA). Participants answered a Sexual Relationships and Activities Questionnaire (SRA-Q), which included an open comment box for further details, 1,084 (1/7) of which were completed. These data were analyzed using Template Analysis, and findings on the experiences of sexual difficulties are presented in this article. Sexual difficulties were contextualized within the couple relationship and could be detrimental to the relationship, particularly if the partner would not seek professional help. Participants reported that sexual difficulties could also have a negative impact on psychological well-being, described mainly as frustration, depression, and sadness. For some participants the supportive nature of their relationship buffered these impacts. Few had sought professional help; those who had reported helpful and unhelpful experiences. These findings add to the limited evidence base and have implications for health care in the context of global aging and a growing recognition of older adults' sexual rights.

Introduction

Over the past 20 years there has been a shift in many developed countries in the way that the sexual lives of older adults are viewed. Previously positioned as asexual, the sexual health and well-being needs of older people have tended to be ignored or met with disdain. In 2010, the World Health Organization emphasized that sexual health was important across the life course, thus legitimizing the sexual activity of older adults. Around the same time, other governing bodies began to include older adults in their guidance and health policy documents, whereas before they did not,

and some governments actively promoted sexual activity as part of an aging well agenda (Hinchliff & Gott, 2016; Marshall, 2010). The research evidence base began to grow as large-scale studies, many of which had previously not included older adults (e.g., National Survey of Sexual Attitudes and Lifestyles [Natsal]) recruited people aged 60 and older to answer their questions. However, in-depth (qualitative) research on the sexual well-being of older adults has remained limited. In this article we address that gap by presenting an analysis of qualitative data on sexual difficulties collected during Wave 6 (2012–2013) of the English Longitudinal Study of Ageing (ELSA).

Sexual Practices of Older Adults

There is consistent evidence that many older adults are sexually active and that they find sex both pleasurable and rewarding (Ferris et al., 2008; Fileborn et al., 2015; Lee, Nazroo, O'Connor, Blake, & Pendleton, 2016; Lee, Vanhoutte, Nazroo, & Pendleton, 2016; Waite, Laumann, Das, & Schumm, 2009). However, studies also report that older adults engage in sexual activity less frequently when

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compared to younger cohorts. For example, the recent Natsal-3 found lower levels of sexual “function” (a combination of “sexual response, sexual function in the relationship context and self-appraisal of sex life,” p. 382) for sexually active women and men in the older age groups compared to younger cohorts (sexually active participants were those who reported having at least one same-sex or different-sex sexual partner in the past year) (Mitchell et al., 2013). The Natsal-3 survey also found that the lowest reported frequencies of recent sexual activities (vaginal, oral, anal, other genital contact) with members of a different sex were in the oldest age group (age 65–74) (Mercer et al., 2013).

Behaviors that older adults consider as sexual activity are often broader than those of younger people (Bouman, 2013; Hinchliff & Gott, 2004a; Waite et al., 2009), encompassing physical intimacy more than traditional modes of sexual activity like penetrative sexual intercourse. Sexual activity and physical intimacy within couple relationships have been found to play a part in quality of later life (Hinchliff & Gott, 2004a; Tetley, Lee, Nazroo, & Hinchliff, 2016). The first study in the United Kingdom to explore heterosexual older adults’ attitudes toward the role and value of sex in later life found that it was important to all who had a sexual partner, many of whom rated it as very or extremely important (Gott & Hinchliff, 2003). The findings of the nationally representative Australian Longitudinal Study of Health and Relationships echo these results, with high numbers of heterosexual women and men agreeing that an active sex life was important to their sense of well-being (78% women; 91% men) and that they found their sexual relationship “very” emotionally satisfying (72% women; 86% men) (Ferris et al., 2008, p. 337). Quantitative findings from ELSA Wave 6 also show a connection between sexual well-being and sexual activity or sexual problems. Overall, they demonstrate that participants who reported higher sexual desire, more frequent partnered sexual activities, and fewer functional problems scored more favorably on sexual well-being measures (Lee, Vanhoutte et al., 2016). Interestingly, there is evidence of historical and cultural influence here, as the longitudinal study by Beckman, Waern, Gustafson, and Skoog (2008) of heterosexual 70-year-olds, carried out at four different time periods (1971–1972, 1976–1977, 1992–1993, 2000–2001), found an increase from the first cohort to the last cohort in the number of participants who believed that sex was a positive factor in their lives. This trend was consistent for those who were cohabiting, married, and unmarried (Beckman et al., 2008).

Positive benefits such as these tend to be emphasized in health materials and campaigns when sexual activity is promoted as beneficial to aging health. Indeed, there has been a shift in some areas of public health where sex in later life is viewed as a marker of successful aging (Marshall, 2010), which coincides with a more general (Western) societal shift from viewing older adults as

asexual to sexually agentic. However, not all older adults are sexually active, or want to be, and reasons include the availability of a sexual partner, physical and mental health difficulties, side-effects of the medications (e.g., those used in the management of long-term conditions), relationship issues, living environment (e.g., lack of privacy), and the presence of sexual difficulties.

Sexual Difficulties

General changes to sexual function with older age include erection problems, such as the inability to achieve an erection and a slower response time (Schlesinger, 1995). Women may find that it takes them longer to become aroused and they may experience less intense orgasms (Schlesinger, 1995). Difficulties associated with reduced vaginal lubrication and thinning vaginal tissues after menopause can make penetrative sex painful (Bouman, 2013). While some men and women experience a decline in sexual desire with age, others do not, and a large-scale study found that the age at which sexual desire starts to fade can differ markedly (DeLamater & Sill, 2005).¹ Again, the influence of culture and time are significant, as the longitudinal study of 70-year-olds, noted previously, found a decrease in the proportion of men reporting erectile dysfunction (ED) but an increase in those reporting ejaculation difficulties (Beckman et al., 2008). The proportion of women who reported having an orgasm during intercourse increased, and the number of women who said they had never had an orgasm decreased. Men’s sexual difficulties were reported over the whole 30-year study period as the main reason why intercourse came to an end for those who had a sexual partner. The authors argued that these changes could be connected to a combination of factors, including better health in the more recent samples, changes in relationships (e.g., an increase in cohabitation and divorce), societal shifts, including attitudes toward sexuality, better socioeconomic status, higher educational levels, and legislative changes (e.g., the provision of compulsory sex education in schools).

Some long-term conditions, which are more likely to be diagnosed in people aged in their 50s and older, affect sexual function. Physical and mental health problems can decrease sexual desire, make it difficult to hold a sexual position, increase anxiety (e.g., that sexual activity may trigger another heart attack), and affect sense of sexual well-being generally (Bouman, 2013). Prescribed medications can have sexual side effects; for example, hypertensive drugs can cause erectile problems, many of which are prescribed to people aged 50 and older. Bouman (2013) pointed out that the prevalence of drug-related sexual problems is higher in older adults given their sensitivity to the side-effects of drugs.

¹ The authors do not present data on sexual orientation of participants.

While not everyone who experiences a sexual difficulty will necessarily be worried or concerned by it, there is evidence that sexual difficulties can have a negative impact on sense of self and interpersonal relationships. Research is growing in this area; however, a small number of qualitative studies from different countries (Jowett, Peel, & Shaw, 2012, United Kingdom; Potts, Grace, Gavey, & Vares, 2004, New Zealand; Sandberg, 2011, Sweden; Wentzell, 2013, Mexico) have identified that older men (heterosexual, gay, and bisexual) with erection difficulties report similar psychological and psychosocial impacts. These include a fear of failure during the sexual encounter, feeling less masculine, and concerns about securing and maintaining a sexual relationship. An erect penis could be central to sexual activity, even if such activity does not include penetration, and gay men describe it as being part of their identity (Jowett et al., 2012). But some men resist this phallogocentric model and renegotiate sex by practicing other types of sexual activity or engaging in activities that prescribe new forms of masculinity that are not sex related (Sandberg, 2011; Ussher, Perz, Gilbert, Wong, & Hobbs, 2013). Indeed, Ussher et al. (2013) found that heterosexual women and men and gay men renegotiated sexual activity after cancer treatment and acquired sexual pleasure from actions that did not require an erect penis (e.g., masturbation, mutual genital touching). One qualitative study of 69 heterosexual participants (aged 31 to 92) identified that the impact of sexual difficulties could be mediated by age. For example, participants aged 50 and older tended to perceive their sexual difficulty as age related, and this buffered its impact on well-being, making sexual difficulties such as ED less of a concern for an older man than a younger man (Hinchliff & Gott, 2004b). However, examination of the ELSA Wave 6 quantitative data identified dissimilar results: Men who were sexually active (defined as any sexual activity in the past year) became more concerned about their sexual desire levels, ability to get an erection, and orgasmic experience with age, and sexually active women reported increased concern about their ability to become sexually aroused with age (Lee, Nazroo, et al., 2016).

Evidence is growing which suggests that older adults do not always seek help for sexual difficulties (see Hinchliff & Gott, 2011) and that health professionals do not routinely ask older patients about sex for several reasons, including a lack of confidence, discomfort, and feeling deskilled (Gleser, 2015; Mellor et al., 2013; Wei & Mayouf, 2009). Given that sex can be a quality-of-life issue for older adults, and that they may experience sexual difficulties but not receive appropriate care, it is important to explore the area further to increase our understanding. The majority of research carried out in the area of sex and older adults has been quantitative; consequently, we do not know much about experiences of sexual difficulties and how they may interfere with an individual's life or relationships. This article draws on a unique qualitative data set from the ELSA to explore self-reported sexual difficulties of older women and men.

Method

Measures and Procedure

The ELSA has a nationally representative cohort of community-dwelling men and women aged 50 to 90 in England and has been running since 2002. In this article we focus on Wave 6 (2012–2013), when the Sexual Relations and Activities Questionnaire (SRA-Q) was included for the first time. Male and female versions of the SRA-Q were available (see <http://www.elsa-project.ac.uk>). The SRA-Q asked questions about the frequency of sexual activities and behaviors; difficulties with sexual activities and function; concerns and worries about sexual activities, function, and relationships; attitudes toward sex; and details about current sexual partnerships. At the end of the SRA-Q there was an open comment box that invited participants to provide additional information. The specific prompt read: "If there is anything else you would like to tell us, please write in the space below. We shall be very interested to read what you have to say." Participants completed the SRA-Q in private and then sealed it in an envelope. All responses were anonymous. The qualitative data provided in the open comment boxes ranged from one-sentence statements to six-sentence descriptions. Ethics approval was obtained from NRES Committee South Central–Berkshire, and full details of the study design have been described elsewhere (Steptoe, Breeze, Banks, & Nazroo, 2013).

Participants and Recruitment

Participants were recruited to the ELSA through their participation in the Health Survey for England: A total of 10,601 individuals participated in Wave 6, of which 7,079 completed and returned the paper-based SRA-Q.² (For an analysis of the SRA-Q quantitative data, see Lee, Nazroo, et al., 2016; Lee, Vanhoutte et al., 2016.) A total of 1,084 people completed the open comment box of the SRA-Q to provide additional qualitative data.³ Prior to being released to the research team, the comments were reviewed by the data holder to make sure that the statements did not breach anonymity. More women ($n = 680$) than men ($n = 404$) completed the open comment box. Of these responders, 668 women and 395 men had complete matched quantitative data. As shown in Table 1, the majority were heterosexual, married or cohabiting, had left education at age 15 to 18, and considered themselves to be in very good/excellent health. Some gender differences were evident, with proportionally more women having depressive symptomology, a lower likelihood of reporting any sexual activity in the past 12 months, and fewer lifetime sexual partners than men (all $p < 0.05$).

² Analysis was restricted to core ELSA members living in private households in England, excluding partners who were aged < 50 (as they were not representative of the < 50 age group), leaving 6,201 individuals in the final sample.

³ Complete quantitative data were only available for 1,063 respondents.

Table 1. Characteristics of Women and Men Who Provided Comments in the Free Text Box as Part of the ELSA Sexual Relationships and Activities Questionnaire (SRA-Q)

Variable	Women (n = 668)	Men (n = 395)
	Number (%)	
Age (years)		
< 50	18 (2.7)	4 (1.0)
50–59	146 (21.8)	61 (15.3)
60–69	273 (40.7)	141 (35.3)
70–79	172 (25.6)	133 (33.3)
80–>90	62 (9.2)	60 (15.0)
Current partner		
Married/cohabiting	410 (61.2)	295 (73.9)
Divorced/separated	79 (11.8)	39 (9.8)
Never married	33 (4.9)	27 (6.8)
Widowed	148 (22.1)	38 (9.5)
Age left education (years)		
≤ 14	43 (6.4)	37 (9.3)
15–18	479 (71.4)	269 (67.4)
≥ 19	149 (22.2)	93 (23.3)
Self-rated general health		
Excellent/very good	286 (42.6)	145 (36.5)
Good	199 (29.7)	127 (32.0)
Fair/poor	186 (27.7)	125 (31.5)
Depression		
CES-D score ≥4 ^a	133 (20.0)	51 (13.0)
Any sexual activity in last 12 months ^b	380 (57.8)	279 (70.8)
Reported number of lifetime sexual partners		
None	12 (1.8)	4 (1.0)
One	230 (35.1)	119 (31.0)
Two to four	245 (37.4)	103 (26.8)
Five or more	169 (25.8)	158 (41.2)
Self-reported sexual experiences ^c		
Entirely/mostly with opposite sex	634 (94.9)	380 (96.2)
Self-reported sexual desires ^c		
Entirely/mostly with opposite sex	625 (93.6)	379 (96.0)
Smoking status		
Current	70 (10.4)	45 (11.3)
Frequency of alcohol consumption ^d		
Never/rarely	249 (38.3)	78 (20.4)
Regularly	277 (42.5)	205 (53.7)
Very frequently	125 (19.2)	99 (25.9)

Note. Complete quantitative data available for only 1,063 respondents.

^aEight-item version CES-D (Centre for Epidemiologic Studies Depression scale): Score of 4 or more denoting likely depression.

^bSexual intercourse, masturbation, petting, or fondling.

^cQuestions about lifetime sexual experiences and sexual desires included at the end of the SRA-Q.

^dFrequency of alcohol consumption over the past year (Never/Rarely = Never to Once or twice; Regularly = Once every two months to Twice a week, Very frequently = Three days a week to Daily).

There were also some key demographic differences (aside from gender) between participants who responded to the open comment box and those who did not (see the Appendix). Responders were marginally older, less likely to be married or cohabiting, and in poorer health, and they consumed alcohol less frequently than nonresponders.

Data Analysis

In recognition of the value of open comment data, we chose a method of analysis that was rigorous and appropriate for managing textual data that ranged in size. To

begin analysis, one of the authors (JT) started with 20 sets of responses from ten men and ten women, which she coded to develop an initial concept map. A concept mapping approach is particularly suited to analyzing open-ended survey data as it allows researchers to look at the meaning of text while also coding thematically (Jackson & Trochim, 2002). This method therefore enabled us to analyze the data in a way where we could bring the responses together to look at connections, similarities, and differences. Given the volume and varied nature of the SRA-Q qualitative data, this approach was appropriate as a first step because original responses remain as units of analysis (Jackson & Trochim,

2002), which helps to avoid overcoding and further fragmentation of the short-form qualitative data.

Once the concept map was complete, the next step was to analyze the remaining data. Template Analysis—an established method of analyzing qualitative data (Cassell, 2008)—was chosen because of its fit with the concept mapping approach (Brooks, McCluskey, Turley, & King, 2015; Crabtree & Miller, 1999; King, 2012). Here, the concept map was used as a basis from which to analyze the whole data set and develop a main template. Taking an interactive approach to coding the data (each comment box response constituted a unit of data), two authors (JT and DL) worked collaboratively to group and sort the data units, a process where data were considered and debated to identify the key issue(s) contained within. This process of systematic coding identified patterns in the data, including disconfirming evidence (negative case analysis). The authors met several times to compare themes and agreement on coding decisions, and the initial concept map was modified as new themes were identified. The final themes formed an overarching template that represented the whole qualitative data set. It consisted of four core interlinking themes: health, relationships, sexual satisfaction, and aging and sexuality, each with subthemes (see Tetley et al., 2016). The process of data analysis revealed that the data which informed these core themes, particularly the sexual satisfaction theme, were underpinned by gendered aspects of sexual difficulties. All authors interrogated these data further; findings are presented in the section that follows.

Findings

Three components were identified: the ways in which a sexual difficulty could affect psychological well-being; the impact a sexual difficulty could have on the interpersonal relationship; and issues around help seeking and treatment available for sexual difficulties. Each is discussed here, supported by participant quotations from the qualitative data set. There is considerable overlap among these areas, and relational context was central throughout.

Impact on Psychological Well-Being

The majority of participants reported that either they or their partners had a current sexual difficulty; however, not all stated that it had a detrimental effect on their lives. For some, though, living with a sexual difficulty could affect their psychological well-being, which was framed negatively and described using terms such as depressing and frustrating:

Having difficulty getting erections in the past few years has been very depressing as I've always had a strong sex drive. (Male, aged 50–59)

My sex life came to an abrupt halt after a hysterectomy at age 42. It has caused tension and heartache for the last 23 years. There was no warning that this could be a difficulty and HRT

[hormone replacement therapy] caused depression and other side-effects. A real bummer. (Female, aged 60–69)

These quotations illustrate that a sexual difficulty could be experienced as a disconnection from a past active sexual life to one where sexual activity reduced in frequency or stopped all together. Such a disruption was particularly difficult to handle if the participant wanted to be sexually active and viewed sex as important to the relationship, and also if the participant believed that the change had come at an inappropriate time in her or his life course.

It is hard sexually having a partner with prostate cancer. For a year or two he was completely impotent. Now sex is possible but his sex drive is 10% of what it was. I feel too young for this. (Female, aged 50–59)

In the quote above the participant, who is in her 50s, clearly constructed this as an age where she expected to be sexually active as she felt “too young” to have experienced such a significant change in her sex life. Indeed, analysis of the quantitative data from the ELSA SRA-Q ($n = 6,201$) revealed that concerns about the frequency of sexual activity were lowest in the oldest age group (80 to 90+) for both women and men (see Lee, Nazroo et al., 2016).

Frustration was evident in the accounts provided by women who wrote that their husbands were not willing to talk about or seek help for their ED, an issue to which we will return. In some relationships, both partners experienced a sexual difficulty, and this combination could exacerbate the frustration. In other relationships, though, having a sexual difficulty that existed alongside a partner's sexual difficulty made it easier to accept that sex (which we assume to mean penile-vaginal intercourse) was no longer a key component of the relationship.

Missing the intimacy of sexual activity, and experiencing sadness at its loss, was also a feature here. However, for some participants the negative impact of sexual difficulties was placed in context of their own or their partner's health. They reported health difficulties, such as prostate cancer, as having a direct or indirect bearing on their sex lives, which altered their views on sexual activity and sexual pleasure:

I have had my prostate removed, right testicle removed, 18 inches of my bowel removed, and my spleen removed. All cancerous. Sex is the last thing on my mind! (Male, aged 80+)

My wife and I have been together 56 years and after many, many years of happy marriage [and] a healthy sex life it does get frustrating, but I put her health before my pleasure, and I have to switch off. (Male, aged 70–79)

Being able to “switch off,” as described by this participant, was a way of coping with an absence of sex in the relationship, and formed part of putting his partner's health needs before his own desire for sex. Other ways of dealing with sexual difficulties were highlighted and included fantasising about sex and/or engaging in masturbation.

Sex has always been very important for me. I enjoyed masturbation but found it difficult to climax with a partner. With age the desire for sex has decreased but I would welcome any help. (As men can take Viagra.) (Female, aged 60–69)

Here, the importance placed on sex is discussed in relation to autoeroticism and also a decreased sexual desire. That this participant would “welcome any help” suggests that she would prefer to boost her sexual desire. Another female participant mentioned that masturbation was a way of dealing with her own sexual needs since becoming a widow, as she did not want another sexual partner. However, a male participant (married) wrote that while he missed sexual activity, the act of self-pleasure exacerbated existing negative feelings.

This lack of physical affection is a MAJOR source of concern to me. I feel I would still like to engage in sexual activity with a woman. I feel guilt and shame at having to masturbate. (Male, aged 50–59)

This quotation illustrates the contradictory position of masturbation in that it could be a source of pleasure (e.g., tension release) and pain (e.g., guilt and shame). Some participants, both male and female, mentioned that they had considered taking another sexual partner as a way of coping with a lack of sex in their primary relationship.

Currently my wife appears to be “going through the change” therefore her sex drive seems dramatically reduced. This led to feelings of “affairs” but I could never see myself as going that as we have both gone through divorces by our partners having affairs. (Male, aged 50–59)

However, views on how a relationship should be (i.e., monogamous) alongside previous experiences of betrayal meant that participants rejected ideas about taking another sexual partner while still married.

My husband due to medical reasons cannot have sex but that does not halve love. Of course I do miss that intimacy and release but I believe in monogamy. (Female, aged 50–59)

For many participants, the love and commitment of their current relationship was emphasized over and above their sexual difficulties (an issue we return to in the following section). Thus, despite the absence of sex being experienced negatively by some participants, potential ways of managing this were not always desirable or beneficial. Interestingly, it was only women who expressed concern about their partner’s sexual needs not being met as a result of their own sexual difficulties. Indeed, one woman, who no longer experienced sexual desire, engaged in sexual activity with her husband for this reason.

Since the menopause and M.E. [myalgic encephalopathy] I have no sex drive. It doesn’t worry me but I do want to keep

my husband happy so we make love. Kissing and cuddling is very important and having a sense of humour and being kind to each other. (Female, aged 60–69)

In this quote, the participant did not view her lack of sexual desire as a difficulty, but it is clear that she was concerned about the impact a lack of sexual activity could have on her marriage. She made love with her husband to keep him “happy,” as such she put her partner’s need for sexual pleasure before her own need for sexual abstinence. Again, this was contextualized within a committed relationship.

Many participants reported that the sexual difficulties they experienced did not have an impact on their psychological well-being. Indeed, both women and men wrote that they had accepted the absence of sex, that life was fulfilling without it, and that “sex was not everything”:

As my husband has had prostate difficulties for many years and finally [had it] removed, sex has not been an issue for a good many years but we have been happily married for 55 years so sex isn’t everything! (Female, aged 70–79)

These participants were keen to stress that physical intimacy, predominantly in the form of cuddling and holding hands, remained an important part of their relationship and, indeed, one that kept the relationship strong.

Impact on Relationship

Clearly, relationship context was central regardless of whether the sexual difficulty had an impact on psychological well-being. Interpersonal relationships were important to the participants, and the majority did not report that a lack of sex had a negative impact on their relationship. Indeed, some specifically pointed out that they remained close.

No sexual activity with my wife for many years due to difficulties of “the change” following hysterectomy but we remain a loving couple. (Male, aged 70–79)

As my partner suffers with COPD [chronic obstructive pulmonary disease] sex is rare, but we are very close in every way. (Female, aged 60–69)

These participants reported that they were intimate in the absence of sex and engaged in close physical contact such as hugging, cuddling, and kissing. However, intimacy was avoided by some men who experienced embarrassment in connection with their ED; for others, remaining intimate could be negated by the health of the participant or her or his partner:

Unfortunately my wife is in the grip of Alzheimer’s so sex is out of the question now and is the least of my concerns. (Male, aged 70–79)

In this quote, the health and well-being of the partner again took precedence over the sexual relationship; the participant had other concerns to prioritize. This finding was common in

the context of ill health. For some participants, an absence of sex in their relationship had a negative impact on the relationship or at least how the participant felt about her or his partner.

My wife stopped having sex with me for over 12 years. She says she is not interested in sex. It made me feel frustrated, annoyed and angry and now not caring for her. Sex means a lot to me. I have not cheated on her at all but if I was living in rented accommodation I would leave her. I feel rejected. (Male, aged 60–69)

Here, feelings of rejection and anger seemed to have reached a point where the participant stopped caring for his wife and, again, brought consideration of taking a new sexual partner. This frustration resonates with the experiences of female participants who disclosed that their partners would not talk about, or seek help for, their ED. One participant disclosed that the reluctance of her husband to try an erection-enhancing medication (EEM) had changed the way that she viewed him:

My husband has erection difficulties but is reluctant to try Viagra or similar, this has led to a lack of intimacy and some loss of respect. (Female, aged 50–59)

Analysis of the data indicated that communication with the partner about sexual difficulties was not always easy and could exacerbate existing tensions rather than resolve the issue. Sometimes it was this chain of events that had a negative impact on the relationship. For example, in the following quote, the participant indicates that it has halted discussions about sex all together:

I wish my partner would seek help. We've talked about it. But it ends up in a row. So I don't bother. (Male, aged 60–69)

Help Seeking and Treatment Options

It is clear from the findings that not seeking help for a sexual difficulty could be harmful to the relationship. Indeed, for those who had sought help, or were considering it, the negative impact on themselves and/or their relationships were the primary drivers for seeking help. A general practitioner (GP) or doctor was the main source of help for participants who disclosed this information. Only two women referred to other sources, such as sexual counselors; no men did. Interestingly, help seeking and the treatments available for sexual difficulties were described primarily in relation to ED, where male participants mentioned their own ED and female participants mentioned the ED of their partners. Treatments included EEMs, such as Viagra, penis injections, penis pumps, and sexual and relationship counseling. Some men had sought help and, at the time of data collection, had experience of using an EEM.

Take a generic Viagra occasionally as it does make me last longer and stay harder but without this, it is not a difficulty just makes even better. (Male, aged 50–59)

Here, an EEM was taken to enhance sexual pleasure rather than to enable penetrative sexual intercourse to take place. However, the success of EEMs could be short-lived in that their effectiveness reduced with continued use.

Have had erectile dysfunction for at least 15 years. Originally prescribed Viagra but as time progressed became less and less useful, so do not take medication now or have sought any medical help. (Male, aged 60–69)

Similarly, EEMs and other treatments (e.g., penile injections) may not work in the first place. With regard to the perceived causes of sexual difficulties, and particularly ED, long-term conditions and the medications used to manage them were seen as primary, and for many participants this was accompanied with a sense of acceptance: that nothing could be done to help. Some men had discussed this with their doctor, who had confirmed the medical cause of their difficulties. It was unclear from the data whether the men had sought help specifically for their sexual difficulties or whether discussions about sexual function had come about as a result of something else (e.g., being prescribed a new drug).

Not all participants who experienced a sexual difficulty had sought professional help. Some did not want it—they mentioned that were okay as they were—while others encountered barriers to seeking help. One barrier mentioned primarily by female participants was their partner's unwillingness to ask for help for ED:

My partner is unable to maintain an erection and refuses to ask for help. Short of dropping Viagra in his tea, I don't know what to do! (Female, aged 60–69)

In this quotation we can see that a refusal by the partner to seek help for his ED left the participant unsure what other action to take. Indeed, as indicated earlier, not seeking help for sexual difficulties could have an impact on the relationship, in terms of arguments, and on psychological well-being, in terms of feelings of frustration.

Of the participants who mentioned having a consultation with their GPs, some expressed a need for better care. One man had sought help for sexual difficulties but reported that the doctor "was not keen to help"; however, he did not elaborate on how the doctor was unhelpful. Another believed that his GP should have been more proactive and offered him an EEM as part of the treatment for his prostate cancer: a disease known to have a significant impact on erectile function.

Since having or being unable to have full sex since treatment for prostate cancer I feel strongly that my GP could and should have been more interested in providing help such as Viagra or related treatments. (Male, aged 70–79)

Similarly, the female participants who had sought help for sexual difficulties gave examples of unhelpful practice. In

the quote that follows, the doctor suggested that the participant should pursue sexual and relationship counseling to help with her low sexual desire.

I had a 20 minutes consultation two months ago with a doctor/specialist at my local sexual health clinic to discuss my lack of libido, but I was told to consult Relate and no further help was offered. (Female, aged 50–59)

The specialist at the sexual health clinic implied that the root of the participant's sexual difficulty was her relationship. Being referred to a different specialist service was not what the participant expected to hear and indicated that the doctor was unwilling to discuss her sexual difficulties further. Indeed, another participant reported that when she sought help for her current lack of sexual desire she was asked by the doctor to talk about her experiences to a group of students. Again, this was not something she expected to encounter, and it put a stop to her help seeking.

There was evidence that participants perceived health professionals to hold ageist attitudes, and that this played a part in the lack of help participants received:

NHS [National Health Service] seem reluctant to help with sexual problems in someone of our age. Penetrative sex is incredibly painful and I have been advised due to age. (Female, aged 60–69)

Think that more discreet help should be available to older people other than GP. Also believe ED medication should be available at pharmacies rather than rely on Internet suppliers where products are not always genuine. (Male, aged 60–69)

In this quote, the issue of buying EEMs from suppliers other than the NHS, which was viewed by participants as risky as the drugs may be counterfeit, was raised and placed firmly in the context of a lack of help for older people. Women who had mentioned professional help for sexual difficulties did so primarily in the context of menopause. Indeed, the perceived main cause of their sexual difficulties was menopause related, including vaginal dryness, which made penetrative sex painful, and a lack of sexual desire.

I have always had a very active, healthy and very regular sex life until menopause, when my desire has plummeted, but not physical ability. GP says I have the need of HRT, and I am currently taking a herbal supplement (3 months) which does seem to be working and I do not believe it to be placebo. (Female, aged 50–59)

In this quotation, the GP was proactive and suggested hormone-replacement therapy to help address the participant's reduced sexual desire. Many participants took HRT; however, it is unclear from the data if they took it as a result of seeking help specifically for a sexual difficulty or for symptoms of menopause generally. Believing that there were no treatments available to help, and difficulty in

broaching the topic of sex with the doctor, could prevent the women from seeking help for their sexual difficulties in the first place.

Discussion

The purpose of this article was to explore self-reported sexual difficulties in a sample of women and men aged 50 and older. This was achieved by analyzing a qualitative data set, collected during ELSA Wave 6, of 1,084 participants. The findings demonstrate diverse experiences of sexual difficulties and mixed findings as to whether a sexual difficulty was experienced negatively in terms of psychological well-being and interpersonal relationships. Our research supports previous findings that significant life events, in particular changes to health status, can have varying impacts on an older adult's sex life (Fileborn et al., 2015).

In the present study, there was a difference as to whether sexual difficulty within the relationship had a negative impact on psychological well-being. When it did, it was connected with a number of factors, including the desire to remain sexually active and the importance of sex to the participant. Here, a disconnection from one's previous sexual life was described as frustrating and depressing. Other studies have highlighted that sexual difficulties can have similar impacts on psychological well-being. Qualitative studies with heterosexual and gay men who experience erection difficulties have found that some men are embarrassed, and a fear of failure affects not only their current relationship but concerns about future sexual relationships. However, other men did not experience such an impact, which all the authors related to the men having found ways to obtain sexual pleasure that did not require an erect penis (Jowett et al., 2012; Sandberg, 2015; Ussher et al., 2013; Wentzell, 2013).

Similarly, qualitative research with women has identified divergent perspectives as to whether their own sexual difficulties caused them any distress. Nosek, Kennedy, and Gudmundsdottir (2012) interviewed heterosexual menopausal women in the United States and found that, for some, a lowered sexual drive and vaginal dryness created concern about current relationships and the potential loss of partner. In an earlier study, we found that for women aged 31 to 58 (mean age 42.9) a sexual problem (sexual desire loss, usually coexisting with other sexual concerns such as vaginal dryness, pain on intercourse, difficulty achieving orgasm, and husband's ED) could impair their sense of womanhood and "normality," as well as engendering feelings of sadness at the loss of sex (Hinchliff, Gott, & Wylie, 2009). However, this sample included only women who had sought professional help for their sexual difficulties on the basis that they experienced distress about sex.

There was indication in the present study that younger participants (those in their 50s) expected to be sexually active and thus seemed to experience more negative impact. This

supports an earlier study which identified that, for older adults in England, age buffered the impact of sexual changes because they were understood as a “normal part of aging” and therefore inevitable (Hinchliff & Gott, 2004b). However, analysis of the quantitative data of the ELSA SRA-Q shows a gender difference here: Men reported increased concern with sexual difficulties overall with age, yet women expressed less concern about sexual difficulties overall with age (Lee, Nazroo, et al., 2016). This discrepancy between the qualitative and quantitative findings for men might reflect the different methods of data collection which captured different aspects of the participants’ experiences and views.

The findings presented here also demonstrate that the couple relationship was central to experiences of sexual difficulties. ED, predominantly the result of prostrate difficulties including cancer and its treatment, clearly had an influence on the female partner’s sex life. This supports the findings of a study of older Australians, where Fileborn et al. (2015) concluded that a woman’s male partner was a “significant influence” on her sex life. We found that the same applied to men, as women’s sexual difficulties, particularly vaginal pain and low sexual desire, influenced men’s sex lives. Similar to other studies (Fileborn et al., 2015; Hinchliff & Gott, 2004a), some of the participants in the present study altered their sexual repertoires, mainly by increasing physical intimacy, to assist with sexual changes. Taken together, these studies suggest that a broader range of sexual activity had a connection with low/no impact on the relationship when sexual difficulties were experienced. This supports previous research. Winterich (2003) identified that women in lesbian relationships adjusted to sexual changes at midlife better than women in relationships with men because they already had a broad sexual repertoire. More recently, Gillespie (2016) found that a wide range of sexual behaviours was associated with increased sexual satisfaction in heterosexual, lesbian, gay, and bisexual adults aged 50 and older.

For some participants in the current study, experiencing a sexual difficulty did not have a negative impact on the relationship, which supports the findings of earlier work with older British heterosexual women and men (Hinchliff & Gott, 2004a). However, for others, reverberations within the relationship could be severe, with descriptions of a loss of love and respect for the partner. This seemed to be exacerbated if the partner experienced a sexual difficulty, resulting in a mismatch of sexual desires, but he or she would not talk to their partner about it or seek professional help.

A finding which related only to female participants was that they engaged in sex, which we assume means intercourse, even though they experienced a sexual difficulty. This indicates that the participants put their (male) partner’s sexual needs first, which can be read as a way of managing an interpersonal relationship in the context of experiencing a sexual difficulty and not knowing how else to manage it. Indeed, Yang, Kenney, Chang, and Chang (2016) found that heterosexual Taiwanese women of menopause age felt guilt and frustration over the perceived impact of their sexual difficulty for their husbands, which created a pressure to

have intercourse. Ussher, Perz, and Parton (2015) reported that heterosexual women at menopause with no desire for sex engaged in it because “they and their partners viewed coital sex as important to their relationship” (p. 454). We should be mindful of the social and historical time period in which the participants grew up. For the cohort aged 50 and older, traditional gender relations in many countries prescribed that part of a woman’s role was to be sexually available to her husband. However, having sexual intercourse outside the context of desire has been found in studies of younger women’s (and men’s) heterosexual relationships, where intercourse was viewed as “normal” and “natural” and thus prioritized over other forms of sexual activity (Gavey, McPhillips, & Braun, 1999).

Help seeking for a sexual difficulty seemed to be triggered by an impact on self or relationship. Of those who had sought help, there were examples of practice where the health professional had been proactive and/or open to talking about the participant’s sexual difficulties. But there were also examples where practice could be improved, particularly as it can take patients a long time to feel confident and comfortable seeking help for a sexual issue from their GP in the first place (e.g., due to embarrassment). The majority of those who had sought help pointed out that their health professional had not been helpful, and examples of perceived ageism of these health professionals were given. Other studies have identified similar barriers to health professionals asking about sex, including assumptions of asexuality, embarrassment, lack of confidence, feeling deskilled (Mellor et al., 2013), and discomfort based on the age of the patient (Wei & Mayouf, 2009).

Not everyone who reported a negative impact from their sexual difficulty had sought help. Thus, the connection between experiencing a sexual difficulty and seeking professional help for it was not straightforward. Similarly, there were mixed findings about EEMs, where some men had tried them but others had not; the reasons why they did not remain unknown. The individual differences highlight that we should not make assumptions about the sex lives of older adults. The extent to which sexual difficulties had a negative impact varied, and this has implications for academic research and clinical practice. It is important to recognize that while many older adults have sexual needs, not all wish to be sexually active.

Strengths and Limitations

This article has provided important insights into the experiences of sexual difficulties in a large sample of women and men aged 50 to 90, thus adding to the limited evidence base in this area. On a methodological note, we have demonstrated that qualitative data can be collected as individual “chunks” of text to constitute a unique data set which, when analyzed, reveals findings that represent a diversity of experiences. Qualitative data gathered as part of a survey can enrich the understanding of participants’

responses gathered as part of that survey (ten Kleij & Musters, 2003). Indeed, participants' responses were primarily personal and sensitive, and they added depth in this way. While a challenge of working with this method of data collection was the limited qualitative context around the comments, we were able to obtain an overview of participant characteristics from their responses to the questions on the SRA-Q.

Open comment boxes are used in surveys to enable participants to provide additional information or qualify their responses to closed questions (Fielding, Fielding, & Hughes, 2013; Jackson & Trochim, 2002). Indeed, it was clear from the ELSA data that participants used this box for these reasons: some clarified their answers to questions on the SRA-Q by making specific reference to that question, while others expanded on topics raised within the questionnaire. Thus, a large part of the qualitative data was shaped by the preceding questions. But some participants introduced new information as they wrote about the impact of health or relationship quality on their sex lives, which suggests that the SRA-Q questions did not completely constrain participants' responses in the open comment box.

While the content of the qualitative responses was diverse, they sat within a quantitative context, which differs to the way that qualitative data tend to be collected. The knowledge was thus not coproduced during data collection (e.g., by interviewer and interviewee); however, it was coproduced through the process of analysis. As Sandelowski and Leeman (2012) pointed out, findings from qualitative studies are composed of the researchers' interpretations of the data generated. They are "the researcher's configuration of segments of coded data assembled into a novel whole," and it is this analytic work that provides a "new conceptualization" which advances understanding of the topic of study (Sandelowski & Leeman, 2012, p. 1406). To help ensure the rigor of analysis, we undertook a process of peer debriefing, which involved scrutinizing and discussing one another's interpretations as well as searching for disconfirming evidence.

The findings should be understood in context of the ELSA sample, but they provide a basis from which subsequent research findings can be compared. To determine transferability, similar projects that employ the same methods but are conducted in different settings and with different participant groups would be valuable. Following Shenton (2004), we argue that an understanding of a phenomenon develops gradually as the result of several studies, and that differing results may reflect multiple realities, which is in itself a valuable form of data. Future studies should include individuals with nonbinary gender and sexual identities, who were underrepresented in ELSA. Indeed, the majority of research in sex and aging overall has been conducted within a heteronormative framework, which is a significant limitation of the evidence to date. Qualitative research that explores the ways that sexual difficulties intersect with age, race, ethnicity, disability, and social class would be illuminating and further our understandings of sexuality and aging.

Conclusion

Older adults can experience sexual difficulties in different ways. For some, they have a negative impact on their psychological well-being; for others, they do not. Similarly, whether a sexual difficulty within the relationship has a negative impact within that relationship differs between couples. There is a diversity of experience. Some participants mentioned becoming more intimate as a way to deal with sexual changes, and it may be that they renegotiated sex away from a phallogocentric model. Variations in the way that health professionals approach sexual difficulties in the over-50s age group indicate that there is likely to be unmet need, and thus more research is required to help build the evidence and make improvements in services.

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Appendix. *Characteristics of Participants Who Did or Did Not Provide Comments in the Free Text Box as Part of the ELSA Sexual Relationships and Activities Questionnaire (SRA-Q)*

Variable	Comments (n = 1,063)	No Comments (n = 6,016)	p*
	<i>M (SD)</i>		
Age (years)	67.5 (9.7)	65.4 (9.5)	< 0.001
	Number (%)		
Gender			
Female	668 (62.8)	3,287 (54.6)	< 0.001
Male	395 (37.2)	2,729 (45.4)	
Age (years)			
< 50	22 (2.1)	123 (2.0)	< 0.001
50–59	205 (19.3)	1,634 (27.2)	
60–69	411 (38.7)	2,365 (39.3)	
70–79	303 (28.5)	1,410 (23.4)	
80 > 90	122 (11.5)	484 (8.1)	
Current partner			
Married/cohabiting	702 (66.1)	4,224 (70.2)	< 0.001
Divorced/separated	114 (10.7)	733 (12.2)	
Never married	60 (5.7)	349 (5.8)	
Widowed	186 (17.5)	709 (11.8)	
Age left education (years)			
≤ 14	80 (7.5)	414 (6.9)	0.38
15–18	742 (69.8)	4,324 (71.9)	
≥ 19	241 (22.7)	1,277 (21.2)	
Self-rated general health			
Excellent/very good	429 (40.4)	2,620 (43.6)	0.009
Good	325 (30.6)	1,911 (31.8)	
Fair/poor	309 (29.1)	1,483 (24.7)	
Self-reported sexual experiences ^a			
Entirely/mostly with opposite sex	1,014 (95.4)	5,763 (95.8)	0.55
Self-reported sexual desires ^a			
Entirely/mostly with opposite sex	1,004 (94.5)	5,700 (94.8)	0.69
Smoking status			
Current	115 (10.8)	744 (12.4)	0.16
Frequency of alcohol consumption ^b			
Never/rarely	327 (31.6)	1,637 (27.9)	0.02
Regularly	482 (46.6)	2,981 (50.8)	
Very frequently	225 (21.8)	1,252 (21.3)	

*p value for difference between comments and no-comments groups.

^aQuestions about lifetime sexual experiences and sexual desires included at the end of the SRA-Q.

^bFrequency of alcohol consumption over the past year (*Never/Rarely* = *Never to Once or twice*; *Regularly* = *Once every two months to Twice a week*; *Very frequently* = *Three days a week to Daily*).