Module: Professional practice and ethics

Introduction and description

A fulfilling and pleasurable sex life can play an important role in maintaining the overall health and well-being of adults in later life. Good sexual health contributes to the physical, mental and emotional well-being of adults and the expression of sexuality is a core component of human interaction that does not diminish with age. While the way in which sexuality is expressed may change over time due to natural social and physical changes that occur with age, the desire for emotional and physical intimacy and sexual satisfaction remain an important facet of human existence.

While vaginal and anal intercourse, oral sex and masturbation often continue to be important forms of sexual expression as a person ages, many older people re-define sexuality to include other forms of expressing intimacy- such as touching, caressing and holding hands (Gott & Hinchliff 2003; Rheaume & Mitty 2008). Nonetheless, multiple studies have found that the sexual health needs of older adults are often overlooked in interactions with health and social care professionals. Moreover, there are often significant barriers to accessing care and information in interactions between older people and health and social care professionals. Some of the most common barriers can include:

- shame and embarrassment on the part of the older adult or health and social care professional
- health literacy levels of the client
- gender and age differences between the health and social care practitioner and the client
- attributing sexual health problems or dysfunction to 'normal aging'
- perceiving sexual health problems as unserious
- perceived discomfort on the part of either or both the health and social care practitioner and the older adult
- lack of training for health and social care professionals
- health and social care practitioner attitudes towards later-life sexuality

(Gott, Hinchliff & Galena 2004; Hinchliff 2011).

Such barriers are often related to and compounded by factors such as stereotypical cultural and societal views about aging, gender roles and sexuality.

Unit 1 (of 4): Communication around sexuality

Introduction

One of the greatest barriers to achieving good sexual health in later life is the lack of communication between health and social care practitioners and their older clients because of one or more of the factors mentioned above. In spite of an acknowledgement by many health and social care practitioners of the continued importance of sexuality to older clients/patients, this is an area of healthcare for older people that is frequently routinely overlooked in consultations (Gott et al. 2004). Indeed, this was highlighted in the Global Study of Sexual Attitudes and Behaviors, which found that only 9% of men and women had been asked about their sexual health during a routine visit to their health and social care practitioner in the previous 3 years (Moreira et al. 2005).

More importantly perhaps, it is widely recognised that older adults will not usually initiate conversations about their sexual health. Nonetheless, when prompted older adults are often open to discussing their sexual health needs and concerns. Health and social care practitioners therefore need to have a proactive attitude to discussing the sexual health needs of their older clients and best practice guidelines recommend that health and social care practitioners should bring up the topic at an opportune time during routine healthcare checks (Farrell & Belza 2012; Hughes, Rostant & Curran 2014; Kotz 2005; Kuehn 2008).

Key Messages

- Sexual activity has many benefits for health and well-being
- There are many barriers to health and social care practitioners communicating with their older clients around matters of sexuality and sexual health
- Often older people will not initiate discussion, but when asked, many will value the opportunity to discuss their situation, queries and concerns with health and social care professionals
- Routine healthcare checks provide an excellent opportunity for health and social care practitioners to prompt discussion surrounding sexual matters with their clients

Learning objectives

At the end of this unit students are expected to:

1. Be able to recognise barriers to promoting discussion around sexual health matters that can confront older people and social and health care practitioners
2. Be aware of communication strategies and approaches for engaging older people in conversations around sexuality and sexual health

3. Be aware of ways in which to empower older people through appropriate communication approaches

Content

Empowerment, communication and the PLISSIT model.

In order for this to happen an individual must be well informed as to the conditions that are necessary for achieving optimal health and wellbeing. By improving communication between the health and social care practitioner and the client, a practitioner can help empower a client to take control over their sexual health by involving them in the decision-making process in order to address and fulfil their sexual needs and to maintain their sexual health generally. As such, beginning the conversation is a crucial first step. Developed in the late 1970s, the PLISSIT model offers an approach to initiating and engaging in a conversation with a client about their sexual health.

The PLISSIT model has four interconnected parts – Permission, Limited Information, Specific Suggestions, Intensive therapy.

The PLISSIT Model	
P	***Permission-*** ask permission from the client to speak to them about their sexual health.
LI	***Limited Information-*** give the client limited information on sexual health issues that might apply to the older adult.
SS	***Specific Suggestions-*** provide the client with specific suggestions on how to improve their sexual health.
IT	***Intensive Therapy-*** offer a referral to a specialist if the client's problem goes beyond the scope of the health and social care practitioner.

For more information about the PLISSIT model and to view a video by Meredith Wallace PhD and the Hartford Institute for Geriatric nursing on the management and assessment of the sexual health of older clients visit: https://consultgeri.org/try-this/general-assessment/issue-10

Factors that can facilitate using the PLISSIT model to engage in discussion with an older person.

- Ensure that the space in which the conversation is taking place is private and reassure the client that all information is strictly confidential.

- Adopt an open-minded and non-judgmental manner and, utilise neutral non-gendered language- for example, partner instead of husband or wife.
- Ensure that one's own beliefs and attitudes do not impinge on the discussion, for example, refrain from showing surprise.
- Be mindful that there may be possible cultural and gendered differences in attitudes towards sex. If the client/patient has a cultural background that is different to the health and social care practitioner and the practitioner is unsure of what may or may not be appropriate, the simplest solution is to ask the client in a respectful and sensitive manner.

Role play
Practise using the PLISSIT model with a colleague or friend, using the following hypothetical case studies:

Mrs. Black is a 65 year old married woman who has come to visit her GP for her annual check-up. Mrs. Black has been on hormone replacement therapy for eight years. This has helped her with problems she previously encountered with lack of lubrication. However, over the past year she has been taking a low dose (20mg) of a selective serotonin reuptake inhibitor (SSRI), citalopram, for mild depression. Since starting these anti-depressants, she has been experiencing a decrease in her libido and is concerned about how this is affecting her marriage.

Mr. White is a 68 year old divorced man. He self-identifies as gay, having come out 15 years ago after the break-up of his marriage. He has been with his current partner for five years. He used to take anti-anxiety medication (Xanax) but discontinued using it around four years ago. He is currently taking statins (Lipitor) to control his cholesterol, but otherwise is in good health. He occasionally experiences erectile dysfunction.

Questions for facilitating the role plays (perhaps, include in trainers materials).

- If it's alright with you Mrs. Black, I'd like to ask you a few questions about your sexual health?
- Many patients have issues with their sexual health as they get older, would it be ok if I asked you some questions about how your sexual health has been?
- Some of the medications you are currently taking can affect your sexual health, would you mind if I asked you some questions about your sexual health?
- What concerns have you about your sexual health?
- How has your sexual function changed since your diagnosis with...?
- How have your sexual feelings changed since starting your new treatment regime?
- Can you tell me how you express your sexuality?

- What concerns or questions do you have about fulfilling your continuing sexual needs?
- In what ways has your sexual relationship with your partner changed as you have aged?
- What interventions or information can I provide to help you fulfil your sexuality?

Unit 2 (of 4): Intercultural competence and cross-cultural communication

Introduction

The free movement of people in Europe has been a core part of European Union policy since its inception and, with the signing of the Schengen Agreement in 1985, Europeans have been able to freely travel and work between countries in the Union. This, along with the effects of globalisation and post-colonialism mean that European societies have become increasingly more culturally diverse. In addition, in 2014 there were over 33.5 million non-EU nationals living in EU member states (Eurostat 2015). Thus, with a population of over 500 million people, Europe is one of the most linguistically and culturally diverse places on Earth. For instance, within EU borders there are 3 distinct alphabets, 24 official languages, 60 other European languages and an estimated 175 non-EU nationalities (EC 2015), each with their own varied cultural and linguistic heritage.

This diversity can present significant challenges for health and social care practitioners, particularly around topics such as ageing and sexuality, since these are very much influenced by culture, traditions and customs. Moreover, linguistic differences between health and social care practitioners and clients can exacerbate the challenge. Thus, cross-cultural communication is an area of growing importance in health and social care.

Key messages

- Cross-cultural communication is increasing required in health and social care
- Cultural influences may be particularly strong around topics such as ageing, sexuality or sexual health
- health and social care practitioners should be mindful of the manner in which their views and values have been shaped by their own culture and/or religious background

Learning objectives

1. Raise awareness of the importance of appreciating cross-cultural approaches to communication

2. Promote cultural awareness amongst health and social care practitioners, which encourages them to recognise their own cultural background as well as those of clients

3. Recognise strategies to engage effectively with culturally diverse client groups

Content

Culture has been defined many times and most definitions consider culture to include norms, beliefs, values and social practices that are shared by people from a particular national, ethnic, social or religious background. Culture can affect behaviour, patterns of thinking and ways of communicating and interacting with others. As such, cultures are almost as diverse as the people who inhabit them. Thus, there may be little surprise that intercultural communication theorists often use the analogy of an ice-berg to help explain culture (see for example, Hall 1989). On the surface there are the things we can see and easily identify such as dress, food, music or language. At the same time, below these surface elements are the things that are not so easily seen and understood, such as core beliefs and attitudes, concepts of time and patterns and norms of interaction (Hall 1989).

Among these "below the surface" aspects of culture are attitudes and beliefs in relation to matters such as aging, sexuality and gender roles, as well as approaches to doctor/patient interaction, notions of modesty, patterns of verbal and non-verbal communication and definitions of obscenity- all of which can have an impact on how a person from a particular cultural background might interact with a health and social care practitioner and respond to a discussion about sexual health. In particular, beliefs and attitudes about health and illnesses, aging and sexuality can all be affected by a person's cultural background. Roach (2004), for example found that staff of Swedish nursing homes had a more relaxed attitude to expressions of sexuality among residents than their counterparts in Australian nursing homes, largely because of the more liberal cultural attitudes to aging and sexuality that exist in Sweden.

The Culture and Health Assessment Tool (CHAT) may be used as part of the PLISSIT model when communicating with patients/clients with a distinct cultural background to that of the health and social care practitioner (Rosen et al. 2004). CHAT is a 14 item checklist that includes Kleinman's 'Questions for Eliciting a Patient's Explanatory Model' (Kleinman, Eisenberg & Good 1978). CHAT is designed to be used in many clinical settings, but with a slight adjustment in language- such as substituting 'problem' or 'issue' for 'illness', it is perfectly suited to be integrated into the PLISSIT model when discussing issues of sexuality and/or sexual health with clients from diverse cultural and/or linguistic backgrounds. The questions are designed to stimulate conversation and give a health and social care practitioner "a greater understanding of the patient's health-belief model, health practices and expectations for treatment" (Rosen et al. 2004: 127). Questions that are not relevant to the client's particular case or situation may be omitted as seen fit by the practitioner.

CHAT

Culture and Health Assessment Tool (CHAT)
1. Where appropriate I have discussed the role of the interpreter with both the interpreter and the patient.
2. What do you think caused your illness/problem?
3. Why do you think your illness/problem started when it did?
4. What does your illness do to you
5. How bad (severe) do you think your illness/problem is? Do you think it will last a long time, or will it be better soon, in your opinion?
6. What do you fear most about your illness?
7. What are the chief problems that your illness has caused for you?
8. When you have a problem, to whom do you turn for help?
9. For your future care, who would you like to be involved?
10. What have you done to treat your illness/problem?
11. What kind of treatment do you think you should receive?
12. What are the most important results you hope to receive from treatment?
13. Is there anything that might conflict with your treatment regimen?
14. Are you feeling uncomfortable or uncertain about what we have decided?

Reflective Activity

A number of questions in the CHAT tool, particularly questions 6, 7, 8, 9 and 13, relate to the interface between care and social, cultural or religious influences. Reflecting on each of these questions, consider how your society, cultural or religious background might shape your responses.

Unit 3 (of 4): Residential care facilities and dementia

Introduction

The intrinsic need and desire to express oneself sexually does not end at a particular age, nor does it necessarily end once a person has reached a stage of their life when they may need to enter into an assisted living or residential care facility or where they may suffer from an age-related cognitive impairment such as dementia or Alzheimer's disease (Bach et al. 2013; Gott & Hinchliff 2003; Kontula & Haavio-Mannila 2009; Laumann et al. 2004; Lindau et al. 2007; Moreira et al. 2005). Although research in this area is still emerging, the existing literature suggests that facilitating the sexual expression of older adults in residential care has many health benefits, both physical and psychological, and can contribute to their overall well-being. For example, one study conducted in the United States amongst residents of a retirement community found that sexually active residents were more likely to be taking fewer medications, had a more active social life, where more physically active and reported higher levels of life-satisfaction and quality of life generally than residents who were sexually inactive. Indeed, sexually inactive residents were more likely to have bladder and bowel issues, mental ill-health concerns and higher risk levels for diabetes, hypertension, cardiovascular disease and dementia (Bach et al. 2013).

Research on best practice suggests that in so far as is possible, the rights of an older person who is resident of a care facility, to self-determination and autonomy of self-expression should be respected and that those rights should extend to freedom of sexual expression (Elias & Ryan 2011; Rheaume & Mitty 2008; Tarzia et al. 2012). Nonetheless, challenges arise for health and social care practitioners with regard to how to facilitate a resident's right to express themselves sexually, particularly when the older person may be living with dementia or other forms of cognitive impairment. Health and social care practitioners must therefore weigh up complex issues of autonomy and the right to freedom of expression against issues of capacity to consent, and possibly the feelings of family members who may be uncomfortable with or reject the idea of their older loved one engaging in sexual activity.

Key messages

- Older people in residential facilities are likely to confront extra barriers to engaging in a healthy sex life
- Older people with cognitive conditions who are living in residential facilities are particularly likely to confront barriers
- Older people with cognitive conditions can raise complex issues for health and social care practitioners, especially in areas such as consent and autonomy

Learning objectives

1. Be aware of the barriers to engaging in a healthy sex life applicable to residential facilities
2. Have knowledge of the manner in which cognitive conditions may impact sexual expression
3. Be aware of strategies that can assist health and social care practitioners in care facilities to empower older people

Content

While many older people confront barriers in the area of sexuality and intimacy, older people living in residential facilities can confront particular challenges. Common barriers can include:

- attitudes and perceptions of staff, often due to a lack of adequate training
- concerns over family disapproval or objection
- religious, cultural and societal values in relation to aging, disability and sexuality
- attitudes and social values of other residents
- structural factors including lack of privacy or double beds
- restrictive practices, lack of policy and a conservative organisational ethos

One of the main barriers identified is the attitudes and perceptions of care facility staff, often related to a lack of training or familiarity with the area. In such circumstances, displays of sexuality can be viewed by staff as reflecting problematic or challenging behaviour rather than as expressions of a need for intimacy, love and affection. Staff attitudes to sexuality are often informed by wider societal views on aging, infirmity and sexuality, and perpetrate the common myths in this area. Because of the widespread perception of older people as “asexual”, many staff may feel that sexual relationships are inappropriate. This can be compounded by a lack of training generally, as well as a lack of policy in care facilities on how to address and facilitate the sexual expression of residents. Where residents may have cognitive conditions, the situation is even more complex and common concerns of care facility staff may include concerns that a relationship may be coercive rather than mutual and, a fear of potential disapproval or even litigation by family members.

Further challenges can arise for care facility staff in relation to sexual relationships and displays of sexual behaviour amongst residents. Chief among these is the capacity of an individual with cognitive impairment to give consent. With patients with moderate to advanced dementia, who may have limited vocal capabilities, assessing capacity to consent

can be especially problematic. As a consequence, the response of many care facilities in dealing with a sexual relationship of residents with dementia, which is deemed to be problematic either by staff or by family members, is to separate the individuals who are engaging in the perceived "inappropriate" behaviour. This, however, can lead to adverse effect on the individuals involved- causing them distress, as well as potentially harming their physical and psychological health.

Case study

Dorothy is 82 and Bob is 95. Both are residents of the same care facility and both suffer from dementia. Dorothy's husband died from a heart attack sixteen years ago and Bob has been widowed three times. Bob had been popular among the female residents but had never displayed any interest in return. When Dorothy moved into the care home, however, Bob's attraction to her was immediately apparent and the feeling was mutual. They began a courtship, spending all their time together. She would play the piano and they would sing together. After a short while, their relationship became sexual and Bob began visiting Dorothy's room at night to stay over. He even proposed to Dorothy and began referring to her as his wife. Although neither management at the facility nor Dorothy's family had a problem with the couple, Bob's son was not happy when he found out about the relationship accidentally when he walked in on his father and Dorothy in bed one day. He felt that his father "should be old and rock in the chair" and was concerned that Dorothy was taking advantage of his father. The private duty-nurse who tended to Bob was also uncomfortable with the relationship. At first she thought it was cute, but, for religious reasons, started to object when the relationship became sexual and she asked staff members to help keep the couple apart. Conflicts arose between staff as to what was the best course of action. As a result, Bob and Dorothy began secretly meeting when they could and their intimacy became "more open and problematic". On one occasion the care facility manager had to intervene to stop Bob from "pleasuring" Dorothy in the lobby whilst Dorothy had a strategically placed pillow on her lap. Dorothy's daughter was happy for the relationship to continue and was concerned at the distress that attempts to separate the couple were causing her mother. A mediator was brought in to try to resolve the conflict but a resolution was never reached. Finally Bob's son had Bob moved to another facility. Dorothy never got to say goodbye. Dorothy's health began to decline after Bob's departure- she became withdrawn and depressed, she stopped eating, lost nine and a half kilos and had to be hospitalised for dehydration. Her doctor thinks the loss may have killed her, only for her Alzheimer's caused the memory of Bob to fade away relatively quickly (Henneberger, 2008).

Reflective exercise

How did the lack of a clear organisational ethos or policy on resident relationships impact this situation?

How might good communication between all parties have been facilitated?

What was the influence of culture and religion on the situation and how might these issues have been addressed?

Can you suggest what actions might have been taken that may have produced a different outcome?

Unit 4 (of 4): Sexual violence against older people

Introduction

Older people, particularly those with dementia or those living in assisted care facilities can be particularly vulnerable to sexual violence. Problems with detecting sexual violence against older people and issues of under-reporting of sexual assault generally mean that this is a much under-researched area. The World Health Organisation defines sexual violence as: 'any act, attempt to obtain a sexual act, unwanted sexual comments or advances...against a person's sexuality using coercion, by any person...in any setting' (WHO, 2015, p. 35).

Key messages

- Older adults can be especially vulnerable to sexual violence and abuse, especially those who have a cognitive condition
- There is a general low level of reporting in this area, which can contribute to abusive situations or relationships going undetected

Learning objectives

1. Be aware that sexual violence and abuse may be largely under-recognised in older populations
2. Be aware of the types of abuse and potential indicators
3. Understand strategies to assist health and social care practitioners to respond to incidents or signs of sexual violence or abuse

Content

Acts of sexual violence against older people can include:

- Rape- including penetration by non-bodily objects
- Assault- including unwanted touching of the genitals and forced masturbation and/or oral sex
- Taking sexual photos of the older person without their consent
- Intrusive and unnecessary procedures involving the rectum or genitals
- Exhibitionism and/or voyeurism- i.e., masturbating in front of or exposing oneself to the older person and/or watching an older person in a state of undress without their consent

- Any unwanted touching that is sexual in nature
- Threats of sexual abuse and sexual harassment

(Chihowski & Hughes, 2008; Ramsey-Klawsnik, 2004).

Sexual violence or sexual abuse of older people can be perpetrated by partners, family members, strangers and care-givers. Older people living with dementia and women are especially vulnerable to sexual abuse (Burgess & Phillips, 2006). Sexual violence and sexual abuse of older people can lead to significant psychological and emotional problems for the victim, as well as having an adverse impact on their physical health and well-being. Moreover, older people are more likely than younger victims of sexual violence to require hospitalisation and to suffer serious injury and genital trauma (Burgess & Philips, 2006; Burgess, Hanrahan & Baker, 2005; Eckert & Sugar, 2008). For patients with dementia, especially those with limited verbal abilities, detection of sexual abuse can be problematic and often as low as only one in eight are able to self-report abuse (Burgess & Philips, 2006).

Recognising the signs

In the absence of victim disclosure, a health and social care practitioner should be on the lookout for physical signs of sexual abuse. While patients with dementia are more likely to be physically coerced than patients without dementia, any signs of physical trauma in a patient should be thoroughly investigated. Possible physical signs of sexual abuse may include:

- Bruising on the arms and wrists from being forcible restrained
- Bruising or tenderness of the genital area
- Vaginal or rectal bleeding
- Abrasions, swelling, redness or tears in the perianal area

Many older patients who are cognitively impaired with dementia and/or Alzheimer's disease may communicate their distress through behavioural cues if unable to communicate verbally (Benbow & Haddad 1993).

Such behavioural disclosure can occur in a number of ways-

- Indirect statements (as in, for example, "don't let that man near me!")
- Sudden behavioural change, including becoming withdrawn, refusing personal care, or retreating into the foetal position

- Displaying a fearful or an ambivalent response towards a suspected abuser
- Displaying a guarded response when asked about abuse
- Becoming upset or distressed while receiving personal care

Strategies for addressing potential abuse

As many older people, particularly those with cognitive impairments, are frequently accompanied by a care-giver it can be especially challenging for health and social care practitioners who may be suspicious that abuse is taking place, to raise the issue. In such circumstances, assessing the suspected victim on their own is advised (O'Connor et al., 2009). In cases where an older person has a cognitive impairment, health and social care practitioners should be conscious to:

- Use clear, direct and non-emotive language
- Speak slowly and clearly
- Use non-leading questions
- Ask one question at a time
- Ask questions about who, what, where and when, but not why
- Be patient in tone and demeanour
- Use language and terminology appropriate to the person
- Employ visual aids, where possible

(Downes et al., 2013: 16).

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