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Sexuality is a continuing human need common to all people. However, sexuality of the aging population has received minimal attention as a significant component of older adults' lives. Residents of long-term care facilities are particularly burdened with numerous barriers to achieving sexual satisfaction. Despite the barriers, the continuing sexual needs of the elderly must be addressed with the same priority as nutrition, hydration, and other well-accepted needs. This article provides practical guidance to assist health care professionals assess and manage the sexual needs of older residents of long-term care facilities. (*Annals of Long-Term Care: Clinical Care and Aging* 2003;11(2):53-59)

Introduction

Senator Charles McMathias stated in 1979 to the American Geriatrics Society,[1] "I simply cannot believe that we, who accomplished the miracle of prolonging life, are willing now to watch that miracle turn into a Frankenstein Monster. We cannot let longer lives mean only more suffering and greater loneliness. We must make those extra years shine for our elderly. I believe we will." Since that time, the Omnibus Budget Reconciliation Act of 1987, as well as greater funds for research into the care of older adults, have resulted in positive changes among this population. Many older adults have been found to be living healthy, active lives well into their nineties and sometimes over age 100. However, sexuality of the aging population has received minimal attention as a significant component of older adults' lives.

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Older Adults' Continued Need for Sexuality and Intimacy

According to Healthy People 2010, 65-year-olds can expect to live an average of 18 more years than they did 100 years ago, for a total of 83 years. Those age 75 years can expect to live an average of 11 more years, for a total of 86 years.[2] To those working with older adults in long-term care, these statistics are well-accepted and provide the framework for the great advances in geriatric care delivery over the past two decades. However, while providers are becoming well-prepared in the many aspects of the care for the older population, the sexuality of this population has largely gone unexplored. Comfort[3] stated, "In our experiences, old folks stop having sex for the same reason they stop riding a bicycle–general infirmity, thinking it looks ridiculous, no bicycle."

Despite Comfort's frequently quoted statement, the fact is that Masters and Johnson[4] determined in 1966 that older adults continue to enjoy sexual relationships throughout their lives. The Janus Report on Sexual Behavior[5] found that on a weekly basis, sexual activity for both men and women continues past middle age. Recently, a survey of 1126 older adults found that 30% had participated in sexual activity over the past month.[6]

Not only do older adults remain interested in fulfilling their sexual needs and desires, it is actually necessary to do so. Sexuality is a continuing human need, common to all people. Even if older adults have not participated in sexual relationships or even thought about anything sexual for a long time, they are still sexual people. Sexuality extends beyond sexual intercourse to include the fulfillment of older adults' sexual goals and desires in whatever way possible or necessary. In some older adults, this will mean having sexual intercourse. In others, sexuality may include intimate conversation and closeness or other methods of sexual fulfillment.

Sexuality has a role in all lives. For those who pay attention and nurture this aspect of life, sexuality has many benefits. Karlen[7] reports that "Eroticism raises self-regard and enriches companionship at every age." Duffy[8] believes that sex has a restorative function and inspires healing and enhanced energy. Pangman and Seguire[9] define *sexuality* as "a fundamental and natural need within everyone's life, regardless of age and physical state."

Barriers to Sexual Fulfillment of Older Adults

There are numerous barriers to achieving sexual satisfaction for older residents of long-term care facilities. One of the barriers with the most negative impact results from the discomfort nurses, physicians, and other health care providers in these facilities have in discussing sexuality with older adults. Lack of experience and general discomfort with sexuality among health care providers prevents these professionals from addressing the sexual needs of older adults.[10,11] Most basic health care education programs continue to provide insufficient gerontologic knowledge. In almost all cases, the sexuality of older adults is excluded from sparse gerontologic curriculums. Without education and experience in managing sensitive issues around sexuality, long-term care health professionals are not comfortable opening the door into this arena.

Another barrier surrounding the sexual fulfillment of long-term care residents originates from the lack of knowledge and understanding the elderly have about their sexuality. Sexuality was not addressed in formal education systems as the older adults developed, and was rarely discussed informally. Older long-term care residents may possess values from the Victorian era.[11] These values are likely to impact sexual action, freedom, and desires and lead to both sexual frustration and conflict. Masters[12] reports that older women were raised to believe that when menstruation ceased they would cease to be feminine. Knowledge is essential to the successful fulfillment of sexuality for all people. In a study of 68 older adults living in the community, it was found that the group was able to answer only 67% of sexual knowledge items correctly.[13]

Consequently, embarrassment, shyness, and apprehension surrounding sexuality are common among residents in long-term care facilities. In addition, this population may view the normal changes of aging as embarrassing or indicative of illness, and may experience further reluctance to discuss these changes with health care professionals. In fact, Steinke[14] compared two studies of knowledge and attitudes toward sexuality among the elderly and found that overall, older persons possessed only a moderate amount of knowledge and permissive attitudes toward sexuality. The relationship between knowledge and attitudes toward sexuality is unmistakable. Walker and Ephross[13] also found

a high relationship between knowledge and attitudes toward sexuality in their study sample of older adults.

The loss of relationships with significant, intimate partners is unfortunately common among long-term care residents. The lifespan of men in the United States is shorter than that of women, which often leaves older women without sexual partners. Loss of a partner is the biggest barrier to sexuality for aging individuals, especially for women.[8] The loss of these relationships often ends communication about the importance of self to the person experiencing the loss. The absence of sexual partners often leads to a cessation of sexual activity.[11] In addition, societal taboos often prevent the remaining partner from seeking a new mate. Masters and Johnson[15] refer to this as "The Widower's Syndrome." It happens when the remaining member of the relationship tries to become sexually active again with a new partner, only to find that he or she is having some difficulty performing. This problem may result from previous comfort in the relationship with the partner and the anxiety associated with a new relationship.

In long-term care facilities, families are an integral part of the interdisciplinary team. However, with older couples—especially those in relationships with new partners—it is often difficult for their families to understand that their older relative can have a sexual relationship with anyone other than the person they are accustomed to as their relative's partner.

Sexuality Changes with Age

Though it has been supported that older adults continue to have sexual desires and participate in sexual relationships, little is known about how sexuality changes for people as they age. In fact, the experience of sexuality for older adults may be very different from that of younger people. In a study including 161 older adults, men were found to have a higher interest in sexual intercourse than women, who preferred hearing loving words.[16] Sex can be just as exciting for older adults as it is for younger people; it can also bring tension. Men may feel performance anxiety.[16] Older men and women both may not be familiar with the risks of sexually transmitted diseases and appropriate prevention. Negative self-concepts and role changes frequently seen as a result of chronic illness often impact the experience of sexuality for older adults.[17] It is important to note that older adults may experience fear of rejection or failure, as well as some boredom or hostility surrounding their sexual performance.[18] Past sexual history, such as delays in sexual development or sexual abuse, may continue to impact sexuality in the later years.[19] However, older women may become less inhibited and more assertive sexually.[6] Many women are more open about achieving pleasure and adventurous in seeking it.

Physiologically, a decrease occurs in circulating estrogen, resulting in a thinning of the vaginal epithelium, the labia majora, and the subcutaneous tissue in the mons pubis.[20] The vaginal canal shortens and loses elasticity. Follicular depletion of the ovaries, as a result of a decrease in circulating estrogen, leads to a further decline in the secretion of estrogen and progesterone.[12] In response to these physiological changes, dyspareunia (painful intercourse) may result.[21] Orgasmic dysfunction, and vaginismus may also result from the decrease in the amount of circulating estrogen and progesterone in the aging female.[21]

Viropause, andropause, and male menopause are new and controversial terms to describe the physiological changes that affect the aging male sex response. The syndrome, usually beginning between the ages of 46 and 52, is characterized by a gradual decrease in the amount of testosterone.[22] The loss of testosterone is not pathologic and does not result in sexual dysfunction. However, men may experience fatigue, loss of muscle mass, depression, and a decline in libido.[22]

The reduced availability of sexual hormones in both

male and female older adults result in declines in the speed and overall responses to sexual arousal.[12] The physiological changes in hormone secretion affect four areas of sexual response: arousal, orgasm, postorgasm, and extragenital changes.[11] In men, these changes are seen in the increased time needed to develop an erection and ejaculate. Erections also may require direct penile stimulation.[23] The volume of semen declines, and a longer period of time is needed between ejaculations. In addition to the decline in vaginal lubrication and painful intercourse as a result of the physiological changes of older women, the aging female may also experience fewer orgasmic contractions or painful uterine contractions during sexual activity.[11] Infrequent rectal sphincter contractions and a postcoital need to urinate may also be present.[11]

The normal changes of aging may change or delay the sexual response of older adults; however, sexual dysfunction is not a normal process of aging. The frequent occurrence of chronic illnesses and the use of multiple medications among older adults frequently interferes with the normal sexual function of elderly men and women. Medication usage, diseases such as diabetes and depression, and surgery to structures involved in the sexual response (eg, prostate, breast) are among factors that result in sexual dysfunction among older adults.[24] In these cases, removal of the medication causing the dysfunction, treatment of the chronic medical illness, and psychological therapy are interventions that significantly contribute to the resolution of sexual dysfunction.[25] Medications, vacuum erection devices, and surgery are options for resolving erectile impotence when other interventions fail.

Long-Term Care Considerations

Addressing the continuing sexual needs of older residents of long-term care facilities is a highly needed and yet very difficult task to accomplish. The barriers that prevent health care providers and older adults from addressing the complex needs of aging sexuality pervade the long-term care environment. Despite the perceived difficulty among all involved, the continuing sexual needs of older adults must be addressed with the same priority as nutrition, hydration, and other well-accepted needs. A phenomenological study with experienced nurses in long-term care concluded that the use of humor was an effective method for addressing the sexual needs of older adults.[26] Specifically, humor was used to open the door to sexual issues, and joking and teasing were effective in addressing undesirable sexual behaviors.

As with all health care concerns, addressing the sexual needs of older adults begins with an assessment and leads to appropriate interventions. A model to guide sexual assessment and intervention is available and has been well used among younger populations since the 1970s. The PLISSIT model[27] begins by seeking permission (P) to discuss sexuality with the older adult. This permission may be gained by asking general questions such as, "I would like to begin to discuss your sexual health; what concerns would you like to share with me about this area of function?" Questions to guide the sexual assessment of older adults are available on many health care assessment forms.

The next step of the model affords an opportunity for the health care provider to share limited information (LI) with the older adult. Normal changes of the aging male and female may be presented at this time, as well as the influence of specific diseases and medications on older adults' sexual functioning. Ten percent of all AIDS cases are among people age 50 and older; 25% are over age 60.[28] In response to this rise and the presence of other sexually transmitted diseases, it is essential to provide older adults with safe sex information at this time.

In the next part of the model, specific suggestions (SS) are provided to older adults to help fulfill their sexuality. These suggestions may range from compensating for normal changes of aging or the influence of diseases and

medications on sexual function to finding a partner or telling the family about an existing sexual relationship.

The final part of the model allows for intensive therapy (IT) to be provided to the older adult regarding sexual issues that may arise during the assessment. This may include the discovery of sexual inhibitions or fears that may have roots in confused sexual identity, rape, or earlier sexual abuse.

Unmet intimacy needs of older adults may be fulfilled by a simple human touch on the hand, face, or shoulder. Mattiasson and Hemberg[29] underscore the importance of touch as a continued need, which may be fulfilled by health care professionals. However, the authors caution professionals to assess the resident's perception of touch in all cases. Earlier work on touch indicates that when human beings lack touch, the experience is equivalent to malnutrition and may possibly cause psychotic breakdown.[30] Because of the loss of partners and friends, as well as translocation and institutionalization, touch deprivation is highly likely to occur in older adults.

Privacy is a major issue in long-term care that often prevents older clients from fulfilling their sexual needs and desires. Once the desire to participate in a sexual relationship has been determined, arrangements for privacy must be made. The resident's own room may be used, while facility staff assist in finding other activities for the resident's roommate. To maintain the safety of both residents, they should be educated to advise a trusted health care professional regarding the sexual activity and to keep his or her call light within reach during sexual activity. If a resident's room is not available or appropriate for sexual activity, a common room may also be used for private visits or for the older adult along with his or her sexual partner. If necessary, adaptive equipment such as hospital beds, siderails, or trapezes may be needed to allow residents to safely fulfill their sexual needs. Based on information gained during the sexual assessment, it may become the role of health care professionals to order the necessary equipment and demonstrate proper use to the older couple.

Health care professionals in long-term care facilities frequently witness what is viewed as inappropriate sexual behavior among the residents. Calling out to the staff in suggestive language, exposing oneself, masturbating, or openly participating in sexual activity with another resident are the behaviors most often seen and may be very troublesome for health care professionals in these facilities to manage. The behaviors are seen as attention-seeking. While this may be true to some extent, the behaviors will not likely disappear without interventions that both set limits and fulfill the sexual needs underlying the behavior. Often, the staff's perceptions and lack of privacy are two causes of inappropriate sexual behavior among long-term care residents.[16] Suggestions include clear communication with the resident on expected behavior and that which is unacceptable. A nursing diagnosis, such as "Altered Sexual Patterns," and a clear plan to manage the behavior must be implemented for older adults exhibiting inappropriate behavior. Pathologic hypersexuality may rarely appear among older residents of long-term care facilities.[31] The cause of this condition, manifesting itself in intense sexual urges and fantasies, is usually related to the presence of neurologic and cognitive disorders in older adults. A careful medication review is necessary to uncover drugs and interactions that may be causing or exacerbating the problem. Antipsychotic medications have traditionally been used to treat hypersexuality. However, antiandrogens, estrogens, gonadrotrophin-releasing hormone analogues, and serotonergic medications may be successful when other methods are ineffective.[31]

It is often difficult for the family to understand that their older relative may have a new relationship. If the family is concerned regarding a resident's sexuality, a family meeting, with a counselor if needed, is appropriate.

At this time, the family members may bring forth their concerns regarding the relationship, and the resident may address them with a neutral party present. It is very important for the continued health of all relationships for the family to understand and to accept the health care professional's decisions about the relationship. However, if no agreement that is amenable to both the resident and family can be reached, the resident's needs should be considered the priority.

In light of the disparity between the sexual needs of older residents of long-term care facilities and the perception of these needs by their health care providers, sexuality in long-term care continues to be an ethically bound issue. When faced with the sexual needs of older adults in long-term care facilities, health care professionals frequently balance their actions and beliefs with the needs and rights of the patient. Mattiason and Hemberg[29] suggest the following guiding principle: "The caring responsibility can never be interpreted as a right to act against the wishes of the patient, then the key aspect will be respect."

Staff development regarding older adult sexuality and the development of policies and procedures to manage sexual issues of older residents is essential in all facilities that care for older adults. Training sessions must address the prevalent, societal myths around sexuality in this population. Members of the long-term care staff should be encouraged to discuss their own feelings about sexuality and its role in the life of older adults. Role-playing may be effective in helping staff to gain a better understanding of their own personal values regarding sexuality and the older adult.[32] It is essential that staff members accept that their own personal sexual values cannot influence the care of older adults.[33]

Normal changes of aging and the impact of diseases and medications on sexual function are part of the knowledge base necessary for health care professionals to assess and manage the sexuality of the elderly. Interventions available to compensate for normal aging changes and to eliminate the impact of diseases and medications on sexuality should be included in discussions with health care professionals. Skinner[34] developed a game used to educate nursing staff about sexual dysfunction in older adults. In a pilot study of five nurses, completing both pre- and post-game tests, knowledge regarding sexual assessment and treatment increased after playing the game.

In addition to knowledge regarding the nonpharmacologic interventions to facilitate the sexual expression of older residents of long-term care facilities, it is essential that health care providers in these facilities become aware of the pharmacologic interventions available. Erectile impotence in older men is often effectively treated with sildenafil citrate. However, successful treatment with this medication is dependent on the presence of neurovascular bundles and may not be helpful to men with neurological damage in this area related to surgery or chronic disease.[35] Intracoporeal injection therapy using papaverine, phentolamine, and prostaglandin E is another form of pharmacologic therapy for erectile impotence.[36] In long-term care facilities, injection into the penis would be assisted by the nurse to help to develop an erection capable of vaginal penetration. Intraurethral alprostadil urethral suppositories are another pharmacologic intervention with a similar mechanism of action as intracavernosal injections.

Sexuality Among Cognitively Impaired Residents

It is estimated that about 4.8 million Americans suffer from dementia, and this number is projected to triple by the year 2050.[37] Cognitively impaired older residents of long-term care facilities continue to have sexual needs and desires, which presents a challenge to health care professionals. Accurate assessment and documentation of the ability of cognitively impaired older adults to make competent decisions regarding

sexual relationships while in long-term care is essential. If the resident has been determined to be incapable of making competent decisions, the health care staff must prevent him or her from being taken advantage of by a spouse, partner, or other resident.

Sexual behaviors common to cognitively impaired older residents of long-term care facilities may include masturbating in public places, stripping, exposing him- or herself, or making overt gestures to other residents or staff.[38] Such behavior may illuminate unmet sexual needs of the older resident. Masturbation is historically surrounded by societal myths. These myths are false and in need of dispelling. Masturbation is a method in which both men and women can become sexually fulfilled in the absence of partners. Health care professionals in long-term care facilities may assist older adults to fulfill their sexual needs and desires by simply providing an environment in which the older adult may masturbate in private.

Conclusion

Many barriers continue to prevent older adults from fulfilling their sexual needs and desires. Long-term care facilities continue to care for large numbers of elderly persons in the United States. It is imperative that these facilities set the standard of care for older adults by providing assessment and management of older adults' sexuality in a sensitive and caring environment. Knowledge is power, and learning about the barriers and interventions available regarding this population's sexuality enables health care providers to make changes for the highest possible quality of life.

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