Sexuality and sexual intimacy in later life

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Abstract

Sexuality is as important in older age as it is throughout life, and its expression can be positive, empowering, joyful and life-affirming. The concept of sexuality has many dimensions including identity, need and desire, relationships and behaviour, all of which develop through ageing and life experiences. The evidence on all aspects of sexuality in later life tends to focus on biological dysfunction rather than fulfilment, well-being and quality of life, and does not acknowledge the enormous diversity of older people in terms of age, sexualities, ethnicity and culture. However, the evidence base is growing and, in broad terms, what older people want is becoming more clearly articulated.

This article acknowledges the current evidence and, building on this, suggests ways in which nurses working in health and social care services can address some of the challenges, enhance their own understanding and skills, and work creatively with older individuals to offer services that help them to live, and end, their lives according to their individual identities, choices and deepest, most personal, priorities.

Aim and intended learning outcomes

The aim of this article is to enhance your understanding of sexuality and sexual expression in older people, and your confidence in working with older people in these aspects of care. After reading this article and completing the time out activities you should be able to:

» List important dimensions in the overall concept of ‘sexuality’ and, for each of these, identify specific considerations for older people.

» Describe the benefits of sexual expression and sexual intimacy for older individuals and couples.

» Outline the biological, psychological and social changes in later life that can affect sexual expression and intimacy.

» Explain how older people have said they adapt to the changes they experience in sexual expression and intimacy.

» Identify a range of approaches you could use to open meaningful dialogue with older individuals about sexuality and their sexual priorities.

» In the context of the P-LI-SS-IT Model (Annon 1976), discuss how you, and your workplace, could enhance the service you offer to support older people’s expression of sexuality, sexual needs/desires, choices and priorities.

Relevance to The Code

Nurses are encouraged to apply the four themes of The Code: Professional Standards of Practice and Behaviour for Nurses, Midwives and Nursing Associates to their professional practice (Nursing and Midwifery Council (NMC) 2018).

The themes are: prioritise people, practise effectively, preserve safety, and promote professionalism and trust. This article relates to the Code in the following ways:

» Prioritise people – appreciate individuality and diversity in older people and, addressing any personal discomforts, put aside your beliefs and treat everyone with respect and dignity.

» Practise effectively and preserve safety – enhance your knowledge in these aspects of care, and know where to seek expert advice when appropriate, to ensure you work from a sound legal and professional evidence base.

» Promote professionalism and trust – acknowledge your own level of competence in addressing issues of sexuality and sexual expression.
**TIME OUT I**

**Human sexuality**
Write down the words ‘human sexuality’. Then write down all the terms you associate with these words, for example, gender, sexual orientation and relationships, and a few words to clarify your understanding of these terms.

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**Introduction**

Humans are sexual beings from birth to death and sexuality influences all aspects of our lives. Expressing ourselves as sexual beings can be positive, empowering and life-affirming, particularly in the context of mutually appreciative relationships. Despite sexuality being so fundamental in human life, many nurses find it a difficult area of practice, particularly with older people. To address the difficulties, this article offers information on sexuality, ageing, sexual functioning and intimacy in later life. It then focuses on how nurses can enhance their practice in supporting these dimensions, not all of them are always experienced or expressed in all individuals.

The concept of sexuality is multidimensional. The word ‘sexuality’ usually indicates sexual identity, gender identity or sexual orientation but, in its broader meanings, sexuality encompasses sexual need and expression, intimacy, eroticism, pleasure and reproduction. It is influenced by the interaction of biological, psychological, social, economic, political, cultural, legal, historical, religious and spiritual factors. Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviours, practices, roles and relationships. While sexuality can include all these dimensions, not all of them are always experienced or expressed in all individuals.

Sexual images can be powerful and, in Western societies, they are all around us. They are used to entice, persuade and seduce us to behave in ways that the image promoters want – usually to subscribe to their products, services or ways of life. By depicting primarily young, fit people, these images imply that sex is irrelevant or unimportant to people who do not see themselves reflected in the images – people with different body shapes, who have a disability or disfigurement, and people who are older. Older people in their sixties lived their formative years in the era of ‘free love’ and improved prevention technologies. Cultural and religious mores have influenced their values and choices in terms of intimate relationships and sex.

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**TIME OUT 2**

**Societal influence**
Consider an older person in your care. Write down when and where they were born. Then note down what was happening in their society during their childhood and teenage years. Reflect on how these experiences could have influenced their values and choices in terms of intimate relationships and sex.

**Older people**

The term ‘older’ is used to categorise a group of people who are diverse. They cover an age range of 50+ years and have different life experiences. Those in their nineties and older lived through the second world war and will have been influenced by their parents’ experiences of the first world war; in contrast, people in their sixties lived their formative years in the era of ‘free love’ and improved prevention of pregnancy through medications and technologies. Cultural and religious mores have a profound influence on sexual conventions, for example, if sex is permissible outside marriage, in the role that women take in relationships, for example, individual older people (Garrett 2017, Lee and Tetley 2017) and older lesbian, gay, bisexual or trans (LGBT) people (Gillis et al 2017, Hillman 2017). Research has tended to focus on the biological aspects (DeLamater and Karraker 2009) and to ignore the social, cultural and relationship influences that may affect older people’s sexual activities and relationships (Hinchlif and Gott 2004, Galinsky and Waite 2014). The partnership aspects of sexual relationships are also commonly overlooked (Verschure et al 2010), as are sexual functioning and fulfilment in the context of overall health and well-being (Lee and Tetley 2017).

Nevertheless, evidence on the importance of sex to older people’s quality of life is growing. Kiecolt-Glaser and Newton (2001) concluded that regular consensual sexual expression contributes to older people’s physical and psychological well-being and may reduce physical and mental health problems. Using the Satisfaction With Life Scale, Lee and Tetley (2017) found that, in men and women aged 50–90+, there was a positive association between the frequency of kissing, fondling and petting and overall levels of subjective well-being. From her research seeking older people’s views, Garrett (2014, 2015, 2017) concluded that sexual expression, sexual activity and intimacy are not only normal and natural in later life, they are positive, healthy, empowering and life-affirming.
or the age of mothers having a first child. Increasing numbers of older people in the UK are from diverse racial and ethnic backgrounds (British Medical Association 2016).

As we go through life, our perceptions of ourselves as sexual beings develop. For example, our concept of our own physical body changes in the context of the prevailing societal norms. In the 1950s, for example, ‘curvy’ women like Marilyn Monroe were iconic, while in the 1960s iconic women such as Twiggy had slimmer, less curvy bodies. Through life we experience a range of relationships that, in various ways, offer a mirror through which we reflect on ourselves as sexual beings, sexually attractive or sexually repressed. Many individuals experience significant or even traumatic events, such as sexual abuse or violence, and these influence our perceptions of ourselves as sexual beings. The longer we live, the richer the accumulation of such experiences.

TIME OUT 3
LGBT service users
Looking at your older service users, do you know which individuals identify themselves as LGBT? Do they have any particular care needs and how well do you consider these are met by your service? Write down your suggestions on how the service offered to these individuals could be enhanced. (NB If you cannot identify any individuals, please question this assumption. Surveys estimate that at least 5-10% of the population are lesbian, gay or bisexual and, particularly among older men, this is likely to be an underestimate (Stonewall 2011)).

TIME OUT 4
Ageing, sexual functioning and intimate

In their review of medical and social science literature, DeLamater and Karraker (2009) identify four determinants of sexual functioning in older adults: biological, psychological, social context and the interactions of these with each other.

Lee and Tetley (2017) suggest that psychosocial changes experienced in later life can influence sexual functioning and activity even more significantly than physiological changes. Later life can bring changes in employment and financial status, more time for leisure, more time with a partner as children leave home, and removal of the fear of pregnancy. It can also bring caregiving roles for parents and grandchildren. There are also the stark realities of divorce, separation, confronting illness and the loss of a partner, after which older people may form new unions. Mental health is also linked to sexual functioning (Basson 2007), for example, depression is a risk factor for sexual dysfunction as are some medications used for its treatment (Box 1).

Physiologically, endocrine, vascular and neurological changes all produce direct and indirect effects on sexual functioning, affecting sexual arousal and performance (Yee 2010) (Box 2).

Sexual identities

The umbrella terms ‘gay’ or ‘LGBT’ are used to encompass a variety of people who identify themselves as lesbian, gay, bisexual, trans, intersex, queer, questioning or other. While it is important to be inclusive, it is essential to recognise that individual LGBT people remain unique and distinct from one another (Hillman 2017); for example, someone may be trans in terms of gender identity but their sexual orientation may be lesbian, gay or bisexual.

In reviewing research into the lives of older gay people, Kean (2006) identified widespread stereotyping and concluded that the lives of diverse gay older people were inaccurately described and, due to historical intolerance of homosexuality and the stigma of HIV/AIDS, particularly during the 1980s, older gay men commonly hid their sexual orientation. As Joseph, an older gay man, explains (Knocker and Smith 2017): ‘We started out life as “criminals”. Homosexuality was illegal ‘til 1967 so many of us lived in fear of being caught, losing our jobs and even our families.’

In contrast to older heterosexuals, older gay people may have looser family ties and large and supportive friendship networks (Kean 2006). This has significant implications for next-of-kin status, liaising with caregivers, rights to information or visitation, hospital discharge planning or transfer of care.

As Knocker and Smith (2017) highlight: ‘Being LGBT is about more than your sex life or whether you are in a relationship or not. It shapes the way you have experienced life, your interests, likes, dislikes, humour, family, friendships and attitudes. It might also inform the books you read, films you watch and music you enjoy.’ Encompassing these important aspects of an older individual’s life in their care plan is therefore essential. A care plan that neglects to include this huge part of a person’s individuality is incomplete and is likely to fall short of meeting that person’s needs (Knocker and Smith 2017).

Other determinants include:

Physical

Physiological changes occur throughout life, including the age-related changes that start with puberty and continue through the menopause in women. These changes affect sexual functioning and activity even more significantly than physiological changes. Later life can bring changes in employment and financial status, more time for leisure, more time with a partner as children leave home, and removal of the fear of pregnancy. It can also bring caregiving roles for parents and grandchildren. There are also the stark realities of divorce, separation, confronting illness and the loss of a partner, after which older people may form new unions. Mental health is also linked to sexual functioning (Basson 2007), for example, depression is a risk factor for sexual dysfunction as are some medications used for its treatment (Box 1).

Physiologically, endocrine, vascular and neurological changes all produce direct and indirect effects on sexual functioning, affecting sexual arousal and performance (Yee 2010) (Box 2).

Other determinants include:

Emotional

Emotional factors are related to sexual functioning and activity even more significantly than physiological changes. Later life can bring changes in employment and financial status, more time for leisure, more time with a partner as children leave home, and removal of the fear of pregnancy. It can also bring caregiving roles for parents and grandchildren. There are also the stark realities of divorce, separation, confronting illness and the loss of a partner, after which older people may form new unions. Mental health is also linked to sexual functioning (Basson 2007), for example, depression is a risk factor for sexual dysfunction as are some medications used for its treatment (Box 1).

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Other determinants include:

Psychological

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Other determinants include:

Social

Social factors are related to sexual functioning and activity even more significantly than physiological changes. Later life can bring changes in employment and financial status, more time for leisure, more time with a partner as children leave home, and removal of the fear of pregnancy. It can also bring caregiving roles for parents and grandchildren. There are also the stark realities of divorce, separation, confronting illness and the loss of a partner, after which older people may form new unions. Mental health is also linked to sexual functioning (Basson 2007), for example, depression is a risk factor for sexual dysfunction as are some medications used for its treatment (Box 1).

Physiologically, endocrine, vascular and neurological changes all produce direct and indirect effects on sexual functioning, affecting sexual arousal and performance (Yee 2010) (Box 2).

Other determinants include:

Local culture

Local culture is related to sexual functioning and activity even more significantly than physiological changes. Later life can bring changes in employment and financial status, more time for leisure, more time with a partner as children leave home, and removal of the fear of pregnancy. It can also bring caregiving roles for parents and grandchildren. There are also the stark realities of divorce, separation, confronting illness and the loss of a partner, after which older people may form new unions. Mental health is also linked to sexual functioning (Basson 2007), for example, depression is a risk factor for sexual dysfunction as are some medications used for its treatment (Box 1).

Physiologically, endocrine, vascular and neurological changes all produce direct and indirect effects on sexual functioning, affecting sexual arousal and performance (Yee 2010) (Box 2).

Other determinants include:

Personal identity

Personal identity is related to sexual functioning and activity even more significantly than physiological changes. Later life can bring changes in employment and financial status, more time for leisure, more time with a partner as children leave home, and removal of the fear of pregnancy. It can also bring caregiving roles for parents and grandchildren. There are also the stark realities of divorce, separation, confronting illness and the loss of a partner, after which older people may form new unions. Mental health is also linked to sexual functioning (Basson 2007), for example, depression is a risk factor for sexual dysfunction as are some medications used for its treatment (Box 1).

Physiologically, endocrine, vascular and neurological changes all produce direct and indirect effects on sexual functioning, affecting sexual arousal and performance (Yee 2010) (Box 2).

Other determinants include:
The most common changes reported by older males are erectile difficulties or dysfunction, which can be due to age-related hormonal changes or underlying neurological or vascular processes. Erectile dysfunction can be exacerbated by emotional anxiety, some medications or the effects of treatments particularly for prostate disease. Treatment includes medications such as phosphodiesterase-5 inhibitors, for example, sildenafil, which increase blood flow to the penis thereby enhancing erection. This medication should be used with caution in people with cardiovascular disease and is contraindicated in people taking nitrates (GP Notebook 2018).

The most common problems reported by older females are vaginal dryness and/or pain during sexual intercourse, arousal difficulties and orgasm difficulties. Vaginal dryness can occur at any age but becomes more problematic during and after menopause (Lee and Tetley 2017). Lubricants can be purchased over the counter and various hormone-based treatments are available.

Physical health is closely linked with sexual functioning and is more important in predicting sexual dysfunction than chronological age (DeLamater and Karraker 2009). Changes in sexual functioning can be a marker for serious health conditions, for example, erectile dysfunction in men may suggest asymptomatic coronary disease or diabetes.

Age-related changes are complex but Lee and Tetley’s (2017) research concluded that men and women remain sexually active and intimate into their seventies, eighties and nineties. Sexual activity changes over time, with increasing emphasis on the quality of the relationship, intimacy and non-penetrative activities, but partnerships can remain satisfying, caring and rewarding.

For some older people sexual satisfaction can be even greater than when they were younger (World Health Organization 2015). In Lee and Tetley’s (2017) research, older interviewees explained how they adapted to remain sexually intimate with their partner:

- ‘Now too old [for penetrative sex] but my wife and I sleep in the same bed, and kiss and cuddle each other before settling down to sleep. We enjoy each other’s company’ (man, 80+).
- ‘We have never been happier in bed than we are now and intercourse never comes into it. Just lots of laughter, kisses, hugs and silly fun!’ (woman, 60–69).
- Garrett’s (2017) interviews with couples over 75 years old also highlighted the increasing emphasis on intimacy and the quality of the relationship:
  - ‘Intimacy in my life is essential but not necessarily penetration’ (older person wrote anonymously on a postcard).
  - ‘I guess the analogy would be, if you cannot walk … as far as you used to be able to you can still enjoy a short walk … you have to accept it’ (‘Philip’, 75).

The older people in Garrett’s (2017) study explained how they enjoyed their sexual intimacy in a range of ways:
- Being together, sharing the days, doing things together, feeling close in many ways:
  - ‘We have not had intercourse for some time now but … cuddling … that sort of being close and touch. Over the 42 years we have been married … if you love one another and stand by one another you grow closer and closer and closer … Sometimes when we are in the kitchen I will creep up behind her and give her a cuddle, it is important, it keeps our marriage alive. When we watch telly I always sit down and hold her hand’ (‘Richard’, late seventies).
  - Being physically close, and maintaining intimacy in changing circumstances, cuddling and kissing, sharing a bed, poking, tickling, mutual masturbation, being naked together ‘skin to skin’:

Box 1. Psychosocial changes that can affect relationships and sexual expression in later life

- Changes in self-image consequent to age-related physical and health changes
- Removal of fear of pregnancy
- Loss of employment status; retirement from paid work
- Changes in financial status and reduced potential to earn money
- Increased opportunity for leisure, voluntary activities and new learning
- Increased time with partner, children leaving home
- Caregiving roles for parents, older relatives, partner or grandchildren
- Loss of partner, death of friends, divorce, separation, living alone and loneliness
- Mental health issues dealing with changes and loss
- Opportunities for new socialising activities, relationships and partnerships

(Bassin 2002; Lee and Tetley 2012, Age UK 2018a, 2018b)

Box 2. Age-related biological changes affecting sexual function

In older men:
- Erectile response is longer and erections may require more intense or prolonged physical stimulation
- Erections may be less rigid with some softening during sexual activity
- Ejaculations may be of decreased intensity and volume, and there may be delay in ejaculation
- Increased refractory period

In older women:
- Decreased vaginal lubrication and clitoral engorgement
- Decreased breast swelling
- Diminished preorgasmic sweating
- Diminished orgasm intensity

‘We get upset if we get two single beds when we go away … just touching feet or something you know but you even do it in your sleep you know that the other person is there’ (‘Ray’, 79).

‘We always sleep with nothing on, so we cuddle up, we appreciate each other, that’s very important’ (‘Philip’, 75).

Laughing and joking:

‘It is not always about sex. Sometimes the best intimacy is where you lay back and laugh at silly things, hold each other and enjoy each other’s company’ (woman, 77, email).

Listening to music and dancing together:

‘… 60s 70s music … we like to listen a lot to that and to love songs on a Sunday morning on the radio’ (‘Joan’, 75).

Sexual adjuncts were mentioned by some of the older people interviewed in the study by Garrett (2017). Adjuncts included the use of drugs in the sildenafil group for men experiencing erectile dysfunction, and accessing erotic magazines or erotic sites on the internet.

From her research, Garrett (2017) offered a definition of sexual intimacy: ‘In the context of partnership relationships, particularly those of long-standing, sexual intimacy for older people may be seen as a reciprocal or mutual action or sense of presence which results in a shared experience or frisson. This moment or moments in time invoke a sexual excitement, contentment or pleasure which have both physical and emotional elements that are life-affirming.’

As Age UK (2018a) summarise: ‘sexual desire does not disappear as you get older, and it is natural to continue to want to have sex. Sex in later life may be different from when you were younger, but although you may need to make some adjustments, getting older does not mean giving up on sex.’

TIME OUT 5
Supporting sexual expression
Make a list of the potential difficulties in supporting older service users’ sexuality and sexual expression in your workplace, such as difficulty finding private places to have sensitive discussions. Beside each, write how you and your colleagues could work to overcome these

Supporting sexual expression in practice
While older people generally welcome opportunities to discuss their sexual concerns, research has identified that health professionals are often reluctant to initiate conversations (McAuliffe et al 2007) and nurses at all levels can be uncomfortable doing so (Haesler et al 2016, Baker-Green 2017). The barriers discouraging staff from discussing sexuality issues with older patients include:

» Their own lack of confidence and/or relevant experience.

» Lack of knowledge of sexuality issues in later life, of treatments or means of helping older people experiencing problems, or where to refer for help.

» Embarrassment and fear of causing patient embarrassment.

» Fear of causing offence.

» Personal, cultural or religious beliefs, for example, about different types of relationships such as people from different backgrounds or generations, homosexuality and if people should be sexually active.

» A dominant care culture that does not regard sexual and sexuality issues as important so discourages their expression.

However, addressing sexuality issues remains a central element of the nursing role (Evans 2013, Garrett 2014). In the context of health changes affecting sex, such as diabetes, pain, breathlessness or neurological disease, asking about sexual functioning is a legitimate area for nursing enquiry. Do not fear that you must be a psychosexual therapist to help; opening the dialogue with the older person, actively listening to what they are saying and being prepared to discuss sexual issues can be helpful. You can refer to someone with greater expertise when appropriate.

A care plan that does not address these fundamental aspects of an older person’s life is not complete. More importantly, care that does not address such fundamental aspects of an older individual’s identity, their most intimate relationships and most heartfelt desires can cause unresolvable unhappiness that can remain until death.

The P-LI-SS-IT Model
The P-LI-SS-IT Model was devised by Annon (1976), an American psychosexual therapist, as a cognitive-behavioural programme to assist those experiencing sexual dysfunction. This work has since been adapted in nursing to represent different levels of psychosexual care and the contribution made by nurses and healthcare practitioners dependent on their role and specific level of expertise (White 2002).

Based on the original P-LI-SS-IT Model, the Extended-P-LI-SS-IT Model was described by Taylor and Davis (2006). This emphasises that all interventions should begin with, and are underpinned by, permission-giving.

Using P-LI-SS-IT as a framework, the following sections describe how organisational environments, cultures, systems, practices
and interventions in health and social care can support sexuality expression in older service users, along with the staff skills and competencies to work at each level.

**Level 1: Permission**
The care context, environment, systems of care delivery and staff attitudes all communicate that sexuality, intimate relationships and sex are integral to the services being offered; for example ‘permission’ for these issues to be addressed is implicit. Creating a climate of ‘permission’ may challenge established care practices where sexual issues have previously not been integral to the service, for example, cultures and practices based on heterosexist assumptions.

Environments: resources such as leaflets or educational material, posters, contact details, self-help group or counselling facilities, including for LGBT individuals and those with disabilities such as hearing impairment. Spaces available for private conversations and for couples to have private uninterrupted time together. This can be difficult in some services such as acute wards or emergency departments, but many have designated sexual private rooms with clear ‘engaged’ or ‘do not disturb’ signs that all staff agree to respect.

Organisational cultures, care practices and interventions: ‘permission’, implicit and explicit, for sexuality and sex to be central in the work of the service is integral to organisational cultures, for example, for staff as well as service users to be open about sexual orientation if they choose. ‘Permission’ initiates and underpins all care practices.

Issues encompassed: all aspects of sexuality and sexuality expression; all aspects of sexual need and sexual expression.

Nursing skills and competence: addressing sexuality and sexual expression is as fundamental to nursing as addressing hydration, nutrition or bowel functioning. All registered nurses should feel confident about creating a climate of permission to address this and should take responsibility for their own development to enhance their confidence. This may involve an honest interrogation of personal values, beliefs and attitudes to, for example, older people having sex, diversity in relationships and different sexual practices. A great deal of nursing literature is now available to support nurses to develop their understanding, for example, Matthews (2009), Blagbrough (2010), Garrett and Tomlin (2015) and Burch (2016), and through a broad range of organisations (see selected resources for practitioners at the end of this article).

**Level 2: Limited information**
Working in a context of ‘permission’, offering limited information encompasses acknowledgement of the effect of sexual issues on health and offering general guidance. For staff working with older people, this requires a broad understanding of the diversity of older individuals, the experience of growing older and of general sexual issues in later life. Staff should seek to learn about the importance of intimacy to older individuals and couples, and how older people might adapt their lifestyles to enhance the quality of their intimacy.

This level of working encompasses understanding of the effects of ageing, of conditions and diseases common in later life, and of common drugs and treatments and the potential side effects of these. Staff should also be aware of the effects of lifestyle on sexual activity, for example, exercise, smoking and excessive alcohol, and be able to offer general guidance. Advice on safer sexual practices should also be available if required.

This level of working requires staff to know what sources of help are available to support older people, particularly organisations such as Age UK and Alzheimer’s Society, and where to refer when more specific support is required. Resources are readily available on, for example, sex with arthritis, heart problems or cancer, and on all aspects of intimacy in older age, including dating (Age UK 2018b) (see selected resources for older people at the end of this article).

**Level 3: Specific suggestions**
This level of working takes place in a therapeutic relationship in which practitioners can offer suggestions on specific situations such as sexual activity after prostate or gynaecological treatment, in Parkinson’s disease or diabetes, with incontinence or an indwelling urinary catheter or with chronic pain. Supporting people with dementia is a growing area of practice. This level of work is usually undertaken by nurse specialists or advanced practitioners, but nurses in all settings can develop their expertise to this level if they choose and are able to work in this way in their practice area. Again, practitioners should be aware of services to which they can refer older people who need more specialised help.

If adequate psychosexual support is offered, few individuals or couples need intensive therapy. However, if this is required, nurses can make referrals.

**Level 4: Intensive therapy**
This level of working is usually offered by professionals with specialist training in
SELECTED RESOURCES FOR OLDER PEOPLE

Sexual health
tinyurl.com/NHS-good-sex
Sex in later life
tinyurl.com/AgeUK-sex-later-life
Dating in later life
tinyurl.com/AgeUK-dating-later-life
Sex, relationships and arthritis
tinyurl.com/Versus-Arthritis-relationships
Sex, sexuality and cancer
tinyurl.com/Cancer-Research-sexuality
tinyurl.com/Macmillan-research-sexuality
Sex and heart conditions
tinyurl.com/BHF-sex-heart
Sex, intimacy and dementia
tinyurl.com/Alzheimers-Society-intimacy
tinyurl.com/Alzheimer-Scotland-sexuality
Older People's Understandings of Sexuality (OPUS) Research Initiative
tinyurl.com/MICRA-sexuality

specialist teams or centres, who offer intensive therapy over time. Psychosexual work typically addresses the physical, psychological and interpersonal or relationship components of sexual difficulties, adopting an eclectic mix of behavioural, cognitive and psychodynamic approaches in working with individuals or, more commonly, couples (White 2002). Teams can comprise psychosexual counsellors, and specialists in psychosexual medicine or in erectile dysfunction.

This specialist help can be accessed through a range of sources, including GPs with special interest, social services, clinical psychology or psychiatry services, genitourinary medicine departments and psychosexual clinics.

TIPS FOR BROACHING SEXUALITY ISSUES

Asking highly personal questions with skill and sensitivity is fundamental to nursing (Evans 2013, Garrett 2014), but broaching issues related to sexuality or sexual activity can be assisted by:

» Developing your own knowledge of aspects of sexuality, sexual health and sexual expression in later life relevant to the people you are nursing, including the effect of specific conditions, medications and other treatments.

» Creating an environment of ‘permission’ so that older people are clear that sexuality, sexual activity and sexual health are integral to the care being offered. Create time and space for an unhurried, uninterrupted discussion.

» Remembering that sexuality and sexual activity are important to individuals and that, for couples, intimate relationships can be positive, joyful and life-affirming.

» Remaining open to addressing discomfort in yourself and the person.

» Taking the older person’s lead in terms of the ‘tone’ of the discussion – worried, sad, seeking, resigned or humorous.

» Adopting an objective, non-judgemental and professional manner. Being kind, understanding and empathic. Avoiding making assumptions.

» Providing pertinent information and having resources in a range of accessible formats readily available in your work area. Being prepared to leave information with the person so that they can digest this. Returning to them to invite questions or further discussion.

» Asking broad and open questions; inviting the older person to share information and encouraging questions.

» Listening carefully to the language and terminology they use and trying to reflect this in your responses.

» Developing your own ‘menu’ of questions which you can use to open dialogue. Useful topics of focus include health condition, treatment, medication and relationships. For example, ‘has your diabetes affected your intimate relationships?’ Or ‘has the cancer treatment changed how your body responds, for example, sexually?’ Giving information is also a useful opener, for example ‘this medication is known to affect people sexually – is this an issue for you?’

» Actively listening to what the older person is saying and being open to deeper meanings in what is being said, but also remaining vigilant for all cues the person is giving, for example, through changes in vocal tone, eye movements and body language.

» Awareness of timing – this is important. Opening such conversations when you sense that the person is ready and when you have time to take the conversation to fulfilment. If someone dismisses your questions with responses such as ‘what, at my age?’, remaining vigilant for further discussion opportunities when they have had time to reflect and are ready to disclose to you. In this situation, remember that the person’s reluctance to talk further is not an indictment of the nurse, they are merely expressing their current preference.

» Documentation. Recording the important details of your conversation so that these are not lost or forgotten.

» Drawing on evidence-based guidance, such as Heath et al (2018) so that you can develop your practice from sound foundations.


CONCLUSION

Despite prevailing Western stereotypes that sex is the province of people who are young and perceived as ‘beautiful’, research incorporating large-scale and in-depth studies reveals that

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people in later life want to continue to enjoy expressing their sexuality, along with  enjoying their choices in sexual intimacy and sexual  activities, in all their diversities.

To avoid what Lee and Tetley (2017) describe as ‘over-simplistic and unhelpful’  views on older people’s sexuality, it is important to acknowledge the diversity of older individuals in age, background, life experience, sexualities, lifestyle choices, intimate relationships, health, views and priorities.

Addressing sexuality issues remains a central element of nursing older people and this article has offered a range of strategies that nurses can use to do this. A starting point is creating a climate where permission to discuss sexuality is implicit in the environment, care  regimens and staff communication. In the context of the long-term conditions that many older people experience, explicitly asking how health changes or treatments affect sex is an important nursing function. Nurses should work to develop their confidence and competence in addressing sexuality issues and should not be dettered by thinking they have to be psychosexual therapists to address sexual issues; opening a dialogue with an older person, actively listening and responding honestly to what they are saying can be immensely helpful and further support can be sought as appropriate.

TIME OUT 7
The Code
Applying the themes of the Code (NMC 2018) to your professional practice, set out three reflective examples of how you will change your practice as a result of the learning you have gained from this article. Include one example of your future learning needs in relation to the content of this article. Choose one example to discuss with a senior colleague and make this change to count towards your revalidation

TIME OUT 8
Reflection
Now that you have completed the article you might like to write a reflective account as part of your revalidation. Guidelines to help you are at rcni.com/reflective-account

References
Sexuality

TEST YOUR KNOWLEDGE BY COMPLETING THIS MULTIPLE-CHOICE QUIZ

1. Sexual activity in older age may focus on:
   a) Fondling
   b) Non-penetrative sex
   c) Kissing
   d) All of the above

2. Research with older people has found that they consider sexual expression to be:
   a) Life-affirming
   b) Unhealthy
   c) Disempowering
   d) Irrelevant

3. In contrast to older heterosexuals, studies have found that older gay people may have:
   a) Large friendship networks
   b) Supportive families
   c) Strong family ties
   d) No friends

4. A psychosocial change that can affect relationships in later life is:
   a) Decreased vaginal lubrication
   b) Change in employment
   c) Decreased ejaculations
   d) Diminished orgasm intensity

5. The most common change in sexual functioning reported by older men is:
   a) Pain during sexual intercourse
   b) Erectile difficulties
   c) Increased rigidity of erections
   d) Increased intensity of ejaculations

6. Phosphodiesterase-5 inhibitors such as sildenafil should be used with caution in people who have:
   a) Pulmonary hypertension
   b) Diabetes
   c) Cardiovascular disease
   d) Insomnia

7. A barrier to staff discussing sexual concerns with patients is:
   a) Fear of causing offence
   b) Lack of knowledge
   c) Embarrassment
   d) All of the above

8. Permission is level 1 of the P-LI-SS-IT Model. How might the physical care environment indicate that permission to address sexuality has been recognised?
   a) Availability of condoms
   b) Availability of spaces for private conversations
   c) Staff being open about their sexual orientation
   d) Patients being open about their sexual orientation

9. An example of level 3 work – Specific Suggestions – using the P-LI-SS-IT Model is:
   a) Poster displays with contact details for self-help guides
   b) Psychosexual counselling
   c) Patient information leaflets
   d) Practitioners offering advice on sexual activity to people living with incontinence

10. Nurses might broach issues of sexuality with older people by:
    a) Adopting a subjective approach
    b) Asking closed questions
    c) Offering information in a limited range of formats
    d) Creating time and space for an unhurried discussion

This activity has taken me __ minutes/hours to complete. Now that I have read this article and completed this assessment, I think my knowledge is:

Excellent □ Good □ Satisfactory □ Unsatisfactory □ Poor □

As a result of this I intend to:

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How to complete this assessment

This multiple-choice quiz will help you test your knowledge. It comprises ten multiple choice questions broadly linked to the previous article. There is one correct answer to each question.

You can read the article before answering the questions or attempt the questions first, then read the article and see if you would answer them differently.

You may want to write a reflective account. Visit rcni.com/reflective-account

Go online to complete this multiple-choice quiz and you can save it to your RCNi portfolio to help meet your revalidation requirements. Go to rcni.com/cpd/test-your-knowledge

This multiple-choice quiz was compiled by Lisa Berry

The answers to this quiz are: 1  2  3  4  5  6  7  8  9  10