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Older Adult Sexuality, Intimacy, and Sexual Orientation

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Guest Editor's Message

Addressing the Elephant in the Room

Dealing with Matters of Sexuality and Sexual Orientation in Care Management Practice

By Lenard W. Kaye, DSW, PhD

Talk about the proverbial elephant in the room! I would hazard to guess that the prospect of dealing with matters of sexuality, intimacy, and love with your clients will give virtually all of you pause no matter how seasoned a mental health professional you may be. Fear not – you are not alone. These are issues that the vast majority of helping professionals likely avoid addressing as a matter of course in their daily practices.

More than “correct” language is needed to insure adequate levels of understanding and informed care as we encounter issues of intimacy and sexual satisfaction expressed by older adults. Tenets that guide formal and

informal models of service delivery are often entrenched in past societal mores. These, too, warrant fresh perspectives in order to encourage change and progress.

This issue of the Journal of Geriatric Care Management will address highly relevant subject matter dramatically impacting the lives of older adults that has been, unfortunately, ignored by too many of us for far too long. Whether we perceive matters of sexuality and intimacy to be controversial, embarrassing, or socially taboo, we have steered clear of addressing them in our work with older clients and patients and their families. The fact that these are matters that are

emotionally charged and commonly avoided by our clients as well has only served to feed this tradition of neglect.

Our expert contributors will broach the topics but no doubt realize that they can only scratch the surface of such complex matters. I believe I speak for them in expressing the hope that their presentations will encourage a beginning discourse on a set of issues extremely relevant to more fully understanding the challenges impacting our older clients and patients.

Multiple dimensions of the subjects of sexuality, intimacy, and sexual orientation will be addressed in the pages to follow, including the impact of physiological changes of aging on sexual expression and long-



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Multiple dimensions of the subjects of sexuality, intimacy, and sexual orientation will be addressed in the pages to follow, including the impact of physiological changes of aging on sexual expression and long-standing myths held of older people, sex, and sexuality that are perpetuated in our youth-dominated culture.

standing myths held of older people, sex, and sexuality that are perpetuated in our youth-dominated culture. The authors will examine why there is discomfort with exploring this topic among many professionals and allied health care providers. In addition, issues of sexual identity among the 60-and-over age group will also be examined. Special attention will be directed at the anticipated impact of having a dramatically expanding cohort of lesbian, gay, bisexual, and transgender (LGBT) baby boomers using a wide range of health and social services, including both community and institution-based forms of care in the coming years.

Marilyn Gugliucci and Shirley Weaver set the context by presenting foundational information on the issues that affect both heterosexual and homosexual older adults, including such matters as terminology, stereotypes associated with aging in our society and with older adult sexuality, as well as associated psychosocial factors, care strategies, and resources available to providers and older adults.

Amanda Smith Barusch, drawing on her research into elder romance and love, presents four vignettes on late-life intimacy with direct implications for geriatric care managers. She includes special attention directed at "Living Apart Together" relationships, late-life infatuations, and the insidious effects of ageism on intimacy in late life.

Nancy Orel and Wendy Watson explore the heterogeneity of the older adult population and provide

a useful framework for practitioners to use that systematically considers ten cultural factors and personal attributes that influence sexuality. The authors maintain that appreciating the importance of these factors for their older patients will enable providers to more appropriately and adequately meet their needs in the arena of sexuality and sexual health.

Finally, Noell Rowan addresses a rarely discussed issue in clinical practice -- the older chemically dependent lesbian and her health and mental health needs. Rowan considers the issues faced by older lesbians with alcoholism and further research necessary to enhance our understanding of the lived experiences of these individuals. She includes an illustrative case study to demonstrate a variety of critical issues likely to be faced by practitioners working with this client group. We very much hope readers will want to read more about the topics raised in this special issue, and to that end Jennifer Crittenden and Lindsay Day have prepared a compendium of professional resources, information, consumer resources, and training materials on love, relationships, and sexuality in older age. The authors have provided them as a general starting point for considering, discussing, and exploring issues of older adult relationships and sexuality.

Lenard W. Kaye, DSW, PhD, is Professor of Social Work at the University of Maine School of Social Work and Director of the University of Maine Center on Aging. A prolific writer in the field of health care and aging, he has published approximately 150 journal articles and book chapters and 12 books on specialized topics in aging including home health care, productive aging, rural practice, family caregiving, controversial issues in aging, support groups for older women, and congregate housing. His pioneering research and writing on older men's caregiving experiences and help-seeking behaviors, is widely recognized and frequently cited. His current book project is a self-help manual for mid-life and older men on healthy, active aging. Kaye sits on the editorial boards of the *Journal of Gerontological Social Work* and *Journal of Geriatric Care Management* and is a Fellow of the Gerontological Society of America.

Defining Moments: Sexuality and Care of Older Adults

Marilyn R. Gugliucci, MA, PhD, AGSF, GSAF, AGHEF
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Summary

Health care providers are reticent to discuss intimacy and sexual issues with their older adult patients or the patients' adult children. This article is written with the provider in mind and presents foundational information on older adult sexual health and intimacy issues that affect both heterosexual and homosexual older adults. We begin with defining sex, sexuality, physical and emotional intimacy; we then present stereotypes associated with aging in our society and with older adult sexuality. Once this underpinning has been presented we introduce some of the psychosocial factors, care strategies, and resources available to providers and older adults.

Many would agree with Henneberger. In our society it is rare to discuss the intimacy and sexual needs or desires of older adults. It is rarer still for health care providers to discuss intimacy and sexual issues with their older adult patients or the patients' adult children. There is good reason why this topic is often times controversial or misunderstood in our society. In this article some of these issues will be addressed as we present foundational information on the issues that affect both heterosexual and homosexual older adults. We begin with terminology to ensure we are all on the same page and then present stereotypes associated with aging in our society and with older adult sexuality. Once this underpinning has been presented we introduce some psychosocial factors, care strategies,

*"We are squeamish about the sex lives of the elderly
...even more so when those elderly are senile or our parents"*

*—An Affair to Remember,
Henneberger, 2008*

and resources available to providers and older adults.

Introduction

Temporal definitions tend to define old age in relation to a certain number of birthdays one has had. Most commonly, in contemporary society, having reached the age of 65 a person is considered to be in the young-old category. It is important to note that regardless of age, there are aspects of life, such as the basic drives, that continue unchanged. The older adult, like the young adult, feels the need for physical comfort, love, and status. Habit systems persist with great tenacity, as do characteristic ways of meeting frustrations, personality patterns of dominance or submission, and the individual's whole array of attitudes. As one elder woman stated in a seminal study by Cavan, et al., 1949, "I see no change in myself as I enter the period of old age; I am the same self I always was" (pp. 1-2). This sentiment continues to be stated by older adults in the United States.

With age perceived by the older adult in this way, one could wonder why sexuality or sexual expression is

such an issue. We are who we are throughout life – hopefully gaining wisdom as we move through the ages, but still the "same person" inside. This simple realization could greatly aid us in providing positive descriptions of aging and a more realistic understanding of life-long issues of sexuality. This is something that we hope will become more prevalent as we advance

through the 21st century and welcome the Baby Boomers into older adulthood. As of January 1, 2011 between 8,000 and 10,000 people turn 65 years old each day and this will continue for the next 20 years! (Love, 2010). This growth in our aging population impacts all aspects of society, including health care, social security, the work force, social services, education, and societal views of aging. As health care providers, how well we address older adults' physical and emotional needs for sex and intimacy will, in large measure, determine their quality of life.

Defining Moments: What is Sex and Intimacy?

Little is known about the sexual behaviors and sexual function of older people. While moral issues associated with sex are the driving forces in our culture, they will not be addressed in this article. Sex often times is defined using scientific terms leading it to be considered as an act involving biological and physiologic manifestation of libido and hormones (Lindau, 2007). However, for the purposes of this discussion, a broader perspective is necessary so as to include the social-

emotional conditions. There are four key terms we want the reader to be familiar with -- sex, sexuality, physical intimacy, and emotional intimacy; we chose the following definitions: (1) Sex is defined as any mutually voluntary activity with another person that involves sexual contact, whether or not intercourse or orgasm occurs (Lindau, 2007); (2) Sexuality, on the other hand, is defined as an intrinsic lifelong aspect of being human and is not limited by age, physical appearance, health, or functional ability (Stausmire, 2004); it includes “the capacity of the individual to link emotional needs with physical intimacy” within the constraints of their ability (Gilley, 1988, p. 367); (3) Physical Intimacy is defined as sensual proximity and/or touching including an expression of feelings (such as close friendship, love, and/or sexual attraction and includes holding hands, hugging, kissing, caressing, and sexual activity (Miller & Perlman, 2008); and (4) Emotional Intimacy, which is a dimension of interpersonal intimacy that varies in degree and length of time, allows the ability to feel emotions and express feelings both verbally and/or non-verbally (Miller & Perlman, 2008).

The medical field, however, seldom reveals a broad conceptualization of sex or sexuality in relation to aging or older adults. Rather, health professions training has narrowly focused on factors which impact sexual performance (intercourse or orgasm) for older adults. It is important that health care providers are able to discern the importance of the differences between sex, sexuality, and intimacy, and how they impact quality of life for older adults. We advocate for health care that affirms the total self by promoting all older adults’ ability, regardless of age or condition, to share love and affection through either one or both forms of intimacy – physical and emotional.

Stereotypes of Aging and Their Effect on Intimacy

Negative stereotypes of older age persist in our society. Common misconceptions continue such as

older adults are lonely, bored, or are dissatisfied with life. Additionally, it is believed that all older adults are the same (homogeneous), and as a group they encounter the same negative health and psycho-social experiences. It is bad enough that society believes this to be true, but the real travesty is that it is often believed by older adults themselves! This infusion of negative beliefs and resulting inaction or passivity in challenging societal impositions has a variety of historical reasons. For example, one of the first “proven” theories of functional aging was entitled “Disengagement Theory,” by Cumming and Henry (1961). Disengagement theory proposed that starting in middle age the individual was both accepting and desirous of decreased interaction in old age. This was gradual and inevitable and led to a mutual withdrawal of the elderly from society and of society from the elderly. According to this theory, the process of change enabled the elderly to adapt more successfully to the issues of biological decline, physical decline, and losses in old age, which is the “functional” or “successful” basis for this theory. So, our take on this theory is that if you want to age successfully or functionally – and according to what is deemed best for the older adult and society – then death would be your best option. Although this application may be absurd, an historical and seminal theory such as this (later debunked, although is printed in textbooks), continues to drive the beliefs about withdrawal and decline of older adults in our society.

Thirty years after the ascendancy of the Disengagement Theory, Friedan (1993) as an “older woman” and a researcher of aging stated in her book *The Fountain of Age*, that older adults have been posed with two options: (1) they were either expected to disengage from life in order to prepare for death (Disengagement Theory) or (2) act “youthful” through remaining active or redefining another mechanism to compensate for loss of youth. Friedan (1993) wondered, “Why are we not looking at age as a new, evolving stage of human life –

not merely as a decline from youth, but as an open-ended development in its own terms, which, in fact, may be uniquely ours to define?” (p. 192). She asserts that public policies have reinforced the terror of age: the weak, catastrophic, victimized face of age. Friedan set out to separate the complex issues of biological aging from aging as pathology. Her belief in the importance of maintaining control over your own life, remaining viable, and employing open choices could lead to transformation for older people. The fact remains that although many of us wish to support older adult empowerment, older adults often face additional challenges due to society or family pressure.

When will our society, and more specifically health care providers, learn that old age and sexuality is not just the sum of the parts of one’s past; it is life as one has lived it and continues to live it. Older adults dynamically integrate a wide range of experience to construct a current and viable identity; they do not think of themselves as purely “socialized” beings, learning and then acting out a set of socially appropriate rules of behavior; nor is their identity merely the sum of the parts of their lives (Kaufman, 1986 - seminal work). Age doesn’t need to imply a passive decline and disengagement. Being old is not a central feature of the self, nor is it a source of meaning in and of itself. Older people do not relate to aging or chronological age as a category of experience or meaning. They know who they are and what matters to them now. They have an identity that maintains continuity despite the physical and social changes that may come with old age (Kaufman, 1986). And so, as noted by Weeks (2003), an authority on older adult sexuality, the most important sexual organ is between our ears. The way we think of ourselves, at any point in our lives, but especially so in our later years, will aid us in finding ourselves, our sexuality, and our place in this world. Weeks postulates that our sexuality is where we experience ourselves as real people; it provides

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us with our identities, our sense of self, men and women, regardless of whether we identify as heterosexual or homosexual at any given time (2003).

Older Adults and Sex/Intimacy

Human sexual behavior doesn't fit neatly within imposed societal, cultural, or religious structures. Regardless, when asked about satisfaction in their sex lives, older adults responded that they: (1) apply more open attitudes toward sexuality; (2) rate their health better; (3) participate in Internet dating; and (4) take advantage of available medications that address erectile dysfunction (Lindau, et al, 2007). Both the Starr-Weiner Report (Starr & Weiner, 1981) and the Love, Sex and Aging Consumer Union Report (Brecher, 1984), were among the first to include older adults in their research. They concluded that older people are sensual and have needs for closeness and intimacy that included feelings of love, passion, and pleasure. It may seem odd to cite research that supports a fact that should be obvious, but earlier research contributed to the asexual stigmas associated with older adults. Whether it is physical or emotional intimacy, older adults continue to have sexual activities (intercourse, masturbation, mutual masturbation, oral sex) and the physical capacity for male erection and male and female orgasm continue almost indefinitely. Older adults find they have more time, more privacy, and less stress in their lives from when they were younger, all of which aid in increasing a feeling of comfort and satisfaction. However, the "Love, Sex and Aging" research also revealed that older adults felt the need to keep sex secret due to the response from society, their children and friends, and their health care professionals.

There is no surprise that our society presumes that older adults have no interest in sexuality, that romance and physical attraction decline, and that age-related physiological change

make a meaningful sexual relationship impossible. The societal reinforced disease/decline and withdrawal model of aging poses the contradiction that older adults are either prudish and asexual, or at the other extreme are considered to be "dirty old men" as evidenced by the term "Condo Casanovas" that applies to men who have multiple sex partners in condominium communities.

Nowhere are the contradictions and confusions of competing notions of older adult sexuality more evident than in the evolving social acceptance of alternative life styles, such as homosexuality, and rising awareness of transgender health issues. In 2001, the U.S. Office on Aging recognized that Lesbian, Gay, Bisexual, and Transgendered (LGBT) elders are underserved by the federally funded programs that receive support through the Older Americans Act. The 2010 census report, citing nearly a million same sex couples and changing geographic living patterns, gives evidence to baby boomers' willingness to declare their life style and suggests changing social attitudes. Yet, despite the considerable efforts of organizations as diverse as Area Agencies on Aging (AAA), Services and Advocacy for GLBT

Elders (SAGE), American Association of Retired Persons (AARP), and the Institute of Medicine (IOM) to educate the public and providers on the issues affecting the health and health care of LGBT older adults, stigmas persist.

Table 1 outlines the similarities and differences in social perceptions of the issues facing the older heterosexual and homosexual adult. It becomes increasingly clear that older adults' expectations of health care providers' accommodation of their sexuality is emerging as an imperative. As health care providers, it is essential for us to promote an atmosphere of comfort, consciousness, and compassion so that communication is supported and understanding enhanced.

Nursing Homes (Residential Long-Term Care)

This article will only whet the reader's appetite regarding the topic of sex within nursing homes. Briefly, nursing home law states that nursing-home residents are guaranteed some small degree of privacy, along with the right to "psycho-social well-being" – this includes free sexual expression (Engbar, 2007). As a result, the administrator must balance resident

T A B L E 1

Issues for Older Heterosexual and Homosexual Adults

Older Heterosexual Adults	Older Homosexual Adults
Ageism	Double stigma of homosexuality & ageism
Depressed, isolated, desperate, and sexless is prevalent	Depressed, isolated, desperate, and sexless is prevalent
Empty nest syndrome – little family support	Empty nest syndrome tempered by support of friends and "chosen" family
Health care system traditionally unresponsive	Health care system traditionally unresponsive of the person and lifestyle
Partnerships relied upon	Partnerships not recognized
Concerned about housing	Concerned about housing that is sensitive to lifestyle
World shrinks as age progresses	World shrinks as age progresses and there are few resources to either (a) meet supportive people or (b) adjust to their reorientation for newly "out" LGBT adults

Adapted from Raymond M. Berger (1996) *Gay and Gray: The Older Homosexual Man*. Haworth Press.

rights with their ability to consent to sex. Ironically, there is a term referred to as “gray rape” that does not apply to hair color or the age of the population having sex. The term originated with the young adult (college student) population and applies to sex that falls somewhere between consent and denial. “Gray rape” is even more confusing than date rape because often both parties are unsure of who wanted what. As such, the nursing home administrator and staff need to ensure that sexual encounters are not an elder version of “gray rape” and that consent is mutual.

Although numbers may vary from home to home, on average an estimated 50 percent of nursing home residents are diagnosed with some degree of dementia, which, depending on its severity, can make them unaware of their own behavior. Four (4) conditions affecting this population regarding sexual activity were identified: (1) certain kinds of cognitive impairment can enhance sex drive; (2) approximately 25% of those with dementia lose interest in sex; (3) about 14% experience a heightened libido; and (4) up to 8% become unable to control their sexual behavior, which manifests as incessant masturbation and repetitive sexual advances (Engbar, 2007). Communicating about sexuality/intimacy with older adults and their families (significant others) as a part of the standard admissions procedures is a proactive approach to supporting sexual health. Additionally, conducting a comprehensive sexual history that includes a medication review regarding the indications and contra-indications on sexual or intimate behavior for each resident, will aid the home in being prepared.

A confounding issue in nursing homes is personal care provided by staff, with the need for resident/patient touch and intimacy. Such practices as putting lotion on a resident or bathing can be sensual activities depending on how these are performed and by whom. A resident’s

“spouse” (LGBT included) may lovingly apply lotion that creates an intimate if not sexual encounter. Conducting staff training on older adult sex and intimacy is critical to instituting an environment that supports appropriate sexual health and intimate behaviors. Establishing proactive policies in the home will support administration and staff to proactively work with residents and families throughout the time they reside in the nursing home or skilled unit.

With the aforementioned assumptions and stereotypes about older adults and sexuality that are prevalent in our society, there is no wonder that something as vibrant as intimacy and sexuality would be a struggling concept for health care providers to work with effectively.

Practitioner Approaches

With the aforementioned assumptions and stereotypes about older adults and sexuality that are prevalent in our society, there is no wonder that something as vibrant as intimacy and sexuality would be a struggling concept for health care providers to work with effectively. There are three (3) key points for providers to keep in the forefront when working with older adult patients: (1) knowledge of past psycho-social sexual health; (2) role of communication; and (3) issues related to medications.

Knowledge of Past Psycho-Social Sexual Health: Providers may enhance effectiveness in addressing sexual health and intimacy for older adults through increased understanding of their patients’ past experiences and attitudes, as these could impact current issues. Psycho-social indicators include (a) attitudes toward sex and intercourse; (b) reactions to physiological changes and illness; (c) reactions to attitudes

of others; (d) performance anxiety (males performing “up to par”); (e) lack of availability of a partner (35% of men vs. 70% of women do not have partners); (f) attitudes towards and acceptance of alternative sexual activities; and (g) reaction to environmental (adult children, physician, institutional) attitudes and opportunities for privacy (Thienhaus, 1988).

Role of Communication:

Communication is essential in any medical or health care field. Seminal work published by Mehrabian (1981) established that communication effectiveness is reliant on three components – words, voice tone, and body language. Mehrabian found that words contribute to only 7% of what is communicated; voice tone was responsible for conveying 38% of the message, and body language contributed to 55% of communication.

As health care providers discuss sex and intimacy with their patients, words may be important, but it will be the combination of their body language (posture, facial expressions, appearance, touch, body movements, “air” of confidence, hair style, body position, breathing, eye contact) and voice tone (voice cadence, pitch, inflection) that will be responsible for creating an atmosphere of trust and openness. Health providers may think they have adequate training and tools to work with older adults regarding sexuality and intimacy; however, words combined with voice tone and body language will speak volumes about the providers beliefs, attitudes, and values on sexual health when conversing with a patient. In return, providers need to look, listen, and consciously observe their patients to determine how best to proceed with communication on this topic.

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Issues Related to Medications:

It is essential for providers to at least have a foundational knowledge or awareness of the effects that pharmaceuticals and poly-pharmacy have on older adults. Social work training rarely requires a pharmacy course and certainly not a course on older adult pharmacokinetics. It is not the intention of this article to educate the reader about pharmacology, but to note that drugs affect older adult function, sexual or otherwise. What is critical for the provider to know is that physicians may not factor in the sexual health of the patient when prescribing drugs – prescription and over the counter (OTC). At the core of “traditional” sexual performance for men, certain drugs may affect erections and libido (sexual urge or desire); for women, they may affect vaginal dryness and libido as well. Certain psychoactive drugs, especially those prescribed for Parkinson’s disease—can serve as love potions (Engbar, 2007).

Some questions that will aid providers as they ponder and discuss sexual health issues with their colleagues and older adult patients could include: How do we foster satisfaction and intimacy as one ages?; As health changes?; As a person’s world gets smaller?; As independence is compromised?; At the end of life? Providers that (1) apply the broadest definitions of physical and emotional intimacy; (2) know their own attitudes and beliefs; and (3) understand the stigmas and societal stereotypes associated with older adults; will no doubt be best prepared to address these questions.

Conclusion

We have established that the topics of sex and intimacy are often times controversial or misunderstood in our society. Many older adults continue to be sexually active and exhibit good sexual health. Of importance for health care providers is the knowledge that both emotional and physical intimacies are accepted forms of sharing love and caring. As there are many definitions for sex, sexuality, and intimacy, a provider would

In supporting the humanness of older adults, let’s not be ahistoric about their desires (or lack thereof) and prior intimacy practices. Inclusion of sexual history and current sexual/intimacy behaviors of older adults will aid in the comprehensiveness of care plans. Ascertaining this information in an environment and manner that promotes comfort and openness is essential.

benefit from choosing the definitions that are congruent for the provider – an expression, if you will, of the provider’s level of self-awareness and comfort with the subject. There are a number of resources that support older adult sexual health; some of the long standing resources are presented in Table 2.

In supporting the humanness of older adults, let’s not be ahistoric about their desires (or lack thereof) and prior intimacy practices. Inclusion of sexual history and current sexual/intimacy behaviors of older adults will aid in the comprehensiveness of care plans. Ascertaining this information in an environment and manner that promotes comfort and openness is essential. The authors are eager for the day that care providers are taught proper sexual history-taking and this practice becomes a standard component of promoting sexual health in all care settings.

Footnotes

1. The young-old are 65-74; the old-old are 75-84; and the oldest-old are 85 years of age and older (Rieske and Holstege, 1996).
2. movement of drugs within the body.

T A B L E 2

Resources

Resource	Location
National Institute of Aging - Age Page – Sexuality in Later Life (2010)	http://www.nia.nih.gov/HealthInformation/Publications/sexuality.htm Also printed in Spanish
Safe (and Enjoyable!) Sex for Seniors: Tips from the American Geriatrics Society’s Foundation for Health in Aging (2008)	http://www.healthinaging.org/public_education/safe_sex_tips.php
American Journal for Hospice and Palliative Care: Is there a place for sexuality in the holistic care of patients in the palliative care phase of life? (Redelman, 2008)	http://ajh.sagepub.com/content/25/5/366.full.pdf+html Provided by SAGE Journals Online Publications
Beers’ Criteria for Potentially Inappropriate Medication (PIM’s) Use in Older Adults American Geriatrics Society	http://www.patientsafetyolutions.com/docs/December_2011_Beers_Criteria_Update_in_the_Works.htm List is in the process of being updated by the AGS, 2011
The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding Released: March 31, 2011 Consensus Report	http://www.iom.edu/~media/Files/Report%20Files/2011/The-Health-of-Lesbian-Gay-Bisexual-and-Transgender-People/LGBT%20Health%202011%20Report%20Brief.pdf
US Department of Health and Human Services, CDC. A Guide to Taking a Sexual History	http://www.cdc.gov/std/see/HealthCareProviders/SexualHistory.pdf Can also be ordered as a spiral bound pocket book.

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Intimacy in Later Life: Reflections on Love and Care

By Amanda Smith Barusch, PhD

Summary

This article draws from research and literature to offer four vignettes of late-life intimacy with significant implications for care managers. Noting that intimacy in later life can arise outside the context of marriage, we begin by considering “Living Apart Together” relationships and the challenges of talking about love. The article then turns to Henry Miller’s late-life infatuations, both of which offer lessons in the complex dynamics of this powerful aspect of romantic love. Finally, consideration turns to ageism and its insidious effects on intimacy among older adults.

Despite its importance, late life intimacy has been neglected by gerontological researchers. Gerontologists have made considerable progress in the study of sex, but relatively little in understanding romantic love and intimacy in later life. This led Robert Kastenbaum to observe that, “[W]e do not have a comprehensive gerontology unless we know something about this realm . . . Loving is not encompassed by the frequency of reported sexual interests and activities . . . All the ‘dirty old men’ jokes in the world do not dilute the poignancy of love and sex in later life” (Kastenbaum, 1973).

Those seeking to understand intimacy may benefit from the study of poetry and literature. While behavioral scientists struggle to “operationalize” love, poets seek to evoke the experience. Consider, for instance, a definition of intimacy offered by an anonymous poet: “Henceforth there will be such a oneness between us – that when one weeps the other will taste salt.”

Living Apart Together

In American culture, marriage is central to romantic aspirations and experiences. The Census Bureau reported that in 2009 approximately 85,807 Americans aged 65 years and over were married in the United States (U.S. Census Bureau, 2011). This is but the tip of the iceberg of romantic relationships among older Americans. Beneath lie a variety of relationships that may not have legal sanction but are vital (as in life-sustaining) to the participants. Some take the form that sociologists in Western countries around the world describe as “Living Apart Together” (LAT) (Levin, 2004). California researchers Strohm, Seltzer, Cochran, and Mays (2009) estimate that a third of Americans classified as “single” are involved in LAT relationships. In these intimate relationships, couples live separately but consider themselves – and are perceived by others – as a committed couple. While most of the limited research on this topic has involved younger adults, a few studies have explored the LAT relationships of older adults. For instance, studies in Europe suggest that living in separate homes may confer freedom and egalitarianism not available to cohabiting couples (De Jong and Gierveld, 2004). The arrangement might also avoid or mitigate the concerns of adult children.

The experiences of two older adults whom I will call Ginnie and Saul illustrate some of the dynamics of LAT relationships. The two met in at a retirement home and fell in love when Saul was 88 years old and Ginnie, 78. They quickly became an “item.” As Ginnie explained, “So, we just got very close, and then it got so the help [staff], particularly,

they’d see us coming hand-in-hand and they’d start humming or singing, ‘Here comes the bride.’ And they tried pushing us to get married but we decided to just be good friends.” At first Ginnie and Saul “very much” wanted to get married. But in time, as Ginnie explained, they decided “it was a good thing not to get married . . . he didn’t want to put his health problems – burden me with them – and I didn’t want to burden him with mine either.” Given subsequent events we might also suspect they were also concerned about the reactions of Saul’s children.

A few months before she and I met, Ginnie had what she called “a run in” with the youngest of Saul’s two boys. Saul had been in the hospital for a few days, and when he was scheduled for discharge Ginnie mentioned to the doctor that he had been having trouble with his intestines and she thought he should be evaluated before he went home. The doctor agreed. But when the son found out, “He said, ‘Who ordered that?’ and he found out that I was the one that brought it up and got so mad he started yelling in the hospital and he started out the door and he turned around and he said, ‘And you, Lady! You stay out of it!’” Saul told his son to leave and Ginnie took him home the next day. Saul refused to let his son visit until he apologized to Ginnie. Finally the apology was offered but relations at the time of our meeting were still strained. After telling this story, Ginnie said, “I’m sure they’re very happy that he’s not gonna get married.”

Four months before Ginnie’s interview, Saul moved out of the retirement home. His caregiver had moved, so he went with her to the new facility. Once they no longer lived in the same facility it was more difficult

for Ginnie and Saul to see each other – not impossible, because Ginnie could still drive. But they relied more on phone contacts. Ginnie said, “Every morning . . . either I call him when I get up, or he calls me, at 7:00 every morning, and then we talk again just before lunch, and then I go over there usually around 2:00 and come back there at 4:30 and then we call each other about 7:30 at night” (Barusch, 2008).

Although neither Ginnie nor Saul had a care manager, this case illustrates some of the challenges posed by LAT relationships. First, the care manager must be alert to the possibility that a client’s intimates may not be his or her spouse. This underscores the importance of discussing intimacy during assessment and care planning. Second, in LAT relationships the extent to which partners are willing and able to contribute to caregiving varies considerably – probably more than in marriage relationships. Although Ginnie and Saul voiced the desire not to “burden” the other with their illnesses, Ginnie was clearly involved in Saul’s medical care, which brings us to the final challenge illustrated by this case – potential tensions with adult children. Clearly a care manager must be able to successfully navigate the complex dynamics that arise between a client’s LAT partner and his or her adult children.

Communicating About Intimacy

Caught up in the physical needs of frail and vulnerable clients, care managers may find it difficult to devote time and energy to emotional needs, not the least of which is the vital need for love. Many professionals find it hard to talk about intimacy. Some think it unprofessional to ask clients about love, preferring euphemisms like “primary relationship” or “attachment.” Love is complicated and sensitive, so it is tempting to use this jargon to maintain distance from the lived experiences of clients, not to mention the manager’s own romantic issues. Unfortunately older adults may

not understand professional jargon, so clients and managers can find themselves talking at cross-purposes.

Simple language choices can bridge this gap. Some older adults refer to romantic partners as a “friend” or a “special friend,” terms that might easily be adopted by care managers. Strohm, Seltzer, Cochran, and Mays (2009) used a more long-winded approach in their study of LAT relationships, asking “Do you have a main romantic involvement – a (man/woman) you think of as a steady, a lover, a partner, or whatever?” Regardless of the specific term, care managers owe it to themselves and their clients to develop a comfortable approach for discussing intimate relationships both in and outside of marriage.

Dynamics of Infatuation

Like many younger adults, Lois Judson (2009) had fairly limited romantic expectations for her old age:

When I’m eighty – if I’m ever eighty – I expect my shape . . . to be sad and droopy, the odd bumps and wrinkles progressed past the power of cosmetics to soften them. Sexual striving, with its undignified explosions and tremors, will have passed away, and I do not expect to miss it. All I will ask of my body then is that it carry me to my garden and back, and that it allow me to hold a grandchild or two, and that it let me see and smell and taste a few seasons more (p. 280).

Likewise, before his own late-life infatuation, Tom Ireland thought he had “finally used up my lifetime allowance of love . . .” (p. 287). These beliefs are unnecessarily self-limiting.

Older adults can and do experience intense infatuations. Throughout his lifetime, 20th century literary giant Henry Miller was a poster child of infatuation (and lust). At the age of 76, he became wildly infatuated with a 27-year old singer from Japan, Hiroko Tokuda. She sang in the bar of a Japanese restaurant, and every night Miller would sit at a table and, as his friend and biographer Kathryn Winslow put it, “gaze on her until closing time” (p. 328). Winslow

suggests that, “A slight friendship developed during the more than a year that he pursued her, and then fate played into his hands. When he saw her dismay upon hearing from the United States Immigration Service that her visa had expired and that she would have to leave the country, he explained that married to him she would not have to leave” (p.328). In September, 1967, Tokuda became Miller’s fifth wife despite the objections of Miller’s adult children, ex-wives, and friends. As others had predicted, Tokuda exploited Miller and made his life miserable until she moved out in 1974. Afterwards he wrote, “Everybody had her number, it seemed, except me. . . . She was like one of those numbers that are indivisible. She had no square root” (Winslow, p. 330).

This experience illustrates why so many adult children object to their parents’ new love interests. Aware of the overpowering intensity of infatuation, they seek to protect their parents’ from suffering. Despite her conflicts with Saul’s children, Ginnie was sensitive to another possibility – that they were still grieving the lost parent. As she noted, “. . . it’s only two years for them that their mother’s been gone.” Of course, more selfish motivations may also be in play. Robert Butler suggested that “many adult children continue to be bound by a primitive childhood need to deny their parents a sex life . . .” (Butler, 1988, p. 11). Clearly adult children’s reactions to parental love are driven by complex motivations and histories.

Following his disastrous fifth marriage, Miller fell madly in love with a young actress-playboy model, Brenda Venus. By this time, 81-year old Miller suffered from severe disabilities. But he pursued this romance with characteristic vigor. It proved a marked contrast to his previous love affair. In one touching scene, Venus told of an evening when they went out for dinner on a rainy night. The only parking place they could find was far from the entrance to the restaurant, and Miller was unable to navigate the distance. Despite her high heels, she “scooped up Henry and set off across

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the broken parking lot” (p. 90). His friend, Lawrence Durrell reflected on the role Venus played in Miller’s last four years: “Everyone was absolutely delighted for him, not the least his children and friends. . . He would have been forced to drowse away his last years with the needle and knockout drops for company! Poor Henry! As it was, he lived them in an ecstasy of love bequeathed, valued, and reciprocated” (Venus, 1986, p. 9).

Miller’s experiences illustrate the complexities of late life infatuation. While individuals seem to have different tendencies towards infatuation, no one is too old to become infatuated (Barusch, 2008). In the intoxication of early infatuation, the lover becomes obsessed with the beloved and can (like Miller) be deaf to voices urging caution. The Jungian perspective holds that infatuation is essentially a projection. I like to think of it like a movie projected (by the lover) through mist against a screen (the beloved). In time, the mist clears and the projection fades. The lover faces the reality of his or her beloved and with it the opportunity to convert infatuation into lasting love. Typically this happens 12 to 18 months after the initial infatuation (Fisher, 2004). While some lovers navigate the transition with no problem, others are surprised or displeased by what they see and the relationship can face a crisis. Care managers can support older adults and their families by understanding these dynamics and approaching late life infatuation with the respect it deserves, but sometimes ageism gets in the way.

Ageism and Residential Care

Ageism, a negative attitude towards old people and the process of aging, permeates our personal and cultural expectations of older adults. Its impact on the romantic possibilities of late life is not always readily apparent. It arises, for example, when popular myths fuel self-imposed

limitations regarding what is and is not possible in old age. Ageism can also rear its head when older adults fall in love. This may have especially dire consequences for those living in residential care facilities.

Melinda Henneberger told the story of a couple she called “Dorothy” and “Bob” (Henneberger, 2008). Bob was 95 and Dorothy was 82 when they met and fell in love. They were both residents in an assisted-living facility, and they both had been diagnosed with dementia. The situation exploded when Bob’s son walked in on the couple enjoying a sexual moment in the privacy of Bob’s bed. The son was furious and demanded that staff make sure that Bob and Dorothy were never again left alone together. As a result, Dorothy stopped eating, lost 21 pounds, and was treated for dehydration and depression. When Bob was eventually moved out of the facility, Dorothy sat next to the window and waited for him. Her doctor suggested that without the forgetfulness of Alzheimer’s, the loss might have killed her. Commenting on the story, one reader said that “the idea of geriatrics having sex freaks people out.” She called it “the ick factor.” This story does seem to clearly illustrate the destructive power of ageism. Other issues may also be at play.

When older adults enter residential care they have a right to privacy under federal law. If married, they have a right to conjugal visits and if both are residents of the same nursing home to share a room (Centers for Medicare & Medicaid Services, n.d.). But, unmarried residents, particularly those with cognitive impairments do not have a right to intimacy. This led Anne Holmes (2008) to – perhaps facetiously – suggest that older adults should have a “sexual power of attorney.”

While it is tempting to attribute this to ageism and/or prudishness on the part of administrators and staff, physical intimacy among residents can pose risks. Staff and family members face the delicate question of insuring that sexual activity involving a cognitively impaired older adult is consensual. They are also charged

with prevention of sexually transmitted diseases. Assuming these considerations have been responsibly addressed, professionals must help family members deal with their own concerns, both founded and otherwise.

Conclusion

The four vignettes presented here illustrate important themes for care managers to keep in mind regarding late life intimacy. First, Ginnie and Saul’s LAT relationship was vital to them, but might easily have been ignored in a traditional care management assessment, which underscores the importance of learning to talk about love with older clients. Second, Henry Miller’s problematic fifth marriage reveals the intensity and the self-delusion that can be part of late life infatuation. On the other hand, the third vignette – his final infatuation – conveys the life-giving power of reciprocated passion. Finally, the sad tale of Dorothy and Bob, points to the impact of ageism and the vulnerability of intimate relationships among adults in residential care. Love is a basic human need, and romantic love can arise at any age. With sensitivity, care managers can tap into its power to enhance the quality of life for their clients.

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Addressing Diversity in Sexuality and Aging: Key Considerations for Healthcare Providers

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Abstract

The purpose of this article is to explore the heterogeneity of the older adult population and to provide a framework for systematically considering factors that influence sexuality and the importance of these factors when assessing the needs of older clients in the arena of sexual health. The acronym ADDRESSING will be used to illustrate ten cultural factors and personal attributes that impact sexuality. To appropriately and adequately serve older patients, health care providers must seek to understand the patient's perspective and how each of these areas of diversity bears on one's attitudes, experiences, and needs regarding sexuality and sexual health.

Introduction

Imagine yourself walking into a physician's office. You check in with the receptionist and take a seat close to a window to wait for your name to be called. As you get comfortable in your seat, you glance around the waiting room and take note of the five other people also waiting to see their physicians. You immediately assume that all five of the individuals are older adults, aged 60 or older. Their grey hair (or lack of hair), wrinkled skin, "age spots" on their hands, and bifocals tend to confirm your assumptions. You also categorize the waiting patients as two older white women, a white older male, an African-American older woman, and a Hispanic older man. You cannot help

You wonder if perhaps the other five patients are also seeking medical attention due to issues surrounding sexuality and sexual health, but you quickly dismiss this thought.

but to wonder what brings these five individuals to the doctor's office today. Although your appointment with the physician is to seek some type of relief for your painful and burning urination, you doubt if this is the same issue for the other five patients. You attribute your current health concerns to the fact that you are 72 years of age and have just begun engaging in weekly sexual intercourse after being celibate for the past fifteen years. You wonder if perhaps the other five patients are also seeking medical attention due to issues surrounding sexuality and sexual health, but you quickly dismiss this thought.

This scenario illustrates the human tendency to make generalizations and to categorize people (especially older adults) so that order can be given to vast

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amounts of information. However, the tendency to generalize and categorize can also lead to bias, stereotyping, and/or marginalization. Inaccurate generalizations concerning sexuality and sexual health in later adulthood have led to misperceptions and the exclusion of older adults from receiving adequate attention from health care providers. The purpose of this article is to explore the heterogeneity of the older adult population and to provide a framework for systematically considering the multiple cultural factors and personal attributes that influence sexuality and the importance of these factors when assessing the needs of older clients in the arena of sexual health. An understanding of the diversity that exists in the expression of sexuality would lead to sexual respect and dignity.

ADDRESSING Framework

Older adults are a diverse and heterogeneous group of individuals, with only age being the common denominator. There are cultural factors and personal attributes that define their unique and varying subgroups. These

cultural factors and personal attributes also contribute to the difficulty in designing services and programs that would meet the needs of any specific subgroup of older adults. Therefore, programs that are available must be mindful of the diversity that exists within groups based on these cultural factors and personal attributes.

Drawing upon the work of Hays (1996), the acronym ADDRESSING will be used to illustrate the cultural factors and personal attributes that influence sexuality in later adulthood and the importance of these factors in health and health care. ADDRESSING diversity in sexuality and aging requires practitioners to consider ten primary cultural influences, namely, Age and cohort effects, Degree of physical ability, Degree of cognitive ability, Religion, Ethnicity and race, Socioeconomic status, Sexual orientation, Individualistic life experiences, National origin, and Gender. In addition to recognizing these ten cultural factors and personal attributes that influence sexuality, it is just as important to identify the “dominant discourse” of each of the personal attributes in order to foster an understanding of the diversity that exists in the expression of sexuality. The dominant discourse is a particular way of conceptualizing or talking about a subject. In this discussion, the dominant discourse refers to biases that are held by a dominant

group and if reinforced by political, economic, and social power lead to “isms” (e.g., ageism, sexism, racism, etc.). Table 1 illustrates the ten cultural factors/personal attributes and their corresponding dominant discourse and isms (where evident).

Assessing the Differences in Older Adults’ Sexual Health using the ADDRESSING Framework

A key task for health care practitioners when assessing the sexual health of older adults is to discover and determine what cultural factors and personal attributes are important to their lives and thus contribute to their sexual health and well-being. The ADDRESSING framework can assist practitioners in making accurate assessments by increasing practitioners’ awareness of “specific cultural influences and minority identities that they might otherwise overlook” (Hays, 1996, p. 335) as well as decrease the likelihood that important aspects of the patients’ lived experiences would be unnoticed, ignored, or disregarded. Likewise, discovering the specific significance or salience of one personal attribute over the others for any one patient requires that practitioners possess “culture-specific knowledge and skills.” To appropriately and adequately serve older patients, health care providers must seek to understand the patient’s perspective and how each of these areas of diversity bears on one’s attitudes, experiences, and needs regarding sexuality and sexual health.

Returning to the scenario presented in the introduction, the waiting room patients were simply identified as being two older white women, a white older male, an African-American older woman, and a Hispanic older man. However, these five patients represent heterogeneous experiences that might impact their views of sexuality and play a role in their sexual health histories. Consider the following additional information about the five patients:

Martha is a 75-year old Caucasian widow who wants a complete physical

TABLE 1

Cultural Factors/Personal Attributes and Corresponding Dominant Discourse and Isms

Personal Attribute	Dominant Discourse	“ism”
Age	Youth	Ageism
Degree of Physical Ability	Able-bodied	Ableism
Degree of Cognitive Ability	Able-minded	Abelism
Religion	Christian	
Ethnicity and Race	European American	Racism
Socioeconomic Status	Middle Class	Classism
Sexual Orientation	Heterosexual	Heterosexism
Individual Life Experiences	Expected Roles and Experiences	
National Origin	American Born	Ethnocentrism
Gender	Patriarchy	Sexism

examination. She is dating again for the first time in six years. Martha is a first generation American. Her family emigrated from Italy in 1932. Martha was raped as a child and has never told anyone about this experience. She does not think of the rape often, but it has colored her enthusiasm for beginning a new sexual relationship.

Eighty-five year old Odessa was brought to the physician's office by Marvin, her 68-year-old son. Odessa currently lives in a long-term care facility and the administrator has requested that Odessa be evaluated for dementia because she has repeatedly made sexual advances towards staff and other residents. Odessa has been brought against her will and refuses to be examined by "those doctors."

Marvin (Odessa's son) is a Caucasian male. He is a Veteran of the Vietnam War and lives with his wife of twenty-five years. Although Marvin is in the doctor's office because of his mother, he has intentions of speaking to the doctor about his hearing loss and erectile dysfunction, both of which are interfering with his relationship with his wife. Marvin is also struggling to make ends meet financially.

Adrienne is a 64-year-old African-American woman who lives with Ruth, her partner of 10 years. Adrienne has two grown daughters from a previous heterosexual relationship, and she is currently responsible for watching her three grandchildren (ages 11 months, 2 years, and 4 years) while their mothers work. Adrienne has been experiencing shortness of breath and fears that it may be heart-related.

Jack is a Hispanic male who appears to be much older than the 64 years indicated on his driver's license. Jack's physical complaints are numerous. He has been experiencing numerous bouts of the flu, and is in chronic pain. Jack is demanding that pain medication be prescribed for him so that he can

return to his place of employment -- as a security guard in an in-patient hospice care facility.

Collectively, these five patients are specifically seeking either a comprehensive physical/cognitive examination or medical attention for a specific health concern or issue (e.g., hearing loss, erectile dysfunction, shortness of breath, chronic pain). The brief descriptions would lead one to believe that only Odessa and Marvin have identified concerns related to sexuality and

Age and Cohort Effects

Because of the dominate discourse of "youth," society erroneously assumes that older adults are not sexually active, despite current research that documents that individuals continue to be sexually intimate throughout the lifespan (DeLamater & Still, 2005; Lindau et al., 2007). The myths surrounding sexuality in older adulthood are generally unquestioned throughout the United States. Researchers perpetuate

these myths by excluding older adults in their studies of sexuality, which in turn may result in physicians not conducting comprehensive sexual health histories with their older patients. There are many physicians who hold the belief that sexual activity is not important in later life and therefore they do not ask about sexual histories in patient assessments (Gott, Hinchliff, & Galena, 2004). Physicians who unknowingly abide by these myths not only exclude sexual intimacy as an important aspect of the older patients' lives, but they

also place older adults at risk by not informing them of safe sexual health practices. Although the experience of aging and the experience of sexuality across the lifespan are extremely diverse, the traditional view of sexuality in later adulthood tends to be negative. Conversely, with the advent of sexual enhancement medication (e.g., Viagra), it is now assumed that older men must participate in penetrative sexual activity.

Ideally, older adults will recognize that there is no correct or clearly defined manner in which sexuality must be expressed in later adulthood (Hillman, 2008). However, it is important to recognize that older adults' attitudes and definitions of sexual relations have been shaped by their culture and the historical events related to sexuality. Table 2 illustrates a few of the historical changes that older adults have experienced related to sexuality and sexual health:

Because of the dominate discourse of "youth," society erroneously assumes that older adults are not sexually active, despite current research that documents that individuals continue to be sexually intimate throughout the lifespan

(DeLamater & Still, 2005; Lindau et al., 2007).

sexual health. However, every health care practitioner should complete a comprehensive sexual health history with every patient. Societal ageism reinforces the stereotypes that older adults are not sexually active, and thus comprehensive sexual histories are not usually obtained for patients over the age of 50 (Gott, Hinchliff, & Galena, 2004). As previously indicated, a key task for health care practitioners who are assessing the sexual health of older adults is to discover and determine what cultural factors and personal attributes are important to their lives and thus contribute to their sexual health and well-being. Applying the ADDRESSING framework, each of these cultural factors and personal attributes that contribute to sexual health and well-being will be briefly discussed and the five patients previously described used to illustrate the potential application of the framework.

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From this brief listing of historical events related to sexuality that older adults have witnessed and lived, it is evident that the current cohort of older adults is less likely to have experience with birth control (e.g., the pill, condoms) and safe sex practices. Additionally, the current cohort of older adults is less likely to openly discuss their sexuality and/or sexual orientation and have lower levels of education and financial resources when compared to younger cohorts. Health care practitioners must recognize that older adults have been influenced by different political and historical forces, with distinctive sets of social attitudes and opportunities.

Degree of Physical Ability

Research indicates that frequency of sexual activity, a good quality sex life, and interest in sex are positively associated with health in middle and later adulthood (Lindau et al., 2007) and a satisfying sex life among married couples may delay mortality (Seldin, Friedman, & Martin, 2002). However, research has also shown that an older adult's level of physical activity affects his/her sexuality. Chronic diseases, certain surgeries, certain medications, personal reactions to physiological changes, substance use, incontinence, acute illness, etc. can individually and collectively affect sexual well-being (Hillman, 2008; Steinke, 2005). All of these health conditions and an older adult's ability to perform Activities of Daily Living (ADLs) must be taken into consideration when assessing sexual health. Because the attribute of degree of physical ability intersects with gender, practitioners must also be mindful of the research that indicates that men lose more years of sexually active life as a result of poor health than women (Lindau et al., 2007).

T A B L E 2

Select Historical Changes Older Adults Have Experienced Related to Sexuality

1928	Margaret Mead concluded that attitudes toward sex are culturally prescribed.
1949, 1953	Kinsey Reports on Male and Female Sexuality are published.
1953	Playboy and Cosmopolitan begin publishing.
1960	Contraceptive pill is approved by the U.S. Food and Drug Administration (FDA).
1966	NOW (National Organization for Women) is established. Human Sexual Response, the Masters and Johnson research is published.
1969	Stonewall Inn Riots – beginning of gay liberation movement.
1970	Everything you Always Wanted to Know about Sex is published.
1972	Joy of Sex is published.
1973	The Roe vs Wade decision guarantees limited right to abortion. The American Psychiatric Association eliminates homosexuality as a mental disorder.
1975	Against Our Will: Men, Women and Rape is published. The Equal Rights Amendment to the U.S. Constitution is passed by the U.S. Congress and defeated in states.
1976	The Hyde Amendment to the U.S. Constitution prohibits federal funding of abortion.
1979	The Moral Majority is established.
1981	HIV/AIDS is identified among gay men.
1987	The Gay March on Washington revitalizes the gay movement.
1992	The National Health and Social Life Survey – the first scientific study of U.S. sexual behavior is published.
1993	"Don't Ask, Don't Tell" policy in the U.S. Armed Forces.
1994	U.S. Surgeon General Joycelyn Elders is fired for recommending education about masturbation.
1996	The federal Defense of Marriage Act forbids gay marriages.
1997	Ellen Degeneres comes out on "The Ellen Show."
1998	Viagra is approved by the FDA.
1999	The emergency contraception pill is approved by the FDA.
2000	RU486 (medical abortion) is approved by the FDA.
2004	Eleven states pass amendments to define "marriage."
2007	New England Journal of Medicine publishes A Study of Sexuality and Health among Older Adults in the United States.
2011	First baby boomers turn 65 years of age.
2011	"Don't Ask, Don't Tell" policy is abolished.

Degree of Cognitive Ability

An older adult's level of cognitive ability affects his/her sexuality. Mental health issues, issues related to performance anxiety, dementia, depression, attitudes toward self as a sexual being, and level of sexual knowledge and comfort with intimacy must be explored. Research also indicates that cognitive impairment does not prevent sexual desire, but it may complicate its expression. The most

likely change in the sexual behavior of an older adult with dementia is indifference or apathy (deMedeiros et al., 2008). However, the majority of research on dementia and the expression of sexuality has focused on improper sexual behaviors among older adults with dementia (Ward et al., 2010). As in the case of Odessa, most health care practitioners will request a psychological evaluation for an older adult who is displaying "inappropriate sexual behaviors" and

rarely request an assessment if sexual indifference or apathy is evident.

Religion

When completing a sexual health history with older adults it is imperative that religious beliefs are recognized and honored. Limited research indicates that religious and spiritual beliefs play a significant role in older adults' view of sexuality (Stancil, 2004) and that religiously inclined older married individuals tend to have more pleasurable sex than nonreligious older married individuals (McFarland, Uecker, & Regnerus, 2011). However, the limited research on the role of religion in shaping sexual frequency and satisfaction amongst older adults did not make distinctions among religious traditions. There are theological guidelines regarding sex or sexual activities, but there are considerable differences in sexual morality among followers of different religious traditions. For example, Christianity (the dominant discourse) sanctions sexual activity mainly between a husband and wife, and sex is seen as serving the purpose of procreation. Further research is needed to explore how the connection between religion and sexuality in later adulthood varies by religious traditions, cultural factors, and other personal attributes.

Ethnicity and Race

There is limited research on the impact of race and ethnicity on sexuality and sexual health in later adulthood. However, Mahay, Laumann, and Michaels (2001) have indicated that ethnicity and race influences attitudes concerning sexual expressiveness. Likewise, sexual norms, practices, and preferences are shaped by race and ethnicity. Limited research indicates that because the U.S. culture tends to depict older persons as being white, middle class, and male, the sexual experiences of minority elders are poorly accounted for in research. Although the U.S. has a growing population of non-Caucasians, the vast majority of research on sexual functioning has been conducted among Caucasians

(Cain et al., 2003). Health care practitioners must not resort to ethnic or racial generalizations or assumptions, as could be the case with Jack, a Hispanic older man.

Socioeconomic Status (SES)

There are markers of SES that influence one's sexuality. These include level of education, economic class, style of life, occupation, and living conditions. Changes in living arrangements (e.g., moving in with adult children, residing in a long-term care facility) can contribute greatly to changes in levels of sexuality among older adults.

Sexual Orientation

Although sexual activity and health among older adults is an understudied topic, even less is known about the sexual health and well-being of lesbian, gay, bisexual, and transgender (LGBT) older adults. It is extremely important to recognize that LGBT older adults came of age when their sexual orientation was regarded as a form of mental illness and that sexual behaviors between individuals of the same sex was considered illegal and/or immoral (for a comprehensive review of LGBT and aging literature, see Kimmel, Rose, and David, 2005). Older adults who self-identify as LGBT have faced numerous challenges due to the prevailing heterosexist and homophobic attitudes within the culture. Health care providers when assessing the sexual health of older adults must refrain from heteronormativity – or assuming that all patients are heterosexual. This would only compound the invisibility of LGBT older adults. A health care practitioner working with Adrienne must listen for subtle messages concerning the salience of her sexual orientation on her current health concerns.

An exploration of the sexual health of LGBT older adults must take into consideration the similarities between the social construction of sexual orientation as a sexual minority status, and the social construction of aging. Kimmel, Rose, Orel, and Greene (2006) indicate that both social

categories are evaluated negatively, with flagrant acts of discrimination associated with them. Because it is possible to conceal sexual orientation and, even to some extent, chronological age, sexual orientation and age have similar social constructions. For example, "within an ageist and heterosexist culture, the phrase (and former policy) 'Don't ask, don't tell' is applicable and often applied to both older adults and LGBT persons by those who would prefer that they remain invisible" (Orel & Fruhauf, in press).

Individualistic Life Experiences

Each older adult has personal life experiences that have influenced their sexual beliefs and attitudes and thus their sexuality. Most significant is an older adult's past history of sexual experiences and activities. This would also include a past history of sexual abuse that may play a role in one's ability to experience intimacy. Likewise, people who have experienced life-altering experiences (e.g., physical abuse, violence, trauma, natural disasters) may find that these experiences affect their views about sexuality and intimacy.

A history of STIs/HIV/AIDS is another critically important life experience that can influence sexual beliefs and attitudes. This would include aging with HIV or contracting HIV in later adulthood. The emotional impact of HIV and AIDS on the LGBT community cannot be understated, yet many LGBT individuals also experienced resiliency in the face of adversity. The LGBT community's work in developing effective HIV prevention education programs can be models for developing effective HIV prevention education programs specifically tailored for an older adult population. The Centers for Disease Control and Prevention (CDC) currently reports that 24% of persons living with HIV/AIDS are over age 50 (2008) and that by the year 2015, 50% of those living with HIV/AIDS will be 50 years of age or older. Health care professionals must obtain thorough sexual histories from their older adult

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Addressing Diversity in Sexuality and Aging: Key Considerations for Health-care Providers

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patients and be willing to discuss STIs/HIV prevention strategies.

National Origin

Attitudes and definitions of sexual relations are shaped by one's country of origin. What is considered sexually desirable or appropriate behavior within a particular culture depends on salient aspects of the culture. There is limited research that systematically explores cultural similarities and differences on beliefs and values related to sexuality. What is reported relates to sexual behaviors that are seen as being "positive" or "negative." For example, there is often a global expectation that women should remain virgins until marriage. Likewise, men are likely to have more freedom in expressing their sexuality than women.

Gender

Gendered sexual practices and gendered sexual roles reflect a patriarchal discourse. Interest in sex among middle-aged and older men in the United States has increased since 2000 (Lindau et al., 2007). Overall men have a longer sexually active life expectancy and most sexually active men report a good quality sex life. In contrast, only about half of sexually active women reported a good quality sex life. This disparity and its implications for health require further exploration. Although greater sexual satisfaction is associated with greater sexual frequency for men, sexual satisfaction in women has been found to be more strongly associated with emotional factors. Women tend to emphasize the relationship-bonding aspects of sexuality more than men (Pepleu, 2003). Women's sexual desire in midlife and older adulthood also appears to be more dependent on the availability of a partner than for men (DeLamater & Still, 2005), and women often express a loss of interest in sex that coincides with the disability or death of a spouse (Gott, 2005).

Conclusions

An investigation of personal attributes and the dominant discourses leads to a more comprehensive exploration of issues surrounding sexuality and sexual health among older adults. Health care practitioners and researchers must adopt a broader view of sexuality in later adulthood, one that more accurately reflects the heterogeneity in the lived experiences of individuals. It is important to stress that health care providers must not only consider each dimension, but the interaction of multiple dimensions. Research is needed on sexuality in later adulthood particularly in relation to the intersection of age, degree of physical/cognitive ability, religion, ethnicity/race, socioeconomic status, sexual orientation, individualistic life experience, national origin, and gender.

Most importantly, health care providers who wish to approach the topic of STIs/HIV/AIDS with their older patients will be more successful if they take into consideration the numerous variables that may contribute to risk taking behaviors, STIs/HIV/AIDS knowledge, and older adults' desire to practice safe sex. Basic education on STIs/HIV/AIDS is needed for many older adults, but before risk prevention education programs can be initiated, the personal attributes of the "student" must be known so that the program can be tailored for a specific set of values, norms, and beliefs.

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Older Lesbian Adults and Alcoholism: A Case Study for Practitioners

Noell L. Rowan, PhD, LCSW, CADC

Abstract

There is a significant gap in the literature regarding older chemically dependent lesbians and their health and mental health needs (Satre, 2006; Shankle, Maxwell, Katzman, & Landers, 2003). This conceptual article begins to address the issues faced by older lesbians with alcoholism and considers further research necessary to enhance understanding of the lived experiences of these individuals. A literature review of issues facing this population is provided, followed by focus on alcohol-related older adult health concerns, discussion about older lesbian adults, and a case study to demonstrate issues for practitioners and a summarization with implications for practice and research.

Background and Literature Review

Alcohol and drug abuse and misuse among older adults is one of the fastest growing public health problems in America. Initial evidence demonstrates that the upcoming generation of older adults will have high levels of health problems related to substance abuse (Axner, 2008; Farkas, 2008). For example, Watts (2007) noted an increase in problematic alcohol consumption in older adults and warns of the urgent need to provide competent assessment and treatment for improved health outcomes. An estimated 1.7 million older adults (age 50 and older) are chemically dependent and this group is predicted to increase to 4.4 million by 2020 (Gfroerer, et al., 2002; Korper & Rasken, 2003; Menninger, 2002). In conjunction with the

dramatic increase in the number of older adults with substance abuse and chemical dependency issues predicted in the near future, current rates indicate that up to 17 percent of adults age 50 and older may be struggling with such issues; however, this problem area has not yet achieved prominence in the literature (Blow, 2000; CSAT, 1998; Rowan & Faul, 2007; Shibusawa, 2006).

In each year from 1995-2002, alcohol was the most frequently reported primary drug of choice among those admitted to a treatment facility (The DASIS Report, 2005). It is estimated that 4% to 20% of community-dwelling older adults abuse alcohol (Shibusawa, 2006). These percentages translate to an estimated 2.5 million older adults with problems related to alcohol (Blow, 2000; CSAT, 1998). In health care settings, 6% to 11% of older adults exhibit symptoms of alcoholism; in psychiatric settings, 20% of older adults exhibit similar symptoms; and in emergency rooms, 14% (Shibusawa, 2006). Rates for alcohol-related hospitalizations among older adults are similar to those for heart attacks. Forty-nine percent of older nursing home residents show signs of alcoholism, some of whom may be using nursing homes for short-term rehabilitation (Blow, 2000; CSAT, 1998).

Although these figures are of concern, they still represent an underestimation of the true problem. It is challenging to obtain accurate statistics on the prevalence of alcohol dependence in older adults due to multiple factors, such as the stigma, nonspecific symptoms,

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multiple comorbid health issues, and inadequate screening among this population (He, Sengupta, Velkoff, & DeBarros, 2005; Hooyman & Kiyak, 2008). Nonetheless, these estimated figures have important implications for social work practice with older adults. In addition, the subset population of older lesbian women with alcohol related problems presents particular urgency for more research due to indications of greater physical and mental health risks that substance abuse/dependence entails for this population (Gabbay & Wahler, 2002; Satre, 2006; Shankle, et al., 2003). Moreover, the virtual absence of literature about the lived experiences of older lesbian women who have alcohol addiction and their ability to sustain recovery necessitates further research.

Compared to the general population, lesbian women and gay men have elevated rates of substance abuse problems (CSAT, 2001; Hall, 1996; Hughes & Wilsnack, 1997; Matthews, Lorah, & Fenton, 2005; McKirnan & Peterson, 1989; Ratner, 1988; Roberts, 2006). It is even more difficult to ascertain precise incidence and prevalence information about lesbian women due to the hidden nature of this population, inconsistent methodologies across studies, and lack of attention to sexual orientation in epidemiological research (CSAT, 2001).

Recent research has begun to show an even greater health risk for chemical addiction amongst lesbian women as they present for treatment with more severe chemical abuse histories, co-occurring mental health issues, and increased medical service utilization rates (Anderson, 2009; Cochran & Cauce, 2006; CSAT, 2001; Gabbay & Wahler, 2002; Mercer et al., 2007; Wilsnack et al., 2008). Mercer et al. (2007) also indicated that lesbian women are fearful of disclosing their sexual identity to health providers, which emphasizes a need for culturally sensitive

assessment and intervention strategies. Moreover, Wilsnack et al. (2008) reported elevated risks of hazardous drinking, depression, and history of childhood sexual abuse amongst lesbian and bisexual women with specific recommendations to health and mental health care providers to assess the sexual orientation of women in an effort to design more effective treatment provisions. There is a growing body of literature which demonstrates that differences between heterosexuals and sexual minorities in regard to substance use, misuse, abuse, and dependence extends into middle age and late life (Anderson, 2009; CSAT, 2001; Jones, 2001; Satre, 2006; Valanis, Bowen, Bassford, Whitlock, Charney, & Carter, 2000). While older lesbians deal with the expected stressors of growing older (i.e. physiological changes, retirement, and loss), which have been noted as potential risk factors for developing alcohol problems in late life (CSAT, 1998; Satre, 2006), there are additional vulnerabilities amongst older lesbians. Older lesbian women may have come out before the sexual revolution and gay rights era, thereby experiencing more anti-gay discrimination, a greater sense of isolation, and additional pressure to conceal their identity, resulting in considerable emotional stress (Anderson, 2009; Finnegan & McNally, 2002; CSAT, 2001). They may also sense a lack of acknowledgement in society for their partner relationships, their concept of family, and may face being "lesbian widows," and drinking alcohol or using other substances may have been a major part of their lives (Finnegan & McNally, 2002; CSAT, 2001; Jenkins, Rowan, & Parks, 2008; McFarland & Sanders, 2003). Also, because older lesbians do not qualify for federal privileges of marriage, their surviving significant others/partners typically suffer more financial losses than do heterosexual widows (Anderson, 2009). More specifically, lesbian widows are not automatically consulted with on important health care or family decision-making and do not qualify for bereavement or medical leave, nor can they file joint tax returns or reap financial gain from

income and estate taxes or social security survivor benefits.

The preceding paragraphs establish many of the challenges that play a role in creating stress within the older lesbian population. Furthermore, older lesbian women who are most at risk for alcohol and other drug problems appear to have low self-esteem, anxiety, depression, poorly developed social support networks or have lost once relied upon social networks, and have long periods of stress associated with aging (Satre, 2006). Of specific concern is that compared to heterosexual women, older lesbians are more likely unable to curtail their substance use and are at greater risk for physical and mental health problems (Satre, 2006; Wilsnack, et al., 2008), and other issues particular to sexual minority adults such as more severe substance abuse, greater psychopathology, and increased medical service utilization (Cochran & Cauce, 2006; Jones, 2001) which provides a clear urgency to address this social problem.

Finnegan and McNally (2000) described that chemically dependent lesbians in the late mid-life years of age 50-60, deal with critical issues of losing their former identities and creating new selves in older age and the incredible sense of loss felt when realizing that they have missed out on life experiences while in the midst of their addiction to alcohol or other drugs. Dealing face to face with death when struggling with alcoholism or drug addiction and subsequent recovery takes its toll especially when coupled with the complex issues of aging as a lesbian and many life-changing decisions that need to be addressed during their mid-life and later age years.

As has been noted, little is known about older lesbians with alcoholism who have attained sobriety and the outcomes of formal treatment and informal supports are missing from the literature. While there are some studies that provide treatment outcomes of older adults, sexual orientation information is typically omitted (CSAT, 2001; Satre, 2006). Moreover, there is a dearth of information as it

relates to what helps older lesbian adults obtain and sustain sobriety specifically from a perspective about resiliency and overall quality of life. Due to the history of socializing in lesbian and gay bars, the ability to form safe, supportive community networks that do not involve drinking alcohol or using other drugs has been particularly challenging for this subset of older adults (Satre, 2006). In addition, the negative attitudes and heterosexism as noted in prior studies can create a complex situation when older lesbian adults present for treatment for alcoholism (Eliason & Hughes, 2004). Therefore, more needs to be known about the lived experiences of older lesbian adults with alcoholism in an effort to inform practice with older adults. An overview of the health issues that face older adults with alcohol problems is presented next in an effort to provide specific focus areas for geriatric health care practitioners.

Health Concerns about Older Adults with Alcohol Problems

Health-related consequences of acute alcohol intoxication are more severe with older adults. Changes pertaining to physiology of aging occur in the older adult that account for the development of problems secondary to alcohol use even when the older adult does not increase the amount of alcohol intake over the years. A significant problem is the decreased absorption rate in the gastrointestinal system, occurring as a result of decreased blood flow to the gastrointestinal system. Therefore, alcohol remains in the body longer and at higher rates of concentration. Reduced hepatic blood flow and decreased enzyme efficiency diminish the liver's functional capacity to metabolize drugs and alcohol. Hence, older adults keep an increased amount of drugs in their body for longer periods of time. The mortality rate for cirrhotic liver disease in the aged is about twice the mortality rate for the general population (Menninger, 2002; Benschoff & Harrawood, 2003).

There are multiple consequences of alcohol and other drug abuse

which tend to mimic other problems that are common among older adults. Vague symptoms such as irritability, stomach upset, weight loss, malnutrition, depression, and insomnia may be the first signs of a problem. In subsequent years, evidence of liver, kidney, and heart disease, osteoporosis, incontinence, and pancreatitis may become apparent. Problems associated with the misuse of benzodiazepines overlap with those of alcohol abuse and may include drowsiness, sedation, confusion, memory loss, falls, and other types of accidents. When used in combination, the adverse effects of alcohol and benzodiazepines may be severe (Fingfeld-Connett, 2004).

Most common causes of death in older substance abusers include cirrhosis of the liver, cancers of the mouth, esophagus, pharynx, lung and liver; breast cancer in women; and trauma (Fingerhood, 2000). Gastrointestinal and liver diseases are the main complications of alcohol use with older adults. Esophagitis, ulcer disease, and gastritis are all more common in the older drinker; and aspirin and other nonsteroidal anti-inflammatory drugs commonly taken by older people add to the risk of these alcohol-related problems. Alcohol is also the second leading cause of acute pancreatitis in older people behind gallstone disease and is the cause of chronic pancreatitis in many cases. The complications associated with alcohol use in older adults are no different than in younger people. However, the complications may be more severe and occur at lower levels of alcohol consumption than in younger people (Fingerhood, 2000). These concerns emphasize the importance for practitioners to be mindful of pertinent health issues in older adults that may be complicated by alcoholism.

Older Lesbian Adults: What Do We Know?

Lesbians from varying generations have lived and developed in many different social environments with influences from a range of political, historical, and civil rights

changes. Contrasts may be noted between older and midlife lesbians of today given more public awareness of lesbian mothers, grandmothers, more visible media, and the debates in the media about same-sex marriage and health care provisions with health care surrogate policy changes. There is a need for more research about older lesbian women in an effort to increase the understanding of various health and life span concerns.

The incidence of alcoholism among older lesbians is difficult to pinpoint because many studies do not include data on sexual orientation. According to the available research, the National Gay and Lesbian Task Force (2005) estimates that three to five percent of women in America identify as lesbian or bisexual. According to the updated report (2010), there are almost 38 million Americans over 65 or 12.6 percent of the population. This is predicted to nearly double by 2030, when there will be an estimated 72 million people over age 65. Since the lesbian and gay population is estimated to be between five and ten percent of the general population, this means that today, 1.4 to 3.8 million lesbian and gay Americans are reaching standard retirement age with an estimated 3.6 to 7.2 million projected to be 65 or older in 2030.

Case Study

As a way of illustrating some of the points made in this article about the need to understand more about the lived experiences of this subset of older adults, preliminary findings from the first case of current phenomenological research are discussed in the next section. The case serves to strengthen the points made in the description of older lesbian adults with alcoholism by providing specific examples of how one participant describes her dealings with the intersection of identity in dealing with having alcoholism, being lesbian, and aging. The phenomenological approach was selected in an effort to more fully understand the lived experiences of this

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subset population of older adults. The study was approved by the Institutional Review Board of the researcher's university and informed consent was obtained prior to involvement in the three-part series of in-depth interviews (Seidman, 2006). A combination of purposive and snowball sampling methods were used to identify individuals involved in the study.

A description of the first participant

The participant, Dot (a pseudonym) is a 63-year-old African American lesbian person who lives in Kentucky with her partner of ten years who is Caucasian and fourteen years younger. With some college, she worked most of her adult life and continues to work in mostly clerical positions.

History with alcohol and the transformation to recovery

Dot lived in a heterosexual marriage for twenty years reportedly drinking in "secret" to "take away all of my feelings just to get me in a place where I felt okay about me 'cause I wasn't okay about me." She began going to therapy and Adult Children of Alcoholics and Alanon 12-step groups during the later years of her marriage due to family-of-origin issues with alcoholism. She left the marriage after she began to get in touch with her feelings and get sober. While in individual therapy, she was suicidal at times in her thinking while trying to control her use of codeine and alcohol to numb feelings. Eventually, she reached a point wherein she was confronted in therapy that she needed to address her alcoholism. She described a pivotal relationship with this therapist as vital to her entering an outpatient therapy group that was focused on dealing with alcoholism. The one-on-one safe therapeutic connection that she described with this licensed clinical social worker that she reportedly had been seeing for about two years was

crucial in her decision to listen to the therapist's grave concerns that she address her alcoholism. Dot related that she had developed a nurturing and supportive relationship with the therapist that she did not want to lose. It was during this time that she became sober in Alcoholics Anonymous.

Her involvement with Alcoholics Anonymous was described as very helpful and life changing as she has maintained continuous sobriety for 22 years. She emphasized the empowerment in learning that she could rely on the support of others, that AA is a "we program" which she described as a huge relief to not have to try to attain and maintain sobriety by herself. She reported, "I spent a lifetime trying to take care of me trying to do things by myself and not letting anybody in." She described her current life as beyond her imagination with a large support system in place primarily from her involvement in Alcoholics Anonymous and other 12-step support groups as well as involvement in a church community. She also described a strong faith in God as helpful in difficult times. Dot reported, "I believe that no matter what comes down the pike that God is gonna be there." In addition, she credited both her involvement in professional therapy individual and group sessions along with 12-step support groups as key situations to her attaining and maintaining sobriety.

What do geriatric care managers and other practitioners need to know?

When asked about the vital points that practitioners need to know, Dot stated the importance of a compassionate listener especially with older lesbian adults who may be coming out later in life while simultaneously dealing with having alcoholism. Dot emphasized that, "compassion is needed for older women who are coming out." Due to her struggles of realizing about her sexual orientation after she had been married to a man for many years and having a family, she stressed the importance for social workers "with the ability to listen 'cause sometimes

it's just really hard to step out especially if you've been heterosexual and married and had children." She continues by stating, "the need for a listening ear and guidance and direction [is important] if you run across somebody who is chemically dependent and lesbian... don't be afraid to tell them to go to get help."

Needed programs or services for older lesbian adults with alcoholism

There was an emphasis in the first participant interview on the establishment of needed programs or services for this subset population of older adults. Dot stated the importance of creating settings where assistance is provided for "help with socializing, knowing what's appropriate, how to be around many different situations, with other lesbians... [introduction to] lesbian retirement communities." Given that Dot admittedly had not developed social skills and was coming out as a lesbian in later life, socialization opportunities wherein she could learn to interact without drinking alcohol and other drugs was important to her ability to sustain sobriety and a meaningful quality of life. She found the ability to socialize through her new-found connections in 12-step groups that were lesbian and gay friendly as well as through a lesbian and gay affirming church community. Dot stated that if practitioners could assist with a social support system for older lesbian adults who are newly dealing with their sexuality and alcoholism that this could make a positive impact in the overall quality of life.

Practice Implications

This first participant in current research illustrated some of the points made regarding the need to more fully understand the lived experiences of older lesbian adults with alcoholism. Dot was able to obtain sobriety with a pivotal and strong, safe therapeutic connection with her individual therapist along with other support from group therapy focused on alcoholism in addition to involvement in several 12-step recovery support groups. Her willingness to seek professional help and to attend community support

groups aided her transformation.

Practitioners dealing with older lesbian adults need to be aware of the community support available in their respective areas such as lesbian and gay specific community centers which may provide socialization and community event opportunities, 12-step group contact information, such as national official websites (Alcoholics Anonymous <http://www.aa.org> and Alanon <http://www.alanon.alateen.org/>) and the website for the national Sage Organization that reaches out to older lesbian and gay people (<http://www.sageusa.org>).

Many communities do not have welcoming service centers for older lesbian women and it may well be a geriatric care manager's specific work to help to create social and community opportunities within their home areas. The national Sage Organization is one organization that can provide initial ideas and programming for training to improve cultural sensitivity and treatment for older lesbian consumers of services. As previously stated, there are few resources available for this older lesbian population with alcoholism due largely from stigma and lack of focused empirical research.

Conclusion

Older lesbian women remain virtually invisible even with estimates that there are between one and three million older lesbian and gay adults age 65 and older in America today and are predicted to increase to between two and seven million by 2030 (Shankle, et al., 2003). As previously stated, the multiple challenges facing this particular subset of older adults presents an urgency to address the health and mental health needs of this population in research to inform practice and policy (Butler, 2004; Zodikoff, 2006). The Substance Abuse and Mental Health Service Administration, Center for Substance Abuse Treatment (2001) has noted several areas in which further research is needed which includes the effects of aging, sexual identity, discrimination, and substance use and abuse with the older lesbian population. Much importance has been placed on future

research to address services available and the practice strategies that may work best for older adults with problems with alcohol and other drugs who are lesbian (Satre, 2006).

Recent research has noted a need to focus more study on behalf of the LGBT aging population. For example, Fredrickson-Goldsen and Muraco (2010) in the comprehensive review of the literature, note that LGBT older adults are particularly in need specific to a lack of available community resources and community support. Fredrickson-Goldsen and Muraco (2010) as well as the most recent Institute of Medicine health report (2011) have demonstrated that the LGBT aging population is a hidden and marginalized group in society that is in need of community outreach to address issues of health and behavioral health. Research is currently underway with a phenomenological approach to understand how older lesbian women have recovered from alcoholism. Gaps in understanding are being inquired about related to specific challenges and strengths related to how older lesbians experience alcoholism, access to formal alcoholism treatment, and how they attained and sustain sobriety. Results of this work will be forthcoming in future research presentations and articles.

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Dr. Noell Rowan is Assistant Professor and Director, BSW Program, Kent School of Social Work, University of Louisville. Her research efforts focus on the overarching areas of gerontology, LGBT population and alcohol and other drug addictions, spirituality, and the impact on social work education and practice. She is interested in cultural sensitivity, resiliency and quality of life and health and mental health in social work education and practice.

She is a Hartford Geriatric Social Work Faculty Scholar in Cohort XI and is currently conducting her research on resiliency and quality of life of older lesbian adults with alcoholism. In 2009, she was honored for the Best Research in LGBT at the Diversity Symposium held at Ball State University.

Aging, Relationships, & Sexuality: Tools and Resources for Geriatric Care Managers

*Jennifer A. Crittenden, MSW and
Lindsay Day, LSW*

This resource article is designed to provide key professional resources, information, consumer resources, and training materials on love, relationships, and sexuality in older age. The authors of this article do not endorse any of the organizations listed but rather are providing them as a general starting point for considering, discussing, and exploring issues of older adult relationships and sexuality. The resources provided are listed in alphabetical order and available training curricula are noted in resource descriptions as appropriate.

AARP Love & Sex Website

This is a website set up by AARP to provide information about relationships, love and sex after 50. AARP provides a wealth of resources that are both engaging to read and easy to understand.

Website: www.aarp.org/relationships/love-sex/

AARP Report on Sexuality at Midlife and Beyond

This report details a 2004 survey study conducted by AARP examining the role that sexuality plays in quality-of-life issues for midlife and older adults. The 2004 study also delves into attitudes toward sexuality among older minorities.

Website: http://assets.aarp.org/rgcenter/general/2004_sexuality.pdf

Aging in the Know

40 Fulton Street, 18th Floor
New York, New York 10038
Phone: 212-755-6810

Website: www.healthinaging.org/agingintheknow/

This website was created by the American Geriatrics Society Foundation for Health in Aging (FHA). Aging in the Know offers up-to-date information for consumers on health and aging, including a section devoted to sexuality and sexual concerns.

American Psychological Association's Aging and Human Sexuality Resource Guide

750 First Street NE
Washington D.C. 20002-4242
Phone: 1-800-374-2721

Website: www.apa.org/pi/aging/resources/guides/sexuality.aspx

This is a website developed by the American Psychological Association to educate professionals about aging and sexuality. It contains a plethora of citations for empirical evidence on aging and sexuality, summary chapters, case presentations, and resources to use for education in teaching settings or with clients.

American Social Health Association

P.O. Box 13827
Research Triangle Park, NC 27709
Phone: 919-361-8400
STI Resource Hotline: 919-361-8488

Website: www.ashastd.org

ASHA is recognized for developing and delivering accurate, medically reliable information about sexually transmitted infections. This is where you will find the facts, support, resources, questions and answers, and thorough information on sexually transmitted diseases.

American Society on Aging LGBT Aging Website

71 Stevenson Street, Suite 1450
San Francisco, CA 94105-2938
Phone: 1-800-537-9728

Website: www.asaging.org/education/5

The American Society on Aging (ASA) offers professional education, publications and online information and training resources that are nationally recognized. This website provides a wealth of information on an array of topics related to LGBT and aging.

Hartford Institute for Geriatric Nursing Sexuality and Aging Website

This website features nursing standard practice protocols on issues of sexuality and aging. The information presented on the website is evidence-based content and includes an assessment of sexual health in older adults for professionals to utilize.

Website: http://consultgerirn.org/topics/sexuality_issues_in_aging/want_to_know_more

LGBT Aging Issues Network

71 Stevenson Street, Suite 1450
San Francisco,
CA 94105-2938
Phone: 1-800-537-9728

Website: www.asaging.org/lain

As an affiliate of the American Society on Aging, the LGBT Aging

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Issues Network (LAIN) works to foster professional development, multidisciplinary research and wide-ranging dialogue on LGBT issues in the field of aging. They carry out this mission through publications, conferences, and cosponsored events.

LGBT Aging Project

555 Amory Street
Jamaica Plain, MA 02130
Phone: 617-522-1292

Website: www.lgbtagingproject.org

The LGBT Aging Project is a non-profit organization that was founded in 2001 by a group of advocates from both the aging service network and the LGBT community. The Aging Project collaborates with community partners to conduct research among LGBT elders and providers and has provided training to more than 2,000 people. The LGBT and Aging Project works to increase public awareness of LGBT elders and caregivers and the issues that impact their lives.

National Association on HIV Over 50

23 Miner Street, Ground Level
Boston, MA 02212-3319

Website: www.hivoverfifty.org

The National Association on HIV Over 50 is a volunteer based organization which promotes education, training, and advocacy to those over 50 with a diagnosis of HIV. Their website provides research, education, and communication around the interplay between HIV and aging.

National Coalition for LGBT Health

1325 Massachusetts Avenue NW, Suite 705,
Washington, DC 20005
Phone: 202-558-6828
E-mail: coalition@lgbthealth.net

Website: www.lgbthealth.net

The National Coalition for LGBT Health works to improve the health

and well-being of the lesbian, gay, bisexual, and transgender community by providing advocacy that supports research, policy, education, and training on this topic. The website features a compilation of resources for consumers and providers including information on sexual health.

National Gay and Lesbian Task Force

1325 Massachusetts Ave. NW, Ste 600
Washington, DC 20005

Phone: 202-393-5177

E-mail: info@TheTaskForce.org

Website: www.thetaskforce.org

NGLTF is a national organization dedicated to ending discrimination against gay, lesbian, bisexual, and transgender people at the local, state, and national level. Their aging initiative is in place to raise awareness of the needs of the aging GLBT population through research, networking, and training.

National Institute on Aging Sexuality in Later Life AgePage

This consumer resource discusses common problems and conditions that may interfere with sexuality and sexual expression as one ages in language that is easy to understand. Visit the website for a PDF version of this brochure, or to order hard copies of this consumer education resource.

Website: www.nia.nih.gov/HealthInformation/Publications/sexuality.htm

National Resource Center on LGBT Aging

c/o Services & Advocacy for GLBT Elders (SAGE)
305 Seventh Avenue • 6th Floor
New York, NY 10001
Phone: 212-741-2247
E-mail: info@lgbtagingcenter.org

Website: www.lgbtagingcenter.org

The National Resource Center on LGBT Aging is the country's first and only technical assistance resource center working to improve the quality of services and supports offered to lesbian, gay, bisexual, and

transgender (LGBT) older adults. Established in 2010, the center is led by Services & Advocacy for GLBT Elders (SAGE) in partnership with 10 other organizations from around the country. In an effort to improve the quality of services and supports for LGBT Older Adults, the National Resource Center offers a training curriculum on LGBT cultural competency to service providers free-of-charge. Providers can request this free training on the website.

National Sexuality Resource Center

835 Market Street, Suite 517
San Francisco, CA 94103
Phone: 415-817-4512
E-mail: nsrinfo@sfsu.edu

Website: <http://nsrc.sfsu.edu/issues/sex-and-aging>

The National Sexuality Resource Center is committed to promoting healthy sexuality, dispelling common myths about sexuality, and encouraging sexual literacy. NSRC's website features a section which provides a plethora of information specifically related to sex and aging.

Our Bodies Ourselves

5 Upland Road #3
Cambridge, MA 02140
Phone: 617-245-0200
E-mail: office@bwhbc.org

Website: www.ourbodiesourselves.org

Our Bodies Ourselves (OBOS), also known as the Boston Women's Health Book Collective (BWHBC), is a nonprofit, public interest women's health education, advocacy, and consulting organization. Their mission is to "provide accessible, research-based information about women's health and sexuality."

Project Visibility

Boulder Aging Services Division
P.O. Box 471
Boulder, CO 80306
Phone: 303-441-3570
E-mail: bcaa@bouldercounty.org

Website: www.bouldercounty.org/help/adults/pages/projvis.aspx

Project Visibility is a training program developed in 2004 by Boulder County Aging Services, after the agency conducted extensive focus groups with area LGBT elders. The goal of Project Visibility is “to co-create an aging services community that is informed, sensitive to, and supportive of Lesbian, Gay, Bisexual, and Transgender elders.” The training is designed for administrators and staff of nursing homes, assisted living residences, home care agencies, and other senior service providers, as well as the friends and families of LGBT elders.

Senior Sex: Tips for Older Men

The Senior Sex webpage was developed by the Mayo Clinic to provide tips for maintaining a healthy and satisfying sex life as you get older.

Website: www.mayoclinic.com/health/senior-sex/MC00057

Services & Advocacy for GLBT Elders (SAGE)

305 Seventh Avenue, 15th Floor
New York, NY 1001
Phone: 212-741-2247
E-mail: info@sageusa.org

Website: www.sageusa.org

SAGE is best known as the country’s largest and oldest organization dedicated to improving the lives of lesbian, gay, bisexual, and transgender (LGBT) older adults. SAGE focuses its work on providing programs and services for the LGBT older adult, providing technical assistance and training as well as advocating for LGBT and aging issues nationally. In partnership with the Brookdale Center on Aging of Hunter College, SAGE offers “No Need to Fear, No Need to Hide,” a training program about inclusion and understanding of lesbian, gay, bisexual, and transgender elders for long-term care and assisted living facilities.

Sexuality and Aging Today Blog

Hyatt Hall, One University Place
Chester, PA 19013-5792
Phone: 610-388-5062
E-mail: SAConsortium@widener.edu

Website: www.sexualityandaging.com

This website is part of an educational outreach initiative of the Widener University Graduate Program in Human Sexuality. The mission of this initiative is to “enhance the sexual health, knowledge, and well-being of people in mid and later life by providing quality sexuality education to individuals, couples and to professionals who serve them.” The website features a compilation of resources for professionals and consumers alike with regards to the topic of sexuality and aging.

Training to Serve

2365 N. McKnight Road, Ste 3
St. Paul, MN 55109
Phone: 651-251-5774
E-mail: info@trainingtoserve.org

Website: www.trainingtoserve.org

Training to Serve (TTS) is a training curriculum that was developed by representatives from the Metropolitan Area Agency on Aging (MAAA), GLBT Generations, University of Minnesota, and MN Department of Human Services. Training to Serve is now recognized as an independent organization dedicated to providing training and education about the unique needs of LGBT older adults. Providers can request the TTS training curriculum through the contact information provided on the TTS website.

Aging Sexuality and Intimacy Tipsheet, University of Cincinnati Center for Aging with Dignity Aging

This consumer tipsheet developed by the University of Cincinnati Center for Aging with Dignity provides some basic information about aging and sexuality and some factors that may impact sexuality as one ages.

Website: http://nursing.uc.edu/centers/aging_with_dignity/exploring_aging/aging_education.html

Click on “Part 5 Sexuality & Intimacy”

Jennifer A. Crittenden is the Fiscal & Administrative Officer at the University of Maine Center on Aging. Nearly all research projects and grant-funded programs under her management entail the translation of academic research into professional and public education programs, events, and dissemination activities. Jennifer has developed educational workshops, trainings, conferences, and other activities for a wide range of audiences, including older adults, caregivers, healthcare professionals, social service professionals, and administrators. Jennifer currently develops online educational offerings for professionals and caregivers throughout the country via the Center’s cutting-edge research, evaluation, and training projects. Jennifer received her Bachelor’s degree in Psychology from the University of Maine and holds a Master’s degree in Social Work also from the University of Maine.

Lindsay Day holds a BSW from the University of Maine and is a Master in Social Work candidate at the University of Maine, working as an intern at the University of Maine Center on Aging. She is involved in a number of projects at the Center on Aging including a rural Maine older adult impaired driving project and coordination of the Seventh Annual Maine Geriatrics Colloquium. Lindsay is interested in issues impacting kinship caregivers as well as LGBT aging issues. She recently completed an independent research study that examined quality-of-life indicators and means for addressing quality-of-life issues for transgendered individuals. She is also affiliated with the Hartford Partnership Program for Aging Education at the University of Maine and is pursuing a certificate in Rural Gerontological Social Work.

Save the Dates

for these upcoming educational webinars

JUNE 19, 2012

How Caregivers
Deal with a “Jerry
Springer” Family

PRESENTED BY:
Harold Ivan Smith

OCTOBER 23, 2012

Parkinson’s Disease

PRESENTED BY:
Alida Griffith, MD

JANUARY, 2013

Soldiers’ Stories:
Caring for Veterans
at the End of Life

PRESENTED BY:
*Chelsea Funk, LICSW
and Jennifer Sax, BA*