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## Aging and Sexuality

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# Guest Editor's Note

By Holly Kiger, RN, MN



Sexuality and sensuality are an important part of the aging process. Most people want and need to be close to other people. We want to touch and be touched, both physically and emotionally. As we grow older, some of us become more attuned to our sensuality—our ability to be fully present in each moment and to notice the smells, textures, and sounds that enhance our lives. How sensual you are plays a key role in your overall ability to derive pleasure from life.

Unfortunately, positive images of aging sexuality are not commonly portrayed in our society today. Sexual activity in older adults is often either discussed with ridicule or humor or not discussed at all.

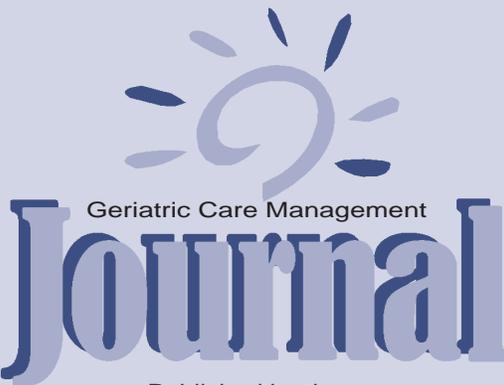
Being informed about the normal physiological changes of aging and the many options for supporting our sexuality is much easier than it was a generation ago. Much more information is available on the Internet, in books, and from the medical community. Also, more middle aged and older adults feel freer to discuss sexuality with their friends and learn from and support each other.

This edition of *Geriatric Care Management Journal* focuses on several aspects of aging and sexuality. Bonnie Genevay, a writer and a consultant in gerontology, speaks about some of the challenges of discussing sexuality during older adult groups. She writes about ageism and countertransference as common barriers to open discussions and encourages care managers to learn more about this sometimes-difficult topic as a part of their professional growth. Kimberly D. Acquaviva, PhD, MSW uses The Standards of Practice for Professional Geriatric Care Managers to guide us through the special needs of lesbian, gay, bisexual, and transgender (LGBT) older adults in our communities. She provides us with guidelines for increasing inclusiveness, ways to reach out to the

LGBT community, and suggests training for staff to be more sensitive to the needs of LGBT older adults. Lorraine Sterman, PhD reviews the inevitable changes and challenges in sexual function that occur with aging, including the factors that influence aging sexuality. She encourages care managers working with older adults to be mindful of the importance of sexuality to older individuals, keep an open and caring attitude themselves, and be able to normalize, counsel, or properly refer those persons who need special sexual counseling, information, or other assistance. Connie Goldman, an award-winning independent public radio producer, author, and public speaker uses personal stories to shine a light on

late-life romance and new relationships. She affirms that love, intimacy, sex, and meaningful relationships are not the exclusive domain of the young. Her stories break many of the stereotypes commonly held about aging love, and introduce us to older couples finding new and creative ways to live, love, and enjoy their older years.

Resources for learning more about aging and sexuality are provided throughout the Journal, starting here. An excellent resource on the subject can be found at [http://www.helpguide.org/elder/sexuality\\_aging.htm](http://www.helpguide.org/elder/sexuality_aging.htm).



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# A Perspective on Sexuality and Intimacy in Older Clients

*By Bonnie Genevay*

Four older people sat in a comfortable niche of their senior center group room, the sun streaming in the windows. They usually talked about how hard it was to compensate for their loss of eyesight, loss of spouses, and loss of mobility. But today one woman spoke of her fifty-second wedding anniversary and how hard it was for her to live without her husband. She cast her eyes at the floor as she expressed what she missed most: his helping her on with her coat and patting her shoulder, how she reached out in her sleep to touch his pillow only to wake up and realize he's gone, and—looking away from the group's eyes—how much she missed their lovemaking. The sole man in the Grief and Loss group shifted uncomfortably as the group discussion turned from loss to sexuality. He cleared his throat and said, "I thought this group was for talking about how to handle our losses—not about sex." There was an awkward silence until the geriatric care manager who was the leader of the group acknowledged how much the loss of a significant loved one needed to be grieved in order to achieve health in old age.

Even older peers sometimes have difficulty recognizing that intimacy and sexuality are necessary for most of us until the end of life. So it is understandable that geriatric care managers of all ages sometimes have difficulty realizing that older people need and want intimacy in their lives. With so many older adults suffering multiple chronic conditions and massive losses, it is sometimes easier for professional helpers to focus on relatively solvable problems and ignore the issues of sexuality and intimacy that are more difficult to deal with.

AGEISM. I believe the primary reason why care managers fail to

include intimacy in their assessment of mental, emotional, and physical health is that ageism is still prevalent in our culture. Some people still cannot imagine that old, wrinkled, and "ugly" bodies (defined by ageist standards) are eligible to give and receive intimacy. When beauty is identified as the anorexic and wrinkleless models prescribed by fashion moguls, it implies that older, "imperfect" beings are asexual and are not acceptable to receive and give affection and closeness. To be care managers of older people, we need to put on fresh glasses and see older clients as experienced reservoirs of wisdom in loving and sexual behavior and, when needed, assist them with grieving the loss of the loves of their lives.

Professionals, including geriatric care managers, sometimes do not receive adequate training, supervision, and support in how to work with and help older clients with intimacy problems: those who want sexual expression when their partners do not, older people who are obsessed with and frequently verbalize about sexuality, and people with dementia who expose themselves. Some care managers are uncomfortable and do not know what to do when older clients make passes at them. Not knowing how to help, some professional helpers ignore cries for help when older clients manifest intimate behaviors. Sometimes helpers reject these clients, rather than assessing the roots of the problem. The kinds of questions that arise in staff training I have done include:

- "Should an 80-year-old who has sexual delusions and talks constantly about them be medicated so he won't embarrass others?"

- "How can I help a family whose grandfather displays lewd pictures and doesn't seem to know it's not appropriate?"
- "What can I do to be of help to a stroke victim whose sexual behaviors toward his wife have changed from sensitive to uncaring and assaultive?"

## **Diverse Root Causes of Intimacy Issues.**

It is helpful to remember that some of these situations are not primarily sexual in nature and may indicate that the older person is undergoing mental and physical changes disguised in a sexual cloak. Even from the standpoint of sexual assessment many of these cases show the tip of the iceberg only, connecting more deeply to core and historic sexual identity, affection and touch deprivation, major life losses, the need for grief work, low self-esteem, and pain management.

Because the behavior is sexual it may intimidate the professional caregiver more than other care challenges. We sometimes jump too quickly to the question of what to do about the sexual behavior—usually hoping to eliminate it—because it makes us uncomfortable. A good question to ask ourselves is, "How can I understand this in the context of everything else that is going on with this older person?" For example, depression has been linked to sexual expression in terms of the older client's loss of self and search for identity in late life. Therefore it would be important to recognize that the sexual expression, no matter how misguided, may represent an affirmation of self in an attempt to deal with the depression.

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## **A Perspective on Sexuality and Intimacy in Older Clients**

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### **The Care Manager's Counter-Transference Issues.**

Care managers bring to each interaction their own personal values, family values, personal sexual experience (or lack of) and cultural biases about old age and sex. This interface between personal and professional thoughts, behaviors, and feelings in regard to human sexual expression may be either unconscious and conflictual or intentional and highly therapeutic for all concerned. The care manager who is able to put himself/herself in the older person's shoes and imagine the difficulties of his/her own old age without a partner, without sexual satisfaction, and without affection and touching, can be a strong advocate for the older client who needs to resolve, grieve over, or let go of longstanding sexual and intimacy issues. It is important for professionals and family caregivers alike to become aware of their own definitions of intimacy and sexuality in unique and broad ways appropriate to them as individuals. This will help them assist their older clients with defining intimacy and sexuality in relation to his/her own life history and experience. A good working definition of intimacy is the freedom to respond to and express human closeness needs, as long as the closeness is mutual and does not conflict with the rights of other persons.

Some expression of closeness is necessary as a mirror of identity. This is especially true as we age. Without response from a significant other, human beings often lose sight of who they are. When power, status, role, physical health and functioning, self-worth, and attractiveness (as our culture defines us) begin to fall away, it is critical to have an intimate other (adult child, spouse, partner, helping professional) remind us, "You are so kind; you are so loving; you are beautiful to me." This kind of human

response confirms that the core self still remains.

### **Summary.**

There are many options for expressing intimacy. Intimacy needs are lifelong and require a tapestry of significant relationships that confirm identity. Great courage is required to search out intimate relationships when we are old, and to repair old intimacies that have gone astray. The role of the geriatric care manager is critical: You may be one of the last important people in an older person's life and can play a key role in helping older clients in this very important area of their life.

The geriatric care manager wondered how he could be of help to a new member of the Grief and Loss group. He had inherited the group from another care manager and the participants often discussed loss of intimacy as a life loss that they needed to address. This new man to the group described himself as lonely and depressed since his wife had died a year ago. He said he couldn't reach out one more time—that he didn't have enough life energy to invest in a third intimate relationship. He felt that fleeting intercourse with one person and another was just a form of masturbation, of pretending to have a loved one while remaining lonely inside. One-night stands had lost their meaning. "I don't want a superficial relationship with another human being," he said, "I'd rather live alone, but the desire to have someone close is still there... being able to reach out and touch another human

being is still the most profound human experience!"

The group was not a "dating bureau for old singles," the care manager reflected, but he believed the combined wisdom of these older people who had accumulated so much life experience would be helpful to the new member.

So the group gathered, engaged in life review, and shared their thoughts, feelings, and insights. Each one gained new perspectives on their own losses and intimacy issues and the care manager was glad he did not have to play "the expert" in the discussion of such a complex and important life subject. He was learning a great deal about sexuality and intimacy from the population he worked with, and understood that the insights would be valuable to his caregiving for his own family—and for himself—as he aged. Gaining new perspectives on

sexuality and aging was a challenge, and an area of professional growth.

***Intimacy needs are lifelong and require a tapestry of significant relationships that confirm identity. Great courage is required to search out intimate relationships when we are old, and to repair old intimacies that have gone astray.***

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*Bonnie Genevay is a writer and a consultant in gerontology, primarily in mental health and aging, grief and loss, and sexuality and intimacy in late life.*

*This article is excerpted, in part, from "Intimacy as We Age," Generations, Summer, 1986 by Bonnie Genevay; "Sexuality and Older People," Generations, Summer, 1985 by Bonnie Genevay; and "It's Time We Sat Down and Talked About Sex—Again" by Bonnie Genevay, Generations, Fall, 1981.*

# Working with LGBT Clients: Strategies for Geriatric Care Managers

*By Kimberly D. Acquaviva, PhD, MSW*

## Serving Your Community

In your work as a geriatric care manager, have you provided care to someone who is lesbian, gay, bisexual, or transgender? If you haven't already, chances are good that at some point in your career, you will. Every geriatric care manager in the United States has lesbian, gay, bisexual, and transgender (LGBT) older persons living in their community. Whether you serve an urban, suburban, or rural community, you have the opportunity (and the obligation) to provide LGBT clients with the same high-quality services you provide all your clients.

Geriatric care managers in communities around the nation are being called upon to provide quality, compassionate care to LGBT persons. It is helpful to understand the ways in which the experiences of LGBT persons may differ from the experiences of other individuals so that the care management process can be facilitated in a manner that acknowledges and respects the lived experiences of the client. Standards 1–4 of The Standards of Practice for Professional Geriatric Care Managers provide an excellent framework for working with LGBT clients:

### Standard 1 Who is the Client?

“While the primary client usually is the older person whose care needs have instigated the referral to a professional geriatric care manager, all other affected by his/her care needs should be considered part of the ‘client system’ (NAPGCM, p. 3).”

For many LGBT clients and their families, the intake process may

present the first barrier to accessing geriatric care management services. A seemingly innocuous social history question—“Are you married, single, widowed, or divorced?”—may present a dilemma to the LGBT person regarding whether they should “come out” (disclose that they are LGBT) to the care manager. Fearing discrimination from healthcare providers, many LGBT individuals have become accustomed to hiding who they are (and who they love) from the professionals who provide their care. The intake process helps to set the tone for the relationship between the geriatric care manager and the LGBT person and their family. This process has the potential to either leave people feeling welcomed and comforted or alienated and disconnected. Imagine that you are Estelle, an 80-year-old woman with cancer who is currently looking for a geriatric care manager. Your partner of 50 years, Katherine, is the most important person in your life and you want to spend as much time as you can with her in the time you have left. The geriatric care manager comes to your house, introduces herself, sits down, and begins asking questions. The geriatric care manager is kind and compassionate and you and Katherine both like her instantly. When the geriatric care manager asks you, “are you married, single, widowed, or divorced,” you don't know what to say. Do you say “single” because you're not legally married even though you have been with Katherine for 50 years? Do you say “married” and simply hope that the geriatric care manager understands and doesn't ask you for the name of your husband?

This barrier is a relatively simple one to remove. Geriatric care managers can easily modify the “marital status” intake question to include “partnered” as one of the choices so that the question is more inclusive of individuals in same-gender relationships (as well as individuals in different-gender, unmarried relationships). Once a client shares that they are in a same-gender relationship, it is important to convey, through words as well as actions, that the relationship is valued and honored the same as the relationship of a married heterosexual couple. For Estelle, her family is Katherine and she deserves the same support that any other spouse would receive from the geriatric care manager. It is important for geriatric care managers to remember that there is no “typical” LGBT patient and family. Not all LGBT persons have a partner—some are single, some are widowed, and some are divorced or separated from a same-gender partner. LGBT persons may have been married to a person of the other gender, and in some cases, LGBT persons may still be married to a person of the other gender. Some LGBT patients have children—either through birth or adoption—and some LGBT patients have grandchildren. Some LGBT patients are extremely close to both their family of choice and their family of origin, while others may not have had contact with their family of origin since they left home (or were “kicked out”) as a teenager. Transgender patients may be male or female, may be gay, lesbian, bisexual, or heterosexual, and may not disclose their status as a transgender person during the geriatric care management

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intake process. When checking off the “gender” box on the intake form, don’t rely on a subjective visual assessment of the client to determine gender. One suggestion is to make it a habit to say to all clients, “I believe people have a right to define themselves, so I like to ask each of my new clients what gender pronoun they’d like me to use to refer to them. What pronoun would you like me to use with you?” As a geriatric care manager, you need to keep an open mind in assessing who the client is and identifying who is part of the client system.

### **Standard 2 Fostering Self-Determination**

“To the greatest extent possible, professional geriatric care managers should foster self-determination on the part of the older person, to enable the person to live in accordance with his or her personal values and goals (NAPGCM, p. 3).”

When working with LGBT clients (as with all clients), it is vital that geriatric care managers ascertain who has decision-making authority in the event that the patient is no longer able to communicate their needs and wishes. This process may be more challenging in a same-gender relationship where there is no automatic legal authority given to the partner, as happens with heterosexual married couples. If there is an advance directive or other legal document which states that the partner is the authorized decision maker, than that directive must be honored by the geriatric care manager. The situation becomes more complicated if there is no advance directive or if members of the family of origin (biological family – i.e. parents, siblings, adult children, etc.) contest the advance directive. This can cause extremely difficult and painful conflicts between members of the family of origin and family of choice, especially in the case of families who have been estranged from the client due to their unwillingness to accept the client

for whom they are but suddenly want to have decision-making rights when the patient is dying. Sadly, it is not uncommon for people to be denied access to the hospital room where their life partner lays dying because the family of origin bars them from visiting. It is extremely important that individuals in same-gender relationships are encouraged to complete advance directives and other legal and financial planning documents to ensure their wishes are honored and that the basic rights of the partner are not denied.

### **Standard 3 Right to Privacy**

“The professional geriatric care manager should respect the older person’s and, when applicable, the client system’s right to privacy by protecting all information that is given in confidence and all information of a confidential nature. It should be made clear to the older person and the client system, the limits of confidentiality as appropriate (NAPGCM, p. 4).”

LGBT clients may be wary of trusting a geriatric care manager because of past experiences they have had with health care professionals and others who have broken confidentiality and violated their right to privacy. These fears are not irrational ones – on the contrary, many LGBT individuals have lost their jobs, their families, their insurance, their housing, and their financial security as a direct result of such breaches of trust. When working with LGBT clients, be very clear with the client about what

information will and will not be kept confidential. If insurance payments are accepted for services, make sure to communicate to the client that, while verbal interactions are confidential, documentation may not necessarily be, since insurance companies have access to this information. Let clients know that if there is certain information they do not want recorded in their chart, they need to speak up about it. The geriatric care manager and the client can then work together to ensure that

documentation is accurate yet does not record unnecessary details that could be damaging to the client if the information were released. The obvious exception to this is when there is a good reason to believe a client is an imminent threat to themselves or others, or when there is an obligation under the laws of the State to report suspected instances of abuse or neglect.

Unless a client has signed an authorization to release information, do not share information about the client with members of the client’s family of

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origin, friends, neighbors, or anyone else. Unfortunately, individuals may try to obtain information about an LGBT client’s medical status, relationship status, and financial affairs, despite the fact that the LGBT client does not want this information shared with them. It is the role of the geriatric care manager to ensure that the client’s privacy is respected and protected. Therefore it is important to ask the client to identify the

individuals who are authorized to have access to the client's information.

### **Standard 4 Personal Integrity of the Older Person and Professional Geriatric Care Manager**

“The professional geriatric care manager should act in a manner that insures his/her own integrity as well as the integrity of the client system” (NAPGCM, p. 4).

Standard 4 is a bit more

complicated that the other standards in that its guidelines grant geriatric care managers permission to “refuse to accept a new case or continue in a case in which she/he is already involved if the professional geriatric care manager believes that remaining in the situation would require compromising his/her own values, beliefs, or standards (p. 5).” Personally and professionally, I find this wording concerning because it could easily be used as a justification for discrimination, and not just in regards to LGBT clients. If a geriatric care manager feels that working with

African-American clients would compromise their standards and thus refuses to work with any African-American clients, would that be acceptable practice under Standard 4, or would that be discrimination? What about if a geriatric care manager was a devout Christian and decided that working with Jewish clients compromised their beliefs? Can geriatric care managers decide not to work with LGBT clients because

of their own religious beliefs about homosexuality? What constitutes a “situation” that “require[s] compromising” one’s values, standards, or beliefs? I would argue that it is never acceptable for a geriatric care manager to refuse to accept a new client or continue working with an existing client based on the client’s race/ethnicity, religion, gender identity/gender expression, sexual orientation, socioeconomic status, housing status, employment

status, immigration status, or any other factor comprising an individual’s identity or history. When I teach nurses, doctors, and social workers, the message I give all of them is the same I give to geriatric care managers—you will have clients who believe different things than you do, look differently than you do, live different lives than you do, act differently than you do, and your role is not to judge them. Your role is to provide the best quality care and services to them, and if at any point you feel uncomfortable enough with

a particular “type” of client that you are contemplating terminating services with them, you need to do two things immediately – (1) talk to a supervisor about what you are thinking and feeling, and (2) talk to a social worker or counselor to help you work through whatever issues you have with that particular “type” of client. Professional geriatric care managers should be able to work with clients whose beliefs, values,

and standards differ from their own without worrying about their own values being compromised.

### **Strategies for Increasing Inclusiveness**

There are many simple things that can be done to increase inclusiveness in work as a geriatric care manager:

- Change intake forms to be inclusive of same-gender relationships or partnered status.
- Determine who has the legal authority to make decisions in the event that the client can no longer do so.
- Ask the client to define his/her family of choice and family of origin and encourage him/her to identify any potential conflicts of which the geriatric care manager should be aware.
- Encourage the client to complete advance care planning, legal (will), and financial paperwork.
- Recognize the potential psychosocial issues related to families of origin and families of choice.
- Consider any medical issues related to transgender clients (i.e female-to-male clients still need to be screened for breast cancer, male-to-female patients may still need to be screened for prostate cancer).

In working with LGBT individuals who have recently experienced the death of a partner:

- Support the partner, especially in the event that the death of his/her loved one isn’t acknowledged by the community as being a loss equal to the loss of a heterosexual spouse.
- Help the partner to express grief, especially if he/she is not “out” at work or in the community, as there may not be public acknowledgement of the loss.
- Advocate for the partner if his/her workplace does not have bereavement leave for unmarried partners.

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*I would argue that it is never acceptable for a geriatric care manager to refuse to accept a new client or continue working with an existing client based on the client’s race/ethnicity, religion, gender identity/gender expression, sexual orientation, socioeconomic status, housing status, employment status, immigration status, or any other factor comprising an individual’s identity or history.*

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In training your staff:

- Teach staff about the unique needs of LGBT people at the end of life.
- Allow staff the opportunity to express their misgivings or fears about caring for a LGBT person.
- Reinforce with staff that it is their job to respect each and every patient and family and provide the highest quality care possible, regardless of how they feel about the patient's sexual orientation or gender identity/expression.

## Reaching Out to Your Community

Many LGBT individuals die without ever engaging the services of a geriatric care manager because of the fear of being rejected or disrespected. Since geriatric care management includes the family as the unit of care, geriatric care management may be intimidating for a LGBT person. As with any community that is underserved, it is important that geriatric care managers take steps to communicate support for the LGBT community. Agencies can staff a booth at the annual gay pride festival or place an advertisement in the local gay newspaper. Support for the LGBT community can be demonstrated by providing partner healthcare benefits

and promoting a supportive work environment. Welcoming diversity begins with support for a diverse workforce. By caring for their own staff, geriatric care managers will communicate to the community that that they are a welcoming organization open to meeting the unique needs of the people you serve.

Everyone deserves high-quality geriatric care management, yet many LGBT persons don't receive it. You can open doors and build bridges to ensure that everyone in your community receives the care and services that meet their unique needs. If you do not provide geriatric care management services for LGBT individuals in your community, who will?

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- *Innovations in education and training for health professionals*
- *Hospice, palliative care, and end-of-life issues*
- *Program design, implementation and evaluation*

*Dr. Acquaviva conducts workshops and presentations on end-of-life issues nationally and serves on the editorial board of the Journal of Gay and Lesbian Social Services. She is Co-Chair of the American Society on Aging's Leadership Council for the Lesbian and Gay Aging Issues Network (LGAIN) and serves on the ASA-NCOA Program Planning Committee and ASA Membership Committee. Dr. Acquaviva holds a Ph.D. in Education from the University of Pennsylvania Graduate School of Education, an M.S.W. from the University of Pennsylvania School of Social Work, and a B.A. in Sociology from the University of Pennsylvania College of Arts and Sciences. Dr. Acquaviva can be contacted at hcskda@gwumc.edu.*

*This article was adapted from: Acquaviva, Kimberly D. "Serving lesbian, gay, bisexual and transgender persons: Comfort, care and compassion when they are needed most." INSIGHTS, The magazine of the National Hospice and Palliative Care Organization. 2004.*

## References

National Association of Professional Geriatric Care Managers. "Standards of Practice For Professional Geriatric Care Managers." Revised June 2003.

*Welcoming diversity begins with support for a diverse workforce. By caring for their own staff, geriatric care managers will communicate to the community that that they are a welcoming organization open to meeting the unique needs of the people you serve.*

# An Overview of Aging Sexuality: Changes and Remedies

By Lorraine Serman, PhD

## Abstract

*This article reviews the inevitable changes and challenges in sexual function that occur with aging. Factors that influence sexuality include one's general health status, psychological attitude, past sexual experiences, expectations, availability of a suitable partner, and sexual desire, all of which are influenced by the dominant cultural milieu. Care managers working with older adults must be mindful of the importance of sexuality to older individuals, keep an open and caring attitude themselves, and be able to normalize, counsel, or properly refer those persons who need special sexual counseling, information, or other assistance.*

•••

Sexuality, a normal, life-long function, is a reflection on how we feel physically, mentally and emotionally, and is related to our self-concept, our relationships, and our cultural milieu. Ask any older person how they really feel inside and most likely they will say, "I feel the same as I always did." Yet age brings changes in all areas of our life. Thus older adults are challenged with aligning their aging bodies with their inner concept of themselves as sexual beings. Because of the close and trusted relationships often formed between geriatric care managers and clients, sexual issues are likely to surface in one form or another. To add to the care manager's current knowledge base, this article provides some general background about sexuality and aging.

The changes in the current cohorts of elderly have given us reason to reevaluate our concepts

and beliefs about sex and sexual expression in older men and women. Sex has become a hot topic since the "baby boomers" have come of age. It demands that we reconsider our past concepts about sexuality. Additionally, the availability and advertising of medications such as sildenafil (Viagra) for erectile dysfunction have made sex more possible for some and has increased the public's awareness that older adults are vitally interested in sex. Some older adults are very candid and forthright in dealing with sexual issues, more so than repressed cohorts in the past. Thus we must be knowledgeable and well prepared to answer their questions and deal with the variety of problems they present to us. We must also be informed, open, and sensitive to our older client's problems, and ready to refer when our answers are not enough.

## General Caveats about Sex and Aging

- Sexuality is normal and natural for everyone and, as one ages, continued interest does not mean there is "something wrong."
- For most people the physical exertion associated with sex takes about the same amount of energy that it takes to walk up two flights of stairs, and should not be feared as harmful.
- Generally speaking, the hormonal decreases in women at menopause change the degree of desire for sex. This may interfere with a couple's experience, especially since men's desire seldom decreases as much as women's libido does during this period.

- As people age, their needs for physical contact and intimacy do not change, even if sex is less frequent. It is important to recognize needs for physical contact that may not be overtly sexual. The need for touch continues from birth to death.
- Desire continues, even if the "flesh is weak." In other words, thoughts and feelings about sex may continue even if one has lost their sexual performance ability or is disabled in some way.
- Sexuality takes many forms, and intercourse is not the only way to be sexual. In fact, it may not be possible for some couples, creating a challenge to be more creative in their intimate sexual contact.
- People in their 70s, 80s, and even beyond may find sex very satisfying, even if intercourse is not possible.
- Current medications are not a panacea for poor relationships or lack of intimate contact. In fact, since these medications are primarily used to treat erectile dysfunction, some women may feel more demand to be sexual for the sake of their male partner's ego when they may not really want to be!
- Sometimes it is important to discuss sexual function issues and other concerns with a qualified professional. This person may be a psychologist, physician, nurse, social worker, or other psychosocial provider.

## Age-Related Changes in Men and Women

Recent research suggests that a high proportion of men and women remain sexually active well into later life. This refutes the prevailing myth that aging and sexual dysfunction are always linked (Meston, 1997). Age-related physiological changes do not keep one from a meaningful sexual relationship or even mean that it is necessarily difficult, providing one has a willing partner and health issues do

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## **An Overview of Aging Sexuality: Changes and Remedies**

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not interfere. It is important for older men and women to find a balance of not falling into the psychological trap of expecting the worse, or the opposite of expecting their feelings and energy of youth to prevail.

Normal aging changes include factors that influence sexuality. This includes changes in physiology, sensory abilities, sleep, and cognition as well as changes associated with loss of a significant other, disabling illness, or other life changes. Even with these changes, there is a great deal of variability, and many elderly people maintain a high level of sexual functioning into advanced age (Carman, 1977). According to Wiley and Bortz (1996) over two-thirds of older people responding to a questionnaire stated that they had an active sexual partner, although 60 percent reported a decreased frequency of sexual activity in the past 10 years. Seventy-one percent of men and 52 percent of women reported a desire to increase the frequency of their sexual activity. Debunking the myths of aging and sex are continuing to offer couples of many persuasions (gay, straight, married or not) permission to act on feelings that past cohorts may not have considered healthy and "normal."

The normal physiological changes for women past menopause are now widely known, including the dramatic decrease in hormones (estrogen and progesterone and some androgens). These hormonal changes cause a decrease in vaginal lubrication, fewer orgasmic contractions, a rapid decrease in arousal after orgasm, sometimes painful intercourse, decreased body hair, and other psychological changes which, for some, decrease desire for sex. Normal changes in older men include a decrease in androgens, resulting in slower, less-full erections, a rapid loss of erection after orgasm, a longer refractory period (meaning more time before another erection is possible), and less volume of semen

and sperm. Other changes include a loss of the intense inevitability stage, or the immediate need to ejaculate with orgasm. For some men, semen "leaks" out rather than feeling a swift ejaculation. Additionally, there is a general loss of bodily strength and muscle mass.

Other factors that may influence our aging clients' sexuality include the use of alcohol or prescription drugs, lack of a willing or available partner, physical or psychological illnesses, obesity, surgeries, and other disabling conditions. Additionally, one's reactions to these factors, anxiety about one's aging body, pain or discomfort, fear of sexually transmitted diseases, performance anxiety, or past beliefs also play a part in how one approaches sexual behavior. Expectations of others including children's beliefs about "proper" sexuality of their aging parents can also have an impact.

With all of these challenges, it is a wonder that we are still interested and capable of sex at all as we age! However, it is important to remember that sex is not simply the sexual act or acts, but rather the feeling of closeness, intimacy, satisfaction, caring, and relief that can come from this special human contact.

### **Common Remedies for Common Aging Sexual Problems**

For aging men, the most common complaints are slowed arousal, less stamina, and difficulty obtaining and sustaining an erection. Another common problem for men is performance anxiety, often related to their past history of how they performed sexually in their younger years and fear that they are not "adequate" enough. This mostly has to do with a lack of self-acceptance and/or inadequate education about physiological changes of aging. Today new medications are on the market to assist men with maintenance of their erection. A recent study of satisfaction with the use of Viagra (sildenafil) stated that 85 percent to 90 percent of men in the study were satisfied with this drug but that their expectations

were often unrealistic (Steers, 1999). This reinforces the need for education and dealing with self-expectations that, of course, deeply affect one's sexual responses.

Penile implant surgery, external erectile devices, and injectable medication (injected into the penis) for erectile functioning are other options open to some men. These options were used more popularly in the past and offered men increased satisfaction with sex, along with decreased depression, sadness, anger, anxiety, frustration, and embarrassment (Tefille, et.al., 1998). However, it may be that the more medication therapy for erectile dysfunction is utilized, the less popular these more invasive methods will be. All men cannot take these medications though, and a careful workup, including cardiac status is necessary before assuming that medications are the ultimate solution for all erection difficulties.

It is important to remember that the single most important element in sexuality as people age is health status. Among the most common illnesses affecting sexual performance for men are cardiac disease, diabetes, and prostate problems (e.g., prostatic hypertrophy or prostate cancer). These all impact the vascular system and target the blood vessels supplying blood to the penis sometimes making both intercourse and masturbation difficult or even impossible. The loss of erectile ability or ejaculation pleasure is a blow to men both physically and psychologically. Older men are challenged to find other ways to connect with their partner and receive pleasure themselves, including focusing on emotional closeness and sensual touch, exploring new erogenous zones, and finding new ways to experience sensual and sexual satisfaction.

When working with older men and their families, it is important to give them permission to talk about their fears or limitations, and to refer them to professionals prepared to handle their particular problem. It can be very reassuring to normalize the types of difficulties many men have with sex as they age. Today more men

are open to speaking with health and mental health providers about their problems. In the medical community, erectile dysfunction is treated almost unilaterally as a “medical” problem.

This may not always be the best solution. Psychologists have advanced training in sexual dysfunctions and can determine whether the problem has a medical or a psychological basis. They usually work closely with physicians (e.g., urologists) who can treat the “medical” part of the problem, while behaviorally treating the psychological part of the problem through counseling and psychoeducation.

For women, the aging body presents different challenges.

The most common sexual difficulties for older women relate to the effects of estrogen depletion at menopause including vaginal dryness, breast tenderness, decreased sexual desire, and a change in feelings of orgasm. Dryness can be helped through the use of many types of water-based lubricants such as Astroglide, Replens, and K-Y Warming gel. Topically applied estrogen gel or estrogen vaginal suppositories also help make vaginal penetration more comfortable and keep the vagina moist. Taking a longer time with lovemaking can decrease anxiety and provide the increased contact, which many women find more satisfying. Touching, caressing, holding, hugging, and talking can do wonders for increasing desire and closeness. As men and women age, they know more about what they like and desire sexually and they know their own bodies. This knowledge, patience, and an open attitude can create a more fulfilling type of sex, with more mutuality,

*As men and women age, they know more about what they like and desire sexually and they know their own bodies. This knowledge, patience, and an open attitude can create a more fulfilling type of sex, with more mutuality, trust, and respect, all the necessary ingredients for an intimate and loving relationship.*

trust, and respect, all the necessary ingredients for an intimate and loving relationship.

Women may require more sensitivity about their bodies than they did when they were younger. Certain positions may be more uncomfortable and modifications may need to be made when challenging sexual behaviors are attempted. For example, arthritis, back pain, fragile bones, and bad knees can interfere with familiar sexual positions. Exploration of new ways of sexual contact can be fun, maybe even de-emphasizing the need for vaginal intercourse. Some older women may experience a loss of bladder

control, or urinate with orgasm. This may be embarrassing and inhibit activity. Some medications can help with this, as can regularly practiced exercises for the pelvic floor muscles known as Kegel exercises. Humor and flexibility help with these problems as well. Also, increased communication regarding what feels pleasant and what is uncomfortable helps both partners feel good about being sexual, even with limitations. Since sexuality is profoundly psychological and physical, continuing to feel good about one’s body assists in feeling good about sex. Diet, exercise, and other good health practices pay off in one’s sexual longevity, barring no major medical illness.

### **Physical Conditions Which Influence Sexuality**

The use of alcohol has both positive and negative effects on sexuality and sexual performance.

For most people, a small amount of alcohol helps to relax and remove inhibitions, making sexual contact more initially pleasant. However, the reverse is true in terms of male performance. So although alcohol may assist initially, it can interfere with erectile ability and sustainability, and thus, defeat the purpose. It is also important for older people who may have a decreased tolerance for alcohol to be aware of their own particular response to this intoxicant.

Illnesses such as cancer, diabetes, obesity, hypertension, coronary artery disease, chronic obstructive pulmonary disease, or other major medical illnesses take their toll on sexuality, regardless of age. It is very difficult to feel sexual when coping with illness, or feeling that one’s body is out of control. Additionally, anxiety, depression or other mental illness may create problems in self-concept and body image, and can affect sexuality with or without any concomitant medical illness. In an aging population, it is not uncommon to have a combination of physical and emotional difficulties. Treatment for the medical or mental illness must take precedence over treating responses to these illnesses. Then, with professional help, the older individual may be able to confront their response to the medical problem, seek treatment for the mental illness, and focus on a healthier life, which hopefully, would include continued sexual functioning and satisfaction.

Hypertension is a common aging problem, and is usually controlled with medication. Unfortunately, anti-hypertension medication, which decreases blood pressure, has an effect on erectile capacity, and often interferes with a man’s ability to get and maintain an erection. Most, but not all, antidepressants also affect libido and arousal as well as erectile and orgasmic functions in both men and women. Diabetes affects circulation and can have unwanted sexual side effects. Obesity can cause one to feel less desirable, less

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sexual, embarrassed, or ashamed of one's body, as well as make sexual expression more difficult. Consultation with professionals is essential to regaining and maintaining health and sexual health if any of these conditions are present.

Mental illness can have a major impact on how one feels sexually. Mental illnesses may cause isolation, embarrassment, lack of caring, anger, frustration, lack of libido, or hyper sexuality. A knowledgeable, caring, empathetic mental health professional can assist in the recovery from or management of mental illness. Sexuality is one of many different factors that would be discussed in proper psychotherapy and treatment of a wide variety of mental disorders.

Social factors affecting sexuality include the normal stressors of life: old and new relationships, divorces, social isolation, death, children, grandchildren, moving from familiar living quarters, financial and job worries. These seem to be multiplied for some older people. The key is to settle the current difficulties, seeking professional help if necessary, in order to control the outside influences which might affect the emotional impact on sexuality. Young people are not the only ones to feel job and family stressors that impact their sex lives.

### **Conclusions and Summary**

In conclusion, sexual expression is important at any age. Even if one is less active sexually, some sex is generally better than none. It is important to "use it or lose it," as

they say, since sexual health has a great deal to do with both physical health and mental health. Touch and caressing continues to be vital to well being at all ages. Most older adults desire and/or long for a comfortable compatible sex partner. Recent cohorts are living longer, healthier lives and expect to look forward to rewarding sexual experiences into late life. Sex role stereotyping is undergoing dramatic change and what is considered acceptable is changing accordingly. For example, until recently, most women "of a certain age" considered relationships with younger men relatively taboo. But new models of female sexuality in aging have given permission for older women to partner with younger men, and thus compete with the traditional "older man, younger woman" stereotype. Older couples are dating, marrying, feeling more "sexy" and less self-conscious than our grandparents or parents did at their same ages. In addition, access to the

***Mental illness can have a major impact on how one feels sexually. Mental illnesses may cause isolation, embarrassment, lack of caring, anger, frustration, lack of libido, or hyper sexuality. A knowledgeable, caring, empathetic mental health professional can assist in the recovery from or management of mental illness.***

Internet and other recently developed forms of communication open new doors for sex education. As the "baby-boomers" age, we should expect more changes in sex role stereotyping, and look forward to models of healthy sexuality, sometimes called Sexual Literacy, into old age. As professionals caring for older people, our own concepts, attitudes and beliefs will help make this so.

### **References**

1. Carman, M.B., *Psychiatric Clinics of North America*. March 1997. (20): pp. 15–24.
2. Duffy, M., *Handbook of Counseling and Psychotherapy with Older Adults*, John Wiley, Inc. New York, N.Y., 1999.
3. Meston, C.M., *Aging and Sexuality*, *Western Journal of Medicine*. Oct. 1997, 164(4), pp. 285–290.
4. Nordhus, Inger H., Gary R. VandenBos, Stig Berg, and Pia Fromholt, *Clinical Geropsychology* APA Publication, Washington D.C. 1998.
5. National Institute on Aging Information Centers: Internet address: [www.nia.nih.gov](http://www.nia.nih.gov)
6. Steers, W.D., *Viagra After One Year*, *Urology*, 1999, 54(1), pp12–17.
7. Wiley, D., and Bortz, W.M. II, *Sexuality and Aging—Usual and Successful*, *Journals of Gerontology: Series A: Biological and Medical Sciences*, May, 1996. 51 (A), pp. M142–M146.

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# Stories of Late-Life Love

## The world isn't made of atoms; it's made of stories.

*By Connie Goldman*

These words from the poet Muriel Rukeyser have been a powerful influence on my work and my life. They have strongly influenced the shape of my career as a public radio producer, writer, and speaker. Like Rukeyser and others, I believe that we learn about ourselves from hearing and reading the stories of others. We gain insights and wisdom from people we don't personally know and may never meet. A story can touch the heart, bring a smile, or cause a tear. It can get a person to think, reflect, compare, or face a challenge or crisis in a different way. A story can inspire resolve, support a courageous stand, open the mind and the heart to a new experience, and ultimately change lives. Facts validate, but stories illuminate. This is why I've chosen to use personal stories to shine a light on late-life romance and new relationships.

Maybe you'd like to learn about the possibility of a new love relationship for an older adult you know—a friend whose husband recently left her or a relative whose wife has passed away. Perhaps you wonder whether older adults really can and do experience deep love and active sex with a new partner. Or maybe you are entering your later years and are feeling the need and desire to have a new love in your life.

Whatever the reason, I can affirm that love, intimacy, sex, and meaningful relationships are not the exclusive domain of the young. (How sad that in our youth-oriented culture things so obvious need continually to be affirmed.) For a long time I've talked with my aging contemporaries about their love relationships. In recent years these conversations have included many in new relationships. I've searched but haven't found any studies or statistics on the number of

older people taking on a new partner in their later years. Yet recently I've been encountering such couples everywhere. In fact, my partner and I are one of those couples.

For over twenty-five years, my work has involved collecting and telling the stories of people in their seventies, eighties, and nineties. My efforts have been aimed at embracing the fullness of life in the later years, discovering who you are now that you're not who you were, experiencing the joys and responsibilities of grandparenting, exploring spiritual growth and aging, and dealing with attitudes of ageism in our society. Now my mission is to share the experiences of older persons who tell of their need for love, companionship, sharing of daily life, intimacy, touching, and sexual pleasure.

Late-life love comes with leftovers from other lives—adult children, grandchildren, health concerns, previous living situations, sexual expectations, financial discrepancies, divorce, caregiving experiences, grief and loss. Some couples have adult children who don't approve of their new relationship and refuse to acknowledge it. Others have joyfully integrated their two families. Despite the fact the baby boomers are now entering their sixties, our society continues to perpetuate negative attitudes about older people. These stereotypes color our ideas about the abilities and desires of older people. I clearly remember a conversation that I had over sixty years ago with two other thirteen-year-old girls. We were at a slumber party, determined to stay up until dawn. As girls of that age often do, our conversations drifted onto the subject of sex. One of my

friends said emphatically, "I don't like to think of my mom and dad in bed with each other and—ish—touching each other!" I reassured her: "Oh, I'm sure they're too old to have sex." Now I'm in my mid-seventies, many years older and considerably wiser. Yet I know that these generalizations persist, despite the lived experiences represented by many people I have interviewed.

### Real Life Stories

Sol, eighty-one, who has been married to his wife, seventy-four, for seven years, shared with me his thoughts about the importance of physical intimacy in the later years: "Sexuality is a part of mature life. Some young people fear it ends at age thirty-five. They're wrong. Every aspect of intimacy is important—handholding and cuddling, as well as actual sex. It's an important dimension of life, and we joyfully partake in it." Bob, seventy-nine, and his partner, Meryl, who is seventy-eight, seconded Sol's comments: "People our age certainly have sexual relations in spite of the myth that old people don't do that anymore." Sharon, seventy-two, and Alex, seventy-nine, live in separate homes, but they share a good deal of time together. Alex told me, "We often spend nights at each other's homes. We have visitor's rights and visitor's privileges." Sharon added, "As younger people we each believed in waiting until marriage for sex. We were both faithful to our partners, and we believed that was right. We now believe that the commitment we have to this relationship, without marriage, allows for sexual intimacy."

There are many ways to "do it," according to Louise, seventy-five, and James, seventy-two, who, like many

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of the couples I interviewed, spoke with surprising frankness about their sexual lives. “About fifteen or twenty years ago,” James told me, “I became impotent. I told Louise about my situation, and she said, ‘Hey, that’s no problem,’ and we proceeded to have wonderful sex. For me it was oral. For her it was manipulation. Sometimes it was oral sex for both of us.” These stories prove again and again that no matter how wrinkled, stooped, or aged a body may be, inside everyone is an ageless spirit—a desire to be physically touched and to touch another, to have some form of intimate relations, and to love and be loved.

In addition to sexuality, many of the older couples I interviewed are sharing their lives in ways that are less traditional than we might expect. For example, while some choose to marry, others choose to form less traditional partnerships. They may live together with no plans to marry. Or they may maintain a committed relationship while living in separate dwellings, cities, or even countries. What the neighbors might think of these relationships doesn’t seem to bother these folks much. This may seem odd for a generation that grew up during a time when you didn’t talk about sex, you didn’t have sex before you were married, and you didn’t live together unless you were married. Apparently, aging has loosened some of the social constraints these couples felt when they were younger.

Max, eighty, and Sadie, sixty-eight, told me that they loved each other and shared a deep commitment even though they were not married and didn’t even intend to move in together. Speaking directly to Max, Sadie said, “I love you, and you love me, but we each have our own place, our own independent activities, and our own kids to spend time with. We live ten minutes apart. And if I need you, you’re here. If you need me, I’m there. Why live together? This arrangement really works for us. We’ve had a relationship for six years now, and this is perfect. Many

of my friends have found a partner and have set up a similar living arrangement. We can be with each other whenever we want, we have our own independence, and we both know we have somebody to rely on and be with who really cares.”

An article in the New York Times recently observed, “Two decades after Woody Allen and Mia Farrow defied convention by living apart even after starting a family, researchers are seeing a surge in long-term, two-home relationships.” The piece focused on couples of baby-boomer age, but the interviews I’ve collected of older couples reflect a similar trend.

Laura, seventy-five, has been with Robert, seventy-eight, for five years. “My dilemma was where to settle if I moved,” said Laura. “There wasn’t any space in Robert’s house for my antique furniture or empty closets for my clothes. Our compromise was interesting. I bought a small condominium a five-minute drive from Robert’s place, and we worked out a way to live together in two houses. Every week we choose what days and nights we’ll pack up the milk, the bread, and the dog, and move temporarily into the other house for a few days. At other times, if one of us feels the need for alone time, we have a quiet retreat available at the other place.”

I admit to being surprised by how liberal, open, and individualized these older couples were in their attitudes and lifestyles. A sense of freedom, justly earned, to make their own choices was evident in each conversation. Although not every couple stated it as bluntly, their actions

reinforced the attitude expressed by one woman: “Why would I, in my seventies, give a hoot about what people think?” Implicit in such a statement is the awareness that, although death may not be imminent, time is much more limited for these couples than it is for younger people entering new relationships. “Aging is really about the bitter and the better,” one couple told me. Another expressed appreciation for simple things with the words, “Each new day is a blessing at our age.” Whether married or not, the traditional marriage vow, “in sickness and in health, till death do us part,” has a particular poignancy and urgency for these couples.

It’s hard to know if the viewpoints expressed during my interviews reflect natural processes of aging, an increasing awareness of mortality, changing social conditions, or simple financial practicality. No doubt, all these factors play a

role, though they work themselves out in unique and special ways in each relationship. And we can say with certainty that as the population continues to age, late-life relationships will continue to become more common.

Older couples confirm the reality that, as a seventy-seven-year-old friend said to me the other day, “In the winter of our lives we can still find summer.”

*Adapted from the introduction in Late-Life Love: Romance and New Relationships in Later Years by Connie Goldman. Copyright © 2006 Connie Goldman. Reprinted with permission of Fairview Press.*

*A sense of freedom, justly earned, to make their own choices was evident in each conversation. Although not every couple stated it as bluntly, their actions reinforced the attitude expressed by one woman: “Why would I, in my seventies, give a hoot about what people think?”*

## LGBT Aging: Resources for Care Managers *By Gerard Koskovich*

A range of resources are available for care managers and other professionals who wish to provide culturally competent services to lesbian, gay, bisexual, and transgender (LGBT) older adults. Following is a sampling of organizations, Web sites, books, and fact sheets recommended by members and staff of the Lesbian and Gay Aging Issues Network (LGAIN) of the American Society on Aging.

**Gay and Lesbian Aging: Research and Future Directions, edited by Gilbert Herdt and Brian de Vries (New York City: Springer Publishing, 2004); hardback, 294 pages; \$45.95.**

An anthology of social sciences research papers on lesbian and gay aging, this book offers a number of articles that will prove enlightening and thought provoking for professionals who work with LGBT older adults and their informal caregivers. Among the issues addressed: depression, measures of psychosocial well-being, social and cultural aspects of HIV/AIDS, and the importance of friendship networks in the lives of single lesbian and gay elders.

### **HRC FamilyNet**

[www.hrc.org/familynet](http://www.hrc.org/familynet)

Sponsored by the Human Rights Campaign, a leading national LGBT advocacy organization, this portal site focuses on resources for LGBT families. The "Aging" section provides a good overview of caregiving, housing and policy issues for LGBT elders, with useful links to a variety of related resources and reports. Click on "Aging" in the navigation bar.

### **Lesbian and Gay Aging Issues Network**

[www.asaging.org/lgain](http://www.asaging.org/lgain)

A constituent group of the American Society on Aging, LGAIN works to raise awareness about the concerns of LGBT people ages 50-plus. The group organizes programming at ASA's annual conference, publishes a quarterly newsletter and a monthly e-mail update, and supports networking among professionals in aging nationwide. In addition, LGAIN maintains a resource-rich home page featuring a directory of Web sites dealing with LGBT aging that includes more than 500 annotated links organized into categories such as "Caregiving," "Health," and "Mental Health."

**Lesbian, Gay, Bisexual and Transgender Aging: Research and Clinical Perspectives, edited by Douglas Kimmel, Tara Rose, and Steven David (New York City: Columbia University Press, 2006); hardback, 303 pages; \$45.00.**

Addressed to mental health and social services practitioners, this superb anthology offers both theoretical and practical

perspectives on psychosocial issues for LGBT people in midlife and old age. A particular strength is the inclusion of overview essays on bisexual and transgender aging. Contributors also address vital topics such as physical and mental health, sexuality and intimacy, elder abuse, alcohol and drug issues, and end-of-life concerns. A 19-page bibliography offers directions for further reading.

### **LGBT Caregiving: Frequently Asked Questions**

[www.caregiver.org/caregiver/jsp/content\\_node.jsp?nodeid=409](http://www.caregiver.org/caregiver/jsp/content_node.jsp?nodeid=409)

Developed by the Family Caregiver Alliance (FCA), a national advocacy and support association, this fact sheet provides a succinct overview of issues faced by LGBT caregivers, including those caring for elders. The page offers a list of resources, as well as links to an FCA fact sheet on legal issues for LGBT caregivers and to FCA's online support group for LGBT caregivers.

**The Many Faces of Aging: Lesbian, Gay, Bisexual, and Transgender Older Persons (Washington, D.C.: Administration on Aging, 2001); 2 pages; free.**

This fact sheet provides a succinct overview of key concerns for LGBT elders regarding family and social support, health, housing, social stigma, and income. It also notes that in many ways, LGBT people age much the same as do their heterosexual counterparts. No longer posted on the AOA website, the fact sheet is available as a PDF in the "Recommended Resources" section of the LGAIN home page at [www.asaging.org/lgain](http://www.asaging.org/lgain).

### **Transgender Aging Network**

[www.forge-forward.org/tan/index.php](http://www.forge-forward.org/tan/index.php)

A national organization that brings together researchers, service providers, educators, advocates, elders, and others interested in the concerns of transgender older adults. The TAN website offers a number of free reports and fact sheets to help professionals who work with older adults. In addition, the organization provides fee-based training and consultation for agencies wishing to develop culturally competent services for transgender older adults.

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## Sexuality and Aging Resources for Care Managers *By Dwight Ross*

### **“Freedom of Sexual Expression: Dementia and Resident Rights in Long-Term Care Facilities”**

[www.terrainova.org/Title.aspx?ProductCode=FOSVHS](http://www.terrainova.org/Title.aspx?ProductCode=FOSVHS)

*Narrated by Anne Meara, this 5-minute video preview looks at sexuality and intimacy as basic human rights that should not be denied simply because the person has a level of decreased cognizance and lives in a nursing home.*

### **Sexuality Assessment for Older Adults (PDF)**

[www.hartfordign.org/publications/trythis/issue10.pdf](http://www.hartfordign.org/publications/trythis/issue10.pdf)

*The PLISSIT (Permission, Limited Information, Specific Suggestions, Intensive Therapy) model has been used to assess and manage the sexuality of adults (Annon, 1976). The model includes several suggestions for initiating and maintaining the discussion of sexuality with older adults. Suggested questions to guide the discussion of sexuality are also provided.*

### **Aging and Human Sexuality Resource Guide**

[www.apa.org/pi/aging/sexuality.html](http://www.apa.org/pi/aging/sexuality.html)

*Great list of books, articles, organizations etc with links to other websites from the American Psychological Association.*

### **Geriatric Nursing Resources for Care of Older Adults - GeronurseOnline.org**

[http://www.geronurseonline.org/index.cfm?section\\_id=44&geriatric\\_topic\\_id=24%E2%8A%82\\_section\\_id=195&page\\_id=387&tab=2](http://www.geronurseonline.org/index.cfm?section_id=44&geriatric_topic_id=24%E2%8A%82_section_id=195&page_id=387&tab=2)

*Excellent overview including definitions, background, assessment tools, nursing care strategies, outcomes, and references.*

### **The Other, Older Face of AIDS**

[healthlink.mcw.edu/article/1031002371.html](http://healthlink.mcw.edu/article/1031002371.html)

*This website gives an excellent overview of AIDS in older adults, including ways to include problem solving and skill building into your work with “adult learners”.*

### **Sexuality and Alzheimer's Disease**

[www.webmd.com/content/Article/41/1738\\_51757.htm](http://www.webmd.com/content/Article/41/1738_51757.htm)

*WebMD answers a question about how to keep sexuality alive when a partner has Alzheimer's Disease.*

### **Aging: Older Women Talk about Sex**

[www.selfhelpmagazine.com/articles/aging/eldersex.html](http://www.selfhelpmagazine.com/articles/aging/eldersex.html)

*Preliminary report of AARP study.*

### **AARP/ Modern Maturity Sexuality Study (PDF)**

[www.hawaii.edu/hivandaids/ModernMaturitySexualityStudy.pdf](http://www.hawaii.edu/hivandaids/ModernMaturitySexualityStudy.pdf)

*77 page research report from AARP Modern Maturity Sexuality Survey, a mail survey of 1,384 adults aged 45+*

### **Sex Therapy for Middle Age and Older Adults | APA Videos**

[www.apa.org/videos/4310615.html](http://www.apa.org/videos/4310615.html)

*Sex Therapy for Middle Age and Older Adults, with Barry W. McCarthy, PhD.*

### **Body Image and Identity | Sexuality in Older Women and Their Partners | Health Professionals | sexualityandu.ca**

[www.sexualityandu.ca/professionals/older-women-2.aspx](http://www.sexualityandu.ca/professionals/older-women-2.aspx)

### **SeniorSex.org | External Aging & Sexuality Links**

[instruct1.cit.cornell.edu/courses/psych431/student2000/dp51/external\\_links.html](http://instruct1.cit.cornell.edu/courses/psych431/student2000/dp51/external_links.html)

*Information for seniors about how to have a better sex life, overcoming harmful attitudes about older adults' sexuality, deal with menopausal issues, etc.*

### **ASA | LEARN—The Older LEARNer**

[www.asaging.org/networks/learn/ol-104.cfm](http://www.asaging.org/networks/learn/ol-104.cfm)

*Survey about perspectives on sexuality, intimacy, and elders*

### **Sexuality in Later Life**

[niapublications.org/agepages/PDFs/Sexuality\\_in\\_Later\\_Life.pdf](http://niapublications.org/agepages/PDFs/Sexuality_in_Later_Life.pdf)

*Six page Age Page from National Institute on Aging. Good information plus resource list.*

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