Late-Life Sexuality Presents Problems, Rewards

Nursing homes face competing values and principles involving safety, dignity, and decision making.

BY DOUG BRUNK
San Diego Bureau

SALT LAKE CITY — Most Americans find it difficult to accept late-life sexuality, according to Dr. Andrew S. Rosenzweig.

"Our culture still has this pervasive negative attitude about late-life sexuality in terms of discreet silence, distaste, and tunnel vision," said Dr. Rosenzweig, an assistant clinical professor of psychiatry at Brown University, Providence, R.I.

Nevertheless, sexual desires among residents are normal and should be accepted, he said at the annual symposium of the American Medical Directors Association.

Not only family members of residents, but health professionals also have biases and can be judgmental on the topic, said Rosenzweig, medical director of MedOptions, a company based in Old Saybrook, Conn., that provides behavioral and primary care consulting services to nursing homes and assisted living facilities.

For instance, one Israeli study observed that nursing staff caring for Alzheimer's residents at a nursing home categorized residents' sexual behaviors in three ways: love and care, romance, and eroticism (Nursing Forum 2006;41:158-66).

The nursing staff showed acceptance and support of love and care, mixed reactions to romance, and strong reactions of anger and resentment to erotic behavior. That some staff found romance between residents troublesome and that most were appalled by erotic behavior reflects narrow biases, Dr. Rosenzweig said. "So clearly there's a lot of staff confusion and ignorance, and lack of training about late-life sexuality. …We should not underestimate the need for affection, for touch, for a connection with someone else."

The goal for nursing facility professionals should be to create an environment that will help residents fulfill their sexual needs and desires while maintaining dignity and protecting rights of competent and incompetent residents. Some of the competing principles and values include the right to privacy, the right to experience a loving relationship, and the right to make one's own decision. Beyond that, however, staff members need to refrain from being judgmental. "It's very easy to project one's own religious, cultural, and personal beliefs on another," Dr. Rosenzweig said.

Sexually inappropriate behavior may include genital exposure, masturbating in public, propositions to others for sexual intercourse, fondling another resident's genitals or breasts, requesting unnecessary genital care from staff, touching a caregiver in a sexually suggestive manner, and openly reading pornographic material. Sexually provocative but less problematic behaviors in nursing home and assisted living settings may include flirting, excessive flattery, commenting on a caregiver's behavior or appearance, and asking staff members personal questions.

The prevalence of sexual-behavior reports among dementia patients in nursing homes ranges from 3%-15% of reports of inappropriate behaviors,"but there have been very few studies," Dr. Rosenzweig said. However, some evidence has linked those behaviors to frontal and temporal lobe pathology, especially disinhibited types of behaviors, he said. Acute onset of sexually inappropriate behaviors may follow stroke, vascular insult, and head injury. Differential diagnosis includes delirium, mania, seizure disorder, dopaminergic drugs, social isolation, and boredom.

Dr. Rosenzweig urged those attending the meeting to consider the barriers that nursing facilities residents face in making intimate human connections.

"Imagine your typical nursing home or assisted living facility, where the amount of privacy is zero and opportunities for expressing sexual desires are zero," he said. "The literature on geriatric sexuality is showing that even with all these obstacles, there is a high amount of sexual desire in our residents, regardless of medical or psychosocial comorbidities."

He cautioned, however, that physicians and staff can underestimate intimacy needs in residents that do not involve sex. "Many people view late-life sexuality as all about genital sex as opposed to intimacy and affection. Older people adapt and reprioritize sex, expressing sexuality in more diffuse ways."

To determine whether a sexual behavior is inappropriate, Dr. Rosenzweig recommends that staff describe and document the behavior accurately, consider the reactions of other residents, identify why the behavior is occurring, and evaluate the competency and consent of all parties. "Many times, nursing home staff doesn't have a problem if the two residents engaging in a relationship are in a similar stage of dementia, but if one of the two is less cognitively impaired that creates a lot of ethical issues," he said.

He also recommends evaluating one resident's awareness of potential risks from another's romantic advances and reporting the situation to their families. Nursing home staff often "view these relationships as taboo and they don't even let the family know until it's gotten to an advanced stage. The better approach is to let the family in on it earlier. But that brings up another ethical issue: Do you let the family make a decision or interfere in the love life or sex life of an elderly couple in your facility?"

Another complexity in evaluating sexual relationships between residents is the issue of their understanding of the involvement. A demented resident may be unaware of the situation altogether. "Sometimes they don't know the name of the person they're having the relationship with, which is fascinating," Dr. Rosenzweig said. "Yet it's just as meaningful and emotionally rewarding to them."

Nonpharmacologic interventions for dealing with sexually inappropriate behaviors include a nursing facility's medical director advising staff to maintain professional boundaries with residents, a concept that can be hard for some nurses to buy in to, Rosenzweig said. The certified nurse assistants see themselves as the resident's friend and confidant as opposed to having that professional boundary," he said.

Other strategies include coworkers consulting with one another to establish a consistent approach to dealing with the behavior; fostering social stimulation and recreational activities, modifying the clothing of a resident acting inappropriately, such as dressing a man in a one- piece jump suit with back snaps and clasps, or discouraging revealing clothing for staff members, avoiding explicit television shows, encouraging appropriate behavior through rewards and attention, and isolating an offending resident from potential targets of inappropriate behavior.

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DR. ROSENZWEIG

Pharmacologic interventions for sexually inappropriate behaviors are poorly studied and ethically controversial, Dr. Rosenzweig said. Medications that have been studied but are without clear indications in this area include hormonal agents, serotonergic agents, antipsychotics, and mood stabilizers. Despite several recent successes with oral estrogen, any drug should generally be "an intervention of last resort," he said.

"You have to be thoughtful and you have to use common sense and trial and error approaches," he concluded.

Dr. Rosenzweig disclosed that he is a member of the speakers' bureaus for Abbott Laboratories, Eli Lilly and Company, Bristol-Myers Squibb, Novartis Pharmaceuticals, and Astra-Zeneca. ■

Marriage Challenges Change as Couples Become Elderly

BY MITCHEL L. ZOLER
Philadelphia Bureau

PHILADELPHIA — Marriage undergoes stress as a couple becomes elderly, partly because "the goals of middle age are gone," Erlene Rosowsky, Psy.D., said at a conference sponsored by the American Society on Aging.

"In middle age, the goal is getting there, but in older age, you're there." The "getting there" has often been the glue of the marriage, and now it's gone, said Dr. Rosowsky, who is a geropsychologist in Needham, Mass. This means that the goals for each person and for the marriage need redefinition.

"What worked at an earlier stage in the marriage is no longer appropriate," she said. For example, at an earlier stage in a marriage, the couple might have been involved in child rearing and a career. However, at the midlife to late-life shift, spouses might reassess their union and wonder what's next.

As a result of these shifts, most couples therapy is essentially communication therapy, said Dr. Rosowsky, also affiliated with the department of psychiatry at Harvard Medical School, Boston.

For the therapist, a goal is to identify communication stoppers, help couples deal with them, and accentuate communication enhancers, she said. The ability to adjust to change is also important. For example, a successful elderly couple needs to be able to change their mode of communication when necessary, she said. Overall, marital interactions tend to be more positive late in life.

In old age, marriage has its own purposes: collaboration, companionship, continuity, affirmation, support, protection, and physical intimacy. Marriages can become more positive in old age if the pair succeeds in bringing a truce to old conflicts, adopting an attitude of letting go, and feeling linked as they pass through old age.

Assessing the marriage of an elderly couple involves observing them, noting what is present and what's missing, clarifying problems for the couple, and exploring the history of the marriage. For example, it helps to know what their own parents were like, how the couple met, and what their expectations were when they were first married.

Issues that need to be explored in therapy are different for older adults. For example, there is the importance of physical concerns and countertransference issues—the powerful emotional responses that are provoked in a relationship. Common themes of a countertransference relationship include futility, hopelessness, pain, and fear—which might include fear of being alone, fear of pain, or fear of humiliation.

Other issues that need to be addressed in therapy are those such as retirement, differential aging between the spouses, bereavement, caregiving, and a sense of running out of time. Illness or disability can cause togetherness and separation. Typical interventions for an elderly couple include psychoeducational, communication training, joint reminiscence, and presentation of models.

One model of couples therapy attempts to move the couple from mutual tolerance to acceptance. The ideal is for both partners to come to believe that their life together was a good personal choice, and something that they each would do again given the chance, Dr. Rosowsky said. ■