I'm Not an It: Sexuality and the Older Resident

Vicki L. Schmall, Ph.D.
Aging Concerns
West Linn, Oregon

The sexual needs of older adults, particularly those living in residential and long term care facilities, often have been misunderstood, stereotyped and denied. As a result, older residents who express themselves sexually sometimes are ridiculed, shamed or reprimanded like children. The topic of sexuality and aging generally is neglected in staff in-service training and care planning. Such neglect may only serve to perpetuate myths for some staff that sexual desire, needs and capacity cease with the onset of old age and that sexual expression by an older person is a sign of "brain disease" or that the person is a "dirty old man."

Sexual behavior considered acceptable for a young adult sometimes causes negative reactions when the same behavior is displayed by an older adult–"what is virility at 25 becomes lechery at 75." For example, Pease[1] found student nurses tended to see their elderly male patients in a grandfatherly role and transferred their expectations for their grandfather onto these patients.

Increasing age and/or frailty does not mean a person becomes asexual. Older people do have sexual thoughts and feelings. Sexuality is an integral part of personhood throughout life and continues to be important to many older adults. However, just as among younger age groups, there is a continuum of sexual activity, needs and interest. Certain factors limiting sexual expression, such as poor health and lack of an available partner, become more prominent in late life. In the institutional setting, staff attitudes and lack of privacy are influential factors.

Sexuality Defined

Sexuality is far more than sexual intercourse or orgasm. It includes the need for intimacy, affection, touch, sexual identity and a feeling of masculinity or femininity. When sexuality is defined narrowly, the majority of older people living alone and in residential and long-term care facilities are excluded from having sexual needs recognized or being able to express themselves sexually.

Intimacy. The need for close physical and emotional contact is part of every human being from birth to death. Unfortunately, many older adults have lost the people with whom they have experienced years of intimacy. Yet, an intimate, affectionate relationship may be more important in late life because of the multiple losses commonly experienced. Evidence suggests the lack of an intimate, empathetic relationship may account for some clinical depression.

The need to maintain relationships should be considered in resident care. A denial of intimacy needs may result in appropriate sexual behavior, reflecting the human need for closeness.

Affection. Caring about someone and having someone care about you is another aspect of sexuality which contributes to mental well-being. A person who feels no one cares will often wonder "Why get up?", "Why dress?", "Why care?" Transformations can take place when individuals believe somebody really cares about them. The resident who is obstinate, cantankerous or physically unattractive usually receives the least affection and yet, may need it the most.

Touch. Touch is one of the most powerful means of communication. It provides comfort, a sense of caring, connection with others, and tells people they are still important and not alone. However, much of the touch older residents receive is impersonal and task-oriented rather than affectional. For some, the only time they receive touch is when they are being

cleaned. Research shows that infants who have only their physical needs met, without love or cuddling, deteriorate mentally and physically. Some eventually die. Could this also be true for some older people? Especially as the senses of hearing and sight become deprived, older people depend more on touch.

Sometimes what appears to be negative sexual behavior may be a reaching out by residents for touch and attention. Some residents, for example, learn through conditioning that certain behaviors--constant demands, inappropriate touch, etc.--result in being touched.

How can positive touch be structured into a facility? Hugs, handshakes and holding hands can let residents know that they are still touchable and lovable. Body, foot and hand massages and back rubs are therapeutic as well as sensually soothing. Staff, however, should be aware of what they say by the manner in which they touch. Does a particular touch say "I care about you. You are an important person" or does it say "This is something I have to do" or "I am in a hurry?"

Programming that includes children and pets is advantageous because both are spontaneous in giving touch and affection. Cuddling and holding them is considered socially acceptable. Dances, games and social gatherings can be designed to meet residents' need for touch.

Sexual Identity. Being thought of as a man or woman and having an opportunity to express one's sexual identity is an important aspect of sexuality for older people. A stroke, disfiguring surgery or cancer, or loss of independence and control can threaten a person's sexual identity. Being talked down to by others and treated as asexual can result in a resident feeling like an "it."

Sometimes negative behavior--e.g., profanity, sexual aggressive behavior and self-exposure—may be an attempt by a resident to say "I'm still a man," "Treat me as a person," etc. Ways in which staff violate residents' sexual identities should be examined. For example, are staff sensitive to exposure of breasts and genitals during bathing?

Most important, staff members should identify ways they can reinforce the residents' sexual identities. Being physically attractive, having some control over the environment, and receiving compliments enhance a resident's sexual identity. Asking a woman, "What makes you feel like a lady?" or a male, "What does 'being a man' mean to you?" may provide clues to reinforcing each resident's sense of masculinity or femininity. One woman may feel feminine when dressed attractively, another woman when her hair is styled and her fingernails manicured, and another, when receiving attention from males.

Inappropriate Sexual Behavior

What constitutes "inappropriate" behavior is often more restrictive for persons in institutional settings than for adults living independently. Too often everyone's behavior is restricted to a level that meets the approval of the most Victorian staff member or resident. Masturbation, for example, may be considered inappropriate by some staff; yet, such behavior is normal and may be the only outlet available to the older person for releasing sexual tension.

Management of Sexual Behavior Problems

Management of sexual behavior problems with the cognitively intact individual is generally a fairly simple matter. Primarily, a human environment, privacy and clear and consistent limits on behavior is needed. However, with the cognitively impaired, management can be a real challenge. Sexual behavior is more likely to be inappropriate in regard to time, place and social context. The individual is more likely to be impulsive, oblivious to the effect of behavior on others, and to forget, within a few minutes, that he/she had been asked not to behave in a certain way.

The goal in management is to find compassionate ways of responding to inappropriate behavior. That response should keep the resident's self-esteem intact and maintain the working relationship between staff and resident. Answers to the following questions can provide insight in dealing with behavior problems.

What is the problem? Inappropriate sexual behavior can arise for varied reasons; therefore, a

multidimensional assessment is essential to understanding a resident's behavior. A clear definition of the problem is crucial to identifying appropriate solutions. Oftentimes, the "presented" sexual problem is not the problem, but rather symptomatic of another physical, psychological or social need or problem. For example, is the older man who displays sexually aggressive behavior really a "dirty old man," or might he be lonely, trying to assert his sexual identity, or trying to gain attention or control over his environment? In regard to masturbation in the lounge, the problem is not masturbation itself, which usually receives the focus, but rather that it occurs in a public area. Also, problems not overly sexual--e.g., non-cooperation, depression, aggression, lethargy and physical complaints--are sometimes rooted in sexual concerns.

Who has the problem? The older person is not always the one who has the problem. Often the problem lies with the attitudes of staff, family or other residents, and lack of information about sexuality in late life.

Under what circumstances is the behavior displayed? The environment and appropriateness of staff behavior should be analyzed to determine any aspects that might be contributing to the problem. Sometimes staff unintentionally encourages "negative" behavior or rewards behavior they wish to eliminate. For example, a staff member who chastised a resident when sexual advances were made actually was found to have provoked the behavior with comments such as "How's my boyfriend tonight?" and "When are you going to show me a good time?" If the primary time a person receives attention (even if the attention consists primarily of scolding and punishing behavior) is when displaying negative behavior, that behavior most likely will continue.

What might be done to alleviate the problem? Alternative approaches for dealing with the behavior should be examined. If staff says "don't" to certain sexual behaviors, but provide no "do's," it is less likely that a resident's behavior will change. Change is greatly facilitated when positive alternatives are offered. For example, asking an individual to refrain from petting in public is more likely to be effective if privacy is provided.

The best solution is most likely to be found when problem-solving is a team approach. Including the older resident(s), when possible, in resolving a problem can have added benefits.

What approach will be followed? Any plan for responding to inappropriate sexual behavior must be carried out consistently by all staff on all shifts. If a resident receives conflicting messages from different staff members, it will be very difficult to extinguish the problem behavior.

Sexual Health Care

Helping residents meet their sexual needs is a part of providing quality care. A first step in providing sexual health care is for staff to assess their attitudes and values concerning sexuality in late life. Staff members need to:

- Accept the normality of sexuality and sexual expression by older persons;
- Identify their personal and professional blind spots;
- Become aware of their limits in dealing with sexual concerns and know to whom they can defer when confronted with a situation they cannot handle;
- Accept differences in each other;
- Practice communicating about sex with comfort.

For personal assessment to occur most effectively, there must be an atmosphere of mutual respect and acceptance among staff members.

A second step is for staff to assess their knowledge about sexuality and older adults and to develop skills for responding to sexual concerns and behavior of residents. Family members, too, often will benefit from information about sexual needs and expression in late life.

If staff and family members are ignorant about sexuality and aging, this ignorance will create unnecessary hardships for both residents and staff. Time spent dispelling myths about sexuality and aging, discussing ways to enhance the sexuality of residents, examining policies and practices, and identifying positive ways to handle disturbing

behavior can save many non-productive staff hours and increase the ability of staff to respond compassionately and empathetically.

Resources

Educational resources that are particularly helpful include:

Publications:

Aging and Sexuality. Fall 1981 issue of *Generations*, San Francisco, California, Western Gerontological Society

Ballard, Edna and Cornelia M. Poer. *Sexuality and the Alzheimer's Patient*. Joseph and Kathleen Bryan Alzheimer's Disease Research Center, Duke University Medical Center, Durham, NC.

Butler, Robert and Myrna Lewis. *Sex After Sixty*. New York, Harper and Row.

Carroll, Kathy. *Sexuality and Aging: In-Service Guide*. Minneapolis, Minnesota, Ebenezer Center for Aging and Human Development.

Hellen, Carly. *Alzheimer's Disease: Activity-Focused Care* (Chapter #10). Woburn, MA, Butterworth-Heinemann.

Poticha, Joseph and Art Southwood. *Use It or You'll Lose It*. New York, Richard Marek Publishers, 1978.

White, Charles et. al. *Sexual Education for Aged People, People Who Work with the Aged, and Families of Aged People: Program Development and Evaluation*. San Antonio, TX, Trinity University, Gerontology Studies Program.

Media:

Sex and Aging: A Game of Awareness and Interaction (education game), Gerontology Specialist, Oregon State University Extension Service, Milam Hall 151, Corvallis, Oregon 97331.

Sexuality and Aging: An Interview with George and Juliet (video cassette), Gerontology Specialist, Oregon State University Extension Service, Milam Hall 151, Corvallis, Oregon 97331.

A Thousand Tomorrows: Intimacy, Sexuality and Alzheimer's, Terra Nova Films, 9848 S. Winchester Avenue, Chicago, IL 60643.

A Rose By Any Other Name (film/video cassette), Adelphi Center on Aging, Garden City, New York 11530

Grief and Intimacy Issues. Primedia Workplace Learning, 4101 International Parkway, Carrollton, TX 75007

Sex After Sixty (film), CBS News, 524 West 57th Street, New York, NY 10019.

The Heart Has No Wrinkles, Terra Nova Films, 9848 S. Winchester Avenue, Chicago, IL 60643.

Pease, Ruth A. Female professional students and sexuality in the aging male. *The Gerontologist* 14(2): 153-157, 1974.