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Sexuality and Intimacy in Older Adults

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In most long-term care settings, staff members tend to view a resident's attempts at sexual expression as "problem" behavior. However, we are increasingly recognizing that interest in, and the right to, sexual expression exists throughout the life span and should be supported. Assisted living nurses need information and tools to adequately address residents' sexual health and to overcome the many barriers to intimacy in this population. This article briefly reviews age and illness-related changes in sexual function; describes the research regarding older adults' and their family's and caregivers' attitudes regarding sexuality and intimacy; discusses sexuality and residents with dementia; and reviews nursing assessment and educational interventions that support healthy sexuality among older adults. (*Geriatr Nurs* 2008;29:342-349)

Sexuality is a core dimension of life that incorporates notions, beliefs, facts, fantasies, rituals, attitudes, values, and rights with regard to gender identity and role, sexual acts and orientation, and aspects of pleasure, intimacy, and reproduction.¹ Influenced by biopsychosocial, economic, cultural, religious, and spiritual factors, the expression of sexuality and desire for intimacy is complex, no less so for an older adult than for a teenager. The notion of sexual health, as with physical health, is not simply the absence of sexual dysfunction or disease but, rather, a state of sexual well-being that includes a positive approach to a sexual relationship and anticipation of a pleasurable experience without fear, shame, violence, or coercion. Assisted living nurses can be key to older adults' attainment and continuity of their individually expressed sexuality.²

"Sexual rights" means having access to sexual health care services, information, and education about sexual expression. It also encompasses certain freedoms: to choose whether to be sexually active, to choose or reject a sexual partner, and to participate in a consensual relationship. This last right has particular relevance for assisted living (and other residential settings) where cognitively impaired residents, those who are hampered in their ability to interpret cues in relationships, might be at risk. In this article we briefly describe the research regarding older adults, discuss their family's and caregivers' attitudes regarding sexuality and intimacy; discuss sexuality and residents with dementia; review age and illness-related changes in sexual function; and review nursing assessment and educational interventions that support sexual health in older adults.

Research on Sex and Aging

Today, broad assumptions about aging, including intimacy and sexuality in later life, are being challenged. Based on both anecdotal reports and formal study, it is increasingly clear that the desire for closeness and sexual contact can endure for a lifetime. Existing research on sexual activity of older adults suffers from inadequate descriptions of the population, particularly across cultures/ethnic groups and with regard to education and financial status. Hence, the "generalizability" of research findings is limited. This leaves health care professionals somewhat in the dark about what older adults want and need to satisfy their sexual interests. However, by becoming familiar with current efforts to understand the issues concerning sexuality and aging, and by challenging their own assumptions on

the subject, nurses can help residents of long-term care communities to attain the level of intimacy and sexual expression that is satisfying to them.

As described by Wallace, older adults (presumably those aged 65 years and older) can have satisfying sexual experiences throughout their adult lives³; weekly sexual activity is common well past middle age.⁴ In a 1999 American Association of Retired Persons (AARP) survey of 1384 older adults, respondents reported that sexual activity was pleasurable, but no clear consensus emerged on the importance of sexual activity to a good relationship.⁵ (This speaks to the influence of a younger generation's mores or interests on "interpreting" what we think an older adult is interested in, sexually or otherwise!) The AARP survey found that older adults with partners felt that a satisfying sexual relationship was important, whereas those without partners did not feel such urgency. Women over age 75 were less likely to have a partner than older men and, as such, seemed to have a less positive attitude toward or interest in sexual activity than men of the same age. Men with or without a partner had more frequent thoughts, fantasies, and feelings of sexual desire (and self-stimulation) than women, with or without partners.

Not surprisingly, the AARP survey revealed that older adults with a chronic medical condition (even if controlled, such as hypertension) engage in less sexual activity than their contemporaries who are not belabored by medical conditions or medications.⁵ Older men reported that elevated blood pressure, diabetes, prostate enlargement, and cancer inhibited their sexual activity and interest. According to these self-reports, impotency increases with each decade, starting at age 60. Few respondents, men or women, were taking any medications to improve sexual performance or satisfaction, but more men than women had sought treatment for sexual functioning. For women, satisfaction with their sex lives was grounded in their attitude toward sex, their partner's characteristics, and their personal self-concept. In men, sexual satisfaction was most influenced by their feeling that their partner was romantic and sensitive to their moods.

Other research suggests that sexual desire diminishes around age 75 and that age is negatively correlated with sexual interest, attitude, participation, and intimacy.⁶ However, overall health is positively correlated with self-esteem, inti-

macy, and sexual attitudes. This kind of information can be reassuring to older adults who express a desire for intimacy in their lives.

Opinions about sex differ across gender and age groups.⁵ The importance of sexual activity in quality of life of women diminishes with age. Older men are less likely than older women to state that they do not enjoy sex nor would they like to live without it. Older men are concerned about their health status and sexual activity, whereas older women are concerned about their partner's health status as well as finding a partner for themselves. Having a partner influences a person's feelings about the importance of sexuality to life quality. Older men and women without a partner ascribe less importance to sexual activity and its necessity for a good relationship. Almost half of male and female respondents, both with and without a partner, felt that sex between nonmarried people was inappropriate. One wonders about the pervasiveness of this attitude on new nonmarital relationships in residential care, especially among those older adults who are cognitively challenged.

Given the reported incidence of depression among assisted living and nursing home residents,⁷ the AARP survey found that depressed older adults were more likely than the general population to say that they do not enjoy sex. Older adults who did not have any chronic or disabling conditions or were not on any significant medications (i.e., presumably healthy people) were less likely to respond that they were quite happy to forgo sexual activity forever compared with the general population, nor did they feel that sexual activity was only for married people. These data are interesting in that better health (i.e., being disease free, not taking any medications) is associated with somewhat liberal sexual attitudes.

The World Health Organization Quality of Life—Older Adults (WHOQOL-OLD) international study that measured quality of life (QoL) of older adults across several cultures consisted of 24 items in several domains: past, present, and future functionality and activities; autonomy; social participation and relationships; death and dying; and intimacy.⁸ Whereas overall QoL was measured by the classic, "How would you rate your quality of life?" (responding on a 5-point Likert scale), the sexuality items addressed sexual drive, expression (i.e., how sexual needs are fulfilled), opportunity, and difficulties. Intimacy was addressed in part by asking if the respondent

was satisfied with the level of intimacy in his or her life. Intimacy did not explain QoL scores, even though it was highly correlated with sexual activity. Personal relationship was the most powerful predictor of QoL; sexuality was important but less so. Health status was also significantly related to QoL. Given the relationship of perceptions about one's health to sexual expression, assisted living nurses should assess—with cultural sensitivity—the older adult's interest in sexual activity and devise an appropriate plan (including education) should the resident have this interest.

Today's older adults do not necessarily equate sexuality with intercourse alone, but, rather, they view the need and sensation of feeling loved as part of their sexual identity. This can be expressed as romancing another, companionship and communication, affection, touch, and a sense of personal attractiveness. In older men, interest in and desire for genital sex often shifts to a desire for intimacy. Clearly, health care professionals who guide older adults in matters of sexual health should consider sexuality more broadly than the models depicted in modern media, arts, and entertainment.⁹

Intimacy, Touch, and Quality of Life

QoL is a complex multidimensional concept. Variables or criteria associated with a “good” QoL include good health, good social relationships, and social support. The data are inconsistent regarding a direct relationship between QoL and age (i.e., being younger rather than older), gender, functionality, marital status, and socioeconomic status. The signal lack of research about intimacy and QoL of older adults might be attributed to the tendency to use the terms *sexuality* and *intimacy* synonymously.

Having or being in an “intimate relationship” connotes various feelings and behaviors—and assumptions (some of which might be erroneous). It is suggested that intimacy consists of 5 distinct components: commitment, mutuality (interdependence), emotional intimacy (includes caring, positive regard), cognitive intimacy (includes thinking about the other; shared values), and physical intimacy (ranging from closeness to intercourse).¹⁰ Intimacy exists but is expressed differently among siblings, between friends, and between parent and child. However, for purposes of this article, intimacy is construed in the context of a romantic relationship.

Viewed from the perspective of privacy, intimacy cannot be forced upon a person even if all the signs indicate that he or she is craving human contact. Rooted in the ethical principle of respect for person, privacy is a personal right.¹¹ Caregiving (e.g., assistance with activities of daily living) straddles the space between privacy and personhood; it is a kind of intimacy that cannot be avoided; it is “task related.” However, caregivers should not assume that a person likes or wants to be touched. Non-task-related “affective” touching, such as simply stroking a person's cheek or holding his or her hand may be viewed as assaultive, erotic, comforting, or presumptuous, depending on a person's cultural background, relationship with the one touching, and personal comfort zone. Nursing home residents regarded touching as acceptable and proper in specific situations, when it did not exceed what the resident wanted or was comfortable with, and when they felt respected while being touched.¹¹ Using humor to defuse a situation in which the recipient seems discomfited by intimate caregiving acts must be approached cautiously, because there is great opportunity for the resident to misunderstand or misconstrue the caregiver's intent.

Barriers to Sexuality and Intimacy

Most of today's assisted living and nursing home residents came of age at a time of conservative norms and double standards, that is, during the first few decades of the 20th century. This was a time when, in general, pleasurable sex was for men only; women engaged in sexual activity to satisfy their husbands and to make babies.⁹ Older adults now in their 70s and 80s were busy raising families and making a living during the “sexual revolution,” which, for the most part, passed them by. Their sexual histories are shaped by concerns other than the need for personal expression—theirs was not the “me” generation! Some of the barriers to sexuality and intimacy in this age group are likely to be rooted in notions of body image, beliefs, and values regarding sexual expression (e.g., outside marriage), and lack of knowledge about or, especially for women, comfort with their sexuality.

Lack of opportunity for sexual experiences is a major barrier to sexual fulfillment for older adults. Loss of a partner through death or incapacity of a spouse is a common scenario in the

lives of older adults. Demographic studies confirm that women significantly outnumber men in the older population: in the 65 to 74 age group, there are approximately 82 men for every 100 women; between 75 to 84 years of age, the ratio of men to women is 65 to 100; and in the over-80 age group, the proportion is 40.7 to 100.¹² The relative scarcity of males in long-term care settings (as well as in the community) can lead to interpersonal conflict among older women as they compete for attention from available men. Assisted living staff need to respond to these situations with sensitivity and approach such conflicts in a manner that preserves the dignity of all concerned parties.

Lack of privacy in the communal living environment of an assisted living residence—and even more so for a nursing home—creates challenges for residents who wish to have an active sex life. Few facilities are designed to accommodate intimate moments, and residents can anticipate interruptions by well-meaning caregivers and other staff, any hour of the day or night. Although having a private room or suite is helpful, residents can still feel inhibited by staff members or other residents in close proximity who might overhear personal conversations or observe intimate behavior. Beyond the issue of physical privacy is the privacy of information, the notion that others can easily become aware of the most intimate aspects of the resident's life. All staff members involved in a resident's care may have access to his or her medical and mental health information, including treatment of any sexual-related medical problem such as vaginal dryness or erectile dysfunction. Fear of becoming the topic of conversation among staff and others can be a deterrent to older adults who might otherwise seek advice from their health care provider or pursue opportunities for sexual fulfillment. Residents with mild cognitive impairment may also sense a loss of autonomy (without necessarily being able to articulate it) and the loss of privacy that this implies. Finally, the attitudes of adult children toward their elderly parents' sex lives may stand in the way of sexual expression among residents and staff attempts to support it.

Attitudes of Health Care Professionals

Health care professionals are influenced by many of the misconceptions, stereotypes, and

myths about sex and aging that are held by the wider society. In Western culture, older men and women are not generally viewed as sexual beings, and this attitude carries over into caregivers' interactions with residents. In a nursing home study of demented residents and sexual behavior, staff was supportive and accepting of "caring acts" between residents with dementia, and they likened "romantic behavior" to "puppy love." However, erotic/overtly sexual behavior generated anger and efforts to protect a resident whom they perceived had been coerced into sexual activity.¹¹ The meager gerontological curriculum in most health care professional education gives even less attention to sexuality of older adults.¹³ This sends the message that sexuality is not an important aspect of gerontological health and contributes to a general unease among health care professionals in raising and discussing sexuality in health care or residential settings.³

Lack of Information

Older adults lack accurate information about sexuality. Sex education was not standard curriculum during the formative or even college years of today's older adults. Sexual values were shaped by circumstances (e.g., economics, war, enculturation), and influenced by societal myths (e.g., that menopause signifies a downturn of sexual desire and loss of sense of femininity; that sexual activity must be initiated by the male; that there is only one correct position for intercourse). Limited knowledge about sex and attitudes about sexuality among older adults are inextricably linked.³ Consequently, older adults may hesitate (or even be loathe) to discuss sexual matters with their health care providers or may be under wildly erroneous assumptions about sexual function in later life. One manifestation of this lack of knowledge or willingness to discuss sexual matters is the rising rates of HIV/AIDS diagnoses in older adults. (Eleven percent of AIDS cases are reported in those over 50 years of age.¹⁴ In older adults, the diagnosis of HIV/AIDS tends to be made later, the disease's course is faster, and prognosis is poorer. Improving HIV/AIDS education for older adults can be an effective strategy for reducing these infections.¹⁵

Western culture places great value on youth, physical attractiveness, and vigor. The pervasive

message—conveyed in countless subtle and not-so-subtle ways—is that aging and sexual desirability are mutually exclusive. We are bombarded with advertisements for skin creams, cosmetic surgery, and hair color formulas, with the underlying assumption that facial wrinkles, sagging breasts, and gray hair are the banes of aging. We consider it impolite to ask an adult his or her age, as if longevity were shameful. This narrow view of aging places limitations on us as individuals and on our society as a whole. Older adults may well share these perceptions and are certainly victimized by the negative stereotypes that these attitudes represent. This can play out in a number of ways, including lowered expectations for sexual fulfillment and avoidance of intimate relationships due to a sense of unworthiness or shame.

Age-Related Changes and Medical Conditions in Men

Decreased desire (loss of libido) can be caused by medical problems, depression, medication side effects, or lack of information about the range of sexual activities that could be pleasurable.¹⁶ Some older men believe that they have erectile dysfunction (ED; once more commonly known as “impotence”) when they are actually experiencing an age-related change in physical response. When compared with younger men, older men require more physical penile stimulation and a longer time to achieve erection, and the duration of orgasm may be shorter and less intense. ED is the inability to achieve and maintain an erection for successful intercourse. It is the most prevalent sexual problem in men, and its incidence increases with age; approximately 75% of men have experienced difficulty achieving an erection at some time by the time they reach 70 years of age. ED is commonly caused by blood vessel disease associated with hypertension, diabetes, high cholesterol, and smoking. Neurological causes of impotence include spinal cord injury and Parkinson’s disease. Impotence can also occur following prostate surgery. Anxiety, depression, and relationship issues may all be implicated in ED. Some men suffer from widower’s syndrome, that is, difficulty achieving erection because they harbor guilt about pursuing a sexual relationship after the death of their spouse.

Medications associated with ED include antidepressants, antihistamines, antihypertensives, antipsychotics, and several over-the-counter preparations (e.g., for heartburn); in most cases, the mechanism for this side effect is unknown. Sexual response can also be adversely affected by alcohol consumption. Testosterone levels have little to do with ED but can have a major influence on libido (sexual desire).

Within the past decade, a class of pharmaceuticals known as phosphodiesterase enzyme type 5 (PE5) inhibitors have become available for the treatment of ED. Currently, only 3 of these medications are on the market in the United States: sildenafil (Viagra), vardenafil (Levitra), and tadalafil (Cialis). They work in concert with sexual stimulation to relax smooth muscle, allowing blood to fill the penis and cause an erection. PE5 inhibitors have vasodilating properties that can be contraindicated in some patients or in the presence of other vasodilating medications. The use of PE5 inhibitors concurrently or intermittently with organic nitrates is contraindicated and can be fatal. In a small number of cases, sudden loss of vision, due to a condition known as nonarteritic anterior ischemic optic neuropathy (NAION), has occurred with the use of PE5 inhibitors, as a result of ischemia of the optic nerve. A cause-and-effect relationship has not been established, however, and the drugs are still widely used (WebMD, 2008).

An alternative to medication for ED is the vacuum pump device. Both manual and battery-operated versions are available and may be covered by Medicare if deemed medically necessary. They work by creating a vacuum that draws blood into the penis, causing an erection.¹⁷ The pumps can have adverse consequences if not used correctly. In a long-term care facility, a caregiver may need to assist the resident in using the device.

Age-Related Changes and Medical Conditions in Women

Aging also affects the female sexual response, including fewer and weaker orgasms, mainly due to hormonal changes, but also as a result of altered body image, relationship and family issues, and medical conditions that may arise in late life.¹⁶ Postmenopausal changes in the urinary or genital tract associated with lower levels of estrogen can make sexual activity less pleasurable. The

resulting vaginal dryness and thinning of tissue can cause pain and irritation during intercourse (dyspareunia) and leave fragile mucous membranes susceptible to infection. Water-based personal lubricants used during foreplay or intercourse can be very helpful. Low-dose topical estrogen creams or estrogen-based vaginal suppositories (typically inserted twice per week after a 14-day period of daily administration) help to plump tissues and restore lubrication, with less absorption than oral hormone treatments.

Body image can be particularly important post-mastectomy, which for some women represents loss of a part of their femininity. Any medical condition that adversely affects mobility and endurance, such as heart disease, diabetes, or arthritis can limit sexual activity and make some positions uncomfortable. Many of the same medications that are problematic for men can adversely affect the female sexual response; these include antihistamines, antihypertensives, antidepressants, antipsychotics, antispasmodics, antiestrogens, and alcohol.¹⁶

Nursing Assessment: PLISSIT Model

First used with young adults, the PLISSIT model is used to assess sexuality and guide intervention in older adults as well.¹³ PLISSIT is an acronym for Permission, Limited Information, Specific Suggestions, and Intensive Therapy. "Permission" has 2 components. Asking permission of the individual to talk about his or her sexual activity puts the individual in control and can alleviate feelings of guilt or anxiety. It is perfectly acceptable to say something like, "I would like to discuss your sexual health with you. What concerns do you have; what troubles you?" The second component is "giving permission" or reassurance that their thoughts, fantasies, and feelings are normal (as long as the behavior does not harm another person, the partner). Providing "limited information" such as basic anatomy and physiology about sexual functioning and age-related changes corrects misconceptions that might be impairing sexual function. Information can also include discussion about illness and the effect of medication on sexual activity.

A sex counselor or therapist should be involved in the third and fourth phases to design an individualized intervention for the specific

older adult or couple. Specific suggestions include practical advice regarding arousal techniques and "mutual pleasuring" exercises. First recommended by Masters and Johnson, the suggestions are designed to reduce stress and anxiety and improve communication.³ Intensive therapy, the fourth phase, is long-term but rarely required except in cases in which the problem is the relationship, as opposed to the sexual activities.^{3,18}

Residents with Dementia

Sexual interest and activity does not disappear with onset of a dementing illness. Those in the first stage of Alzheimer's disease may experience heightened sexual desire or a complete loss of interest in such activity.¹⁹ Hypersexuality is relatively rare but not uncommon in dementia and can be treated with medication. Certain medications, such as benzodiazepines, are associated with loss of sexual inhibition.¹⁹

Assessment of decision-making capacity is essential for residents involved (or potentially involved) in a sexual relationship, with particular focus on comprehension of both parties' intentions or interests; their understanding of physical intimacy and sexual activity; and their expectations of the relationship and of the activity. If there is evidence that understanding is lacking, then the demented person must be protected from sexual exploitation and abuse, including unwanted touching.

There is no simple answer to the dilemma of a demented person who really wants to be intimate or engage in sexual activity but is unable to foresee the consequences—for example, being abandoned, so to speak, after the sexual activity. In situations like these, an interdisciplinary ethics committee meeting or consultation might be warranted.²⁰ Among the questions that can be raised are those addressing the impact of this new relationship on the spouse (in the event that one or both are married), the facility's role in judging the wishes and understanding of the 2 residents and the presence or absence of coercion, whether either resident (or both) is mistaking the other as his or her spouse, and the extent to which this new activity reflects an authentic value expressed in the past by the resident(s).

It is critical to recognize the sexual needs of residents and to make accommodations for these

while preserving the rights of others. For example, masturbation is a normal (for men and women) way of achieving sexual pleasure in the absence of a partner. Caregiving staff should receive support and education about how to respond when they discover a resident masturbating (i.e., they should take steps to ensure the resident's privacy). Sexual activities that are commonly problematic in long-term care facilities include masturbation in public spaces, disrobing in public, inappropriate or suggestive sexual comments, exposing private body parts, reaching out to fondle or grab body parts that are associated with sexual arousal, and attempting to kiss others. These behaviors are distressing to other residents and staff and signal a need for an interdisciplinary sexual assessment. The purpose of this assessment is to determine the underlying need the resident is expressing and how it might be addressed. (The possibility of urinary, vulvar, or vaginal symptomatology should not be overlooked in a resident who frequently touches his or genital area.) Boredom, loneliness, and the need for reassurance can all lead to sexualized behavior that others find objectionable.

A resident might be mistaking another person for his or her spouse and begin exhibiting unwelcome intimate behavior toward that person.²¹ On the other hand, sexual expression between residents could indicate development of a new relationship, as beautifully depicted in the 2007 movie with Julie Christie, *Away From Her*. More recently, former Supreme Court Justice Sandra Day O'Connor poignantly described the relationship between her husband, who has Alzheimer's disease, and another resident in a residential care setting.²²

Overcoming Barriers to Sexuality and Intimacy

Intimacy, if not sexuality, is a continuing human need for most people. Staff misconceptions and negative attitudes about sexuality and aging pose a barrier to sexual fulfillment for long-term care residents. Health care providers need to examine their own attitudes and refrain from labeling an older adult's sexual activity or interest as a "problem." A helpful tool for reaching this goal is the Staff Attitudes about Intimacy and Dementia (SAID) survey, which consists of 20 items

using a 4-point Likert scale (*strongly agree* to *strongly disagree*) regarding aging, dementia, decision-making capacity, sexuality, and intimacy. The survey helps identify discussion topics and the areas in which staff education, sensitivity training, and policy development are indicated.²⁰

Staff education about sexuality and intimacy of older adults encompasses recognition of cues, desires, and interest in sexual activity and intimacy. It also must address the use of and access to pornographic material, assisting expression of sexuality through masturbation, and discussion and debunking of stereotypes (e.g., the "dirty old man"). The Sexual Dysfunction Trivia Game can help educate staff about aging and sexual dysfunction and dispel related myths and misconceptions. Topics addressed in the 100 trivia question include statistics, ED, findings on physical examination that can be associated with complaints of sexual dysfunction, health teaching, age-related sexual changes, and history/interview.²³

In long-term care settings, supporting sexual health of older adults begins with an assessment of sexual history on admission. This includes obtaining information about the person's sleeping habits (e.g., without sleepwear), sexual orientation, history of extramarital affairs, sleep pattern, current sexual activity (e.g., masturbation), and interests.²⁰ It is useful to know the resident's attitude toward sexual humor and entertainment, such as explicit magazines or movies. How does the resident meet his or her need for sexual expression and intimacy?

All residents should be offered a level of privacy commensurate with their individual needs. Ways to promote privacy might include hanging a "do not disturb" sign during conjugal visits and arranging something for the roommate to do during this personal private time. For some residents, the opportunity to pet or stroke an animal may provide the sense of touch they are missing. Gay and lesbian older adults, estimated to number 1 to 2.8 million, may need support to maintain their relationship (if their partner lives in community) or starting one in the assisted living residence.²⁴ Sex education and counseling might be indicated for those residents who express an interest in pursuing or resuming sexual activity. Residents' families might also benefit from sex education or counseling, keeping in mind, however, that the resident's privacy rights are paramount.

Resources

- Service and Advocacy for Gay, Lesbian, Bisexual, and Transgender Elders (SAGE): www.sageusa.org
- New Leaf/GLOE: www.newleafservices.org
- www.nia.nih.gov/HealthInformation/Publications/hiv-aids.htm
- http://instruct1.cit.cornell.edu/courses/nbb421/students2000/dp51/myth_vs_fact.html

References

1. World Health Organization. Sexual health. Available: www.who.int/reproductive-health/gender/sexualhealth.html#2. Cited May 12, 2008.
2. Calamidas EG. Promoting health sexuality among older adults: educational challenges for health professionals. *J Sex Educ Ther* 1997;22:45-9.
3. Wallace M. Sexuality and aging in long-term care. *Ann Long-Term Care* 2003;11:53-9.
4. Janus SC, Janus CL. The Janus report on sexual behavior. 1993. Cited in M. Wallace. Sexuality and aging in long-term care. *Ann Long-Term Care* 2003;11:53-9.
5. American Association of Retired Persons. Modern maturity. Sexuality study. Washington DC: AARP; 1999.
6. Johnson BK. Older adults and sexuality: a multidimensional perspective. *J Gerontol Nurs* 1996;22:6-15.
7. Hybels CF, Blazer DG. Epidemiology of late-life mental disorders. *Clin Geriatr Med* 2003;19:663-96.
8. Robinson JG, Mohlzan AE. Sexuality and quality of life. *J Gerontol Nurs* 2007;33:19-27.
9. Hajjar RR, Kamel HK. Sexuality in the nursing home, part 1: attitudes and barriers to sexual expression. *J Am Med Dir Assoc* 2003;4:152-6.
10. Moss BF, Schwebel AI. Defining intimacy in romantic relationships. *Fam Relations* 1993;42:31-7. Cited in Blieszner R, deVries B, editors. Introduction to journal issue; perspectives on intimacy. *Generations* 2001;25:7-8.
11. Mattiasson AC, Hember M. Intimacy—meeting needs and respecting privacy in the care of elderly people: what is a good moral attitude on the part of the nurse/carer? *Nurs Ethics* 1999;5:527-34.
12. U.S. Census Bureau 2000. Available: www.census.gov/prod/cen2000/dp1/2kh00.pdf. Cited May 13, 2008.
13. Arena JM, Wallace M. Issues regarding sexuality. In: Capezuti E, Zwicker D, Mezey M, editors. Evidence-based geriatric nursing protocols for best practice. 3rd ed. New York: Springer Publishing Company; 2008. p. 629-48.
14. Goodroad BK. HIV and AIDS in people older than 50. A continuing concern. *J Gerontol Nurs* 2003;29:18-24.
15. Falvo N, Norman S. Never too old to learn: the impact of an HIV/AIDS education program on older adults' knowledge. *Clin Gerontol* 2004;27:103-17.
16. American Geriatrics Society Foundation for Health in Aging. Aging in the know. Sexual problems. Available: www.healthinaging.org/AGINGINTHEKNOW/chapters_ch_trial.asp?ch=51. Cited May 13, 2008.
17. Web MD: Erectile dysfunction: vacuum constriction devices. Available: www.webmd.com/erectile-dysfunction/guide/vacuum-constriction-devices. Cited June 30, 2008.
18. Wiki Answers. What is the PLISSIT model of sex therapy? Available: http://wiki.answers.com/Q/What_is_the_plissit_model_of_sex_therapy. Cited May 13, 2008.
19. Tabak N, Shemesh-Kigli R. Sexuality and Alzheimer's disease: can the two go together? *Nurs Forum* 2006;41:158-66.
20. Kamel HK, Hajjar RR. Sexuality in the nursing home, part 2: managing abnormal behavior—legal and ethical issues. *J Am Med Dir Assoc* 2003;4:203-6.
21. USA Today. A new page in O'Connor's love story. Available: www.usatoday.com/news/nation/2007-11-12-court_N.htm. Cited July 1, 2008.
22. Kuhn D. Intimacy, sexuality and residents with dementia. *Alzheimer Care* 2003;3:165-76.
23. Skinner KD. Creating a game for sexuality and aging: the Sexual Dysfunction Trivia Game. *J Contin Educ Nurs* 2000;31:185-9.
24. Blando JA. Twice hidden: older gay and lesbian couples, friends, and intimacy. *Generations* 2001;25:87-9.

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0197-4572/08/\$ - see front matter

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doi:10.1016/j.gerinurse.2008.08.004