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Cover letter

Dated: 16th October 2026

To,
The Editor-in-Chief,
Indian Journal of Psychiatry

Subject: Submission of Clinical Practice Guideline on “Assessment and Management of Sexual Issues in Older Adults” for consideration for publication in Indian Journal of Psychiatry

Dear Editor,

We are pleased to submit our clinical practice guideline, “Assessment and Management of Sexual Issues in Older Adults,” for consideration for publication in the *Indian Journal of Psychiatry*. The draft guideline was presented and discussed at the Indian Psychiatric Society (IPS) Clinical Practice Guidelines National Workshop, held at Jaipur on 1st and 2nd August 2026. It was then revised to incorporate the feedback and suggestions of the experts and delegates who took part.

The manuscript is original, has not been published previously, and is not under consideration elsewhere. All authors have read and approved it and consent to its submission. There are no conflicts of interest to declare, and no external funding was received for this work.

We look forward to your response and are happy to provide any further information as needed. Thank you.

Yours sincerely,

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Assessment and Management of Sexual issues in Older Adults

Executive Summary

Sexual health is an integral component of healthy ageing but remains under-recognized in older adults because of ageism, sociocultural taboos, misconceptions regarding sexuality in later life, and inadequate clinician training. With increasing life expectancy in India, there is a growing need for practical, culturally relevant, and evidence-based guidance for the assessment and management of sexual issues in older adults. This clinical practice guideline was developed under the aegis of the Indian Psychiatric Society through a comprehensive review of the available evidence and expert consensus. Draft recommendations were deliberated during the Indian Psychiatric Society Clinical Practice Guideline Workshop and refined following expert feedback, with adaptation to the Indian sociocultural and healthcare context using a biopsychosocial framework. The guideline distinguishes normal age-related changes in sexual function from pathological conditions and provides a practical approach to the assessment and management of sexual dysfunction, inappropriate sexual behaviours, and relationship issues. It emphasizes comprehensive history taking, medication review, physical examination, assessment of cognitive capacity and consent, and evaluation of medical, psychiatric, psychosocial, and cultural factors. Management recommendations include patient education, lifestyle modification, psychosexual interventions, pharmacological treatment when indicated, and a stepwise approach to inappropriate sexual behaviours. The guideline also addresses ageism, communication barriers, ethical considerations, medication-related sexual dysfunction, and the importance of multidisciplinary care. Sexual issues in older adults are common, multifactorial, and largely treatable. Routine, culturally sensitive, person-centred assessment and evidence-based management should be integrated into comprehensive geriatric mental healthcare to improve quality of life and promote healthy ageing.

Key words: Clinical practice guidelines, sexual issues, older adults, assessment, management

INTRODUCTION

Sexuality remains one of the most overlooked aspects of healthcare among older adults, particularly in India. With increasing life expectancy and the rapid greying of the Indian population, addressing sexual health and wellbeing in later life has become an important component of comprehensive geriatric care. Sexuality is an integral part of biopsychosocial well-being throughout the lifespan and contributes significantly to quality of life, self-esteem, intimacy, emotional connectedness, and relationship satisfaction among older adults. Nevertheless, discussions regarding sexuality in old age continue to be surrounded by stigma, misconceptions, and sociocultural taboos, resulting in under-recognition and under-treatment of sexual concerns in this population.

Traditional social attitudes have often viewed sexuality as primarily relevant to younger adults and reproductive life. Within the Indian sociocultural context, older adults are frequently perceived as asexual or expected to gradually withdraw from sexual expression and intimate relationships. Such perceptions may partly stem from conventional interpretations of life-stage transitions described in Indian philosophical traditions. However, contemporary understanding of healthy aging recognizes that sexuality, intimacy, affection, and companionship remain important needs for many individuals well into later life.

Available evidence suggests that sexual activity and sexual concerns remain common among older adults. In a community-based study from southern India, Rao and colleagues reported that approximately 27.8% of older adults were sexually active, and nearly half of those who were sexually active reported one or more sexual difficulties (1). However, the true prevalence of sexual concerns in older adults is likely to be substantially higher. In clinical practice, geriatric mental health professionals commonly encounter a broad spectrum of sexuality-related concerns among older adults. These range from difficulties in adapting to normal age-related physiological changes and sexual dysfunctions in men and women to problems arising from chronic medical illnesses, psychiatric disorders, cognitive impairment, medication effects, relationship issues, loneliness, bereavement, and social isolation. Older adults who become dependent on others for activities of daily living may face additional psychosocial challenges related to privacy, intimacy, and maintenance of personal

relationships. Furthermore, some individuals with neurocognitive disorders may develop inappropriate sexual behaviors, which can cause significant distress to caregivers and create complex ethical, legal, and management challenges.

Given the growing population of older adults and the increasing recognition of sexuality as an important dimension of healthy aging, there is a need for clinicians to adopt a comprehensive and sensitive approach to the assessment and management of sexual issues in later life. This clinical practice guideline aims to provide a biopsychosocial framework for understanding, assessing, and managing sexual concerns among older adults, while addressing the unique cultural, ethical, cognitive, and psychosocial issues relevant to the Indian setting.

NORMAL CHANGES IN SEXUAL FUNCTIONING WITH AGEING

Ageing affects every organ system, and sexuality is no exception. Normal ageing brings gradual changes in hormone levels, genital anatomy, vascular function, and nerve conduction, all of which influence sexual function. However, these are physiological changes and should not be mistaken for sexual dysfunction. Importantly, ageing does not eliminate the need for intimacy, affection, or sexual expression, and many older adults remain sexually active well into their seventies, eighties, and beyond (2).

Women experience more noticeable hormonal changes because of menopause. Declining oestrogen levels lead to **genitourinary syndrome of menopause**, resulting in vaginal dryness, reduced lubrication, thinning of the vaginal lining, and vaginal laxity. These changes may make intercourse uncomfortable if untreated and often require longer arousal and adequate lubrication. Despite these changes, most women retain the ability to experience sexual pleasure and orgasm. Many even report greater sexual satisfaction after menopause because they are free from concerns about pregnancy and place greater value on emotional intimacy.

In men, testosterone levels decline gradually with age, unlike the abrupt hormonal changes seen in women. This age related decline may result in slower erections, reduced penile rigidity, a longer time to achieve arousal, and a prolonged refractory period. Ejaculatory force and semen volume also decrease, and orgasm may feel less intense. Nevertheless, most healthy older men continue to achieve satisfactory erections and orgasm, although they may require more direct stimulation and more time (3).

Ageing also influences the way sexuality is expressed. Rather than reflecting a loss of sexuality, it often represents a shift in priorities. Many older adults become less focused on penetrative intercourse and place greater importance on intimacy, affectionate touch, kissing, cuddling, mutual pleasuring, oral sex, masturbation, and emotional closeness. As a result, although the frequency of intercourse may decline, overall relationship and sexual satisfaction often remain stable or even improve. The extent of these changes varies considerably between individuals. Physical health, chronic illnesses, medications, mental health, relationship quality, and the availability of a willing partner have a much greater influence on sexual activity than chronological age alone (2).

So, it is essential to distinguish normal age related changes from pathological sexual dysfunction. Healthy ageing is characterized by slower sexual responses and changing patterns of sexual expression, but not by the loss of sexual desire or the inability to enjoy intimacy. Explaining these expected changes can reassure older adults and reduce misconceptions, unnecessary anxiety and encourage timely evaluation when sexual difficulties are more severe than expected or are caused by treatable medical, psychological, or relationship factors in later life. Table 1 provides a summary of preventive recommendations for healthy sexual functioning in older age.

Table 1. Preventive recommendations for healthy sexual functioning in old age

A.	General age related changes and risk factors	Preventive recommendations
1.	Reduced physical fitness and genital blood flow	Regular aerobic and strength exercises; maintain physical activity.
2.	Diabetes, hypertension, obesity, dyslipidaemia	Early detection and optimal control of vascular risk factors.
3.	Smoking and harmful alcohol use	Smoking cessation; limit alcohol intake.
4.	Polypharmacy	Periodic medication review; minimise drugs causing sexual dysfunction where possible.
5.	Sleep disturbance and fatigue	Promote sleep hygiene; evaluate and treat sleep disorders.
6.	Depression, anxiety, stress, loneliness	Screen routinely and treat promptly; encourage social engagement.
7.	Relationship conflicts	Promote open communication; consider couple counselling when indicated.
8.	Myths regarding sexuality in old age	Provide anticipatory counselling and normalize age-related sexual changes.
9.	Risk of sexually transmitted infections	Counsel regarding safer sex practices and condom use when appropriate.
10.	Lack of sexual health assessment	Include sexual health in routine geriatric assessment.

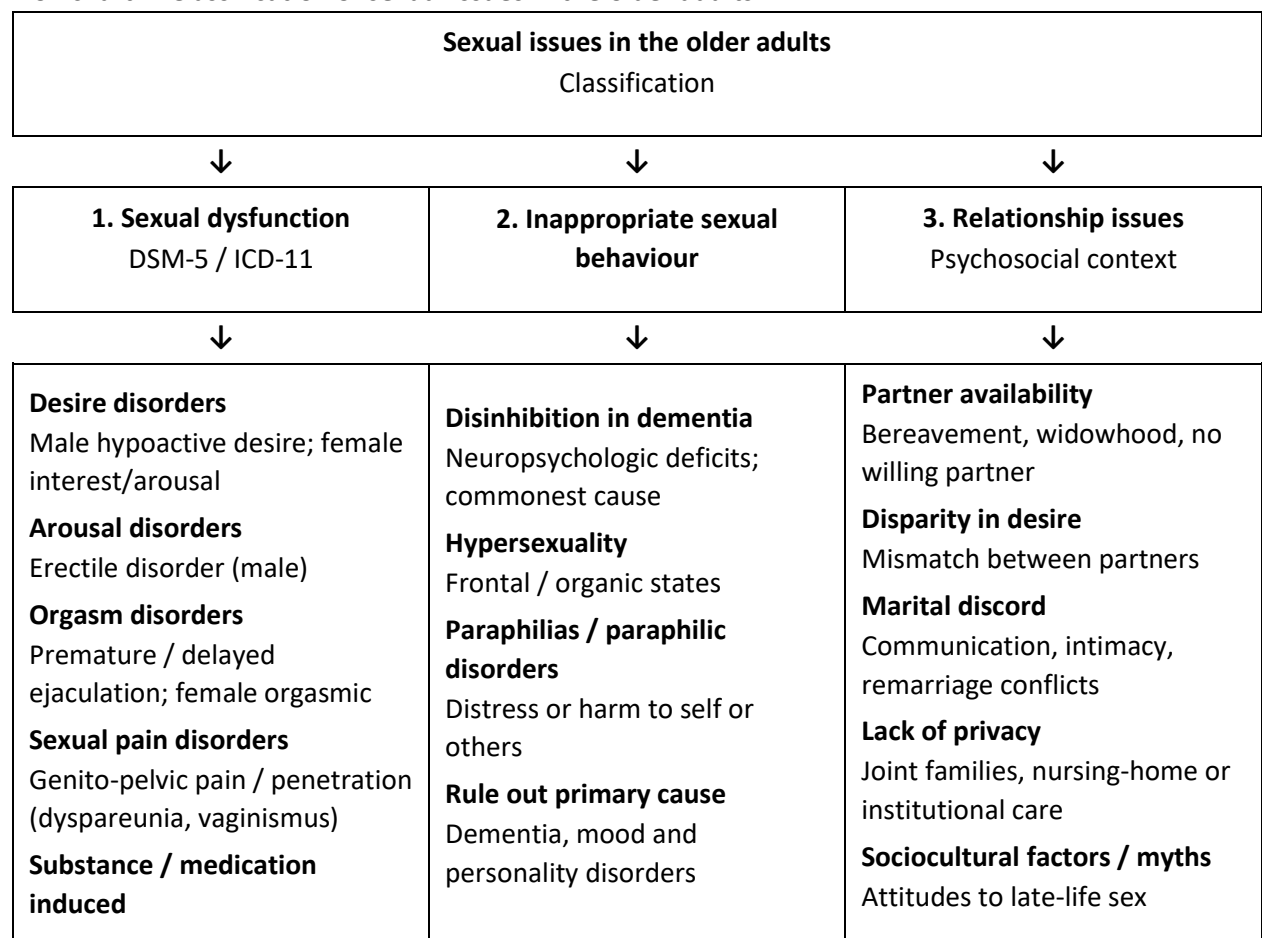
B.	Specific physiological changes in ageing women	Preventive recommendations
1.	Vaginal dryness / Genitourinary syndrome of menopause	Vaginal moisturisers, lubricants, and local oestrogen where indicated.
2.	Pelvic floor weakness, vaginal laxity	Pelvic floor muscle (Kegel) exercises.
3.	Reduced flexibility due to musculoskeletal disorders	Comfortable positions, adequate foreplay, pacing, and positioning aids.
4.	Dyspareunia	Early evaluation and treatment; do not consider pain a normal part of ageing.
C.	Specific physiological changes in ageing men	Preventive recommendations
1.	Slower erection and prolonged refractory period	Reassure; encourage longer foreplay and realistic expectations.
2.	Reduced erectile rigidity	Optimise cardiovascular health; evaluate reversible causes before treatment.
3.	Symptomatic testosterone deficiency	Evaluate only symptomatic men with confirmed low testosterone; avoid routine testosterone therapy.
4.	Lower urinary tract symptoms	Evaluate and treat appropriately to improve quality of life and sexual function.

(EAU), International Society for Sexual Medicine (ISSM), North American Menopause Society (NAMS), and the American Urological Association (AUA).

BIOPSYCHOSOCIAL ETIOLOGIES OF SEXUAL ISSUES IN OLDER ADULTS

Sexual problems in older adults are rarely caused by ageing alone. Instead, they result from a complex interaction of biological, psychological, interpersonal, and sociocultural factors. The biopsychosocial model provides the most appropriate framework for understanding sexual dysfunction in later life and forms the basis of comprehensive assessment and management. Sexual issues in older adults encompass a broad spectrum, ranging from normal age related changes to sexual dysfunction, hypersexuality, and inappropriate sexual behaviour. Recognizing these conditions as distinct yet overlapping entities is essential for accurate assessment and management. Flowchart 1 outlines a practical approach to the classification of sexual issues in older adults.

Flowchart 1: Classification of sexual issues in the older adults





Categories frequently overlap

Assess all three domains; organic and psychogenic factors coexist

The Fifth International Consultation on Sexual Medicine (ICSM) recommends that sexual concerns in older adults be evaluated in the context of physical and mental health, medications, functional status, relationships, and the individual's sociocultural background, rather than focusing solely on genital symptoms (4).

Biological factors

Although normal ageing is associated with physiological changes in sexual response, clinically significant sexual dysfunction is more often related to chronic medical illnesses, frailty, sensory impairment, pain, disability, hormonal changes, and polypharmacy(5). These conditions may impair sexual function through vascular, neurological, endocrine, or musculoskeletal mechanisms, or indirectly by causing fatigue, reduced mobility, pain, and altered body image (6). Common medical conditions associated with sexual dysfunction are summarized in table 2.

Menopause and genitourinary syndrome of menopause (GSM) commonly contribute to vaginal dryness, dyspareunia, and reduced arousal in women, while symptomatic late-onset hypogonadism may contribute to reduced libido and erectile dysfunction in selected older men. Drug-induced sexual dysfunction is particularly important in geriatric practice because it is common, potentially reversible, and frequently overlooked. Therefore, a careful medication review should be an integral part of every sexual health assessment as described in Table 4.

Psychological factors

Psychological well-being strongly influences sexual functioning throughout life. Mood and anxiety disorders, cognitive disorders, body image concerns, bereavement, loneliness, previous adverse sexual experiences, and relationship distress can reduce sexual desire, arousal, and satisfaction. Conversely, conditions such as bipolar disorder, dementia, and delirium may occasionally present with

disinhibited sexual behaviours. Common psychiatric conditions associated with sexual problems are listed in table 3.

Social and interpersonal factors

Relationship quality often determines sexual satisfaction more strongly than chronological age. Poor communication, unresolved marital conflict, caregiver burden, partner illness, sexual dysfunction in the partner, widowhood, and lack of a willing partner are among the commonest reasons for declining sexual activity in later life. Many older adults adapt successfully by redefining intimacy beyond penetrative intercourse, whereas others experience distress because of mismatched expectations between partners.

Social and cultural influences are equally important. Ageist stereotypes that older adults are 'asexual,' embarrassment in discussing sexual concerns, religious or cultural beliefs, and lack of privacy in multigenerational households often discourage sexual expression, especially in the Indian subcontinent (1). Older adults residing in long-term care facilities may encounter institutional barriers, inadequate privacy, or restrictive policies regarding intimate relationships. Healthcare professionals themselves frequently avoid discussing sexuality because of inadequate training, time constraints, or discomfort with the subject, leading to under-recognition of treatable problems.

Thus, sexual dysfunction in older adults should be viewed as a multifactorial geriatric syndrome rather than an inevitable consequence of ageing. A comprehensive assessment should identify potentially reversible biological illnesses, psychiatric disorders, medication-related causes, and psychosocial stressors before attributing symptoms to physiological ageing.

Table 2. Medical comorbidities contributing to sexual issues in older adults

Medical condition/morbidities	Common sexual consequences
Diabetes mellitus	Reduced libido, erectile dysfunction (ED), orgasmic dysfunction, vaginal dryness

Cardiovascular disease	ED, reduced exercise tolerance, fear of sexual activity
Hypertension	ED, reduced sexual arousal (also medication-related, as described in table 3)
Dyslipidaemia/Metabolic syndrome	ED, reduced genital blood flow
Chronic kidney disease	Reduced libido, ED, menstrual disturbances
Chronic liver disease	Hypogonadism, reduced libido, ED
Chronic obstructive pulmonary disease	Fatigue and dyspnoea limiting sexual activity
Obesity	Reduced desire, body image concerns, ED
Osteoarthritis/chronic pain	Pain during intercourse, reduced mobility
Neurological disorders (stroke, Parkinson's disease, multiple sclerosis, spinal cord disorders)	ED, orgasmic dysfunction, reduced lubrication, altered sensation, hypersexuality (especially with frontal lobe involvement)
Dementia	Reduced interest, impaired judgement, altered sexual behaviour
Endocrine disorders (hypogonadism, thyroid disorders, hyperprolactinaemia)	Reduced libido, arousal disorders
Genitourinary disorders (GSM, urinary incontinence, LUTS/BPH, pelvic organ prolapse)	Dyspareunia, ED, avoidance of sexual activity

Malignancy and cancer treatment	Reduced desire, altered body image, treatment-related dysfunction
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Table 3. Psychiatric conditions existing contributing to sexual issues in older adults

Psychiatric disorder	Common sexual manifestations
Depressive disorders	Reduced libido, arousal and orgasmic difficulties
Anxiety disorders	Performance anxiety, reduced arousal, avoidance of intimacy
Bipolar disorder	Reduced desire during depression; hypersexuality during mania/hypomania
Schizophrenia and other psychotic disorders	Reduced desire, impaired relationships, medication-related dysfunction
Dementia	Reduced sexual interest, disinhibition, impaired consent, inappropriate sexual behaviour
Delirium	Transient sexual disinhibition or inappropriate behaviour
Substance use disorders	Reduced desire, ED, relationship problems
Personality disorders	Interpersonal conflict affecting sexual relationships
Trauma- and stress-related disorders	Avoidance, pain, reduced intimacy, fear of sexual activity

Table 4. Drugs causing sexual issues in older adults

Drugs causing sexual dysfunction	Drugs associated with hypersexuality
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SSRIs, SNRIs, tricyclic antidepressants	Dopamine agonists (pramipexole, ropinirole, rotigotine)
Antipsychotics (especially prolactin-raising agents)	Levodopa (occasionally)
Benzodiazepines	Testosterone (supraphysiological use)
Mood stabilisers (lithium, valproate)	Anabolic-androgenic steroids
β -blockers, thiazide diuretics, spironolactone	Psychostimulants (rare)
5- α reductase inhibitors	Dopaminergic agents used in restless legs syndrome
GnRH analogues and antiandrogens	
Opioids	
Anticholinergics	
H2 receptor antagonists (e.g., cimetidine)	
Cytotoxic chemotherapy and hormonal therapies	

INAPPROPRIATE SEXUAL BEHAVIORS IN OLDER ADULTS

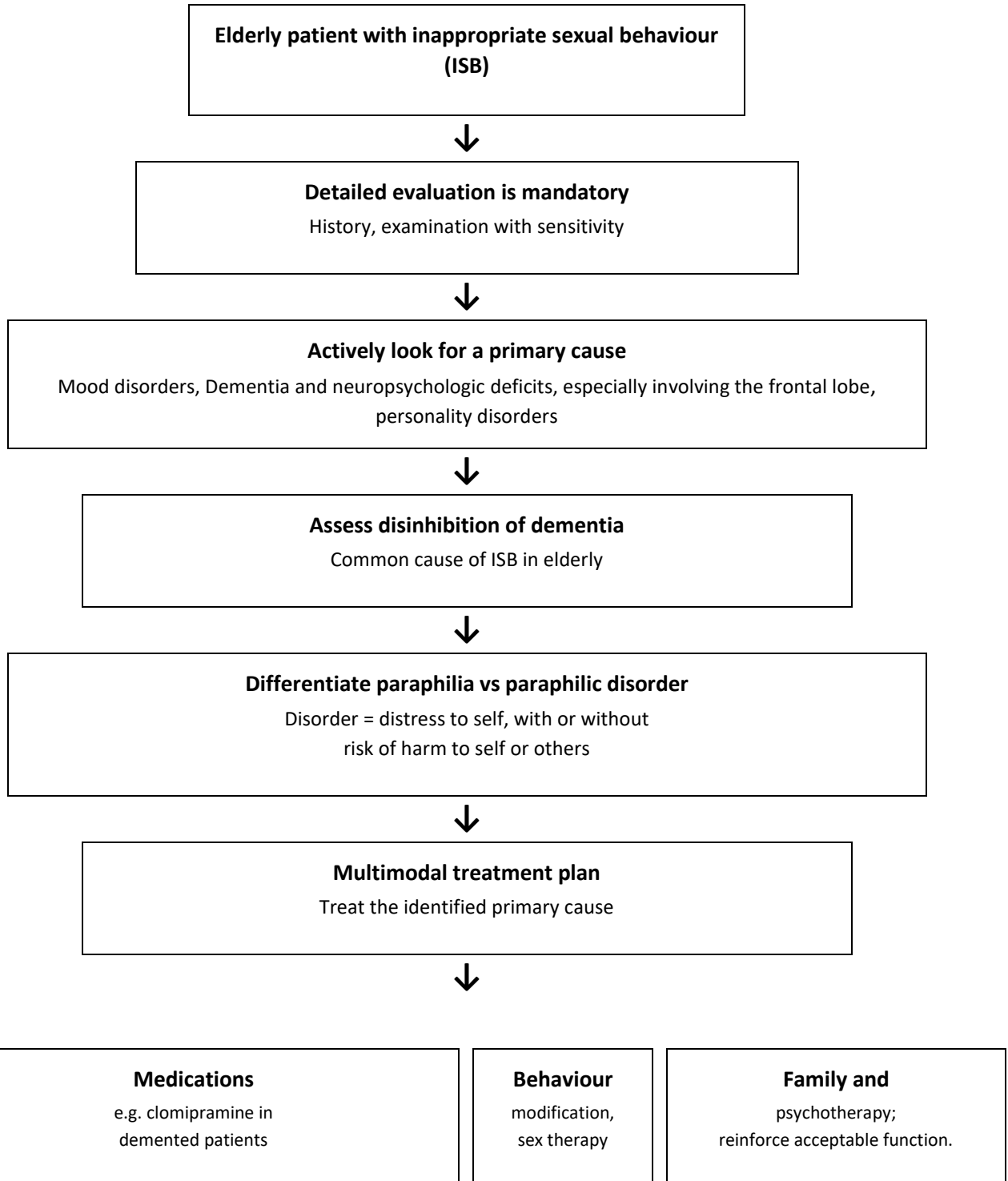
Inappropriate sexual behaviours (ISBs), also referred to as sexually disinhibited behaviors, are verbal or physical sexual acts that are inappropriate to the social or interpersonal context and cause distress, embarrassment, or harm to self or others. It is important to distinguish these behaviours from normal expressions of sexuality in later life. Older adults, including those with dementia, continue to have

emotional and sexual needs. The consensual expressions of intimacy should not be pathologized merely because of age. Rather, ISBs represent a behavioural symptom that usually reflects an underlying medical, neurological, psychiatric, or medication-related disorder (7). The reported prevalence varies widely, ranging from 1.8% to 25% among persons with dementia, depending on the population studied, care setting, and definition used. They are encountered more commonly in institutional settings, where cognitive impairment, reduced privacy, and caregiver burden make these behaviours more apparent (8). The manifestations of ISBs range from mild verbal behaviours, such as sexually explicit language, repeated sexual requests, inappropriate compliments, or flirtatious remarks, to non-verbal behaviours including public masturbation, exposing the genitals, inappropriate touching, grabbing, kissing, or unwanted sexual advances. Severe behaviours, including coercive sexual acts, are uncommon but require urgent assessment because they pose significant safety and legal concerns. The behaviour should always be interpreted in its clinical context, taking into account the patient's premorbid personality, cultural norms, cognitive status, and consent (9).

Neurodegenerative disorders, particularly frontotemporal dementia, are most strongly associated with sexual disinhibition because of impaired frontal lobe inhibitory control. ISBs can also be seen in Alzheimer's disease, Lewy body dementia, vascular dementia, delirium, traumatic brain injury, stroke, and Parkinson's disease. Psychiatric disorders such as mania, psychosis, substance intoxication, and certain personality disorders should also be considered. Medications as mentioned in table 3 can also precipitate hypersexuality or impulse-control disorders. Environmental factors, including boredom, loneliness, unmet emotional needs, and lack of privacy, can further contribute to these behaviors. Assessment should begin by identifying reversible causes rather than attempting to suppress the behaviour. Considering the diverse etiology, a comprehensive evaluation should include cognitive assessment, screening for delirium and other medical illnesses, medication review, psychiatric assessment, evaluation of decision-making capacity and consent, and identification of environmental triggers. Information from caregivers is often essential to establish the onset, frequency, severity,

antecedents, and consequences of the behaviour. Flow chart 2 provides an overview of assessment of inappropriate sexual behavior in older adults.

Flow chart 2. Assessment of inappropriate sexual behavior in older adults



ASSESSMENT OF SEXUAL ISSUES IN OLDER ADULTS

History taking with nuances specific to older adults

History taking is the cornerstone of assessment and should be conducted in a respectful, non-judgmental, culturally sensitive, and age-affirming manner. Many older patients do not volunteer sexual concerns because of embarrassment, cultural beliefs, fear of being judged, or the misconception that sexuality is irrelevant in later life. So, taking sexual history is of paramount importance. The history should include the presenting complaint, onset, duration, severity, associated distress, and the impact on quality of life and relationships. Specific enquiry should be made regarding sexual desire, arousal, lubrication, erectile function, orgasm, pain during sexual activity, satisfaction, frequency of sexual activity, and changes from previous functioning. It is important to distinguish lifelong problems from those acquired in later life.

To explore the underlying cause of the issue in older adults, additional assessment of comorbid medical illnesses, urinary and bowel symptoms, mobility limitations, chronic pain, sensory impairment, sleep problems, substance use, and functional status are required. A detailed psychiatric history also should explore depression, anxiety, cognitive decline, psychotic symptoms, bereavement, loneliness, body image concerns, and previous traumatic experiences.

Relationship factors deserve special attention, including partner availability, partner illness, communication difficulties, and changes in intimacy following retirement, widowhood, or institutionalization. Sexual orientation, gender identity, and current sexual practices should be explored respectfully. In cognitively impaired individuals, collateral information from caregivers may be necessary while maintaining the patient's dignity and privacy. A thorough history often identifies potentially reversible biological, psychological, interpersonal, and

medication related contributors before further investigations are done. Practical approaches to overcome the barriers to assessment of sexual issues in older adults are tabulated in table 5.

Table 5. Practical approaches to overcome the barriers to assessment of sexual issues in older adults

Barriers to assessment	Practical tips to overcome the barrier
Ageism (clinician/ caregiver assumes older adults are not sexually active)	Recognize that sexual health is an integral component of healthy ageing. Routinely include a brief sexual health enquiry during assessment, irrespective of age.
Attitude of the clinician, clinician's discomfort or embarrassment	Normalize discussions using open, non-judgmental language. Introduce the topic as part of routine health assessment (e.g., "I ask all my older patients about sexual health because it is an important part of wellbeing.").
Patient embarrassment or fear of being judged	Ensure privacy, maintain confidentiality, adopt an empathetic and respectful attitude, and reassure that sexual concerns are common in later life.
Belief that sexual problems are a 'normal part of ageing'	Educate patients that while ageing influences sexual function, many problems are treatable and should not be dismissed as inevitable.
Presence of spouse, caregiver or family member during consultation	Politely request time alone with the older adult for part of the consultation, while respecting patient preference and cognitive status.

Multiple chronic illnesses and competing priorities	Include sexual health as part of comprehensive geriatric assessment, especially when chronic illnesses or their treatments may affect sexual function.
Polypharmacy and medication-induced sexual dysfunction	Perform regular medication review, identify drugs affecting sexual function (e.g., antidepressants, antipsychotics, antihypertensives), and consider deprescribing or safer alternatives where appropriate.
Partner-related factors	When appropriate and with consent, assess partner's physical, psychological and sexual health, relationship quality, and caregiving burden.
Cultural, religious or personal beliefs	Demonstrate cultural humility, avoid assumptions, use respectful terminology, and tailor counselling to the individual's values and preferences.
Environmental barriers (lack of privacy, interruptions)	Conduct discussions in a private, quiet setting without interruptions, ensuring adequate time and confidentiality.

Medication review as important step in assessment

Medication review is an essential component of comprehensive geriatric assessment, which is also important while dealing with sexual issues in the elderly. Polypharmacy and adverse drug effects are common and potentially reversible causes of sexual dysfunction as well as sexual disinhibitions, as mentioned in table 3. A 'brown bag review,' in which patients are asked to bring all prescribed medications, over-the-counter drugs, herbal preparations, and dietary supplements and are verified by the clinician. This helps identify duplicate therapies, inappropriate medications, drug interactions, poor adherence, and agents associated with sexual dysfunction or hypersexuality. Medication review

should also consider the temporal relationship between initiation of a drug and onset of symptoms. Wherever feasible, deprescribing, dose reduction, or substitution with a safer alternative should be considered after weighing the risks and benefits.

Assessment in special population

Assessment of sexual issues requires special consideration in certain more vulnerable geriatric populations. In persons with dementia and related cognitive disorders, evaluation should include the type and severity of cognitive impairment, behavioural and psychological symptoms, decision-making capacity, and the ability to provide informed consent. Information from a reliable caregiver is often essential to understand the onset, context, frequency, and impact of sexual behaviors. Reversible causes such as pain, infection, constipation, urinary retention, and environmental triggers causing local discomfort should be excluded before attributing the symptom to sexual disinhibition, especially in cognitive disorders like dementia or even in delirium.

Among older adults receiving palliative care, sexuality should be recognized as an important aspect of dignity, intimacy, and quality of life. Assessment should explore the impact of pain, fatigue, breathlessness, incontinence, treatment-related adverse effects, altered body image, and psychological distress on sexual expression. As discussions about sexuality are often considered culturally sensitive in India, clinicians should use a respectful, patient-centered approach and tailor discussions to the individual's preferences and cultural values.

In the Indian context, most older adults live with their families, while institutional care is largely limited to long-term care facilities and old-age homes. Assessment should therefore consider family dynamics, caregiver attitudes, availability of privacy, and dependence on caregivers, all of which may influence sexual expression. For institutionalized older adults, clinicians should additionally assess opportunities for consensual intimacy, institutional policies, safeguarding concerns, and the risk of abuse or exploitation. Throughout the assessment, respect for autonomy, privacy, and dignity should be balanced with the need to protect vulnerable individuals and ensure valid consent.

Capacity, consent and ethical issues

293
294 Assessment of sexual issues in older adults should always include an evaluation of capacity and
295 consent, particularly in those with dementia, delirium, or severe mental illness. A diagnosis of
296 dementia does not automatically mean that an individual lacks the capacity to consent to sexual
297 activity. Capacity is decision-specific and should be assessed in relation to the situation. The clinician
298 should determine whether the individual understands the nature of the relationship, can identify the
299 partner, appreciates the possible consequences of the sexual activity, and is able to express a
300 voluntary choice. As cognition may fluctuate, especially in delirium, capacity should be reassessed
301 whenever required.

302 In India, discussions about sexuality are often influenced by cultural norms, and family members
303 frequently participate in healthcare decisions. While family members and caregivers can provide
304 valuable collateral information, they should not replace the older person's autonomy or make
305 decisions regarding consensual sexual relationships on their behalf. Clinicians should ensure privacy
306 during assessment, maintain confidentiality, and remain alert to the possibility of coercion, abuse, or
307 exploitation, particularly in cognitively impaired or dependent older adults. A balanced, person-
308 centered approach that respects dignity, autonomy, and safety should guide all ethical and clinical
309 decision-making. At the same time, ensuring the caregiver's safety is also extremely important.

310 **Rating scales**

311
312 Structured rating scales add objectivity to sexual function assessment in older adults, though most
313 were validated in younger populations and need cautious, age-aware interpretation. The Arizona
314 Sexual Experience Scale (ASEX) is a brief, five-item, gender-neutral tool assessing sex drive, arousal,
315 lubrication/erection, ability to reach orgasm, and orgasm satisfaction; its brevity makes it a practical
316 first-line screen, and it has been used successfully in an Indian community sample of older adults
317 (1,10). The Changes in Sexual Functioning Questionnaire (CSFQ), originally developed to capture
318 illness- and medication-related change in sexual function, assesses five domains of the sexual
319 response cycle- desire/frequency, desire/interest, arousal, orgasm, and satisfaction, and is available

as a 14-item self-report short form (CSFQ-14) with separate male and female versions(11,12). It has been applied specifically in postmenopausal and older women, where lower CSFQ-14 scores have correlated with menopausal symptom burden and depressive symptoms, supporting its use in geriatric populations with overlapping mood and vasomotor complaints(13). For men, the 15-item International Index of Erectile Function (IIEF), covering erectile and orgasmic function, desire, and satisfaction, remains the standard tool, with interpretation adjusted for age-related slowing of the sexual response cycle (14).

Examination and investigations

Once the history is taken, every patient should have a physical examination, carried out after consent and with privacy assured. In an older patient the examination does two things. It looks for any local genital problem, but more importantly it looks for the systemic, vascular, endocrine, neurological and drug-related causes that are so common at this age. It is worth remembering that poor sexual function may be the first sign of an underlying illness such as diabetes or heart disease, so the examination should not be confined to the genitals (3,15).

General and systemic examination

A full general examination is done to look for cardiovascular, neurological and endocrine disease. Blood pressure and the peripheral pulses are checked, along with secondary sexual characteristics, the pattern of body hair and fat, any gynaecomastia, vibratory sensation, and the strength and coordination of the lower limbs. A careful examination often does more than confirm the history; at times it turns up something unexpected, such as weak peripheral pulses, vaginal atrophy, small soft testes or a penile plaque (16).

Genital examination in men

The genital examination assesses gonadal function, the vascular supply, neurological integrity and the normalcy of the genitals. Where hypogonadism is suspected, note the muscle bulk, the size and structure of the penis, the position of the urethral opening, and the size and consistency of the testes and prostate. The penis is checked for masses, plaque, angulation, a persistent unprovoked erection

or a foreskin that will not retract. The bulbocavernosus reflex, brought out by squeezing the glans and watching for anal sphincter contraction, is present in roughly seven of ten normal men and gives a quick bedside check of the sacral pathways(16).

Genital examination in women

In women the genital examination is often very informative, particularly when there is dyspareunia or vaginismus, a history of pelvic trauma, or any condition that might affect genital health. If the history points to infection, this is the moment to take a PAP smear or to investigate for a sexually transmitted disease. A focused pelvic examination and a PAP smear are recommended in every case of female sexual dysfunction (16).

Routine and hormonal investigations

Which tests to order is guided by the history and the patient's other illnesses rather than by routine. A sensible baseline in both men and women is urine analysis, a complete blood count, renal and liver function tests, fasting blood sugar, a lipid profile and thyroid function, with an ECG where there is cardiovascular risk (3). Hormonal tests such as FSH, LH, prolactin and testosterone, together with an X-ray of the spine for spina bifida and a penile Doppler are added when the clinical picture calls for them (16). Since diabetes, dyslipidaemia and thyroid disease are both common and treatable in older people, these simple tests are especially worthwhile here, and more specialised endocrine or illness-specific tests are kept for when they are genuinely needed (3).

Special investigations

The more specialised and invasive tests have only a small place in routine geriatric practice and are reserved for selected cases. Nocturnal penile tumescence and rigidity testing helps separate organic from psychogenic erectile dysfunction, while an intra cavernosal injection of a vasodilator such as papaverine, duplex colour ultrasonography, dynamic infusion cavernosometry and cavernosography, and pelvic or penile angiography are used only in particular situations and according to the procedure being considered (3). Assessment of structural abnormalities of the penis and neurological studies

may be added when a vascular or nerve cause is suspected and a specific intervention is on the cards (16,17).

Distinguishing organic from psychogenic dysfunction

The examination and investigation findings are then drawn together to decide whether the problem is mainly organic or mainly psychogenic, bearing in mind that in older patients the two very often overlap. An insidious onset, a course that is global and progressive, and the loss of nocturnal and morning erections point towards an organic cause. A situational onset tied to a particular event, a preserved erectile response to other kinds of stimulation, and an episodic course point instead to a psychogenic contribution (3,16).

In older adults, inappropriate sexual behaviour may be the presenting sign of another primary disorder, so a detailed evaluation is mandatory. Dementia and neuropsychologic deficits, mood disorders and personality disorders are to be actively looked for. Frontal disinhibition is one of the common causes. A paraphilia is then distinguished from a paraphilic disorder which is defined by distress to the individual, with or without risk of harm to self or others. Management is multimodal, directed at the identified primary cause, and may combine pharmacotherapy (e.g. clomipramine in demented patients), behaviour-modification and sex therapy, and family and psychotherapy with reinforcement of socially acceptable sexual function. Flow chart 2 provides an overview of assessment of inappropriate sexual behaviour in older adults.

MANAGEMENT OF SEXUAL DYSFUNCTION

General principles of management of sexual issues in the older adults

The approach to management is patient-centred. The clinician tries to understand the problem from the older person's point of view, and, wherever possible, involves the partner as well (16). Once the assessment is complete, the first task is to give the patient or couple a clear formulation. This is a simple account of what the problem is and what may be contributing to it. A good formulation reassures the couple, shows them how common such difficulties are, and points to the maintaining

factors that treatment will target. It also lets the clinician check that the history has been understood correctly, so the couple should always be asked for their feedback on it.

Some considerations matter more in older patients than in younger ones. Ageing does bring some decline in sexual capacity, but studies suggest that just as many people find sex satisfying in later life as in their youth, and patients need to hear this. Much of the work, therefore, is counselling that is both realistic and encouraging about the normal changes that come with age (3). Older adults also face a range of health-related, psychological and social barriers to sexual expression, and while not all of these can be removed, education and better coping can lessen their effect. It is worth stressing that adopting a healthier lifestyle early such as stopping smoking, controlling diabetes and cholesterol, losing weight and reducing stress, is probably the single most useful step in reducing the burden of erectile and other sexual problems in old age. The WHO principles of affirmative action apply throughout: respect for autonomy, confidentiality and privacy, a non-judgemental attitude, and services that are accessible and equitable (3).

Treatment falls into general measures, which are sex education and relaxation, and specific measures, which may be non-pharmacological, pharmacological, or a combination of the two. In older patients the choice is rarely straightforward, because organic and psychogenic factors usually coexist, comorbid illness and other medications complicate the picture, and the patient's own motivation varies. As a rule, when motivation or psychological sophistication is poor, drug treatment takes the lead; when the patient is well motivated, a combination of psychological and pharmacological measures works best (16).

Non-pharmacological management

Whatever the diagnosis, treatment begins with sex education. The aim is to normalise the patient's experience and take the anxiety out of it by giving accurate information about arousal and the sexual response, correcting myths and setting realistic expectations (16). This step matters particularly in the elderly, where beliefs such as 'sex inevitably gets worse with age' or 'a heart problem means no more

sex' are common and need to be addressed directly (3). Relaxation training, using progressive muscular relaxation or the Benson–Henry method, is usually taught alongside.

Sex therapy in its current form derives from the dual-sex therapy of Masters and Johnson. It is brief, focused on the presenting problem and behavioural in method, and it works best when both partners take part. The couple are reminded that sex is a shared act, the relevant anatomy and physiology are explained, and sensory awareness is built up through sensate-focus exercises. The homework moves in stages, from non-genital sensate focus, through genital sensate focus, to vaginal containment, and a couple is not moved on until they are comfortable with the stage they are on (16). Annon's PLISSIT model offers a convenient graded structure that is: permission, limited information, specific suggestions and, if these fail, then intensive therapy is considered. most patients respond well before the intensive stage is ever reached. When a specific dysfunction is present, specific techniques are added: the stop–start and squeeze methods for premature ejaculation, introduced during genital sensate focus, and a graded programme of self-examination, pelvic-floor exercises and gradual vaginal penetration for vaginismus. Finally, couple and family therapy have an important place, because relationship problems such as poor communication, loss of intimacy, bereavement, loss of a partner, or simply lack of privacy, so often lie behind the complaint in this age group (3,16).

Pharmacological management

Drug treatment needs extra caution in older patients. Comorbidity and polypharmacy are the rule, drug handling is altered, and it is always worth asking whether a medication the patient is already taking is itself part of the problem (16,18).

For erectile dysfunction, the oral PDE5 inhibitors like sildenafil, tadalafil and vardenafil, are first-line, and their efficacy and safety are established even in men with diabetes, cardiovascular disease or a history of radical prostatectomy. Because they act through an androgen-dependent pathway, coexisting hypogonadism may first need correcting. They must not be given with nitrates, they add to the hypotensive effect of antihypertensives, and with alpha-blockers they can cause postural

hypotension, all of which matter more in older men. Tadalafil, being long-acting, suits men who anticipate frequent or early-morning intercourse. A common reason for apparent failure is simply incorrect use, so it is important to educate the patient about the dose, the timing, the need for sexual stimulation and the effect of a fatty meal before concluding that a drug has not worked. If oral treatment fails or cannot be used, second-line options are intra cavernosal or intraurethral alprostadil and other vasoactive agents, with penile prosthesis as a third-line choice; vacuum constriction devices tend to be well accepted by older men who have a stable partner (16). Testosterone should be given only where hypogonadism is documented, and the prostate, PSA and haematocrit must be monitored, since exogenous androgen can stimulate the prostate and raise the haematocrit (3,16).

Premature ejaculation is treated with topical anaesthetics, SSRIs such as dapoxetine, paroxetine and sertraline, and the tricyclics, generally alongside or after the behavioural techniques. In women with hypoactive sexual desire disorder, flibanserin is approved for the premenopausal group, while in menopausal women oestrogen replacement improves vaginal lubrication and function; testosterone can raise desire, though not erectile function, and is used only with careful monitoring. Hyperprolactinaemia is managed with a dopaminergic drug such as bromocriptine (3). Throughout, if a psychiatric disorder or a contributing medication is found, the psychiatric condition is treated and the offending drug changed where ever possible, for instance, by choosing an antidepressant or antihypertensive with a gentler effect on sexual function (16,18). Flow chart 3 provides an outline of management of sexual dysfunction in older.

Flowchart 3: Management of sexual dysfunction in the older adults

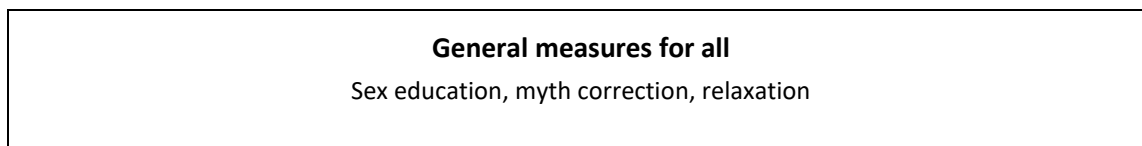
Elderly patient with sexual dysfunction



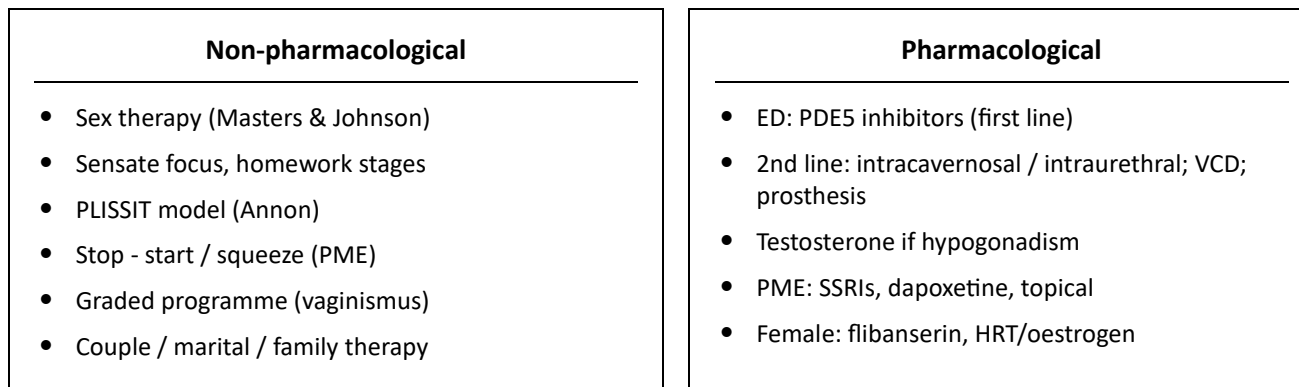
General principles

Patient-centred formulation, balance partners,
realistic counselling, preventive recommendation, lifestyle modifications, WHO principles

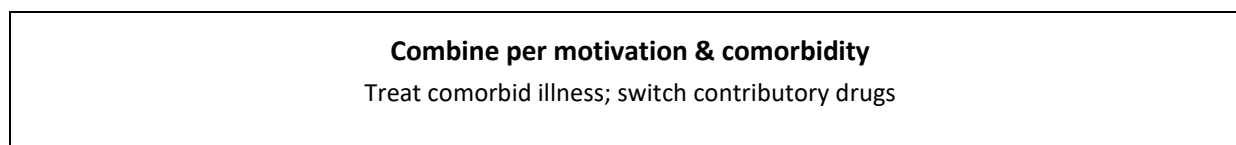
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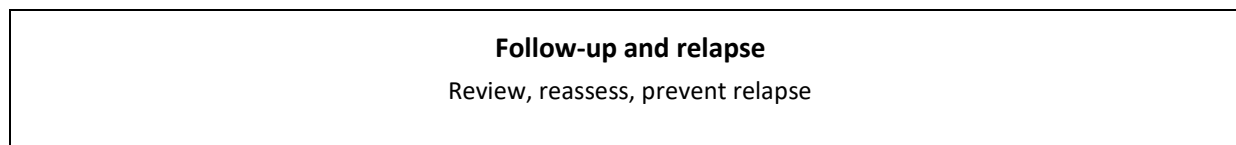
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478 **Management of the inappropriate sexual behavior in older adults**

479 Inappropriate sexual behaviour in older adults adds significant distress among the care givers adding
 480 to the burden. Flow chart 4 provides the step-by-step assessment and management guide to deal with
 481 the inappropriate sexual behavior in older adults.

482

483 **Flow chart 4. Management of inappropriate sexual behavior in older adults**



STEP 1. Initial assessment: screen for acute / reversible causes

- Delirium; medication effects (dopaminergic agents, cholinesterase inhibitors)
- Mania or psychosis; substance use; post-ictal confusion
- Pain, urinary tract infection or discomfort causing undressing (3,19)



Is a reversible / acute cause identified?

YES

NO / ISB persists

Treat the underlying cause (stop/adjust offending drug, treat delirium, infection or pain).
Reassess ISB after resolution.

Proceed to Step 2 (non-pharmacological management).



If ISB persists despite treating the underlying cause, also proceed to Step 2

STEP 2. Non-pharmacological / behavioural and environmental measures (first-line)

- Identify and modify triggers; distraction and redirection
- Adjust clothing / environment for privacy and dignity
- Caregiver and staff education; structured routine and supervised social contact
- Family involvement (9,19)



Is the behaviour adequately controlled?

YES

NO / high-risk behaviour

Continue non-pharmacological measures.
Monitor and reassess periodically.

Proceed to Step 3 (pharmacological management).



STEP 3. Pharmacological management (first-line)

- SSRI; sertraline, citalopram or escitalopram (favourable safety profile in older adults)
- Alternative first-/second-line in men with benign prostatic hyperplasia: 5- α -reductase inhibitor (finasteride or dutasteride) (19,20)



Inadequate response after an adequate trial

STEP 4. Second/third-line

- Add or switch to gabapentin, low dose (e.g. 100 mg two to three times daily) (19)



If urgent control of high-risk / unsafe behaviour is required at any stage

Short-term antipsychotic as a bridging agent

- Risperidone, olanzapine or aripiprazole, combined with the first-line agent
- Attempt to taper and deprescribe the antipsychotic within a few months once stabilised (19)



Refractory despite the above

Refractory cases – hormonal / antiandrogen therapy

- Medroxyprogesterone acetate, cyproterone acetate, leuprolide or oestrogen
- Manage in liaison with a geriatric psychiatrist / endocrinologist given the side-effect burden

Principles applied at every step

- Assess decision-making capacity and consent; involve the patient wherever possible
- Discuss risks/benefits of off-label medication use with the patient and/or substitute decision-maker/family; document clearly
- Review comorbidities and possible secondary indications (e.g. depression, agitation, BPH) when selecting an agent
- Reassess regularly; deprescribe/taper if no benefit after an adequate trial

CONCLUSIONS

Sexuality is an integral part of health and quality of life that does not end with advancing age, yet it remains one of the most neglected areas of geriatric care in India. As the population ages, clinicians will increasingly encounter older adults with sexual concerns, and these deserve the same careful, respectful and evidence-informed attention given to any other health problem. A recurring theme of this guideline is the need to distinguish the normal, expected changes of ageing from true sexual dysfunction, so that older adults can be reassured where reassurance is appropriate and treated where treatment is warranted.

Sexual issues in later life are best understood across three overlapping domains: sexual dysfunction, inappropriate sexual behaviour, and relationship issues. Their causes are biopsychosocial, with medical comorbidity, psychiatric illness, cognitive impairment, medication effects and relationship and social factors frequently coexisting. Assessment therefore has to be broad and unhurried, attentive to capacity and consent, sensitive to cultural context, and willing to look beyond the genitals for systemic contributors. Most sexual problems in older adults are treatable. Management is patient-centred and combines general measures, non-pharmacological approaches and, where indicated,

pharmacotherapy, the last prescribed with particular caution given comorbidity and polypharmacy in this age group.

Inappropriate sexual behaviour, most often seen in dementia, warrants a structured approach that begins with a mandatory evaluation and the exclusion of reversible causes, prioritises non-pharmacological measures, and reserves medication for high-risk or refractory situations, always within a framework of capacity, consent and dignity. Overall, improving sexual health in older adults will depend as much on changing attitudes as on clinical intervention: on destigmatising sexuality in later life, training clinicians to raise the subject comfortably, and building the Indian evidence base through further research. Addressing these needs will meaningfully improve the quality of life of older adults and is an essential component of comprehensive, compassionate geriatric care.

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