Promoting Sexual Health and Wellbeing among Elderly Nursing Home Residents

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Abstract:

The purpose of this study is to provide research based information on the elderly and sexuality as it relates to the concept of impact on the elderly and competence in handling such cases in nursing care during aged-care period especially.

The aim of this study was to investigate the impact of aging on the sexual life of the elderly, their sexual needs, and how those concerns are handled by healthcare professionals.

The method used is literature review. The search engines include; Cinahl, Elsevier Science Direct, Ebsco Academic and PubMed. The researcher adopted inclusion and exclusion criteria in the article selection for this literature review. The selected articles were based on their relationship with elderly and sexuality.

The results were discussed in the categories of the questions under the headings impact, concerns and handling. The impact of aging on sexuality were discussed under biological, psychological, social context, myths about sexuality, male sexual dysfunction, female sexual dysfunction, practical, and delays in seeking help. The concerns include difficulty to consult on sexual problem and results of handling sexual issues among the elderly include inadequate attention, inadequate knowledge and medical Intervention.

The research revealed that the impact of aging on sexuality of the elderly exist, but there are underlying factors that lead to decline in sexual activity among the elderly, where those factors do not exist, the elderly enjoy their sexual life as their younger adults do.

Keywords:	Elderly, seniors, aged, sex, sexuality, nursing home, institutionalized care, concerns, needs, handling.
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FOREWORD

Ebenezer, “Thus far the Lord has helped us” (I samuel 7: 12). I thank God, because I could not have had strength with all the turbulence of combining motherhood, school work and writing this thesis without the hand of Him.

My sincerest gratitude goes to my supervisor, Pamela Gray, for counselling, encouragement, reviews and understanding my situation as a mother of 2 kids and a student. Thanking for entertaining my baby boy during the few times I had to meet you briefly with him. Similarly, I wish to thank my reviewer Satu Vahderpää for her time and extensive review of this thesis. A big thank you to members of the Arcada family and all friends, who contributed one way or the other to the completion of this thesis.

My husband, Ebenezer Owusu-Afriyie, your moral support during this journey was crucial; much love. And to my mother, Beatrice Adjei Kusi, who travelled from Ghana to help care for my kids, so that I could finish my thesis, I say, God bless you. My kids, Connie Miles Owusu-Afriyie and Freeman Johnson Owusu-Afriyie, thank you for the sacrifices you made for me, so that I could work on my thesis. God richly bless you.

1 INTRODUCTION

Sexuality and sexual activity is part of normal life and sexual desire spans from the sexual active ages into the advanced ages. The common knowledge that age is a deterrent to a happy and healthy sex life is unproven. What is proven is that although there is a decrease in sexual activity with age, particularly in women, sexual activity persists well into the senior years. People over 76 were having sexual relations more than twice per month, and sexual interaction does not necessarily mean sexual intercourse (Marsiglio et al,2000). Walan and Nielsen (1990), revealed that the elderly people over 60 still have sexual desires by referencing to an earlier study conducted in Finland by Kivelä, Pahkala and Honkakoski (1986). Walan and Nielsen (1990) also revealed in their study conducted in Stockholm that elderly people 60-80 still have sexual intercourse, but with a decreased frequency as compared to the younger adults.

To further educate the health care professionals on this subject, it would be prudent to do a literature review of the earlier researches combined and/or do a further research on the subject. An in-depth understanding of the subject as demonstrated by evidence-based studies would help healthcare professionals consider the seniors' sexuality in care delivery. Nurses would consider in their care plans how their care delivery methods affect their elderly patients or residents' sexual lives, because, many elderly retain an interest in their sexual lives. Geriatric doctors could check the impact of their mental health treatment for their older adults' patients, for example, the SSRIs (Selective Serotonin Re-Uptake Inhibitors) on their sexual lives. The literature review would therefore, centers on sexual experiences of the elderly, who are residents in institutionalized units such as nursing homes (Wood et al, 2012).

The purpose or aim of this literature review would be to gain insight into the aging sexual experience and concerns of older adults aged 60 years and above, whom are receiving institutionalized care. Specifically, this research would review various literature to ascertain whether older adults' sexual needs and relationships change as they age. Whether

older adults have concerns or questions about fulfilling their continuing sexual needs. Whether older adults' sexual needs and concerns are handled satisfactorily. For the purposes of adequate nursing education and health care delivery, a lot more could be done to upgrade nurses' knowledge on human sexuality, and on the extension, the elderly and sexuality for geriatric nursing. It would be prudent if much attention is given into geriatric nursing education as it is in the case of pediatric education as aging population is growing rapidly. This area has not received much attention of researchers even in the era of aging population. According to Bouman, Archelus and Benhow (2007), staff in the nursing homes or long-term healthcare facilities have shown that they have limited knowledge in sexuality issues and negative attitudes towards the elderly expressing their sexuality in their geriatric care to the elderly. This is more revealing in the staff fresh from school up to 5 years' experience. Influenced by cultural and social background mostly, aged-care staff usually get confused, embarrassed, helpless and sometimes irritated whenever they experience the sight of residents expressing their sexuality through kissing, masturbating, sexual intercourse and so on.

It is therefore, practically important to do academic work such as this literature review of the topic; elderly and sexuality regarding residents in the nursing homes. This review would consider earlier works that focused more on biological or medical perspective on human sexuality, which explains that sexual desire and behavior is reduced by physical changes, hormonal changes, or chronic illnesses as people become older (Tiefer,2004) and similar works that factored psychological and social influences into the picture (John, 2005).

2 BACKGROUND

2.1 Sex and Sexuality

Sexuality has been defined in multiple of ways over the course of history and no one definition could explain it adequately. The common factor in the varied conceptions is sexuality being the most central aspect of each human being and considerably determined by physical and psychological being of each person (Kontula, 2002). According to Kontula (2002), WHO has adopted four of the definitions that touches on the different angles of the subject. Summarizing all the four different levels therefore, sexuality occupies the center of being human and it goes beyond sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction, which is experienced and expressed consciously and unconsciously in thoughts, fantasies, desires, beliefs, attitudes, values, behaviors, practices, human affection, touch and intimacy, roles and relationships. The interaction of biological, psychological, social, economic, political, cultural, ethical, legal, historical and religious and spiritual are the factors that influence the sexuality of each person. Sexuality may be the cause of happiness and satisfaction, whilst sexual dysfunction is the opposite. It is therefore the cornerstone of couple formation. Types of sexuality include straight, lesbian, gay, bisexual, transgender and asexual (Kontula, 2002).

The following are relevant definitions by the WHO as is in their report of a technical consultation in 2002 held in Geneva and published in 2006, which helps in the discussion of subject "sex and sexuality.

"Sex refers to the biological characteristics that define humans as female or male. While these sets of biological characteristics are not mutually exclusive, as there are individuals who possess both, they tend to differentiate humans as males and females. In general use in many languages, the term sex is often used to mean "sexual activity", but for technical purposes in the context of sexuality and sexual health discussions, the above definition is preferred" (WHO, 2006).

"Sexuality is a central aspect of being human throughout life and encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction. Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviors, practices, roles and relationships. While sexuality can include these dimensions, not all of them are always experienced or expressed. Sexuality is influenced by the interaction of biological, psychological, social, economic, political, cultural, ethical, legal, historical, religious and spiritual factors" (WHO, 2006).

"Sexual health is a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled" (WHO, 2006).

"Sexual rights embrace human rights that are already recognized in national laws, international human rights documents and other consensus statements. They include the right of all persons, free of coercion, discrimination and violence, to: seek, receive and impart information related to sexuality; sexuality education; choose their partner; decide to be sexually active or not; consensual sexual relations; • consensual marriage; pursue a satisfying, safe and pleasurable sexual life" (WHO 2006).

The above definitions enrich the sex and sexuality discussion by way of advancing the understanding of the subject in the field of sexual health and quality of sexual life. The central theme of the definitions is how physical, mental, social dimensions of sexuality, and, the notion of sexual well-being is inter-related. In one's sexual expression including the older adults, the picture is supposed to be that of pleasurable and sexual experiences, but sometimes, it is just the opposite. The related factors are may include one or more of the following; sex, marital status, class and socioeconomic status, place of residence, age,

ethnicity, sexual orientation, level and manner of sexual experience (voluntary or involuntary), motivations for sexual activity (affection, status, and needs) and health status. Human beings' sexual orientation is conditioned right from infancy into healthy sexual development and maturity in latter sexual life, and this involve touch, attachment and bonding, early life love and caring with good guidance, natural sexual curiosity, and adolescence experimentation. The journey to sexual maturity or full sexual life allows for natural development of intimate bonds and learning to enjoy the pleasure of sexual activity in preparedness for adult sexual relationships. The sexual life is not without health problems, which comes in the form of sexual dysfunction, gender identity disorders and a variety of other concerns and anxieties. Some of the sexual dysfunction that receive less attention or rarely diagnosed and treated include low sexual desire, erectile dysfunction, inability to achieve orgasm, premature ejaculation, pain during sexual activity (dyspareunia) and vaginismus might later become severe sexual health problem at an older age, which are usually compounded with other chronic diseases (WHO, 2006).

2.2 The Impact of Aging on Sexuality

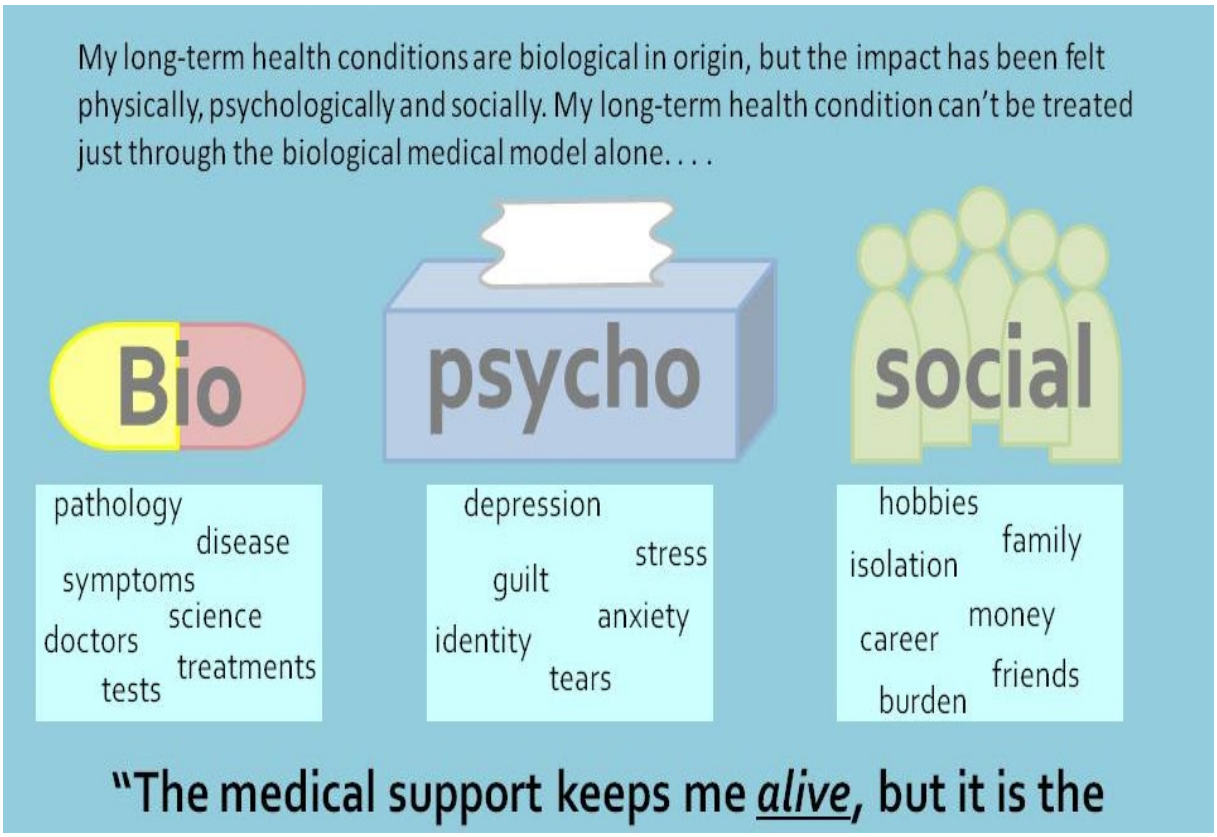

Figure 1Biopsychosocial model

Aging brings some effects in human anatomy and physiology that consequently affects the sexuality in the older adults. An example is women over 50 years of age experiencing post-menopause affects their sexual life, whilst their younger colleagues blame vaginal dryness for their inadequate sexual arousal. The sexual changes in elderly women's sexual functioning used as an example above, cannot be singularly directly attributed to menopause, because there are more factors contributing sexual dysfunction in older women and men, and the graphical complex biopsychosocial model in figure 1 above explains that. (DeLameter 2012; Howard et al, 2006).

Health problems that commonly affect the older adults such as urinary incontinence, pelvic organ prolapse and malignant prostate cancer in older adults may have a considerable impact on their ability to engage in sexual activity. Although most of the older adults with

these health problems are found to be as sexually active as their healthy counterparts, they may harbor the feeling of guilt and disgust towards sexual intercourse as there could be urine leakage during intercourse. This may lead to an outright avoidance of sexual contact (Melin et al, 2008; Tannebaum, 2006). The improvement in healthcare delivery has resulted in longevity of life, that is a positive development, but the elderly who has chronic diseases must live the rest of their lives the related discomfort, such as sexual dysfunction. The healthier elderly function better and have a more sexual satisfaction than those suffering from multiples of chronic diseases, because good health allows good quality frequent sex (Howard et al, 2006; Lindau et al, 2010).

2.3 Medications and Sexuality in Older Persons

Almost all nursing home residents have some form of chronic disease(s) and they take medications for that daily coupled with periodic ones. The nursing homes work in conjunction with pharmacies, doctors and nursing staff to provide and administer the right drugs to the right residents at the right time for the right purpose per the legal arrangement in their jurisdiction. In fulfilling their part of the interdisciplinary teamwork, the pharmacies review each resident's medications monthly or as required by the rules of engagement and agree on mechanism with the nursing home to reduce drug administration errors. Residents have the right to choose their own pharmacy provided the pharmacy is willing to enter agreement with the nursing home's policies. All residents are put under doctor's care in a nursing home per the arrangement available. Residents also have the right to have their private doctors, but in that case, the doctor must agree to comply with the policies and procedures in the nursing home. The nursing home and the doctor, nurse practitioner or physician assistant agree on schedule for regular visits to evaluate residents' condition and review their medications (Brian, 2012).

Normally, the stakeholders handling the medications of nursing home residents fail to consider that sexuality remains an integral aspect of quality of life. As most elderly experience physical and functional limitations, there is the need for assessment to analyze the need to incorporate more intimacy and wider sexual repertoire to include erotic literature,

sexual lubricants, and self-stimulation into their sexual activities. Doctors and nurses may initiate discussions on the issue with the elderly residents for two reasons; the elderly will most likely not initiate the conversation and aiming to achieve comfort level of the resident in a bid to promoting their quality of life (Brian, 2012).

2.4 Nurses Understanding of Elderly and Sexuality

The elderly institutional care is formally an aspect of long-term services. Generally, the long-term care includes personal care, supportive care for frail elderly and the elderly who face limitation in self-care, because of chronic illness such as physical, cognitive, or mental disability. In the nursing homes, where the long-term care services are delivered mostly to the elderly in need, two forms of services are delivered, namely, assistance with activities of daily living (ADLs) and/or instrumental activities of daily living [(IADLs), and health maintenance tasks. Dressing, bathing, toileting, housework and medication management are some of the routine activities in the nursing homes through manual and mechanical means to improve residents' level of functioning and their quality of life on a whole. Holistic nursing is the goal in the nursing care delivery (HHS, 2013).

The primary service in the nursing homes world over is nursing care. Nurses with varied levels of education make up the staff and together with aides, external healthcare professionals and institutions keep residents clean and comfortable, monitor their medical condition, administer medications and look after their daily needs to make sure that the residents have quality of life till death. In a 24-hour shift, there must always be a registered nurse(RN) on duty at least 7 hours on all the seven days in a week. Licensed practical nurses(LPNs) and generic nursing assistants (GNAs) work with the RNs to deliver professional nursing services to the clients under the supervision of RNs. Whilst the RNs and LPNs monitor residents' medical condition and administer medications mainly, the GNAs concentrates on assisting or helping residents bathe, get dressed, eat and move about (Brian, 2012).

The elderly in the nursing home or long term care facilities, especially those with dementia sometimes exhibit sexual behavior that could be very confronting to the staff delivering care to them. How to react to those confrontations could be challenging since the subject has received low priority as far as education is concerned. Nursing training institutions and the aged-care organizations have not tailored programs to give enough training on the subject to nurses. However, promising actions have been taken recently to address nurses' unpreparedness in this area. For example, eLearning education interventions have had great impact the knowledge of the geriatric nursing staff and nursing students' relating to the elderly and sexuality. The increasing knowledge is having a great impact on nurses' attitudes and permissiveness towards late life sexuality and the expression of sexuality by the elderly with dementia (Cindy & Wendy, 2016).

The expression of sexuality by residents in nursing home has characteristically remained unchanged and would remain as such, but structures including staff response could be further pursued as an aspect of holistic care. The result would be improved quality of life, promotion of health and wellbeing of especially the demented residents in nursing home, and reduction of potential tension between staff-resident-family in the event of inappropriate sexual expressions. Some of the structures and measures that could be put in place include workplace policy on the expression of sexuality, intervention of symptoms of wellbeing and ill-being shown by the elderly residents, especially the demented, and the need for guided discussions with family members (Cindy & Wendy, 2016). Nurses are trained to practice holistic nursing and they perceive their clients including the elderly as whole human being with different departments. Perceptively, a nurse sees the care delivered to client as biopsychosocial and spiritual care, which sexuality is an integral part. However, factors that affect patients' sexuality is understudied, and sometimes giving room for the individual nurses to employ their own opinions in clinical judgements, without critically examining factors that could affect the client's sexuality. The following are some of factors that can affect sexuality alongside aging: adaptations in physiology, hormonal levels, sensory capacities that reduce, cardiovascular disease, hypertension, diabetes, arthritis, psychological impacts of illness, surgical intervention and prostate cancer. It is evidently clear that aging is a factor in sexual activity, therefore this literature view

would consider it how directly or indirectly it is a factor (Kontula and Elina, 2009; DeLameter and Plante, 2015).

Aging population is becoming a common phenomenon and many countries are restructuring their socio-economic development to embrace it. More nursing homes, hospice care and many other facilities are being set up to cater for the seniors. A very positive development. What seems to be lacking or inadequate is the training of healthcare professionals to handle that adequately. If there were a thematic area that should be given prominence in educating aged-care nurses, it is the elderly and sexuality. Courses and short programs would improve their knowledge and equip them adequately to the elderly patients' and residents' sexuality. It is worth noting that nurses with enormous knowledge in elderly and sexuality have refined attitudes and beliefs towards residents' expression of sexuality in long-term health facilities such as nursing homes, including gays, homosexuals, lesbians and demented residents. Staff handling of the elderly expressing their sexuality have been very encouraging, when much education has gone into the subject and consequently dispelling misconception about the elderly and sexuality. In most long-term care facilities, the staff in insufficiently prepared to help the residents express their sexuality and meet their intimacy needs. This research work would therefore, review earlier work that has been done to evaluate to train staff to improve their knowledge and their attitudes towards the elderly (Bauer, McAuliffe, Nay & Chenco, 2012).

As gerontology and geriatric nursing boom, the question of how aging impacts on sexual life of the elderly could not wait for more answers or at least, more light thrown on available literature in a way of review. There are more than a school of thought on the question. One of the vital characteristics of human beings from birth till death is sexuality and the desire for intimacy. This school of thought suggests that sexual activity spans throughout human life, and on average, gerontologists and medical experts believe that continued sexual interest and activity can help the elderly in their therapeutic journey of reception of care and achieving quality of life (Willert & Semans, 2000). Expression of love and caring is featured in every human activity, and this characteristic is still alive in the el-

derly. This is further explained that older women, who have intimate partners have a better mental health than their counterparts who lacks this sexual activity (Baumle, 2013). On the other hand, Araujo, Mohr & Mckinlay (2004), Christine, Amber , Ben (2016), have revealed through studies that sexual interest and activity decreases with aging, and there are biological, psychological, ill-health, metal conditions, boredom with the relationship, and widowhood reasons for that (DeLamater, Plante, 2015). It is also argued that though aging has considerable impact on sexuality directly or indirectly, the extent of impact depends on membership in a specific generation. Generations that came after the sexual revolution in the 1960s and 1970s have shifted considerably from dynamics of sexual activities in the past. Age cannot therefore, stand alone in determining effects on sexual activity, interest and satisfaction, generational difference is also a factor. This is one of the reasons why a literature review is more crucial than ever to make literature more relevant in current gerontology and geriatric nursing (Carpenter, Nathanson, and Kim, 2007).

3 THEORETICAL FRAMEWORK

Guidance and counselling is a tested tool employed by healthcare professionals including nurses in several interventions including sexual guidance to discuss sexual health problems with the goal of finding lasting solution. In the situation of sexual guidance, the client is engaged in dialog with the nurse providing information, and welcoming and accepting the client's position. Unlike, counselling, guidance is not centered on process, but the two are used interchangeably in some situations due to the closeness of both concepts. Since the nurse offers sexual guidance as part of his or her professional work, he or she must be guided by the patient's rights and the professional nursing ethics and principles such as physical, social and psychological integrity, safety, continuation of the care, individuality, family centeredness, holistic care and autonomy, respect, dignity and so on. The nurse must show maximum respect and dignity in handling the client's body, provide enough privacy, show much respect to client's family and sexual orientation. Respect, building of trust and professionalism would ensure the client's safety, whilst proper documentation ensure continuity. In order, not to document too much details beyond what the client would allow, nurses should always discuss it with the client or the significant other, where necessary, before the final documentation. For privacy, a third person must not be invited into the meetings without the client's consent, unless the patient has limited or no autonomy. The client enjoys his or her full autonomy, where applicable and has the right to decide whether he wants to discuss anything involving his or her sexuality. He or she has the right to information, an evidence-based one. It is a client-centered approach, but the nurse must also consider his or her sexual feelings to deliver adequate sexual guidance. That is not to say that, the nurse should allow her personal sex orientation to influence the sexual guidance. The nurse's personal introspection may include his or her own sexuality, values, norms and beliefs about sexuality, effect of the guidance on his or her feelings (Ryttyläinen et al, 2010; Ryttyläinen & Virolainen 2009).

Plissit-model was originally produced by Jack Annon (1976) and reproduced by Davis and Taylor (2006) as Extended Plissit (Ex-Plissit). The Ex-Plissit is used for addressing sexuality and sexual healthcare needs and is a proposed tool in sexual guidance in primary healthcare setting. In other words, the nurse employs Ex-Plissit model to identify and

meet patient's sexual health needs by using its step-by-step guidelines to engage the patient in discussion of this sensitive subject. The acronym P-LI-SS-IT stands for the four levels of interventions namely Permission, Limited Information, Specific Suggestions, and Intensive Therapy. The higher the level of intervention the more expertise, greater knowledge, training and skills are needed. The Ex-PLISSIT is an improved version of the linear PLISSIT, where healthcare professionals only progress from a level to the next. On the other hand, the permission-giving becomes the central feature of all other stages as shown in the figure 2 below. This indicates that all the stages of the intervention must start with permission giving, before the nurse proceed what is required at the stage. Additional features of the Ex-PLISSIT are the review and reflection, where review means review all interactions and reflection means increasing awareness by challenging awareness (Davis and Taylor 2006).

The figure 2 below vividly illustrates levels of the Ex-PLISSIT model and it is explained in detail as follows;

Permission-giving stage (P): This is the very first step of the intervention in finding solution to the patient's sexual health needs. The nurse identifies the patient's needs, introduce the topic and give the patient opportunity (explicit permission) to speak out freely of their concerns. No ambiguity, straight to the point, so that the patient will know exactly what the subject is. Displaying posters, distributing leaflets, creating awareness in the waiting room is an opportunity for permission-giving even before any interaction between healthcare personnel and the client. However, creating the awareness alone is not enough for permission-giving.

Limited Information Stage (LI): The nurse serves as a source of information to the patient at this stage of PLISSIT and Ex-PLISSIT. The precise evidence-based information on the impact of patient's health problem on sexuality and effects of treatments on sexual function must be given to the patient to address his or her concerns raised at the permission-giving stage. Topical issue to clarify and dispel include misinformation, misconceptions, myths through discussion, providing leaflets and recommending websites to the patient.

Specific Suggestions Stage (SS): The specific intervention needed for a specific problem is undertaken at this stage.

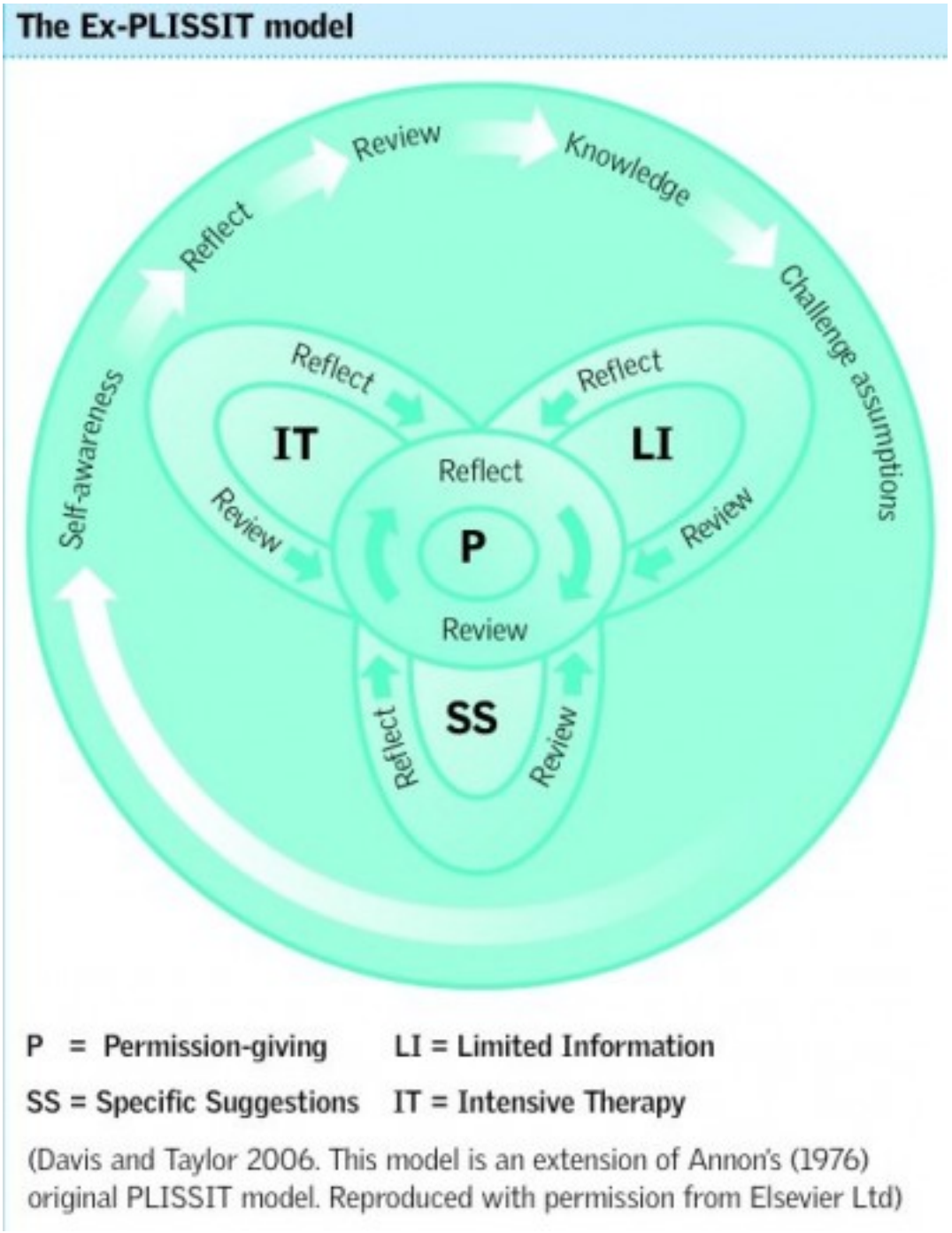

Figure 2. The Ex-PLISSIT model.

Intensive Therapy (IT): The most advanced stage, where more expertise, greater knowledge, training and skills are needed. The patient may be referred to a specialist or specialized unit for further treatment (Davis and Taylor, 2006).

Table. The PLISSIT Model for Identifying Causes of Sexual Dysfunction

Stage	Description	Dialogue Example
Permission	Ask patients for *permission* to engage in discussion regarding their sexual feelings and relationships, enabling patients to feel comfortable discussing such sensitive matters.	"You noted that you are experiencing vaginal dryness and hot flashes. Do you want to discuss how this is affecting your sex life?"
Limited Information	Provide patients with the *limited information* needed to function sexually or on the effect their condition has on their sexuality, dispelling any myths.	"It is normal for sexual activity to continue among people in their 60s and 70s, but it is also OK if you no longer have an interest in engaging in sexual activity."
Specific Suggestions	Offer *specific suggestions* to enable patients to engage in sexual activity at their desired level.	"Uterine prolapse can be uncomfortable and lead to pain during intercourse. There are several treatment strategies that we can explore, including a ring that can be placed to support your uterus. You'll need to remove the ring every week to clean it, but it does not need to be removed for intercourse."
Intensive Therapy	Provide *intensive therapy* if it is required to address patients' sexual concerns, referring them to other heathcare professionals if necessary.	"The conservative approach we've used to manage your vaginismus has not been sufficient, so as the next step, I'd like to refer you to a sex therapist, who will be able to offer you additional treatment options."

Abbreviation: PLISSIT, permission, limited information, specific suggestions, and intensive therapy.

Figure 3. The PLISSIT Model for identifying causes

The figure 3 above is a clear example demonstrating how the PLISSIT sexual counseling model functions in the case of sexual dysfunction. Care providers are given descriptive guidelines on how to counsel their clients at each stage. Additionally, dialog example has also been stated to guide the all health care providers. Figure 3 is a sample of how the PLISSIT sexual-counselling model functions (Sung, Jeng & Lin, 2011).

The Ex-PLISSIT or the PLISSIT model is not the only framework through which health care providers may offer support and effective strategies to conduct sexual intervention in clinical practice, but it is recommended by Sung, Jeng and Lin (2011). They believe the PLISSIT model have been used extensively in clinical practice and it can be conveniently and easily employed by health care providers into already laid down structures to offer sexual intervention more effectively and efficiently. The EX-PLISSIT also has a feature for reviewing all interactions and reflecting on them by increasing and challenging awareness. This can easily be incorporated into the evaluation aspect of care plans (Davis and Taylor 2006; Sung, Jeng & Lin, 2011).

4 AIM AND RESEARCH QUESTIONS

The purpose or aim of this literature review would be to gain insight into the sexual experience and concerns of older adults aged 60 years and above, who are receiving institutionalized care. Specifically, this research would review various literature to ascertain; Whether older adults' sexual needs and relationships change as they age, whether older adults have concerns or questions about fulfilling their continuing sexual needs, and whether older adults' sexual needs and concerns are handled satisfactorily by the healthcare professionals.

This literature review is to discuss and review literature that answers the following questions;

1. Does aging have an impact on the sexual life of the elderly?
2. What are the sexual needs and concerns of residents in nursing homes.
3. How do nurses handle sexual needs and concerns of clients?

5 METHODOLOGY

The research type, research questions and the aims of the researcher play a crucial role in choosing the method of the research. What should not be among the factors for choosing a research method is the personality, skills or the thoughts and perceptions of the researchers to get unbiased answers to the research questions. The literature review as a method is therefore chosen to research into questions about sexuality and elderly receiving institutional care in nursing homes (Gorard & Taylor 2004).

Literature review is characterized by a thorough examination, all-inclusive study, a detailed analysis of the literary works that are significant research topic and or research questions, identifying issues and research through research answers, the discovery and validation of new ideas and systematic approach of considering elements of ideas as a fraction of any additional work. This study was conducted by reviewing existing literature, and by explaining the logical combination around a specific field of study (Salkind, 2010; Aveyard, 2010).

Literature review employment in the social and health care field is so vital that it opens the doorways into works that have already been completed on a certain subject. The review also analyzes and reassess the materials and information available within the framework of the literature review. Consequently, a meticulous step should be employed in gathering and reviewing of information and materials in the research work on the subject in question. Again, the methodology used should also clearly spell out the evidence of existence of earlier materials or literature on the subject, make room for expertise application and evaluate the research conclusions (Aveyard, 2010).

5.1 Data collection

5.1.1 Literature Search

The researcher started literature search in the spring, 2017, and the search engines includes the following databases; Cinahl, Elsevier Science Direct, Ebsco Academic and PubMed. The key search words for collection of data on the various search engines or the databases, included the following; elderly, seniors, aged, sex, sexuality, nursing, nursing home, institutional care. The literature search yielded multiple outcomes, the desired results were used and unsatisfactory results were modified by using the words "and / or" in continuing the search in different databases. Through this method, enough relevant information was collected.

5.1.2 Article selection

The researcher adopted inclusion and exclusion criteria in the article selection for this literature review. Selection of articles was meticulously done through analyzing each article based on the research topic and, aims and research questions. The selected articles were based on their relationship with the impact of aging on sexuality and sex life of older people and how their sexual needs are met by health care professionals such as nurses.

Inclusion Criteria

- Relevant publications on the research topic
- Literature available in English language
- Publications from year 2006 upwards
- Full text online publications
- Relevant literature work relevant on sexuality and elderly
- Publications with abstracts relevant to the research topic

Exclusion criteria

- Publications on opinions
- Literature published before 2006
- Irrelevant literature works to the research topic
- Non-English Language publications

5.1.3 Result of search

After thorough reading through the publications, the researcher chose 11 out of them. The selected publications and/or literature had contents that were relevant to the research topic, and provided answers to the question of research. The publication years were mainly between 2006 and 2016, and the topics they discussed included sex, sexuality, elderly, aged, nursing home, aged-care nursing. All the chosen publications and literature were from the field of nursing or health and written by distinguished writers in the field from around the world with majority coming from the western world. The table below is the presentation the articles reviewed following the various search engines.

Table 1. Presentation of Articles

No.	Title	Author(s)	Journal and year of publication
1	Sexuality in Older Age: Essential Considerations for Healthcare Professionals.	Abi Taylor And Margot A. Gosney	Age Ageing.2011
2	Nottingham Study of Sexuality and Ageing (NOSSA II) Attitude of care staff regarding sexuality and residents: A study in residential and nursing homes	Bouman,W.P. Arcelus, J. and Benbow, S.M.	Sexual and Relationship Therapy.2007.
3	Sexuality & dementia: An eLearning resource to improve knowledge and attitudes of aged-care staff.	Cindy Jones & Wendy Moyle. 2016.	Educational Gerontology. 2016.
4	Persistent sexual side effects after SSRI discontinuation.	Csoka AB, Shipko S.	Psychother Psychosom. 2006.
5	The qualitative content analysis process.	Elo, S. & Kyngäs, H.	Journal of Advanced nursing. 2008.
6	Using the Extended PLISSIT model to address sexual healthcare needs.	Taylor B, Davis S	Nursing Standard. 2006.
7	Sexual function in the geriatric patient.	Wise TN, Crone C.	Clin. Geriatrics. 2006.
8	The Relationship Between Sexual Activity and Urinary Incontinence in Older Women.	Tannenbaum C, Corcos J, Assalian.	Journal of the American Geriatric Society. 2006.
9	Between Sexual Desire and Reality.	Osmo Kontula and Elina Haavio-Mannila.	*The Journal of Sex Research*. 2009
10	Sexual function in obese women: impact of lower urinary tract dysfunction.	Melin I, Falconer C, Rossner S, Altman D.	International Journal of Obesity. 2008
11	Sex, health, and years of sexually active life gained due to good health: evidence from two US population based cross sectional surveys of ageing.	Lindau ST, Gavrilova N.	British Medical Journal. 2010.

5.2 Data analysis

Inductive content analysis was the method employed in the data analyses. Content analysis could be explained as the process of analyzing written, verbal or visual communication messages. This method could be dated back to the ages of hymns, periodical publications analyses. The same method had been used to analyze speeches for political gains. In the work of nursing literature analysis, content analysis has been chiefly used in public health studies, psychiatry and in gerontology. Whether there is adequate fore knowledge about a subject or not, inductive content analysis is a method that can be employed in all situations and, when the information is available in fractions. A preparatory phase, the holding phase and the reporting phase are the three-main classification of inductive content analysis process (Elo and Kyngäs, 2007; August & Kyngäs, 2007).

The researcher read through all publications severally and made sure that abstracts that are relevant to the studies were selected for the review. Then the researcher took steps to go into the thrust of the publications, articles, journals or literature to study and analyze it for information that answers the research questions. In the process of studying and analyzing the information, the researcher had a step-by-step process to gather the needed information. The information or studies that answered the research questions were coded by highlighting similar information with the same color or differentiated themes with different color markings. The researcher then formed a cluster of similar ideas with the same color coding to form various themes or sub-categories. The sub-categories were further studied, analyzed and re-grouped into main categories and finally used the results to answer the research questions as shown in graphical presentation, see figure 4, of the analytical process of the data below (Burns & Grove 2005).

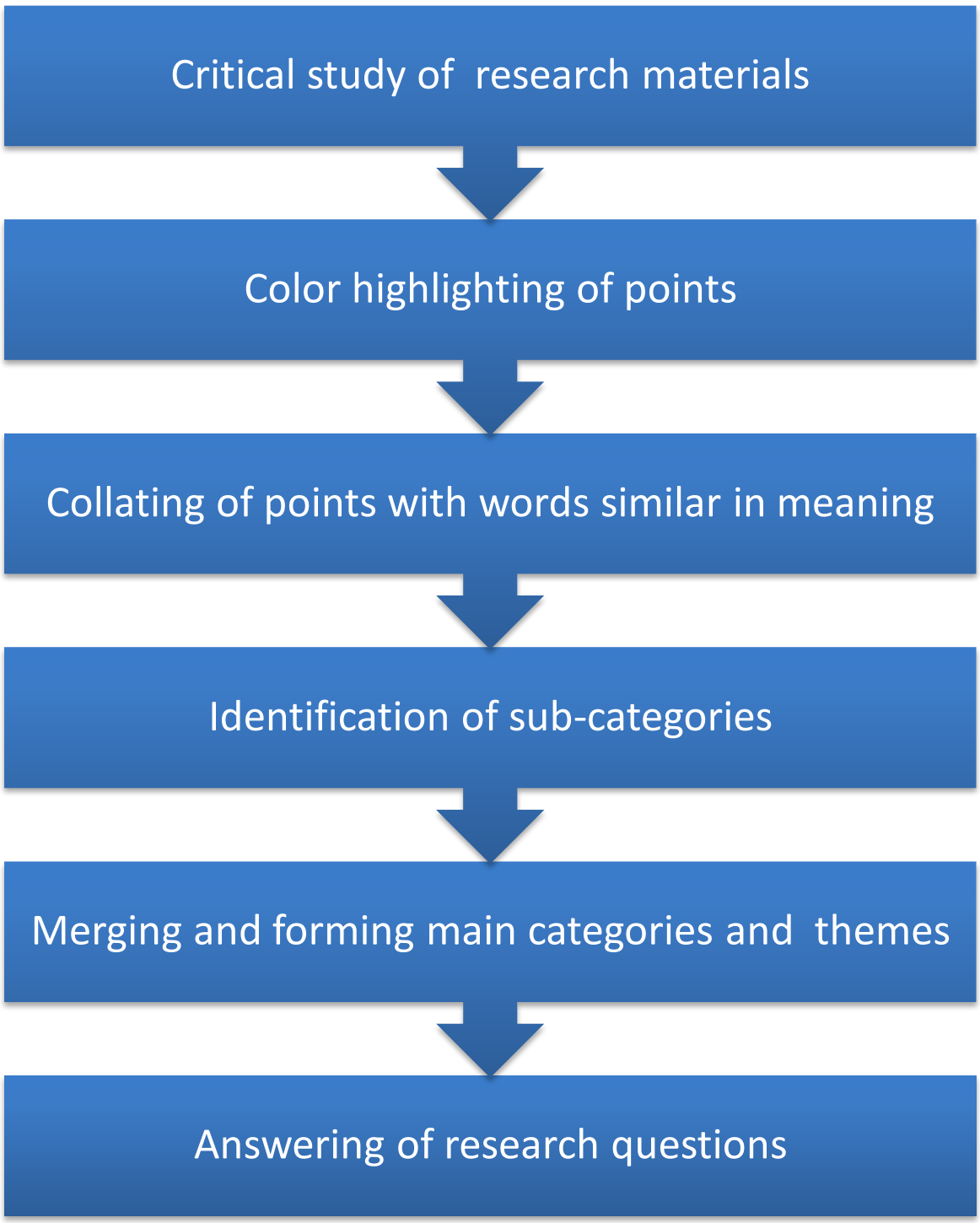

Figure 4: Process flow of data analyses

5.3 Ethical aspects of the research study

The quality of all research study is measured by the values of standards and ethics. For researchers to ensure that their work meets the standards, they must do their research strictly according to those principles of research ethics and make sure that accuracy and relevance is the hallmark of their work (Fawcett & Garity, 2008).

The researcher paid attention to the ethical aspect of this study and gave credit to anyone whose work, ideas or words were borrowed to make this work complete to avoid plagiarism and ethical fraud. The study was done without misrepresentation and false disclosure, and information presented are objectively done without personal beliefs or prejudice. Much efforts were put into the writing to minimize all manner of errors as much as possible (Resnik, 2011).

6 RESULTS

The purpose and aim of the study was to review literature to find out the impact of aging on the sexual life of the elderly, the sexual needs and concerns of residents in nursing homes, and how nursing home residents' sexual needs and concerns are handled. The researcher formulated questions as a guide to arrive at the desired outcome. The researcher formed a cluster of similar ideas with the same color coding to form various themes and sub-categories of the data collected. The sub-categories were further studied, analyzed and re-grouped into main categories and finally used the results to answer the research questions. The results are therefore discussed in the categories of the questions and illustrated in the figure 6 below. In figure 6, there are three separate categories or headings namely, impact, concerns and handling. Under each category or heading is listed the results, which would be described in detail in the following paragraphs.

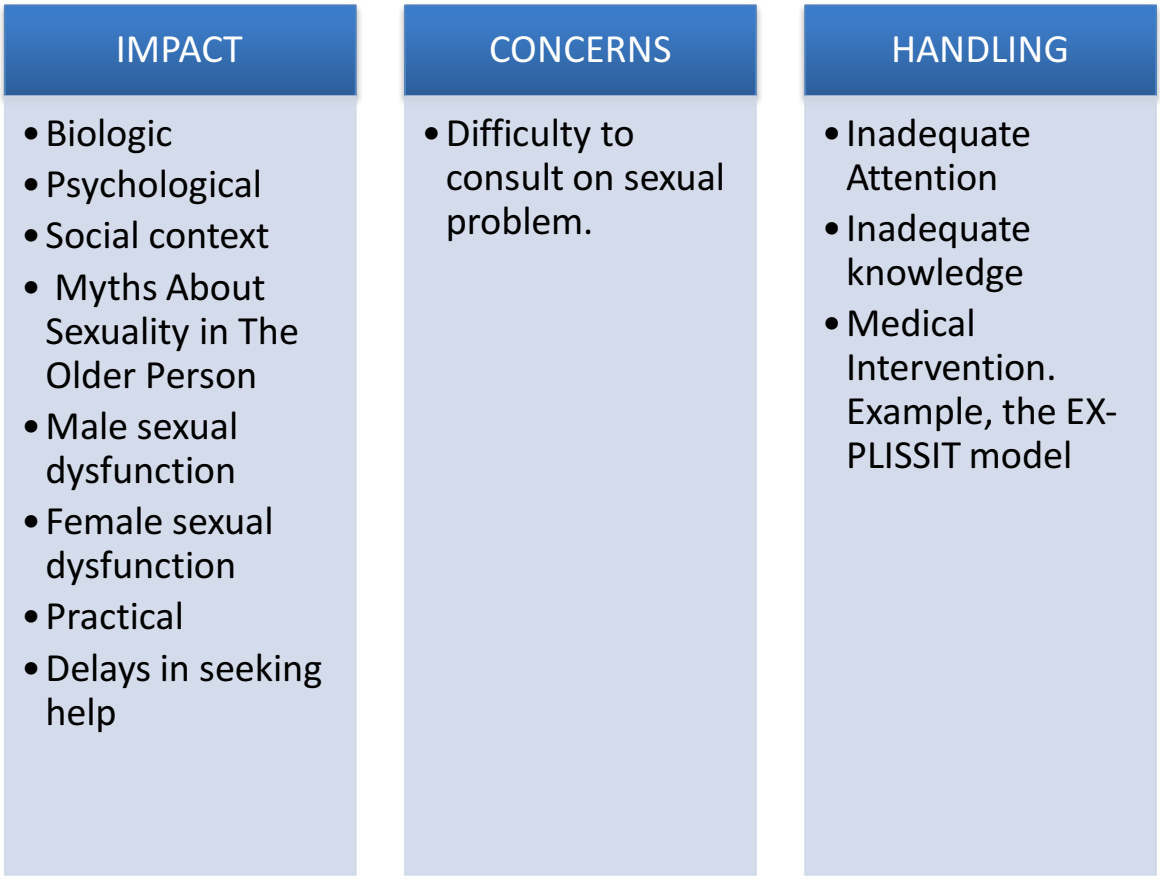

Figure 5 Graphic presentation of the results.

6.1 Impact of aging sexual life of the elderly

Sexuality can be discussed by determinants and variations, through which the impacts can be well assessed. The determinants of sexual function include biologic, psychological, social, life course, and interactions among these determinants. The variations of sexual function include age, gender, and race and ethnicity (Araujo et al (2004; Bancroft 2007).

6.1.1 Biological

According to Araujo et al (2004), sexual activities declines as people age, because changes occur in the determinants of sexuality. The decline affect frequency of desire, frequency of erection, frequency of intercourse, and all the circumstances surrounding sexual activities. Bancroft (2007) also adds that the declines are due to chronic medical conditions and declining levels of testosterone serving as undercurrent. It is further explained that sexual activity may be stable with aging if there were no associated human weaknesses such as self-rated physical health. Pains from physical health problem for example make men climax too quickly and aging exasperate it. Furthermore, several chronic illnesses, including metabolic syndrome, cardiovascular disease, and type 2 diabetes have consequences on reduced sexual desire and increased erectile dysfunction as stated by Genazzani et al (2007). Additionally, menopause is also an example in the case of older women. The older women experience physiologic changes, cessation of fertility, negative attitudes toward menopause, and increased vulnerability to depression, which consequently result in decline in sexual activity, according to Bancroft (2007). He further explained that, estrogen levels decrease during and postmenopause preventing sufficient blood flow into the vagina and therefore, causing vaginal dryness, atrophy and dyspareunia. The clitoris is reduced in size, perfusion decreased, and sexual arousal does not cause full engorgement any longer due to vasocongestion. All the above menopausal and postmenopausal experiences affect sexual functioning considerably (Araujo et al, 2004; Genazzani AR, Genazzani et al, 2007; Bancroft, 2007).

6.1.2 Psychological

Psychologically, human beings' activeness in aspects of life such as sexual functions could be impacted in many forms, and in many cases, even more than physiologic factors. The psychological factors may also affect other factors in the expression of sexuality in the elderly. Sexual drive, which is produced by neuroendocrine mechanism is achieved by such other factors as emotional and interpersonal motivation that determines sexual desire or attitudes about sexuality. As people age, life issues become complicated associated with crisis that sometimes leads to depression, anxiety, anger, isolation, and so on. The affected elderly or person therefore experience diminished motivation both intrinsically and extrinsically to act or react sexually towards others. Depression usually becomes a major risk factor for sexual dysfunction, because besides the depression itself, the medication for treating it may also kill one's sexual desire, which psychologically affects sexual relationship with a given partner. The medications for depression include selective serotonin reuptake inhibitors, and the side effects may include sexual dysfunctions such as anorgasmia, erectile dysfunction, and diminished libido that may persist even after medication use is discontinued (Bancroft, 2007; Genazzani, Gambuaccciani, Simoncini, 2007).

Another psychological factor that affects the sexuality of the elderly is self-perception that may independently affect their attitudes about sexual functions. Negative self-perception, which is not limited to the elderly makes one develop adverse thoughts about their own attitudes, feelings and behavior towards sexual life by concentrating on their observations of external behaviors the circumstances that gave birth to those behaviors. The observation may include others' attitude towards the elderly as they perceive or understand it and/ or their own understanding of their status about their responsiveness to their sexual functions (Baum, Crespi, 2007).

One of the known contributory factors to poor sexual function across all sexually actives ages is psychological problems such as depression and the associated treatment including

medication. Whereas psychological problems and the related sexual dysfunction are easily identified among the younger adults, the case is opposite for the older adults. In most cases, either it is identified late and give appropriate treatment or it is never identified. This is partly because, health care professionals, especially, psychiatrist neglect discussions on sexual history of the older adults as they do to the younger adults, who present symptoms of depression. And even when sexual history is discussed, they fail to attach the same importance as they do to the younger adults to it, and consequently, fail to refer the elderly patient to receive deserving treatment for sexual dysfunction (Gregorian, Golden, Bahce, Goodman, Kwong, Khan, 2002; Bouman, Arcelus, 2001).

6.1.3 Social context

There is not often talk about environmental factors or social context in medical literature also have considerable impact on the elderly and sexuality. A holistic discussion of the topic cannot be achieved without considering the social context. Characteristically, romantic and relationship plays a very important role in the functions of a sexual being in the sense that, being in sexual relationship alone can strengthen and promote sexual function. A survey conducted by Lindau et al within the ages of 57 and 85 revealed that, when there is availability of sexual partners, both sexes are almost at the same level of sexual activity, and in most cases where men have higher level of sexual activity, the reason could be narrowed down to relative shortage of men. There are several reasons for the men-women ratio disparity. Disparity in ages between sexual partners or spouses, where the male partners are usually older, and life longevity of women meaning spending their elderly life without their partners in widowhood are some of the reasons. In a nutshell, the social context may be favorable or unfavorable to the sexuality of the elderly depending largely on the issues raised above, notwithstanding that in most cases, it is unfavorable (Lindau et al, 2006).

Another angle of decline in sexual activity or function is the relationship duration. A decline in sexual frequency may occur because of habituation to sex as relationship lasted longer. An increase in relationship duration in practical terms means the couple's age also

increase, so therefore there is concurrent relationship between age and sexual activity. That is not to suggest that frequency of sexual activity is related to sexual satisfaction. However, sexual functions may well be kept alive very long into an advanced age depending on the characteristics of the partners involved. Their mental, physical and emotional status for example are major determinants of both frequency of sexual activity and sexual satisfaction, meaning the frequency may be declined or forms of functioning be altered, but not totally stopped. For example, sexual intercourse may be altered to oral sex, when one or both partners experience status changes such as erectile dysfunction and vaginal dryness, and frequency of sexual activity reduced when the elderly partner is battling with pains (Lund, 2008).

Cultural experiences and conceptions may well affect the elderly and sexual expression. Different cultures and societies have different ways of looking at sexual activities of the elderly in the society. Misconception in the society may not approve of sexual activeness of the elderly as people may find it strange when an elderly person show their sexual expressions. This is having an adverse effect of openness to sexual functions of the elderly. This is very typical of the traditional societies in the oriental and the African regions, but it could also be witnessed among different cohorts of older Americans, who came of age at different social, political, and technological surroundings. Factors such as sexual revolution, increases in age at first marriage, divorce, cohabitation, and out-of-wedlock births, declines in fertility, age at sexual debut, and changes in family and sexual mores have reshaped cultural experiences and conceptions that may as well affect sexual expression of the elderly. Globalization is however, playing a role in promoting a universal or common cultural sexual experiences (Laumann et al, 2006).

6.1.4 Myths About Sexuality in The Older Person

Sexuality stays with every human even as they get older well into the 90s as the senses also remains prominent part of their lives, but there exists a myth or a believe about sexuality in the older person that the elderly does not have sex or should not have sexual activity. Though the thinking that the older person should not be counted among people

of sexual function persists, but the fact remains, when an older person is physically fit, healthy and has a partner, they engage in sexual activity whenever they want to, because they do not lose their libido, it just decreases. They are also very much alert about their sexuality and sexual satisfaction. What happens is modification in frequency in sexual function and forms of their sexual activity. Mutual musturbation, use of medicines and medical devices, or simply hugging and kissing becomes a way of satisfying themselves sexually due to physical fitness deficiency or functional-ability problems. There is some school of thought that the older people's physiology affect them in such a way that they need longer period to respond to sexual stimuli to achieve orgasm, meaning they have longer refractory period between orgasms. It goes on to argue that it is normal to experience sexual problems with aging, so there is no need to seek help as a younger person would do. A counter argument is that physicians are there to help everyone with sexual problems regardless of age in a professional way without being unbiased and judgmental, and therefore elderly patients are free to contact their doctors to discuss their sexual health problems. They might receive counselling, treatments, and or medication to help them improve if not eradicated. Doctors may also review other health problems and the therapies including medications to see if any of those are affecting their sexual function. A lot of medications are contributory factor why patients' sexual drive is reduced, especially, the elderly, who are might be affected by polypharmacy. In most cases, the impact of medication in reducing sexual drive gets bigger with the presence of physical problems, psychological problems and social factors such as poor body image, feeling less sexy or attractive due to body changes or surgery, feeling less feminine/masculine, fear of rejection, performance anxiety, and fear of isolation, abandonment, and guilt. Medications that may have impact include antidepressants (selective serotonin receptor antagonists are most important), narcotics, antihypertensive (in men), alpha-receptor blockers (in men causing ED), and diuretics. The tables below illustrate how some medications and medical conditions as well as many psychological or social factors have impact or acerbate sexual problems of the elderly (Lindau, Schumm, Levinson, O'Muirchearttaigh and Waite, 2007; Gott and Hinchliff; Lindau and Gavrilova, 2010; Csoka, Shipko, 2006).

Table 2 – Medications and their impact on sexuality in older persons

MEDICATION	**IMPACT**
Antihypertensive	Erectile dysfunction, decreased libido
Alpha-blockers	Erectile dysfunction, decreased libido
Narcotics	Erectile dysfunction, decreased libido
Diuretics	Embarrassment with leakage of urine
Alcohol	Erectile dysfunction, decreased ability to reach orgasm
Antipsychotics	Decreased libido and ability to reach an orgasm, priapism
Anticholinergics	Decreased blood flow to penis
SSRI = Selective Serotonin Receptor Inhibitors	Decreased libido, delayed or no orgasm
Antidepressants	Erectile dysfunction but less than SSRI

Table 3: Medical conditions affecting sexuality in older persons

MEDICAL CONDITION	**IMPACT**
Osteoarthritis or other	Pain with intercourse joint problems
Stroke	Poor coordination and contractures
Parkinson's Disease	Poor coordination
Surgery for breast cancer	Self-image and confidence
Surgery for prostate cancer	Causes incontinence and impotence
Pelvic surgeries	Causes incontinence or impotence Incontinence (urinary or Embarrassment fecal)
Diabetes mellitus	Causes ED and reduces orgasm
Heart and lung disease	Reduces the ability to perform during intercourse
Vision and hearing loss	Reduces the stimuli for sexual excitement

6.1.5 Male sexual dysfunction

Male sexual dysfunction is not limited to the elderly as all males within the sexually active ages could suffer from it. However, sexual dysfunction such as erectile dysfunction (ED) and hypogonadism, which are some of the common sexual problems among men deteriorate even further with age. Many of the known causes of erectile dysfunction such as medications, prostatic surgery or disease, diabetes and vascular disease have more impact on the elderly men's sexual life rendering them almost physiologically impotent. Their potency to have enough erectile function is decreased considerably with age, because they lack the ability to have erection sufficient for intercourse. It is worth to note that while medication or illness play important role in aggravating ED, the problem could not be the sole cause, because age may independently present enough problems to cause ED. Examples of treatment for ED include oral phosphodiesterase inhibitors (e.g. Viagra), intraurethral suppositories (not popular), penile injections, vacuum devices and penile prostheses (JAMA, 2004; Mehraban, Naderi, Yahyazadeh, and Amirchaghmahgi, 2008; Giuglano, Maiorino, Bellastella, Gicchino, GiuglianoD, Esposito, 2010).

6.1.6 Female sexual dysfunction

Like the male sexual dysfunction, the female dysfunction is not limited to the elderly as females at different ages within the sexually active ages could suffer from different levels of female sexual dysfunction. However, the diagnosis of the female sexual dysfunction is quite ambiguous, because it involves participation in sexual relationship as the female wishes, decreased desire or arousal, anorgasmia and dyspareunia. This makes the diagnosis subjective as compared to the objective criteria used in the case of ED. There are good-quality trials and treatments for female sexual dysfunction, but fewer as compared to the male sexual dysfunction, and even that, there is a school of thought that the pharmaceutical companies are working in conjunction with professionals to market their products. Vaginal itching, soreness, dryness, pain during sex are some of the post-menopausal prob

lems referred to as urogenital atrophy. Urogenital atrophy causes post-menopausal problems in sexual functioning, emotional well-being, interpersonal relationships, body image and activities of daily living (ADL) such as prolonged sitting. The end results of these

painful experience is loss of interest in sexual activity in older women, and insufficient treatment get them even more frustrated. Another fact worth noted is that the above-mentioned post-menopausal sexual problems are influenced by psychosocial factors and physical health problems including urinary incontinence, cancers and their medical or surgical treatments (Huang, Luft, Grady, and Kuppermann, 2009).

6.1.7 Practical

As people age, environmental and behavioral changes set in creating unwelcome problems in relationship and consequently creating decrease in sexual activity. One of the practical problems is when a partner is deceased or a partner's poor health. Usually, older women tend to live alone after death do them apart with their ex-husband, because they live longer. Also, a partner's poor health issues could be setback to once a healthy sexual relationship. Due to the poor health, personal hygiene issues may arise repelling partners from sexual activities. Institutionalized care usually steal away the privacy of the elderly couple resulting in diminished environment to engage in sexual activity. Those who are a bit lucky could move into a nursing home together, but in most cases, older couple are separated by the institutionalized care. What makes the case worse is the nature of the care received at the nursing homes, where residents cannot enjoy outright privacy. The health care professionals deliver their services according to routines and sometimes entering residents' rooms unannounced. Living conditions therefore makes it unfavorable and inconvenient to function sexually (Gott and Hinchliff, 2003; Ehrenfeld, Bronner, Tabak, Alpert and Bergman, 1999).

6.1.8 Delays in seeking help

Generally, consulting a general practitioner (GP) on sexual dysfunction have been an embarrassment to many, young or old and male or female. Though GP consultation is regarded as the sure way for the required by many, especially older adults are usually re

luctant to do so even when their quality of life is threatened with severe sexual dysfunction. The failure to consult a GP or primary care physician sexual problems are because patients feel embarrassed and therefore hoped that the health care professional initiated the discussion, the thought of being the only facing sexual dysfunction at that age, misconceptions of elderly sexual dysfunction, thought of being considered a sex maniac, fear of being label abnormal for engaging in sexual activity at an advanced age, fear of the thought that they are wasting doctors' time must be reserved for younger adults, the fear of the thought that they are competing for resources with the younger adults such as medication, and internal stereotyping that sex among the elderly is wrong or inappropriate. Paunonen and Hagmann-Laitila (1990) recorded a Finnish study which showed that despite a good number of the elderly engaging in sexual activity, about 50% of the elderly believe that being sexual function is wrong or improper. For the purposes of alleviating the stereotype of an asexual old age, Kaas (1981) coined the term Geriatric Sexuality Breakdown Syndrome. His objective is the provision of steps to inculcate the right attitudes towards elderly sexual activity into the society. The current attitude in the society is that of a stereotype of an asexual old age. Kass' suggestion is that the society would benefit from devising ways and means to educate and inform members of the society about sexual activity among the elderly to promote acceptance of the phenomenon. One way of doing that is making it part of sex education in schools (Kaas,1981; Paunonen and Hagmann-Laitila,1990; Gott and Hinchliff, 2003; Baldwin, Ginsberg and Harkaway, 2003; Huang, Luft, Grady, Kuppermann, 2009).

6.2 Sexual needs and concerns of the elderly

6.2.1 Difficulty to consult on sexual problems

Like the younger adults, the older adults also have some concerns about their sexuality. The difference is that the younger adults in most cases would discuss their concerns freely with their primary health care professionals for help. According to Lynn (2008), the older women would openly discuss their concerns on sexual dysfunction if the health

care professional broke the ice on the topic. The same study entreated health care professionals, especially primary health care physicians to initiate discussion on sexuality if the elderly visited for consultation or if they attended to them at the nursing homes. The concerns of older women include vaginal dryness and dyspareunia that cause them pain with sexual intercourse, lack of company or partners due to death or divorce, chronic medical condition. The concern of older women and men also borders on their inability to seek care making the situation increasing from bad to worse. Their major concern therefore is chronic decline in libido, decline in frequency of sexual activity and misconception of late life sexual activity among the elderly. Treatment for the above-mentioned concerns include hormone replacement therapy, vaginal lubricants, counselling on self-image, self-confidence and widowhood, provision of Phosphodiesterase inhibitors to treat the sexual side effects of selective serotonin reuptake inhibitors, and various interventions for urinary incontinence and osteoarthritis (Lindau, Schumm, et al., 2007; Wise and Crone, 2006; Lynn 2008).

6.3 How nurses handle sexual needs and concerns of clients

6.3.1 Inadequate Attention

The residents in the nursing homes continue to have sexual needs no matter how much decline there might be. Sexual satisfaction is an integral part of their wellbeing, that have effect on their quality of life. Despite this, the aged-care staff do not give the needed attention to the residents' sexual needs. Attention to the sexuality of the elderly in the nursing home is relegated to background and give much of their time to other assignments they deem more important. Nursing interventions, drug preparation and administration, GP's review, nutritional and fluid intake, personal hygiene, physiotherapy interventions, and other activities that make up the daily routine are considered more important than responding to residents' sexuality issues (Michael, Carol and Linda, 2013).

6.3.2 Inadequate Knowledge

Residents of nursing homes also continue to have sexual desire and the desire for intimacy. Usually, the residents do not get appropriate response to their need, because the aged-care staff lack adequate knowledge on the subject and have negative view and beliefs about the elderly expressing their sexuality, especially homosexuals and those suffering from dementia. In some instances, the staff attempts to help, but have limited knowledge of their roles in helping the elderly to fulfil their sexual desires. Training on the subject for the aged-care staff would help do away with beliefs and negative view about the elderly expressing their sexuality. Staff's handling of sexual desires of the elderly would improve considerably after the training. According to Bonnie & Donna (2010), a pilot test conducted before and after taking staff through training materials designed to improve staff knowledge and attitude on older adults' sexual expression confirmed that aged-care staff had limited knowledge prior the training. The training material was called Knowledge and Attitudes Toward Elderly Sexuality (KATES). The results of pre-test and post-test showed that there was significant gain in knowledge (Bonnie & Donna, 2010; Bonnie, Nancy, James & Paul, 2006).

6.3.3 Medical Intervention

Communication is the beginning of the intervention, but unfortunately both the elderly and the primary health care physicians fail to initiate the discussion on sexuality. Sexual guidance and counselling is a tested tool employed by healthcare professionals including nurses to discuss sexual health problems with the goal of finding lasting solution. An example of the tested tools is an Ex-PLISSIT model. The intervention begins from permission stage till the sexual health problem is referred to a specialist. When this barrier is removed, the following are some of the ways the physicians can intervene medically. The older men, who report changes that are symptomatic could be tested for hypogonadism and then given treatment. The treatment may include transdermal gels and patches, and testosterone replacement (may contraindicate with carcinomas, polycythemia, severe

heart failure, and certain other conditions). The transdermal patch treatment in women would increase sexual desire, satisfactory sexual events and self-reported sexual function. The older women could be treated with estrogen replacement therapy to prevent urogenital atrophy (Genazzani, Gambuaccciani, Simoncini, 2007; Davis and Taylor, 2006).

7 DISCUSSION

In this literature review of sexuality and elderly, there has not been one school of thought in most of the thematic areas, and therefore have been a work of diversity of complementary and divergent views. In the arguments, the biological and the medical aspects are emphatically made to explain the impact of aging on the sexuality of the older adults. Another area of contention is the definition of sexuality. There also various school of thoughts on the meaning of sexuality and therefore, its reference to the elderly sprouts from different angles. Those depending on biological processes and indicators of sexual functioning argue that aging has considerable impact on sexuality. Other arguments besides biological processes and indicators factor in gender in their analysis, especially those considering social context for understanding sexual functioning among the elderly. This line of argument explains that presence of sexual partner is very crucial in determining whether later life sexual functioning declines or not. It goes further to explain that lack of partner is one of the main reasons for decline or absence of sexual activity among older women, since they have longevity of life as compared to their male partners. Where the older adults live together as couple, there is a possibility of sexual activity, however low the frequency may be. Sexual activity is not limited to genital sexual activity, but all acts of sexual expression, usually referred to as non-genital activities that are satisfying, especially to the older adults who may have physical limitations. This form of sex allows for physical intimacy and many single older adults would not be considered sexually dysfunctional if they had a partner. Erectile dysfunction, dyspareunia, and orgasmic disorder are some examples of sexual dysfunction, which is explained as the impairments to genital sexual activity. Besides the existing multiplicity of the subject of sexuality and the elderly, there are emergence of interdisciplinary school of thoughts that considers all angles of the subject including biological processes and indicators, and social context (Baum & Crespi, 2007; Wise TN, Crone C. 2006; Susan, Victor & Plummer, 2006).

According to Baum & Crespi (2007), testosterone deficiency remains one of the health problems among the elderly affecting their sexual function and this can be partly attributed to some medications. Baum and Crespi suggested that the elderly, who show

symptoms of hypogonadism should be tested for treatment to be initiated as soon as practicable if needed. The treatment was found to include transdermal gels, patches, and testosterone replacement, which is recommended for the elderly men diagnosed with carcinomas, polycythemia, severe heart failure, and so on. Lindau and colleagues (2010), reported the decline in sexual function among the elderly from the ages in the mid-50s to the 80s. They also named factors that contribute or acerbate the sexual dysfunction and they include age, race, smoking, changes in the clitoris, vaginal dryness from low estrogen levels, atrophy caused by diminished blood flow. On the contrary, drinking of alcohol and health factors aided in reporting sexual intercourse (Lindau and colleagues, 2010).

Bancroft (2007) and Genazzani and colleagues (2007) reported about the role of hormones and menopause in reducing frequency of sexual activity among the older woman. There is ambiguity about the effect of hormones, but menopause or post menopause experiences, which involves physiologic changes, cessation of fertility acerbate the sexual dysfunction in women. Genazzani and colleagues (2007) added various treatments to the discussion on the menopause in women. They reported that transdermal testosterone patch treats hypoactive sexual desire disorder to increase sexual desire, frequency of satisfactory sexual events, and self-reported sexual function. Over-the-counter lubricants may treat dyspareunia, which is caused by vaginal dryness from low estrogen levels and atrophy caused by diminished blood flow, and finally, urogenital atrophy is treated or prevented with estrogen (replacement) therapy.

8 CONCLUSION

This literature review aimed to discuss and review the impact on the sexual life on the elderly, the sexual needs and concerns of residents in nursing homes and how these sexual needs and concerns are handled. The study revealed that despite cultural revolution, modern Western culture still harbor some misconceptions about sexual function of older adult. The older adults like their younger counterparts have a sexual life, but the quality of the sexual life is influenced by several factors. To the disadvantage of the older adults, the society is tailored to offer opportunities for younger adults to express their sexuality. This review discussed the psychosocial and physiological factors that have impact on the expression of older people, the research methodology employed in the collection of data on elderly and sexuality with special attention to nursing home residents, and educational issues concerning health care professionals and the elderly on dispelling myths about older people and training in handling the elderly on sexuality. The discussion also revealed that as one advances in age, physical and pathological changes contribute to the decline in sexual activity, and that there are complementary forms of sexual expression the elderly can use for sexual satisfaction in an environment devoid of societal and culturally adverse expectations and attitudes.

8.1 Strengths, limitations, and recommendations

In this study, it has been established through reviewing various literature that the aging population is growing rapidly worldwide and therefore, more pragmatic should be taken to improve the quality of long life. It is in this light that the following are being recommended after a careful consideration of the strengths and limitations discovered in this study. Though there is enough literature on the subject, most of them were not so current. Interdisciplinary study could be conducted drawing the sample space beyond racial, ethnic, regional and gender groupings, and beyond biologic/medical perspective.

Health care professionals, especially primary healthcare physicians, geriatric doctors and nurses should incorporate assessments of sexual functioning into their practice routines, diagnosis and intervention in their quest for holistic care, and the assessments should not be limited to physical functioning only, but all aspects that will beneficial to sexual functioning. The assessment may include sexual dysfunction screening for older patients, especially those with chronic diseases, using certain medications, showing symptoms of lower urinary tract, showing symptoms of urogenital atrophy. The assessment would also serve as a tool to initiate discussion on the sexuality of the older patients or the residents of nursing homes.

Inadequate education on sexuality issues, especially about the needs of the residents in the nursing homes is one the results of this study. It is therefore included in the recommendation of this study that staff of the aged-care staff should be trained to better appreciate the sexual needs of their clients. When it becomes part of the basic training staff receive at school and/or during the induction period at the beginning of their work, staff would be comfortable with the expression of sexuality by the older adults. Staff should also make it possible for residents to visit their partners at home, go on holidays and partners visiting residents on the premises and facilitates sleep over. Staff interruption should also be avoided as much as possible to promote privacy of residents and their partners. Calling residents' room before service or knocking on doors before entering would also prevent an invasion of privacy.

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10 APPENDICES

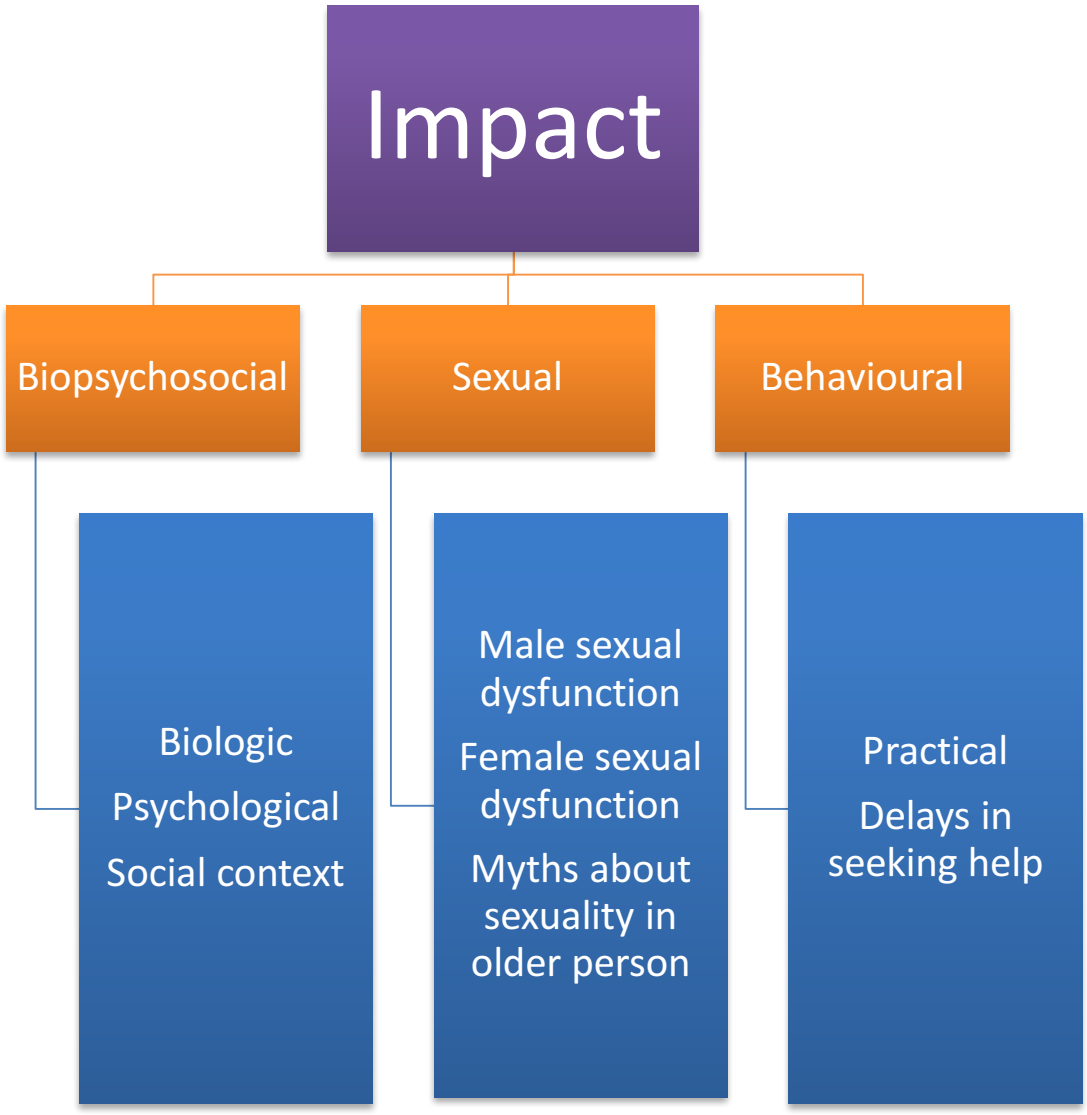
Appendix 1. Database and results

Database	Key terms or search words	Results	Chosen based on title and abstract	Relevant
CINAHL	Response or reaction and geriatric or elderly or aged or older adults and needs or wants and handling or intervention and intimacy or sexual behavior Sexual or sexuality and health or sexual health and nursing home or aged-care and residents or elderly Medication and elderly or residents and nursing home or aged-care and impact or effect and aging and sexual life	307	10	3
EBSCO	Response or reaction and geriatric or elderly or aged or older adults and needs or wants and handling or intervention and intimacy or sexual behavior Sexual or sexuality and health or sexual health and nursing home or aged-care and residents or elderly Medication and elderly or residents and nursing home or aged-	15	8	3

	care and impact or effect and aging and sexual life			
PUBMED	Impact or effect and aging or elderly or senior and sexuality or sexual health Quality of life and sexual health and aging or elderly and aged-care or nursing home or geriatric nursing and needs or desire Sexuality or sexual and aging or elderly or elderly and dementia or mental health and response or reaction or nursing intervention.	57	11	5

The following appendices 2, 3, and 4 show example of the themes, categories and sub-categories.

Appendix 2. Example of categories and sub-categories of results on impact



Appendix 3. Example of categories and sub-categories of results on concern

Appendix 4. Example of categories and sub-categories of results on handling