

Mental Health Treatment and Sexuality in Later Life: The Trade-off Nobody Mentions

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Mental health conditions become more common, not less, as people move into later life, and so does psychiatric treatment: antidepressants, antipsychotics, mood stabilisers, sedatives and anti-anxiety medication are now a routine part of many older adults' daily lives. What is discussed far less often is that these very conditions, and the medications used to treat them, can profoundly affect sexual desire, arousal and satisfaction. For older adults already navigating stigma around both aging and mental illness, sexuality becomes a third, largely invisible layer of difficulty, one that clinicians rarely raise, patients rarely feel able to ask about, and research has only recently begun to take seriously.

This gap matters more, not less, as populations age. People are living longer with chronic psychiatric conditions that once shortened life expectancy considerably, and more people are being diagnosed with anxiety and depressive disorders for the first time in their sixties, seventies and beyond. At the same time, sexuality remains, for most older adults, an important and continuing part of identity and relationship satisfaction. Treating the mind while quietly ignoring what psychiatric treatment does to intimacy is an incomplete form of care.

A Forgotten Problem in a Forgotten Population

Sexual dysfunction in older adults has long been described in the psychiatric literature as a forgotten problem: overlooked by clinicians who assume older patients are no longer sexually active, and under-reported by patients who assume their difficulties are simply a normal, untreatable part of aging (Slack & Aziz, 2020). When a psychiatric diagnosis is added to the picture, this neglect tends to deepen rather than ease. Mental health consultations for older adults typically focus on mood, cognition and risk, leaving little room, and often little clinical confidence, for a conversation about sexual well-being.

Part of the difficulty is structural. Psychiatric appointments for older adults are frequently short, focused on medication review and safety, and shared with family members or caregivers who may be present in the room, making an already sensitive topic feel impossible to raise. Part of the difficulty is also generational: many older patients grew up in eras when sexuality, let alone sexuality in older age or alongside mental illness, was not something one discussed with a doctor. The result is a silence that serves nobody, least of all the patient quietly living with a side effect they assume cannot be treated.

Anxiety: The Quiet Saboteur of Desire

Anxiety disorders are consistently linked to sexual difficulties, through a mechanism that is more physiological than psychological in a narrow sense: heightened sympathetic nervous system activity interferes directly with desire, arousal and orgasm, while worry about sexual performance itself can

create a self-reinforcing cycle of avoidance (Kirana et al., 2025). In older adults, this can combine with health anxiety about the body's changing capabilities, or social anxiety about dating and intimacy later in life, especially after divorce or widowhood.

These anxiety-driven patterns often masquerade as purely physical problems. An older man who develops situational erectile difficulty after a health scare, for instance, may begin avoiding intimacy altogether out of fear of repeated failure, a pattern that has little to do with his underlying physical capacity and everything to do with anticipatory anxiety. Because older patients are less likely to volunteer sexual concerns unprompted, and because clinicians are less likely to ask, anxiety-related sexual difficulties in this age group often go entirely unaddressed, treated neither as a mental health symptom nor as a sexual health complaint.

Antidepressants: A Necessary Trade-off

For older adults being treated for depression or anxiety, selective serotonin reuptake inhibitors (SSRIs) remain a first-line treatment, and one of their most common side effects is sexual dysfunction, affecting an estimated one-third to one-half of patients, with reduced desire, delayed orgasm and difficulty with arousal among the most frequent complaints. For a small proportion of patients, these sexual side effects persist even after the medication is stopped, a condition now recognised as post-SSRI sexual dysfunction.

Effective options exist and are underused. Adjunctive bupropion, a non-serotonergic antidepressant that acts on dopamine and norepinephrine rather than serotonin, has been shown in placebo-controlled trials to meaningfully improve desire and sexual function in patients experiencing SSRI-induced dysfunction (Clayton et al., 2004). Dose adjustment, timing of medication around sexual activity, planned short breaks under medical supervision, and switching to alternative antidepressants with a lower sexual side-effect profile are further strategies that are rarely discussed unless the patient raises the issue first. For older adults, who are frequently already managing several medications for unrelated conditions, this conversation is easy to lose amid the rest of a consultation, but no less important for it.

Benzodiazepines and Sleep Medication: An Additional, Overlooked Layer

Anxiety and insomnia in older adults are still commonly treated with benzodiazepines, medications that carry their own, less publicised, sexual side effects. Reviews of the pharmacological literature describe reduced libido, erectile difficulty and delayed orgasm associated with several commonly prescribed benzodiazepines, through mechanisms that include sedation, hormonal disruption and altered signalling along the hypothalamic-pituitary-gonadal axis (Zoroufchi et al., 2021). Because benzodiazepines are also linked to falls, cognitive slowing and dependence in older adults, their sexual side effects are rarely the first concern raised in a medication review, yet for a patient trying to maintain an intimate relationship, they can be just as consequential as the effects of an antidepressant or antipsychotic, and equally deserving of an open conversation before, not only after, a prescription is written.

Antipsychotics and Mood Stabilisers in an Aging Population

As the population of older adults living with schizophrenia and bipolar disorder grows, alongside longer life expectancy and earlier diagnosis, antipsychotic-related sexual dysfunction is becoming an increasingly relevant, and increasingly overlooked, geriatric mental health issue. Many antipsychotics raise prolactin levels, which suppresses libido and can cause menstrual changes in women and erectile difficulties in men, while sedation and other receptor effects compound the problem further.

Clinical guidance now recommends prescribing prolactin-sparing antipsychotics, such as aripiprazole, where possible, or adding a low dose of one of these agents to counteract sexual side effects from other antipsychotics that cannot be changed (Montejo et al., 2021). Sexual side effects are also one of the most common reasons patients quietly stop taking medication that is otherwise keeping their psychiatric condition stable, an outcome that is preventable when the trade-off is discussed openly from the start, and one with particularly serious consequences in older adults, for whom relapse can mean hospitalisation, loss of independence, or a rapid decline in overall functioning.

Gender Differences That Are Often Missed

The sexual side effects of psychiatric medication are not experienced equally by men and women, though clinical attention has historically focused far more on erectile dysfunction than on the equivalent difficulties experienced by women. A systematic review of sex differences in adverse drug reactions found that women consistently reported a higher overall burden of sexual side effects from antidepressants and antipsychotics than men, alongside sex-specific patterns such as more pronounced prolactin elevation on certain antipsychotics (Shan et al., 2023). For older women, whose sexual health concerns are already less likely to be raised in clinical settings than those of older men, this compounded gap in attention and research is a significant, and correctable, form of inequity in psychiatric care.

A Double, Sometimes Triple, Stigma

Older adults living with a psychiatric diagnosis face a compounding of stigmas rarely acknowledged in either mental health or sexual health services: the assumption that older people are not sexually active, the assumption that people with serious mental illness should not or cannot pursue intimate relationships, and the assumption that raising either topic is somehow inappropriate in a psychiatric consultation. For older LGBTQIA+ adults with a mental health diagnosis, a further layer can be added, as services designed with heterosexual, cisgender assumptions in mind may fail to ask the right questions altogether.

The result is that sexual well-being is left off the agenda from every direction at once, even though patients themselves consistently rate it as an important part of quality of life and treatment satisfaction. Family members and residential care staff, when involved in an older person's care, can unintentionally reinforce this silence further, treating any expression of romantic or sexual interest as inappropriate, confused, or simply irrelevant given the person's age or diagnosis.

Psychological and Behavioural Approaches: Beyond the Prescription Pad

Medication adjustment is only part of the answer. A systematic review of psychological interventions for sexual health in older adults found that educational and cognitive-behavioural approaches, including psychoeducation, communication training and structured couple exercises such as sensate focus, showed encouraging results for improving sexual satisfaction and reducing performance-related anxiety (Vasconcelos et al., 2023). These approaches are particularly well suited to the anxiety-driven and relationship-based sexual difficulties common among older adults with a mental health condition, since they address the psychological cycle of worry and avoidance directly, rather than only its physical expression.

Referral to a sex therapist or a psychologist trained in psychosexual health should therefore sit alongside, not instead of, careful medication management. For couples, brief structured exercises that reintroduce touch and closeness without the pressure of intercourse can rebuild confidence gradually, while individual therapy can help an older adult separate the anxiety of a mental health diagnosis from a realistic appraisal of what their body can still do and feel.

Toward Better Care: Shared Decision-Making

Addressing this gap does not require reinventing psychiatric care, only extending it. Clinicians prescribing antidepressants, antipsychotics, benzodiazepines or mood stabilisers to older adults should raise the possibility of sexual side effects before treatment begins, not only after a patient reports a problem, so that decisions can be made collaboratively rather than in silence. Routine follow-up should include a simple, direct question about sexual function, alongside the standard checks for mood, sleep and appetite, asked in the same neutral tone as any other medication review item.

Where side effects do occur, patients should be offered real alternatives: dose adjustment, medication switching, augmentation strategies, referral to psychosexual therapy, or a combination of these, rather than a choice framed as either mental stability or intimacy. Training for psychiatrists, geriatricians and mental health nurses should explicitly include sexual health, so that discomfort or lack of confidence no longer stands in the way of a conversation that patients are, in most studies, both willing and relieved to have once it is offered.

Mental health treatment in later life should not have to come at the quiet cost of intimacy, nor should intimacy be sacrificed in the name of psychiatric stability. Recognising the sexual dimension of mental health care, for anxiety, depression and serious mental illness alike, across every medication class involved, is not a peripheral concern but a core part of treating the whole older person. Because good psychiatric care, like good sexuality, never gets old.

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