It's time to end the taboo of sex and intimacy in care homes

April 27 2017, by Paul Simpson

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Imagine living in an aged care home. Now imagine your needs for touch and intimacy being overlooked. More than 500,000 individuals aged 65+ (double the population of Cardiff) live in care homes in Britain. Many

could be missing out on needs and rights concerning intimacy and sexual activity because they appear to be "designed out" of policy and practice. The situation can be doubly complicated for lesbian, gay, bisexual or trans individuals who can feel obliged to go "back into the closet" and hide their identity when they enter care.

Little is known about intimacy and sexuality in this sub-sector of care. Residents are often assumed to be prudish and "past it". Yet neglecting such needs can affect self-esteem and mental health.

A study by a research team for Older People's Understandings of Sexuality (OPUS), based in Northwest England, involved residents, non-resident female spouses of residents with a dementia and 16 care staff. The study found individuals' accounts more diverse and complicated than stereotypes of older people as asexual. Some study participants denied their sexuality. Others expressed nostalgia for something they considered as belonging in the past. Yet others still expressed an openness to sex and intimacy given the right conditions.

Insights

The most common story among study participants reflected the idea that older residents have moved past a life that features or is deserving of sex and intimacy. One male resident, aged 79, declared: "Nobody talks about it". However, an 80-year-old female resident considered that some women residents might wish to continue sexual activity with the right person.

For spouses, cuddling and affection figured as basic human needs and could eclipse needs for sex. One spouse spoke about the importance of touch and holding hands to remind her partner that he was still loved and valued. Such gestures were vital in sustaining a relationship with a partner who had changed because of a dementia.

Care staff underlined the need for training to help them to assist residents meet their sexual and intimacy needs. Staff highlighted grey areas of consent within long-term relationships where one or both partners showed declining capacity. They also spoke about how expressions of sexuality posed ethical and legal dilemmas. For example, individuals affected by a dementia can project feelings towards another or receive such attention inappropriately. The challenge was to balance safeguarding welfare with individual needs and desires.

Some problems were literally built into care home environments and delivery of care. Most care homes consist of single rooms and provide few opportunities for people to sit together. A "no locked door" policy in one home caused one spouse to describe the situation as, "like living in a goldfish bowl".

But not all accounts were problematic. Care staff wished to support the expression of sex, sexuality and intimacy needs but felt constrained by the need to safeguard. One manager described how their home managed this issue by placing curtains behind the frosted glass window in one room. This enabled a couple to enjoy each other's company with privacy. Such simple changes suggest a more measured approach to safeguarding (not driven by anxiety over residents' sexuality), which could ensure the privacy needed for intimacy.

Conclusions

Our study revealed a lack of awareness by staff of the need to meet sexuality and intimacy needs. Service providers need guidance on such needs and should provide it to staff. The information is out there and they can get the advice they need from the Care Quality Commission, Independent Longevity Centre, Local Government Association and the Royal College of Nursing.

Policies and practices should recognise resident diversity and avoid treating everyone the same. This approach risks reinforcing inequality and doesn't meet the range of needs of very different residents. The views of black, working-class and LGBT individuals are commonly absent from research on ageing sexuality and service provision. One care worker spoke of how her home's sexuality policy (a rare occurrence anyway) was effectively a "heterosexuality policy". It may be harder for an older, working-class, black, female or trans-identified individual to express their sexuality needs compared to an older white, middle-class, heterosexual male.

Care homes need to provide awareness-raising events for staff and service users on this topic. These events should address stereotyping and ways of achieving a balance between enabling choices, desires, rights and safeguarding. There is also a need for nationally recognised training resources on these issues.

Older people should not be denied basic human rights. This policy vacuum could be so easily addressed over time and with appropriate training. What we need now is a bigger conversation about sex and intimacy in later life and what we can do to help bring about some simple changes in the care home system.

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