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Long-Term Links

FACING THE CHALLENGES of SEXUAL EXPRESSION in the NURSING HOME

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Everyone, regardless of age, needs love, touch, companionship, and intimacy, and the 1.6 million elderly in the 20,000 U.S. nursing homes are no exception. The literature indicates that nursing home residents continue to have an interest in sexual activity regardless of age.¹⁻³ Sexuality, however, is frequently overlooked by physicians and staff working with nursing home residents, and many staff members have only a vague understanding of the sexual needs of the elderly. This results in a perception of residents' sexual interests as behavioral problems rather than expressions of need for love and intimacy. This article discusses strategies for removing barriers to sexual expression in the nursing home, and dealing with inappropriate sexual behaviors in this setting.

Barriers to sexual expression in the nursing home

Nursing home residents are faced with multiple barriers to sexual expression (Table 1). In a survey of 63 institutionalized elderly,⁴ the most common reason for ending sexual activity was lack of a partner (30%). The second most frequent reason for women was loss of interest (28%). Poor health was cited by 19% of both men and women as the reason they ended sexual activity.

Fifteen percent of the men but none of the women gave inability to perform as the reason they ended sexual activity. In this survey, 58% of male and 78% of female residents said they were sexually unattractive. In another study, lack of privacy was the most frequent reason cited by both staff and residents.¹

Sexual behavior is often perceived by staff as a problem rather than an expression of a need for love and intimacy. In one survey of a skilled nursing facility staff,⁵ one-quarter of residents were labeled as having behavioral problems because of inappropriate sexual behaviors. These included using sexually explicit language, exposing genitalia, inappropriately touching staff members, and implied sexual behavior such as reading pornographic material or making requests for unnecessary condom changes. However, some behaviors between staff and residents, such as hugging, or kissing on the cheek, were identified as acceptable by staff.

In another survey, over 60% of employees in one nursing facility did not believe it was necessary for residents to maintain sexual activity. More than two-thirds of respondents did not think that the

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issue of sexuality in a nursing facility was important at all.⁶

Strategies to address sexual needs of nursing home residents

Physicians and nursing home staff have a professional duty to address residents' needs and interests, uphold their legitimate rights, keep them comfortable and improve their quality of life to the maximum extent possible. Addressing needs for love, intimacy and sexual expression may have a positive impact on residents' quality of life, and may help prevent the occurrence of future troubling sexual behaviors. Several interventions may help remove barriers to sexual expression by residents in the nursing home (Table 2).

Education of staff in geriatric sexuality enhances their knowledge and positively impacts their attitudes toward sexual issues in the nursing home. In one study,⁷ an educational program for nursing home staff increased knowledge about sexuality in the elderly and resulted in more permissive staff attitudes. Open discussion and case studies may increase comfort with sexual concerns. Attention to sexual history and ongoing sexual assessment in care planning may allow earlier responses to residents' sexuality, and prevent future troubling sexual behaviors.

Staff should be aware of cues, such as increased touch by the resident, that may reflect unmet

intimacy needs. They should provide sexual information and counseling for interested residents. Allowing conjugal and home visits, using "do not disturb" signs or allowing doors to remain closed may help provide residents with the needed privacy to satisfy their sexual desires. Physicians should evaluate residents' complaints related to sexual functioning. In addition, making beauty salons and cosmetic services available for residents may help them feel physically attractive and sexually desirable. Staff needs to realize that older adults need touch, and family members should be encouraged to include caressing, hand-holding, hugging and kissing when visiting. In addition, encouraging residents to cultivate friendships and relationships as well as providing live pets and offering objects to handle, such as stuffed animals, can help satisfy needs for companionship, love and intimacy.

Managing inappropriate sexual behavior in the nursing home

Inappropriate sexual behavior in the nursing home can create intense burdens for nursing staff, other residents, and family members. If behavioral interventions and counseling fail, pharmacologic therapy may be indicated. Table 3 lists several interventions to control unwanted sexual behaviors in the nursing home. When managing disruptive sexual behavior, it is important to pay attention to the ethical issues involved.

Behavioral therapy

Approaches to nursing home residents who exhibit inappropriate sexual behaviors should aim toward redirecting the behavior verbally, or, if needed, physically. First, the resident should be told that the behavior is not appropriate. Second, targeted behavioral interventions may help eliminate inappropriate acts. Nursing home staff should not ignore inappropriate behavior. For example, a male resident who makes inappropriate sexual advances toward female residents and staff members should be seated away from female residents during social gatherings, and should have his care provided by a male staff member. Exposing and fondling genitals and public masturbation may be minimized by choosing clothing that opens in the back, and by assigning manual activities such as folding towels. These interventions should be employed in conjunction with other means of addressing residents' needs for intimacy and love (Table 2).

Pharmacologic therapy

Selective serotonin reuptake inhibitors (SSRIs) are frequently used in elderly patients exhibiting unwanted sexual behaviors, although the opinion that SSRIs may help is based on only one published case report.⁸ Their relative safety compared to other agents makes them an attractive first-line therapy.

Antiandrogens, estrogens, and gonadotropin-releasing hormone (GnRH) analogues have all been described in case reports of demented patients exhibiting abnormal sexual behavior. While these hormones do lower serum testosterone levels, the levels of residents exhibiting abnormal sexual behavior still commonly fall within the normal range.⁹ The reduction of serum testosterone levels may decrease sexual desires and subsequently eliminate undesired sexual behaviors.

The most frequently used antiandrogens are medroxyprogesterone acetate (MPA) and cyproterone acetate (CPA). MPA is a potent progestogen that decreases serum testosterone levels by inhibiting pituitary luteinizing hormone (LH) and follicle-stimulating hormone (FSH) secretion, while CPA is a potent progestogen that also possesses testosterone antagonistic activity at the receptor level. Major side effects of MPA in men include weight gain, hot and cold flashes, loss of body hair and hyperglycemia.¹³

Adverse effects of CPA include hepatic dysfunction, fatigue, weight gain, depression, and gynecomastia.¹⁴ Cooper¹⁰ administered MPA 300 mg/week intramuscularly for a year to four elderly institutionalized patients with dementia who were exhibiting abnormal sexual behavior. The behavior disappeared within 14 days. After MPA was stopped, serum testoster-

one returned to pre-trial levels, but patients remained free of the disruptive behavior. Weiner¹¹ reported two cases of elderly persons in whom MPA was used successfully to stop unwanted sexual behaviors. While there are no case reports using CPA in older persons with dementia, CPA has been successfully used in younger women with troubling sexual behavior.¹²

There are a few reports in the literature describing the use of estrogens to manage abnormal sexual behavior in elderly demented patients.¹⁵⁻¹⁶ Estrogens decrease LH and FSH secretion, thereby reducing testosterone production. Kyomen et al¹⁵ successfully used diethylstilbestrol (1 mg twice per day) to control hypersexual behavior in a 94-year-old male nursing home resident. Common side effects reported in men receiving diethylstilbestrol included fluid retention, nausea, vomiting, erectile dysfunction, and gynecomastia. Lothstein et al¹⁶ reduced unwanted sexual behaviors in 38 of 39 demented older men who were treated with oral conjugated equine estrogen (0.625 mg daily) or with transdermal estrogen patches (0.05 mg to 1.0 mg once a week). Conjugated estrogen can produce a hypercoagulable state and is better avoided in residents at risk of thromboembolic disease. Benzodiazepines and neuroleptics do not specifically target sexual drive and are thus of limited benefit in managing inappropriate sexual behaviors in nursing home residents.

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Dealing with ethical issues

Sexual situations between residents of the same or different sexes, between residents and staff members, or between residents and visitors raise significant ethical concerns. One study¹⁷ of nursing staff in eight psychogeriatric wards found feelings of confusion, embarrassment, helplessness, anger, denial and aversion when nurses discovered residents having sexual relations in the facility. Nurses often overreacted, provoking anger and even violence in the residents. Mostly, nurses felt torn between moral norms of

the institution and their duty to preserve residents' rights to privacy and the fulfillment of basic needs.

In dealing with a sexual situation in the nursing home, staff should be guided by their duty to create an environment to help residents fulfill their needs and desires, while simultaneously maintaining their dignity and avoiding harm to others. Careful evaluation of residents' decision-making capacity is an integral part of this process. If two residents have the capacity to consent to a relationship, then they probably should be free to engage in sexual activity. Often, however, the solution is not that simple, and may be complicated by restrictive institutional policies and the reluctance of family members. Providing counseling to

family members and educating them about the sexual needs of elderly persons may help avoid ethically challenging situations. In addition, informed consent from the next of kin should always be obtained when starting antiandrogen therapy in a cognitively impaired resident.

Conclusion

Sexual expression in the nursing home, although a complex and challenging issue, reflects a basic human need and is important for the quality of life and well-being of nursing home residents. Enhancing physician and staff education in geriatric sexuality, providing counseling to residents and family members, as well as careful handling of sexual issues as they arise, should help healthcare providers face this challenge.

Table 1. Barriers to Sexual Expression Among Nursing Home Residents

- Lack of privacy
- Mental or physical illness
- Attitudes of staff or family members
- Adverse effects of medications
- Feelings of being unattractive
- Erectile dysfunction in men
- Dyspareunia in women

Table 2. Strategies to Address Sexual Needs of Nursing Home Residents

- Physicians should educate staff on issues related to geriatric sexuality.
- Include sexual history and assessment in residents' care plans.
- Staff should openly discuss their attitudes and concerns about sexual issues encountered in the nursing home.
- Caregivers should be aware of cues that may indicate intimacy needs.
- Promote privacy for residents (e.g., "do not disturb" signs).
- Allow conjugal and/or home visits.
- Have live pets in the facility to provide sensory stimulation for residents
- Offer objects to touch, fondle and hold, such as stuffed animals or baby dolls.
- Encourage opportunities for residents to meet, mingle, and spend time together and encourage relationships.
- Encourage alternate forms of sexual expression such as kissing and hugging.
- Address residents' sexual concerns.
- Make beauty salons and cosmetics available.
- Provide sexual information and counseling to interested residents.
- Educate family about sexual needs of the elderly, and encourage them to include caressing, hugging and kissing when visiting.
- Evaluate residents' complaints about sexual functioning.

Table 3. Strategies to Control Inappropriate Sexual Expression in the Nursing Home

Behavioral Therapy

- Redirect the behavior verbally, or physically if needed.
- Tell the resident that the behavior is not appropriate.
- Isolate the resident from other residents of the sex subject to the act.
- Substitute another staff member of the opposite sex to provide resident care.
- Select clothing that opens in the back for male residents who expose their genitalia or masturbate publicly.
- Ignore unwanted behaviors and encourage appropriate ones.

Pharmacologic Therapy

- Selective serotonin reuptake inhibitors
- Medroxyprogesterone acetate
- Cyproterone acetate
- Estrogens (diethylstilbestrol, conjugated equine estrogen, transdermal estrogen patches).

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MALTCP

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Missouri Association of Long-Term Care Physicians Meeting Minutes • March 16, 2001

Welcome: Steven Zweig convened the meeting as MALTCP President Chuck Crecelius was meeting with other state delegations in his bid for election to the AMDA Board of Directors. Approximately 25-30 people were present for the meeting.

State Advocacy Initiative: Jeff Kerr has worked diligently with the state's Medicaid program to redefine indications for proton pump inhibitors. Progress has been made thanks to Dr. Kerr's efforts.

Treasurer's Report: Cary Bisbey reports that the current MALTCP accounts include over \$10,000.

Division of Aging Projects: Jeff Kerr, Cary Bisbey, Bill Rosen, and Chuck Crecelius met with members of the Division of Aging and other representatives of the long term care industry to discuss various issues. Elopement and decubitus care will be further explored as areas of collaborative efforts. Subjects for further meetings were discussed.

Upcoming state conferences: **Cox Medical Symposium:** April 27 – 28, Clarion Hotel, Springfield, MO.
Caring for the Frail Elderly Conference and MALTCP Annual Meeting, August 24 – 25, Ramada Convention Center, Columbia MO.

Membership: All interested persons are encouraged to return their membership dues. Currently only 43 people are paid up for 2001. Two mailings have gone out to previous members. If you have question about whether or not you are paid up, please contact Susan Kauffman at (573) 882-4991 or KauffmanS@health.missouri.edu.

Missouri Geriatrics Society: Bill Rosen expressed interest in building the Missouri Geriatrics Society, but thought that membership should be merged with MALTCP. He was encouraged to submit a proposal to the MALTCP board prior to the August annual meeting.

House of Delegates Resolutions: Five resolutions were discussed, three of which were submitted by the Missouri delegation.

Attending Physicians Curriculum: Randy Huss and others have developed a 1-2 day curriculum for physicians who provide long-term care. Some MALTCP members participated in a Train the Trainer process this week. All elements of this curriculum can be made available to physicians who either do not spend a great deal of time in long-term care or want to learn more. David Cravens and Randy Huss will discuss opportunities for state involvement.

AMDA Board of Directors: Randy Huss is the

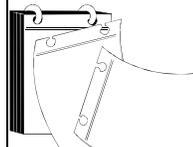
Chair of the AMDA House of Delegates and therefore a board member. Chuck Crecelius was elected to the AMDA board the next day!

MALTCP Board of Directors: President Crecelius is looking for a few good men and women to serve on the MALTCP board beginning this fall. He would like to start a Public Policy Committee to address state and national issues.

Corporate sponsorship: Some state organizations contract with national corporate sponsors to provide expert consultation in return for state chapter support.

Membership was encouraged to consider this option before the next meeting.

• Steven Zweig, M.D.



Mark your Calendar

Nursing Assistants' Week:
June 7-14, 2001. **Career Nursing Assistants' Day:**
June 7, 2001.

Continuing Care Accreditation Commission regional training workshop, Philadelphia, Aug. 6-8. For information contact: Susan Ganson, (202) 508-9471.

Missouri Governor's Conference on Aging Nov. 5-7, Kansas City. With questions contact: Geoff Lanham, (573) 882-9514 or lanhamg@missouri.edu.

Important Notice Regarding Missouri Medicaid Drug Prior Authorization for Anti-Ulcer Drugs

Effective immediately, the Division of Medical Services (DMS) will no longer require the completion of an H. pylori test for a prior authorization request for a patient with the diagnosis of gastroesophageal reflux disease (GERD).

DMS has eliminated the requirement of documentation of diagnostic testing (endoscopy, upper GI, or pH manometry) when the diagnosis is GERD and the physician is requesting the use of an histamine-2 receptor antagonist (H2).

We continue to require documentation of the diagnostic testing for prior authorization of proton pump inhibitors (PPI), unless the physician documents in the prior authorization request why the diagnostic testing would be harmful for the pa-

tient.

When requesting the prior authorization of histamine-2 receptor antagonists or proton pump inhibitors, please provide at a minimum the following information:

- Patient's name
- Patient's Medicaid number
- Patient's diagnosis
- Drug name, strength, dosage form, and total daily dose
- Requesting physician's name, signature, telephone number and fax number (if available)
- If the request is for a PPI, please provide the highest daily H2 dose previously used, and
- If the patient resides in a skilled nursing facility, please provide its name.

Requests for prior authorization are accepted and

responded to via telephone at (800) 392-8030, or fax at (573) 751-2439, Monday through Friday, 8 am to 5 pm. If you have questions about the prior authorization process or the medical exception process in general, call the Drug Prior Authorization Unit at (800) 392-8030.

This memo dated March 1, 2001, is from the Missouri Department of Social Services. If your patient resides in a nursing home, the Department will accept a reasonable explanation as to why he/she cannot undergo appropriate testing (too frail for endoscopy, etc.) Thanks to Dr. Jeffrey Kerr and his efforts on behalf of MALTCP.

Charles Crecelius, MD

MU Nurses help long-term facilities improve resident care

Nurses from the MU Sinclair School of Nursing are working with the Missouri Division of Aging to help improve care for residents of long-term care facilities in Missouri. Based on research conducted at the School of Nursing, the Quality Improvement Program for Missouri's Long-Term Care Facilities (QIPMO) provides free quality improvement consultation to long-term care facilities.

Marilyn Rantz, a Professor in

the School of Nursing, conducted a study sponsored by the Division of Aging in which an advanced practice nurse consulted with long-term care facilities in Missouri. After two years, facilities that had regularly consulted with the APN improved care and outcomes for their residents.

MU QI nurses now visit nursing and residential care facilities statewide to help

improve clinical care and practices for residents. They are not regulators or survey staff.

Facilities are contacted in advance to allow them to schedule staff, such as the quality improvement coordinator, to be available to participate. They are encouraged to take time before the visit to consider what their facility does "best" and to share that information with the MU staff. A primary

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function of this project is to identify “best practices” and disseminate the information throughout the state.

MU QI nurses can provide materials to facility staff about quality improvement methods and practices, and up-to-date clinical information in areas of interest such as skin care, incontinence management, restorative care, and other improvements.

The Division of Aging and MU staff provide each nursing facility in the state with a “Show-Me” quality indicator report showing how they compare with other facilities in areas such as falls, incontinence, skin, activity, or medications. The MU QI nurses help facility staff interpret the report and plan quality improvement activities. They also help with interpreting the federal Quality

Indicator report provided to all facilities across the nation.

In almost two years, QIPMO has assisted 140 different facilities, with very positive responses, and many additional visits requested.

For information or to schedule a QIPMO visit, contact Steve Miller at (573) 882-0241.

Abuse, Neglect and Immediate Jeopardy

• Charles Crecelius, M.D., Ph.D., CMD

State surveyors have new instructions (Appendix Q) on determining abuse, neglect and jeopardy to patients. These rules apply to all certified Medicare/ Medicaid entities, but are especially appropriate for nursing homes. Following is a synopsis of surveyor instructions, and the Issues and Triggers may be found in the insert for this issue of *Long-Term Links*.

Immediate jeopardy occurs when the health and safety of a patient is at serious risk. State survey agencies are to identify and remove any physical or psychological threat, to prevent serious harm, injury, impairment or death. Potential harm, injury or impairment is as important as actual for the surveyor to consider immediate jeopardy.

The number of patients and who is involved (even volunteers, family or visitors) are irrelevant. Psychological and physical harm are equally

serious, and concerns may be for the past, present or future. When such a condition is suspected, the surveyor must investigate until it is verified or dismissed, but the facility’s role in creating the situation and its opportunity to correct it are considered. A specific federal regulation does not have to be selected in order to consider immediate jeopardy.

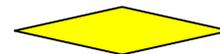
Several key definitions apply to these principles:

• *Immediate jeopardy.* A situation in which the provider’s noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident.

• *Abuse.* The willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting harm, pain, or mental anguish.

• *Neglect.* Failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness.

The issues and triggers are taken verbatim from Appendix Q. It is highly suggested they be read to understand both the exact situations listed and the general concerns suggested. A detailed text, listing examples and interpretations, is not included here, but is available at HCFA’s website (www.hcfa.gov/forms/transmit/r19som.pdf).



The influence of each human being on others in this life is a kind of immortality.

• John Quincy Adams
sixth president of the U.S.
(1767-1848)