

Keys to Addressing Older Adult Sexuality in Occupational Therapy Intervention

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Presented by:
Dr. Helene Lohman, OTD, OTR/L, FAOTA
Dr. Alexandra Kobrin, OTD, OTR/L
Creighton University



- **Once I asked Grandma when do you stop liking sex and she was eighty: She said "Child, you'll have to ask someone older than me"** (Tavist & Sad, 1977).



Presentation Objectives

- » Overview key concepts about sexual activity and sexual health with older adults
- » Explain common myths about sexuality and older adults
- » Discuss normal age related physiological changes and impact on the sexual health of older adults
- » Explain the relationship of generational values to sexual health
- » Understand the application of the Occupational Therapy Practice Framework: Domain & Process 3rd Ed. (2014) to older adult sexual health

Presentation Objectives

- » Clarify the role of OT in addressing sexual health with different clinical conditions
- » Desensitize about addressing sexual concerns in intervention by active audience engagement

Quiz: Review these questions and think about whether you agree or disagree and why or why not?

- Frail older adults in skilled nursing facilities should not be sexually active or be provided privacy for sexual activity.
- The only true and acceptable means of sex for older adults is through intercourse.
- Older people are physically unattractive and therefore, sexually undesirable.
- Older adults do not get sexually transmitted diseases.
- Erectile dysfunction is a normal consequence of aging.
- More older men are sexually active than older women.

Questions adapted from White, 1982 and Lohman, 2011

Definitions:

- **Who Definition of Sexuality:**
A central aspect of being human throughout life and encompasses, sex, gender identities and roles, sexual orientation, eroticism, pleasure intimacy and reproduction (WHO, 2015)
- **Who Definition of Sexual Health:**
A state of physical, emotional, mental, and social well being related to sexuality (WHO, 2015)

Sexuality is:

- Part of a person's self concept
- Related to self esteem (Schultz-Krohn & Pendleton, 2012)
- Contributes to a person's perception of quality of life (Fischer, 2010)



OT Practice Framework and Sexuality (2014)

- Sexuality is listed as an ADL
- Bathing
 - Bowel and bladder management
 - Dressing
 - Eating and Feeding
 - Functional mobility
 - Personal Device Care
 - **Sexual Activity: "Engaging in activities that result in sexual satisfaction and/or meet relational or reproductive needs" (p.S19)**
 - Sleep
 - Toilet hygiene

Reality...



- **In clinical situations, occupational therapy practitioners are just as uncomfortable as other health care professionals to address sexual concerns with clients** (Jones, Weerakoon & Pynor, 2005).

Reality...



- **Why is sexuality sometime excluded from clinical practice?**
- **Discomfort** (Jones, Weerakoon, & Pynor, 2005)
- **Opinions regarding the relevance of sexuality in occupational therapy practice** (Sakellariou & Algado, 2006)
- **Lack of resources and formal training** (Neistadt, 1986).

Research on Students and Discomfort

Discomfort may begin with professional education:

- **Study: 50% of OT students were uncomfortable addressing sexuality** (Jones et. al, 2005)
- **Study: More than half of allied health students including OT students expressed discomfort in addressing sexuality** (Weerakoon et. al, 2004)


Myths about Aging and Sexuality:



Myth # 1

- **Older adults are no longer interested in sex and can no longer engage in sexual activity, sex is for the young.**

Myth # 1

- **Sexual activity continues but declines with age** (Lindau et. al, 2007) # (1550 women and 1455 men)
- 73% sexual activity 57 to 64 years
53% sexual activity 65 to 74 years
26% sexual activity 75 to 85 years
- 

AARP: Sex Romance, and Relationships Survey of Midlife and Older Adults (2010)

- Survey completed every 5 years
- Subjects adults 45 years and older
- Sex is happening but there is a drop in frequency since 2004 for all surveyed adult age groups
- Are older adults getting more prudish?

Findings AARP (Fisher, 2010)



- Better sex life correlated with better finances
- Older men more focused on sex than older women
- Younger respondents (45-59) more sexually active than those over 60

Findings AARP (Fisher, 2010)

- Subjects viewed a happy sexual relationship as...
 - “Having a partner, frequent sexual intercourse, good health, low stress, **no financial worries**”.
- Sexual frequency and satisfaction higher unmarried older adults (p.1)
- Correlation between regular sex partner and positive perceptions about quality of life

Myth # 2

- **The only true and acceptable means of sex for older adults is through intercourse culminating in mutual orgasm. All other sexual activity is "foreplay" and does not count.**

More Findings

- Older adults engage in a variety of sexual practices
- 58% engage in kissing/hugging once weekly
- 44% report touching/caressing once weekly
- 1/4th of all 45+ Americans “self stimulate” weekly (Fisher, 2010)
- Variety of sexual activity decreases with age (Landau, 2007)

What are reasons for stopping sexual involvement among older adults? (Lindau et al, 2007)

- Health problems or limitations
- Grief
- Lack of opportunity
- Religious/cultural beliefs
- Concern about getting a sexual transmitted disease
- Lack of privacy
- Erectile Dysfunction (ED)
- Family and or staff viewpoints

Myth # 3

- **Institutionalized older adults should be segregated according to sex and privacy should be prohibited.**

Federal Regulations



- "If married, is assured privacy for visits by his/her spouse; if both are inpatients in the facility, they are permitted to share a room, unless medically contraindicated (as documented by the attending physician in the medical record)"
- Found in many state laws and federal regulations
- Further regulation states:
- "the patient may associate and communicate privately with persons of their choice"
- OBRA (2014) rights for privacy
- Institute of Medicine (1986). From Improving the quality of care in nursing homes. Existing SNF Conditions of Participation and ICF Standards. Retrieved from <http://www.ncbi.nlm.nih.gov/books/NBK217561/>
- Center for Medicaid and Medicare (2014). State operations manual. Retried from http://www.cms.gov/RegulationsandGuidance/Guidance/Manuals/downloads/som107ap_pp_guidelines_ltcf.pdf

Exercise:

- **A CNA approaches you with the following concern:**
I recently noticed Mrs. Smith and Mr. Jones taking an interest in each other. They are constantly holding hands and have been observed kissing. I have observed other CNAs make fun of them and telling them to stop, but they continue openly expressing their affection. I feel that they have a right to express their romantic side. Who is right?
Discussion questions:
Assuming that both Mrs. Smith and Mr. Jones are not cognitively impaired how would you respond to the CNA?

Myth # 4

- **Older people are physically unattractive and therefore, sexually undesirable.**

Societal equation:
youth + beauty=sexuality

Myth 4

- Less than one in 20 believe that sex is only for younger people (Fisher, 2010)
- Starting to see changes with the media (Dove Soap: Campaign for Real Beauty)

Myth # 5

- **All older adults are Heterosexual. Homosexuality does not exist in the older adult population.**

Sex and Older Adult Homosexuals

- Heteronormativity (Harrison, 2001)
- Paucity of research about homosexual older adults (Wojciechowski, 1998)
- Older adults grew up in a time when overt prejudice was expressed towards homosexuality
- Prejudice still present (Wojciechowski)
- Starting to see research and publications about LGBT and professional education in other professions besides OT (Corliss, H., et al; 2007; Gransee, 2005; Verdonk et. al., 2006)
- **How can you help open up discussion and dispel myths with assessment?**

Myth # 6

- **Older adults do not get sexuality transmitted diseases (STDs).**

STDs and Older Adults

- Older adults are sexually active and can get sexually transmitted diseases
- HIV among older adults accounts for 19% of new yearly infections and are typically diagnosed in later stages (CDC, 2013)
- Older adults may not have as strong immune systems to fight infections (Johnson, 2013)
- Important to teach safe sex (condoms)
- CDC recommends annual chlamydia screening for all sexually active older women with risk factors (CDC, 2013)

Why? The Prevalence of STDs among some Older Adults

- Medicines for erectile dysfunction (Viagra) (Jena et al, 2010)
- Health providers do not routinely discuss STDs with older adults, may misdiagnose signs, nor do older adults ask questions (Benjamin Rose Institute on Aging, 2015; Jeffers & DiBartolo, 2011; National Institute on Aging, 2013)
- Higher mid-life divorce rate (older adults less likely to perceive themselves as risk) (Benjamin Rose Institute on Aging, 2015)
- Many older adults did not get sexual education (Benjamin Rose Institute on Aging, 2015)
- Women are postmenopausal not worrying about pregnancy (Benjamin Rose Institute on Aging, 2015)
- Men may not want to wear condoms (Benjamin Rose Institute on Aging, 2015; Fisher, 2010)

Relevance to knowing facts about STDs to therapy practice?



Physiological Changes with Aging and Sex



Beyond Physiological Changes with Aging

Besides Physiological Changes: Consider the whole person:

- Attitudes/values
- Cognitive impairment
- Coping strategies
- Chronic conditions: diabetes
- Sociocultural influences (religion)
- Interpersonal factors
- Mental Health: Depression
- Personality
- Physical factors: Chronic pain
- Medications

“Use it or Lose it”

Female: Possible Changes

- Decrease in rate and amount of vaginal lubrication
- Orgasmic changes with a decrease in the number of vaginal contractions and a quicker return to pre-arousal stage (Kazer, 2011; Laffin, 2002)
- Structural changes with atrophy of the labia, uterus, and a reduction in the expansion of the vagina width
- Thinning of the lining of the vagina (Kazer, 2011; Laffin, 2002)
- Decreased vaginal contractions and a quicker return to pre-arousal stage (Kazer, 2011)

Female: Possible Changes and Sexual Concerns

- Low desire
- Difficulty with vaginal lubrication
- Inability to climax (Landau et al., 2007)



Male: Possible Changes

- Erection is slower, less full; disappears quickly after orgasm; has a longer refractory period after ejaculation to again achieve erection (usually 12-24 hours)
- Decrease in muscle tone
- Testicles do not achieve full elevation and do not increase in size
- Decreased volume of sperm (Lafin, 2002)



Male: Possible Changes

- Ejaculatory control increase.....
- Ejaculation is less powerful and orgasm is often less intense
- Decrease in ejaculatory testosterone... (Lafin, 2002)

Erectile Dysfunction (ED):

- 3-10 older adult men have some degree of ED (Fisher, 2010)
- 23% diagnosed with ED (Fisher, 2010)
- Men seeking out help (personal physician 40%, specialist 19%, MH 8%) (Fisher, 2010)
- Erectile dysfunction associated with disease conditions such as cardiac (Bohm et al, 2007) or diabetes (Rosen et. al, 2009)

Exercise

- On a home visit you assist an 82 year-old man with his bathing. In the course of conversation he asks if he can confide in you. He states....
 “My wife and I continue to have a satisfying sexual relationship. However, I have noticed in recent years that my first erection is slower and it takes me even longer to achieve an erection the second time. I am afraid to ask my physician about this. Am I normal?”
 Discuss how you will respond.
 Discuss what other members of the interdisciplinary team could assist with his concerns.

Generational Values

Current Oldest Older Adults: Veteran/Traditionalist Generation



- “Almost all of us who are older grew up in an environment where attitudes towards sexuality were more rigid than they are today. We may have learned that we shouldn't talk about sex and that women should not enjoy sex as much as men, or that women should not initiate sex. Because of this early training we may still feel embarrassed or ashamed over sexual issues”

Changes are here...

- ***“Now ...the Boomers are creating a second sexual revolution-one that will change forever the way people think about sex and aging. It's a revolution in spirit and attitude about sexuality in midlife, and at its core is the assumption that health-and age-related physical problems should be treated and overcome rather than accepted as part of getting older”***

(Jacoby, 2005, July/August p. 1)
Retrieved on August 12, 2007 from http://www.aarpmagazine.org/lifestyle/relationships/sex_in_america.html

Intervention Approaches

- PLISSIT Model (Annon, 1976)
- OT performance skills and sexuality (Practice Framework (3rd Ed) (AOTA, 2014)
- Intervention approaches for different conditions
 - Arthritis
 - Cardiac
 - Stroke
 - Cancer

The PLISSIT Model

- **P** Permission
- **L** Limited Information
- **SS** Specific Suggestions
- **IT** Intensive Therapy (Annon 1974, 1976)



Permission

- This stage involves listening in a non-judgmental, knowledgeable, and relaxed manner as the client discusses sexual concerns.
- Do you have any questions/concerns about how your present medical condition impacts your sexual functioning?
- **Keep in mind comfort level with the opposite sex**



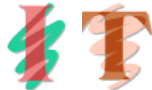
Limited Information

- **Education About:**
 - Normal physiological changes with aging, myths/stereotypes about the aged population and sexuality and psychosocial factors



Specific Suggestions

- Appropriate suggestions to improve sexual functioning
 - Such as about a specific condition
- Referral to a Specialist



Intensive Therapy

- Involves the expertise of a skilled social worker, psychologist, or psychiatrist

General Sexual Educational Intervention Suggestions:

- Experiment with different sexual positions for comfort
- Provide person instruction on energy conservation techniques.
- For persons with decreased energy encourage other forms of sexual expression (Hattjar, Parker, & Lappa 2008, Lohman, 2008)

General Sexual Educational Intervention Suggestions:

- Reassure the person that once medically stable and approved to have sexual activity by physician there is an unlikelihood of sustaining further problems (such as a stroke or a heart attack) from sexual activity
- Talk with the person about any fears s/he may have about resuming sexual functioning (Lohman, 2008)

Specific Conditions



Sex and Arthritis (Not after total hip precautions)

- Exercise to increase and/or maintain ROM and muscle strength
- Warm bath prior (NIA, 2014) or use of mattress warmer during sexual activity (Hattjar, 2012).
- Use energy conservation techniques (Rest prior, consider timing)
- Sexual activity after taking pain medication (Hattjar, 2012)
- Side by side position as well as changing positions to decrease joint pressure
- Use pillows and bolsters for comfort and to support joints (Hattjar, 2012)
- Communicate pain
- Encourage seeking physician guidance if pain occurs
- Stress reduction (Hattjar, Parker, Lappa, 2008)

Sex and Arthritis: Total Hip Replacement



• Posterior Hip Precautions and Sex

1. Critical 4-6 week period for precautions (physician permission)
2. Do not Bend the Hip More than 90°
3. No hip internal rotation or crossing legs
4. Do not adduct hips (Whittington, Mansour & Sloan, 2001)

Anterior Hip Precautions

1. No leg extension
2. Do not lie prone
3. No bridging of hips
4. No external rotation

Sex and Arthritis: Total Hip Replacement



- More than one position can be used with hip precautions (McFadden, 2013)
- Sex in missionary position with involved client on bottom, hips abducted, feet pointed up. Knees can be slightly flexed (with feet on the bed) or knees in extension.
- When lying on the back do NOT roll affected leg towards other leg! (internal rotation) (Whittington, Mansour & Sloan, 2001)

Total Hip Positioning using Precautions with Sex



- When lying on unaffected side keep the affected leg outside the midline of body.
- Women: keep pillows between legs
- Men: use partner's legs to support affected leg (Whittington, Mansour & Sloan, 2001)
- Link for sexual positions post total hip replacement: <http://www.recoversex.com/hip-replacement/sexual-positioning-following-total-hip-replacement>

Positive benefit on sex from THR (Parker-Pope 2013)

- 2013 presentation at the annual meeting of the American Academy of Orthopedic Surgeons. (Pope, 2013, American Journal of Orthopedics, 2013)
- 81 percent patients who had painful hip prior to surgery report increased sexual activity post surgery

Cardiac and Sexuality



- Extreme anxiety and depression (counselling)
- Link between cardiovascular disease and sexual dysfunction with men (ED)

Women and Cardiac Conditions (Addis et al, 2005)



- Found 39% of women subjects (# 2,763) with coronary artery disease remained sexually active.
- 65% (1 in 5) had sexual problems (Examples: lack of interest, difficulty relaxing, discomfort)

Men and Heart Conditions



- ED with men with pre-existing cardiovascular disease and/or diabetes with end-organ damage is greater than 50% (Bohm et al, 2007)

Cardiac Precautions



- Sexual activity with **physician permission** can begin after the acute phase of the illness with the average recovery time being 8-16 weeks- (DeBusk et al., 2000)
- Physician may recommend specific precautions:
 - Example: post CABG and Open Heart Surgery avoid positions that cause discomfort or put stress on the surgical site (Levine et al. 2012)
 - MET level: 4-5 level for sexual activity

Cardiac Sexual Risk Classification System

(DeBusk et al. 2000)

- **Low Risk:** controlled hypertension-can safely resume sex
- **Medium Risk:** mild angina-require further cardiac evaluation
- **High Risk:** unstable angina, or hypertension recommended to be stabilized before reassuming sexual activity (DeBusk et al., 2000, Levine et al., 2012)

Cardiac and Sexuality Concerns

- Shortness of breath
- Chest pain
- Excessive fatigue
- Continuous increase in blood pressure
- Heart palpitations lasting longer than 15 minutes after sex
- Medication side effects (DeBusk et al., 2000; Levine et al., 2012)

Cardiac and Sexuality: Intervention

- Reassure the person of the unlikelihood of a heart attack as a result of sex (Sexual activity causes 1% of all MIs) (Muller et al., 1996 as cited by Levine et al., 2012)
- Sedentary people have higher risk than physically active
- Stay away from extramarital affairs... (Levine, 2010)

Cardiac and Sexuality: Intervention

- To help decrease anxiety, encourage the person to gradually begin sexual activity
- Suggest grading sexual activity
- Encourage the person to talk about any fears
- Consult with the physician and/or pharmacist about possible medication side-effects
- Teach relaxation techniques
- Teach energy conservation; rest before sexual activity (Lohman, 2011)

Stroke and sexuality



Can be impacted by the following deficits:

- **Sensory (tactile and visual systems)**
 - Hypersensitivity or hyposensitivity to touch
 - Hemiparesis
 - Hemiplegia
- **Perceptual**
- **Cognitive**
 - Personality changes
 - Executive function
- **Motor**
 - Hemiparesis
 - Hemiplegia
 - Changes in tone
 - Fatigue and endurance

Stroke and Sexuality



Sensory:

- Use of non-verbal communication such as touch
- Education on the effects of perceptual or sensory deficits on sexual functioning.
- Identify areas of hyper or hyposensitivity to identify sensory limitations (Mioduszewski, 2012).
- Encourage use of a vibrator
- With anesthesia use visual compensation
- With hyperesthesia do not over stimulate the involved side of the body (Lafin, 2002).
- Encouraging use of tactile senses to help compensate for visual losses.

Stroke and Sexuality



Motor:

- Experiment with different positioning
- With spasticity bathe in warm water prior to sexual activity (Mioduszewski, 2012).
- Teach energy conservation (Lohman, 2011, Lafin, 2002)
 - Use positions that require less effort for motor deficits such as side lying and missionary position (Mioduszewski, 2012).

Stroke and Sexuality



Cognitive:

- Avoidance of environmental distractions to orient those with cognitive deficits.

Case Study and PLISSIT Model

- When working with a 72 year old woman post minor CVA she mentions that she is uncomfortable asking her physician about sexuality. She complains of painful sex due to lack of lubrication and wants advise for sexual positioning with a weaker left side.
- Discuss your advise. What level(s) of the PLISSIT Model are you using?

Cancer and Sexuality

Factors to consider:

- Lack of desire
- Pain
- Premature menopause
- Radiation therapy and erection: (Siegel et. al, 2001).
- Radiation therapy in women can lead to hormonal decline affecting sexual desire (Lappa, 2012).
- Psychosocial issues that reduce sexual desire.

Cancer and Sexuality

- Plan timing
- Position with less pressure
- Notify physician of use of lubricants
- Energy conservation methods
- Use of pillows and bolters to increase comfort (Lappa, 2012).

Cognitive Impairment (Alzheimer's Disease and Sexuality)

- 20-30% of couples with a spouse with dementia continue sexual activity and may want health care team guidance about sexual activity (Robinson & Davis, 2013).
- Some older adults with cognitive impairment demonstrate inappropriate verbal and or physical behaviors related to sexuality "Hypersexuality".
- Inappropriate behavior involves a thorough assessment particularly of competent decision making (Joller et. al, 2013; Kazer, 2011).
- With true cognitive incapacity boundaries must be placed on the person for inappropriate behavior.
- Programming, calm approach, re-direction

Summary

- Sexuality is normal with all ages including with older adults.
- Occupational therapy practitioners along with the interprofessional team can and should address when appropriate sexual activity to help maintain sexual health.

Contact Information

- Helene Lohman, OTD, OTR/L, FAOTA
Creighton University
HeleneLohman@creighton.edu
- Alexandra Kobrin, OTD, OTR/L
Alexandrakobrin@creighton.edu

Creighton
UNIVERSITY
School of Pharmacy
and Health Professions

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