Sexuality and intimacy among care home residents

In this article...

- Why sex is considered taboo for older people
- Identifying care home residents’ interest in sexual matters
- How to address the sexual needs of care home residents

5 key points

1. People often incorrectly assume that older people are no longer interested in sex, sexual activity or intimacy
2. Care home staff may find it difficult to raise the issue of sex with residents
3. Staff can look for clues that help to indicate whether a resident has an interest in sexual matters or intimacy
4. Building a trusting relationship with residents is crucial to successfully raising the issue of sex with them
5. Care homes can take steps to highlight their openness to discussing issues of sexuality and intimacy before a resident moves in

Sex and intimacy are, apparently, the preserve of the young. Birthday cards often mock ageing and associate it with the loss of mental, physical and sexual capacity. Indeed, older people are stereotyped as prudish or “past it”. When not excluded from sexual imagery, the sexuality of care home residents – and older people in general – can be considered taboo.

In care homes, the accommodation of residents’ needs relating to sex, sexuality or intimacy can be considered challenging: it can elicit fearful responses because these needs are commonly seen as unexpected or a problem of disinhibition associated with dementia. It seems that residents’ needs concerning sexuality and intimacy are often designed out of care systems – they are absent from policy and practice (Hafford-Letchfield, 2008). The situation might be further complicated for residents identifying as lesbian, gay, bisexual or transgender (LGBT), who can feel obliged to go “back into the closet” when they enter care (Willis et al, 2013).

In the UK, 291,000 people aged over 65 live in a care home (Office for National Statistics, 2014); many of these could be – albeit unwittingly – denied basic rights concerning touch and sexual activity. To challenge these stereotypes and address the lack of scholarship in the UK and Europe, the Older People’s Understandings of Sexuality (OPUS) research initiative was established. The OPUS team comprises of health professionals from a range of disciplines, as well as representatives from older people’s organisations.

The Economic and Social Research Council (Transformative Research initiative) funded the OPUS team to consult with older people, families and staff from care homes on how to address the issue of intimacy and sexuality in care homes.

The study

Fieldwork for the study was conducted from May to August 2014 in two “research-ready” care homes in north-west England associated with the Care Homes Research Group, which brings together care home staff and nursing academics. It comprised interviews with residents and non-resident spouses, and focus-group discussions with care home staff.

Semi-structured, gender-matched interviews were conducted individually with residents. Residents suggested an openness to sex and intimacy that was tacitly being denied.
two residents in each care home. One of the male residents asked to be interviewed with his (non-resident female) spouse and two non-resident female spouses of male residents with dementia were interviewed separately.

Two focus groups – one in each care home – were facilitated by a male and female researcher working together, with nine participants in one group and seven in the other (n = 16). The discussions lasted for just over an hour and comprised mainly female care assistants aged from their 20s to their 60s. Each group also contained qualified nurses and at least one member of staff with significant dementia expertise.

After reading information about the study, all research participants volunteered to take part. During the interviews and focus groups, we used fictitious scenarios with supporting images of older-couple intimacy (opposite and same sex) to:

- Consult on the principle of researching sexuality and intimacy, with a view to meeting needs;
- Ascertain how to go about this in an appropriate manner.

Inevitably, the accounts reflected on:

- How or whether individuals were seen, or saw themselves, as sexual beings;
- What care homes were doing – or not doing – to enable sexuality and intimacy needs to be met.

The scenarios were part of our ethical plan (approved by the Social Care Research Ethics Committee) to avoid over-disclosure. We did not have approval for, nor did we try to obtain, details of sexual/intimate biographies or preferences.

Although based on a small, local sample, the findings provide a starting point from which to consider how best to address this sensitive and neglected issue. While not a representative sample, participants are likely to have drawn upon widely shared ideas concerning ageing sexuality.

Results

Older people’s experiences of sexuality and intimacy are affected by differences of gender, class, ethnicity and biography, and the accounts of those to whom we spoke suggest that lived experience is complex. When talking about sexual activity in particular, residents spoke in ways that:

- Denied the need for sex;
- Expressed nostalgia for something they considered to belong in the past;
- Hinted at openness to sex and intimacy as ongoing concerns.

All participants’ names given in the following accounts have been changed and individuals’ identities disguised.

Residents’ stories

The most common story reinforced the International Longevity Centre – UK’s (2011) idea that residents – and older people in general – exist outside of “sexual citizenship”. Residents might be considered post-sexual, even post-intimate. For instance, one male resident, William, aged 78, spoke of how nobody talked about sexuality or intimacy and residents just “live as we are... We’ve had our sex life way back.” This not only indicates a tacit silence among those in the home, but such assumptions also indicate the workings of an ageist erotophobia – the anxiety over older people as sexual beings, which may include a visceral sense of disgust or a failure to recognise them as such.

However, one female resident, Emily, aged 80, considered that while some women might prefer to busy themselves with children and grandchildren, others might wish to continue with sexual activity. As a widow, she acknowledged the possibility that “things might change” should she become close to another resident. In short, one should “never say never”.

More assertively, John, a 61-year-old resident with Parkinson’s disease, acknowledged that although he was no longer physically capable of sexual activity, he continued to experience desires. Such statements indicate a form of sexual citizenship operating at a more psychological than physical level.

Spouses’ stories

Being worthy of human touch is important – especially when we consider that older, more frail or sick people receive touch largely for the purposes of care, and often through the protective barrier of plastic gloves. Most common in spousal interviews was how later-life intimacy, such as cuddling and affection, rather than sexual activity, figured as a basic human need.

Spousal accounts of intimacy served as markers of the length and depth of a relationship on the one hand and, on the other, to normalise a relationship with a partner who had radically changed (for example, because of dementia or a life-limiting condition).

John’s spouse, Olivia, declared: “I’ll always be his wife and he’ll always be my husband.”

John and Olivia were interviewed together. Their shared humour and emotional support throughout the interview challenged the stereotype of older people as pitiful objects of care, and shows how such individuals are involved in mutual relations of care.

Challenges and responses: staff views

Raising the issue

Although admissions procedures in care homes may cover needs relating to sexuality, staff do not always feel comfortable addressing these issues and may therefore avoid raising them. As one female care worker said:

“It’s not really talked about on our unit... any sexual needs.”

This suggests that certain ways of thinking and working could prevent the meeting of such needs. It can be difficult for carers and residents to initiate or engage in conversations about matters considered very personal, but there may be ways around any such difficulty at an individual level and at the level of the care home. It is worth noting that study participants – regardless of whether they were a resident, spouse or staff member – used the term “intimacy” rather than “sex” as a general way of talking about closeness that may or may not include sexual experience.

Addressing sexual and intimate needs will rely on building rapport and trust with residents at the very least. It will also require vigilance on the part of care staff to assess whether a resident is open to discussing such personal matters. Box 1 offers

**BOX 1. RAISING SEXUAL MATTERS WITH RESIDENTS**

**Before admission**

- Demonstrate that lesbian, gay, bisexual and transgender (LGBT) residents are welcome by displaying LGBT-inclusive cues, such as literature and leaflets, in the home
- Signal to potential residents, through brochures and leaflets, that the home encourages resident-led sensitive discussion about intimacy needs, provided this is the individual’s choice

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advice on how to recognise individuals’ views, which may provide a lead-in to sensitive discussion.

Generational difference
Sexuality and intimacy can be difficult subjects to approach but the situation may also be complicated by generational differences. Several staff spoke of the discomfort of discussing such matters with individuals of their parents’ or grandparents’ age. One female care worker said:

“It’s just something you don’t approach with an older person.”

To circumvent the problem of generational difference, one care staff member suggested that peer educators be trained from within the home, if possible, or that such expertise could be brought in from outside to educate and inform residents and staff. Few people are entirely free of anxiety about sex and intimacy, and training events can help us examine our own habitual ways of thinking, and deep-seated concerns. Given these issues, it is unsurprising that staff raised the idea of training to help them enable residents to meet their own erotic and intimacy needs. One manager also stated that she had confronted several staff members to ask them to reflect on their attitudes towards residents whose sexuality had been mocked.

Legal and ethical dilemmas
Care workers are required to meet myriad legal, institutional demands and negotiate diverse relationships. Staff raised various instances of grey areas of consent within long-term relationships, for instance, where one – or even both – partners showed declining capacity to consent to sex or intimacy.

While residents tended to de-emphasise sexuality, care workers were acutely aware of how sexualised expression could pose ethical and legal dilemmas. Examples given included residents who might want to hire the services of a sex worker, or residents with dementia either projecting sexual feelings towards another or receiving such forms of attention inappropriately.

Sexual citizenship
Although all interviewees in our study appeared heterosexually identified, staff acknowledged that, despite a climate of governmentally sanctioned homophobia for most of their lives.

One care worker spoke in a way that recognised the heteronormative character – involving assumptions of heterosexuality as the benchmark/norm – of the home’s “sexuality care plans”, which routinely failed to record LGBT identification or anything about the sex and intimacy needs of such individuals.

Environmental arrangements
The ideological barriers to meeting sex and intimacy needs also materialised in environmental arrangements and care practices that constrain possibilities for intimacy. Echoing the thoughts of two residents and two spouses, one female manager recognised that the predominance of single rooms and single seating effectively precludes opportunities for intimacy and sexual activity.

One example of an overprotective, possibly infantilising, approach to safeguarding welfare concerned the operation in one care home of a “no locked door” policy, which compromised the privacy necessary for intimacy. One spouse, Olivia, likened this kind of surveillance to “living in a goldfish bowl”.

Both staff and residents agreed on the importance of respecting privacy, for example, by knocking before entering a resident’s room, thereby enabling privacy for “cuddling” or other forms of intimacy. Indeed, such thinking suggests the issues in question are not always about safety-guarding, but also about being aware of how service users give consent.

However, not all accounts of sexuality or intimacy were problematic. In fact, some care home staff were more concerned with enabling, rather than restricting or making a problem, of residents’ sexual/intimacy needs. For example, a manager in one care home described how staff had improvised by placing curtains behind the frosted glass in one room for the benefit of a couple.

All told, the various innovations and solutions described by care staff indicate that a measured approach to safeguarding and enabling intimacy is possible – one that is determined more by the expressed and observed needs/reactions of residents than any anxiety about ageing sexuality.

Implications for staff/providers
The consultation with older people, families and care staff, suggests that:

» Service providers should engage with existing guidance (Box 2) on recognising and meeting needs relating to intimacy and sexuality;

» Relevant policies and practices should recognise resident diversity and avoid “treating them all the same”, which risks reinforcing inequality and falls short of meeting needs relating to sex, sexuality, intimacy and more;

» Events to raise staff and resident awareness of intimacy and sexuality should address stereotyping, moral concerns, and the achievement of a balance between enabling choices, desires and rights, and safeguarding vulnerable individuals.

Conclusion
Raising issues of sexuality and intimacy may be difficult for both care home residents and staff, but steps can be taken, before and after a person has been admitted to a care home, to facilitate such discussions. Acknowledging that older people may still want to be sexually active or intimate is the first step to addressing the issues and overcoming the barriers.

References


Royal College of Nursing (2011) Older People in Care Homes: Sex, Sexuality and Intimate Relationships. Bit.ly/RCNSexSexuality

MEETING INTIMACY GUIDANCE ON BOX 2.


ROYAL COLLEGE OF NURSING (2011) Older People in Care Homes: Sex, Sexuality and Intimate Relationships. Bit.ly/RCNSexSexuality

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