Speaker 1: The Sam and Rose Stein Institute for Research on Aging is committed to advancing lifelong health and well-being through research, professional training, patient care, and community service. As a nonprofit organization at the University of California San Diego School of Medicine, our research and educational outreach activities are made possible by the generosity of private donors. It is our vision that successful aging will be an achievable goal for everyone. To learn more, please visit our website at aging.ucsd.edu.

Annie L. Nguyen: Today, we'll be talking about sexual health and sexual well-being, how it evolves as we age, and what I would like to do with this talk is to first set the context for sexual health within the healthy aging discourse. Then explain why sexual well-being is a very good example of a different way to think about healthy aging, and then finally, I'll share some findings from our study. Let me start here. I want to start on the broader topic of healthy aging because I know that many of you are already familiar with this topic and the research in this area, and you know that when we talk about healthy aging, we actually spend a lot of time thinking about how to promote health and well-being across the lifespan to increase health span. A lot of that work is focused on ways we can preserve physical function, maintain cognitive ability, and support independence for as long as possible. We know that those goals are incredibly important, but my question that I want to pose today is what happens when changes occur? More importantly, does that necessarily mean loss of well-being? The way that we talk about healthy aging can sometimes unintentionally create the impression that if we just do the right things, behave in the right way, do everything that we're told, we can maintain the same level functioning all the way through the end of life. But in reality, we know that aging is much more complex than that. Even with the best behaviors, many people experience physical changes or shifts in their daily lives, and yet, many people are still reporting high levels of well-being. One way to think about this is that healthy aging is not only about preserving function, it is also about how people adapt to change and continue to find meaning, connection, and satisfaction in their lives, no matter what it looks like. I think today's topic of sexual health is actually a really useful lens for how to think about healthy aging in this way. I will begin with this very simple model from Rowe and Kahn, the successful aging model, and it's a classic framework that we use in successful aging studies. It's very simple. It really only emphasizes three main components; low disease burden, high physical and cognitive functioning, and active engagement with life. The image that it really calls to mind is a 79-year-old who is still running and participating in marathons. That's the classic example of someone who is successfully aging. As simple as it is, this three prong model has really shaped much of how we think about what it means to age well, but there's a tension that's inherent in this model, and a very well-known critique of this model is that it does unintentionally create an expectation that one must avoid decline in order to age well. In reality, aging is inherently variable and inherently diverse, and many people experience physical changes and illness and losses and still report high levels of well-being. In that 30 years since the Rowe and Kahn model was published, the successful aging discourse has really generated a lot of alternative perspectives from the life course theory and using this idea of adaptation. One framework that is very well-known is the selective optimization with compensation framework by Paul and Margaret Baltes. This model really leans into the idea that people can adapt to changes by selecting what matters most to them, optimizing what they can do, and compensating for changes. An example of this might be someone who has spent a lot of time outdoors and really enjoys hiking and maybe climbing mountains and over time starts to realize that maybe mountain climbing isn't something that is safe or feasible anymore, and this person might spend more time hiking gentle slopes or flat surfaces and flat slopes, but still find a way to be outside and enjoy the outdoors. This picture on the right is of Arthur Rubenstein, who was an accomplished Polish pianist, who as he got older, was still playing beautiful pieces with expertise. Someone asked him how he was able to maintain that level of expertise and function that into later life, and his response was that he became a lot more selective with the pieces that he chose to play, and of the pieces that he selected, he practiced them more often in order to optimize what he was doing. Then he slowed down on the sections before the fast parks to actually make the speed appear relatively faster, even though he was playing at a slower speed. He was compensating. These are just examples of how this theory

really plays into our day-to-day lives and how we can enact them. The emphasis here is not necessarily on maintaining function to a certain level or threshold, but about that process of how we engage in adjustment over time. Other theories that have emerged include the theory of gerotranscendence by Lars Tornstam, and the idea of gerotranscendence is that as we get older, there's a mindset shift that happens where we start to de-emphasize physical and material desires and move towards finding meaning in personal growth and spiritual connections. From an anthropological and sociology perspective, there are lots of different writings that have looked at this concept of successful aging. Sarah Lamb edited this book called Successful Aging as a Contemporary Obsession, and in it, the anthropologists and sociologists call successful aging a contemporary obsession and described this as a phenomenon, particularly in the West and how we've been enticed by this idea that we have agency and control over how we age, and really lean into this idea of favoring a very specific type of personhood and favoring the idea of permanence that we can be a certain way forever versus the idea of transience, that there are natural changes that occur and that we appreciate the changes for what they are at each phase of our lives. Regardless of the aging lens that we adhere to, whether it's on the successful aging lens and leaning into that biomedical model or maybe more into that gerontranscendence lens, a key idea that really needs to be taken into account in gerontological studies is the idea that aging is simply not a uniform experience. People differ in their health and the relationships that they value, the social environments and the customs that they adhere to and the priorities that they make in their lives. Simply put there is no single trajectory of aging, and thus, the meaning that we make out of our later life experience will also be different and diverse across individuals. Sexual health then is something that becomes a really useful example of how all of these ideas play out. It is an area where people place a lot of personal and cultural value, but it is also an area where we often apply implicit standards. What I mean by that is we tend to define what is normal when it comes to sexual health by metrics of performance or frequency, and anything outside of that is often framed as the claim. But the thing is framing in that way does not fully capture people's lived experiences. When we talk about sexual health, it's not just about activity. It includes physical, emotional, relational, and psychological dimensions, and it is closely tied to overall well-being and quality of life. Within these slides, I'll share some study findings from the literature so that we can get a comprehensive look at what scholars are looking at in terms of sexual health. In this particular study, the authors found among a group of older adults in a British cohort that sexually active older adults report greater enjoyment of life, but it's not just about intercourse, and there are a range of activities defined within sexual activity, including kissing and feeling emotionally close to one's partner. This really highlights the multidimensional nature of how we should think about sexual health and not just in terms of frequency of intercourse. It is especially helpful to distinguish between three related but distinct concepts. We have sexual interests, sexual activity, and sexual satisfaction. Sexual interest refers to desire to engage in sexual activity. Activity is the behavior itself however we define that activity, and sexual satisfaction is how people evaluate their experiences. It's important to note that these do not always move together. In large population studies, it's been shown that many older adults remain sexually active, but at the same time, sexual activity does tend to decline with age. The University of Michigan poll on healthy aging looks at this in their surveys, and among adults ages 65-80, they have found that about 76% agreed that sex is an important part of a romantic relationship at any age, and a little bit over half of those in romantic relationships reported that they are currently sexually active. Just for reference, among younger adults, so we're talking more like in the 18-60 range, the statistic is more like 90% to 75% of younger adults are sexually active. If we look at the data from the National Social Life, Health, and Aging Project or NSHAP, if we're breaking it down by age buckets from age 57 up to 85, you do see a decline in the percentage of older adults within those age buckets who report being sexually active. But if you look at it, it is a range, and even within the 57-64 range, that number is 73%, which is very close, essentially to the statistic for younger adults. We do know that sexual activity does decline with age, that has been well documented in the literature, and in this particular study, the authors looked at life expectancy in men and women, and then they compared it to life sexually active life expectancy

among men and women. If we look at the line, so we can see that the top red dotted line represents life expectancy for women, which is a little bit higher than the life expectancy for men represented by the solid blue line. But if you look at the dotted green line, that's the sexually active life expectancy for men, which is a little bit higher than the sexually active life expectancy for women. If you look at it as a whole, if you step back and look at this, what we're seeing is that there's a natural, the decline in sexual life expectancy follows the slope that you would see in life expectancy for both men and women. The difference is about the same, but you're flipping men and women. The authors also looked at the ways that health status impact years of sexually active life left. Among men, men who are in good health gain about 5-7 years of sexually active life, and women who are in good health gain about 3-6 years of sexually active life. We're appreciating that there are different patterns as we move through life across different life stages, and there are different patterns when it comes to gender as well. These patterns are shaped by a number of factors that may become more common or may accumulate with age, but it's important to note that the changes are not simply about age itself. It's an accumulation that is associated with age. Things like health conditions, arthritis, pain, or different chronic conditions, physiological changes like hormonal changes, medications that may impact libido and performance, partner availability, we do know that women are more likely to be unpartnered at the later stages of life compared to men, and social stigma and context and perhaps stigma around sexual activity for older adults, stigma around dating after age 65. All of these things interact and matter in forming the different patterns that we see. In this particular study, it really highlights why this context really matters because the authors here are looking at respondents who were sexually active in the previous year at these different age groups and breaking it down by health status. What you can appreciate without even maybe getting into the details of what the circles and the triangles and the pluses mean is that you do see a downward slope so that as we see age group increase, we are seeing sexual activity decrease. But if you look more carefully at the icons within each of the age buckets, we can see that there's very clearly a difference between those who are in excellent or very good health and those who are in fair or poor health. If you're comparing, let's say, looking at the plus signs compared to the circles, we're seeing there is quite a bit of an appreciable difference between those with different health status and whether or not they are sexually active, and that's true across all the different age groups. If you were to look at the colors, if you're able to differentiate, more of that blue color represents men and the red color represents women. But let's just say, let's take age 81-85 and we're looking at men in excellent or very good health that's represented by the plus sign here, if you draw your eye across the age groups, you could see that the percentage of men who are sexually active who are in excellent or very good health at this age group, that number is comparable to other age groups in terms of different health status. Really, what this is telling us and what this is visually depicting for us, it's not just about age, there's an interaction here with health status as well. And there are lots of reasons for lack of sexual activity, and the patterns are shaped by a number of factors that again, also become more common or accumulate with age. In that same study, the authors asked participants what were the top reasons for lack of sexual activity. For women, the top reasons were their partners' physical limitations. That was number 1, followed by own lack of interest, and then partners lack of interest. For men, it was their own physical limitations, partner's lack of interest, and then partner's physical limitations. We can really see here, too, that it's not just about the individuals, the personal factors for the one individual, but because it's a partnered activity or sexual activity can be a partnered activity, that there are different considerations and contexts for the other person in the relationship as well. One of the most consistent findings in this literature is that relationships play more of a central role in sexual well-being as we age. In particular, sexual satisfaction is not just about physical function or frequency of sets; it is strongly tied to emotional intimacy and the value that is placed on relationship quality and communication between partners. When we think about sexual health in later life, it is important to move beyond a purely biomedical lens. It's really a relational and social experience as much as it is a physical experience. That helps to explain why some aspects of sexual health may remain stable, even as other aspects change. In this particular study, the authors looked at not sexual activity or

frequency, but sexual satisfaction among older adults. They were able to differentiate between sexual minority adults and heterosexual adults, and the patterns are basically the same. What you see is somewhat of a decrease over time or over age group in terms of experienced sexual satisfaction. But you might be able to appreciate that the slope is not as steep as we have seen for sexual activity. Same here with this particular slide and with this study, again, looking at sexual satisfaction across different age groups, but starting from a younger age category with 20, moving up to about 90. There's a slight decrease. But the slope is not incredibly steep, but there is still a gender difference. If you look at the blue line versus the red line, that's the difference between men and women. Again, it's following that same pattern for sexual activity where there are differences in the starting point between men and women, but yet, the rate at which that decline is happening is roughly the same. In this study, this was a study performed on the Rancho Bernardo study here in the San Diego area, and the authors looked specifically at women, only at women. So, among the older women in this study, regardless of whether or not they were sexually active, 61% said that they were satisfied with their sex lives. And of the women who were sexually active, most of them were moderately satisfied or very satisfied with their sex lives. We're seeing that there is a bit of a difference between sexual activity and sexual satisfaction. If we look at sexual well-being and we look at sexual health, if we were to tease apart these two things, we would see slightly different patterns that we see that both may decline with age, but sexual satisfaction declines more slowly. This represents a shift away from behavior to the value that is placed on that behavior. This brings me to the research that we conducted. I'll share the findings with you in this talk. For our study, we really wanted to look at these two factors together and ask the question, "How do sexual interest and sexual satisfaction vary across different age groups within later life?" Then, importantly, how do these patterns differ between men and women? We also wanted to understand whether any of the observed differences could be explained by factors like relationship status and general health status. Here in this study, we use data from the UCSD SAGE study. We focused the analysis on adults who are ages 60 or older, and we had a total sample of 359 participants in our analysis. One strength of this dataset is that we were able to include a really wide age range within later life and had a sizable number of people who were in their 80s and 90s, which really allowed us to look at these differences more closely. If you think about the slides that we saw earlier, we see a fair number of studies looking at older adults and sexual health. It is within this realm that really focuses more on the younger age range. We just don't see as many studies that look at folks who are in their 80s and 90s. This was really a benefit for us in using the SAGE study for this analysis. Just to show you who was in our dataset, this is a table showing the sample characteristics by sex. What I want to point out is that we had roughly the same number of men versus women. You can see that in terms of the age groups, we had a really nice distribution of those who were in their 60s, 70s, 80s, and 90s. We had not as racially ethnic diverse population with the majority identifying as non-Hispanic White, fairly educated crowd, and some differences in terms of their marital status. First, we looked at sexual interest. I'll share our findings around sexual interest, and then we'll look at our findings around sexual satisfaction. When looking at sexual interest by marital status, we did see a significant difference in that sexual interest was higher among those who are married or in a partnered relationship versus those who were not, versus those who were single. One marital status, we know, is one variable or a factor that can influence one's interest in sex. General health status is another one. We looked at several studies that I really teased apart the differences in health status and how it can influence sexual activity and engagement in sex. When we looked at sexual interest by general health status, we did see a significance. You might be able to see there's a blue line that runs sloped. It's a positive slope. It's not a very steep slope, but there is a positive slope telling us that as general health status increases or gets better, sexual interest also increases as well. When we started to look at it by age and sex, so breaking down the different categories. So among women who were in their 60s, 70s, 80s, versus 90s, and then among men who are in their 60s, 70s, 80s versus 90s. I'll walk you through this graph, but what we basically found was that first, among women, we see that sexual interest, represented by the bars, decreases as we move into the later age decades. The difference as we move down is significant among women. The same

with men. We see that step-wise, the bars are stepping down as we go from the 60s to the 90s. That difference was significant across multiple groups. What was also significant is the difference between those who were in their 60s and looking at men versus women. If you look at the blue bars, so the blue versus the blue, the orange bar versus the orange bar, the gray bar versus the gray bar, those differences were also significant, meaning that women in their 60s were less likely to be interested in sex compared to men in their 60s. Women in their 70s were less likely to be interested in sex, compared to men in their 70s, and the same for those in their 80s. We did not see differences among men and women in their 90s. So what we're seeing here is not just a difference or a decline or reduction in sexual interest by age, but that there are also gender or sex differences highlighted. Here, what we did was we looked at levels of sexual interest, breaking it down by age and breaking it down by gender, but also accounting for the fact that marital status makes a difference for sexual interests, and accounting for the fact that general health status makes a difference in sexual interests. These are general linear models that we ran. You can see that it graphically depicts basically the same pattern that if you're just looking at men or you're just looking at women, you see a decline over the different age groups and age categories. But there's also a difference in terms of where women are starting and where men are starting. In effect, if you look at sexual interest among men who are in their 90s and you pull your eye across to where it represents the dot for women in their 60s, it's kind of roughly the same. Right, or maybe somewhere between, might be somewhere between here and here. If you're looking here, men in their 90s and we're kind of pulling across, and it's somewhere in the realm of women in their 60s and women in their 70s. There is a persistent difference in sexual interest by age and sex, even after accounting for marital status and general health status. When we looked at different models, statistical models, to see what are the different factors that might predict sexual interests. So not just looking at whether or not there are differences, but predicting sexual interest. I'll walk you through the model. But ultimately, the model that we're going to land on is the fourth model. But what this is basically telling us is that when we use a model that accounts for someone's age, their gender, their race, ethnicity, and marital status, that it's really just age, gender, and marital status. That makes a difference in predicting the difference in sexual interest. When we start to throw in other psychological factors like morale or self-compassion, or satisfaction with life, the variables that have the stars and the asterisks, that tells us the things that remain significant as predictors. That would be age, gender, marital status, and morale. Now, in model number 3, we've added in some health variables. So looking at that general health, which we saw earlier, and then physical function, which are two distinct concepts of health. Here, we see that physical function is significant, is a predictor, marital status remains a predictor. Gender remains a predictor, and age remains a predictor. In our final model, which with R^2 of about 0.31, tells us that if we consider these variables, this is going to explain about 31% of the differences in why there are different variations in sexual interests. Really, it has to do like 31% of it can be explained by age, gender, marital status, and physical function. Older age, I'm sorry, that should be younger age. Younger age, those who are men who are married or partnered, and have better physical function, that predicts higher sexual interest. Looking at sexual satisfaction, so going through the same exercise, but using sexual satisfaction instead of sexual interest, when we compared sexual satisfaction by marital status alone, we found no significant difference. Among people who are married and among people who are married a partner versus not, there was no difference in sexual satisfaction. When we look at general health status, there was a significance, meaning that as people's general health scores increased, it also led to an increase in sexual satisfaction. Now, interestingly, when we looked at age and sex, so using that same breakdown by breaking down gender, so looking at women by themselves and men by themselves, and then breaking down to those who were in their 60s, 70s, 80s, and 90s, basically, across the board, we found that there was no difference in sexual satisfaction. While we sell lots and lots of differences in sexual interest by sex and age, even though you look at this, and you can see that there are some differences in the levels of the bars. But statistically, this is telling us that there's no appreciable difference in the level of sexual satisfaction that's reported by age or by sex. We went through that same exercise of

accounting for marital status and accounting for general health status, and we did not find a significance. Again, just looking at how the lines are really different from the other one that we saw, it's pretty even, and we're seeing that sexual satisfaction really holds across gender, and it holds across age categories. Looking at different predictors of sexual satisfaction, we can see here that in our first model, it's really even after accounting for some of these demographic models, it's really age. Age is something that might predict sexual satisfaction. But when we start to add in and account for other factors like psychological factors here, morale, self-compassion and satisfaction with life, morale becomes significant. Age is still significant. In Model 3, we throw in those health variables. What happens is age actually becomes non-significant. It goes away. Morale goes away, physical function becomes significant. But we have this general health function in there that's messing up the model. In our final model, what we really see in the end is that it's morale and it's physical function. About 15% of the variation in sexual satisfaction can be explained by morale and physical function. Those with higher morale, so higher sense of morale. The psychological concept of morale, and greater physical function, are more likely to report greater sexual satisfaction. So I know that was a lot of different graphs and things to digest. But when we put these findings together, we see that sexual interests and sexual satisfaction really do follow different patterns, and it suggests that there are distinct dimensions of sexual health, and they should not be treated as interchangeable. So interest may be lower in older age groups, even after accounting for marital status and health, but satisfaction levels are really more stable across age groups. And there are gender differences. We saw this in the literature, we also saw this in our study. Compared to women, men maintained higher levels of sexual interest throughout the later stages of life. But for our study, we didn't see any gender differences when it came to sexual satisfaction. Thinking about what those different predictors were, so age, gender, marital status, and physical health, predicted about 30% of that variation in sexual interest. Morale and physical function predicted about 15% of the variation in sexual interest. You might say that 30% and 15%, that doesn't sound like a lot, and it certainly isn't 100. It's not close to 100, but it's pretty impossible to find a model that will fit something 100% of the time or predict something with 100% accuracy, if you will. Thirty percent and 15% actually gives us a really good starting place to think about things that can be potentially modifiable or intervened upon if we're thinking about how we can help people achieve greater sexual interest or maybe achieve greater sexual satisfaction. So in thinking about some of the implications for healthy aging, one way to interpret the patterns that we see here is that sexual satisfaction may depend less on frequency or performance and more on relational and psychological factors. There are things that we weren't really able to measure because it wasn't in the dataset. But things like emotional intimacy and communication and expectations may well play a role and become very important or more important over time. This is also where that idea of adaptation comes back in. So as people age, they may adjust their expectations, redefine what is meaningful to them, and focus on aspects of intimacy that remain accessible and fulfilling. So even as some aspects of sexual health change, satisfaction in that way can still be maintained. These findings have implications for clinical practice. Sexual health is often overlooked in conversations with older adults. Whether or not it's because of implicit assumptions or ageism or other factors that influence the clinical conversations, there may be assumptions that this is just simply not a relevant topic for older adults, or maybe there's even some discomfort on one or both parties in raising the topic. But given its connection to well being, it is important for healthcare providers to create space for these discussions, and for patients and providers alike, to approach this conversation in a way that is open and non judgmental and responsive to individual values. So overall, what this work highlights is that sexuality in later life is diverse, it's adaptive, and it's shaped by context. It does not follow a single predictable pattern and cannot be reduced to just simply a single measure. So in thinking about our closing thoughts, I want to bring it back to the question that I started with around successful aging and healthy aging. What does it mean to age well? What happens when change occurs? I think that sexual health really provides us with a useful lens for thinking about this. We see that there are some aspects of life that change, and those changes do not necessarily lead to loss of well being. In fact, people adapt. They

adjust their expectations, their relationships, and their experiences in ways that help to maintain positive connections and satisfaction. So if we were to look at this from a broader perspective and think about healthy aging, it shows us and teaches us that it's helpful to recognize that people age in different ways, hold different values, and find well being through different pathways. Sexual health reminds us that well being doesn't disappear. It just evolves.

Danielle Glorioso: Thank you so much, Dr. Nguyen, for such a fantastic talk. It's so great to see data from this age study.

Annie L. Nguyen: Yes. Thank you.

Danielle Glorioso: I love that. So I'm just curious, Dr. Nguyen, when you were doing this research, were there any findings that surprised you?

Annie L. Nguyen: Yes. We did expect to see that there were going to be differences in sexual interests across age and across gender. We expected to see some differences in sexual satisfaction, and I showed some background from the literature that tells us that we should have seen perhaps some decline or some differences between men and women. We did not see that in this study. I think what that really just shows us is the variability and the diversity of experiences. It really depends on who is answering the survey. It really highlights how different these experiences are for different groups of people.

Danielle Glorioso: Great. Thank you. We have a lot of questions that have come in, and here's a good one that's about grief and bereavement. It's interesting that there's no mention of the impact of grief and bereavement on future sexual activity. If they've lost a life partner, future desire could be significantly impacted. I don't think that's something we've looked at, but do you have thoughts on that?

Annie L. Nguyen: I do. I think that's tied to some of the gender differences that we see. Grief and bereavement is experienced by everyone, regardless of your gender. But from a research perspective, if we're able to look at the data, we do know that women are more likely to be widowed at the end of life in the later stages of life in older adulthood compared to men. So what happens is that it limits access to partners and limits maybe opportunities to engage in sexual activity, which could be related to someone's level of interest. There's also the grief stage and the bereavement stage in which there is there are other things going on emotionally and psychologically in which interest in sexual activity just becomes less important and is not perhaps top of mind. So I think there are a lot of different ways that loss and bereavement and grief, really interacts in determining desire, in determining interest, and even availability of partners for those who are interested.

Danielle Glorioso: Yeah, that makes sense. So here's a question that has to do with gender differences. What role do you think ED drugs, so erectile dysfunction drugs for men, play in gender differences when there doesn't seem to be a comparable option for women?

Annie L. Nguyen: Yeah, that's an interesting question, and we didn't look at any of the studies around performance, really. So the studies that I pulled for background and the variables that we looked at for the study were really around interest and satisfaction. I suppose that ED drugs and the use of ED drugs could have an impact on sexual interests, but I think it could also be the other way around that those who are more interested maybe more willing to seek out different drugs and other things that might help them fulfill that interest. But I think this is certainly something that is relevant and influences the way that we think about sexual health for men and women. The point that there aren't really comparable, there are some, but not in the same way. There aren't drugs that are comparable for women as there are for men. So certainly that could make a difference.

Danielle Glorioso: Okay. Can you remind our audience how you measured and assessed sexual

interest?

Annie L. Nguyen: Sure. This was measured using a standardized measure within a toolbox called the promise toolbox. So it's not a single question. There are several questions that the participant answers, and then it's summed up for a standardized score. The standardized score is then compared across a national mean, if you will, and it includes lots of different things. So it's exactly as you would think sexual interest might represent, how often someone is thinking about sex, how often they want to have sex, whether or not there's a difference in the level of your interest and the frequency at which someone is having sex. So there are a number of questions, a number of items that go into the scoring for this.

Danielle Glorioso: Great. Thank you. How about the physical changes due to menopause? Can you speak on that?

Annie L. Nguyen: Yeah, and I think that goes back to some of the factors that we talked about, reasons for changes in sexual activity and interest and maybe even satisfaction. As people are getting older, with physiological changes and changes with hormones, with menopause, that has a lot of impact on lubrication and performance. If someone is feeling pain during sex, that might not be a very satisfying experience, and that might lead to a feedback loop where that person may start to avoid it, unless there's some adaptation that happens. So I think certainly looking at menopause and thinking about the physiological changes and hormonal changes associated, makes a big difference.

Danielle Glorioso: Okay. Great. Thank you. How should clinicians or providers think about sexual health in older adults based on your findings? Are there takeaways for them?

Annie L. Nguyen: Absolutely. I should say that not all providers are exactly the same. So there are providers out there who are very attuned to the different needs of older adults, and there may be some who are not. It's not just with older adults, but sexual health in general, it tends to, in the US and the Western US cultural context, may not be thought about in a clinical sense when it's not thought about in a more reproductive sense. So if we're not talking about reproduction, we're talking about really sexual well being and for relationship development, for pleasure. These are different things than what we might normally talk about in a clinical setting. So I think the main thing is to remember that all humans are sexual beings, and that doesn't necessarily change just because of age. It doesn't necessarily change just because of a relationship status change. Just because someone's been in a long marriage and is divorced or has been widowed, that doesn't necessarily mean that sexual desire goes away, and it doesn't necessarily go away with age. So there are, I think, opportunities to create space in a clinical dialogue to have those conversations and I would say that the patient and the provider as well, both people have to be comfortable enough to bring that up and have that conversation in a non judgmental way.

Danielle Glorioso: That's great. Here's a question that I think a lot of people will want to hear. What's the impact of current medications and polypharmacy on sexual health?

Annie L. Nguyen: In our particular study, we weren't able to look at medications. We didn't have access to that variable. Polypharmacy, I don't believe we had access to that particular variable to look at polypharmacy, as well. But I think this is all very much rolled into that broader context of physical health and general health status. So I think we would reasonably assume that people who have high levels of polypharmacy, general health status would be less or their physical function would be lower. So it's accounted for in that. It's not specifically accounted for. But I think it's all tied together into how well somebody feels. So not just what the different medications and drugs may be doing in terms of interrupting libido, or desire, or performance, but how well someone feels and whether or not they feel up for the physical activity that is related to sexual activity.

Danielle Glorioso: Great. I'm curious, how do you think cultural attitudes towards aging affect people's

sexual expression? Do you have thoughts on that?

Annie L. Nguyen: Yeah, I think that's a really great question. In the US Western context, we think about sexual health in a different way than others might in other cultures, in different countries. All of that has an impact on how we think about, and not just think about but how we talk about sexual health. Whether or not you even talk about it as something that happens for reproduction, or if we talk about it as something that is integral for pleasure and integral for general life satisfaction. There are big cultural differences, I think, in how that conversation is had just in this country versus others.

Danielle Glorioso: Yeah. Okay. So with that, I would love to thank you so much for your time today, Dr. Nguyen, and for your amazing research that is clearly making an impact on the field. This is a topic that the Stein Institute has not covered, so it feels great to have you shed some insight on that today. So thank you so much for this great talk. I want to remind you all that we have another public lecture in May, which will be on a movement intervention. So we're looking forward to seeing you back in May. Those of you who want to donate and support our work, please find us at aging.ucsd.edu. So with that, thank you so much for a great talk today, Dr. Nguyen. I love hearing about your research.

Annie L. Nguyen: Thank you, everyone. Thank you, Danielle. Thank you for your time.