

Hafford-Letchfield, T. (2021) The role of professionals and service providers in supporting sexuality and intimacy in later life: Theoretical and practice perspectives. In P.Simpson, P.Reynolds, and T. Hafford-Letchfield, (eds) *Desexualisation in Later Life: The Limits of Sex and Intimacy*. Bristol, Policy Press pp.191-210.

The Role of Professionals and Service Providers in Supporting Sexuality and Intimacy in Later Life: Theoretical and Practice Perspectives.

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Introduction

The transformation of intimacy and sexuality issues within historically and culturally dependent institutions is challenging established views about ageing (Bildtgard and Oberg, 2017). Health and social care are one such institution yet to respond fully, to the growing empirical evidence on what contributes a meaningful life for older people interacting with care services in relation to sexuality and intimacies across different sexual and gender identities. Transcending established views about the role of health and social care professionals in providing meaningful engagement and support for older people to fulfil their sexual needs, requires providers to recognise opportunities for responding to the complexity of issues arising in care. Being open to the range of peoples' relationship situations; making spaces within assessment and provision of care to enable information and support on sex and intimacy to be made available and to engage proactively with the topic is beginning to be recognised within workforce development (SfC, 2017). Building on these involve developing new structures and methods of embedding sexuality within professional education, in policies and care practices and in the commissioning of, and evaluation of services (Hafford-Letchfield et al, 2009; 2020).

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This chapter engages with the literature focusing on what we know or need to know about how professionals and providers within health and social care exchange and interact around sex as a meaningful concept in the provision and quality of care. It focuses on themes that are important to initiating and supporting sexual expression in later life and addresses important transition points where older people are considered 'vulnerable' in care services and where their sexual rights are less likely to be promoted or transgressed. As we saw in Chapter 9, issues may occur in residential care, for people with cognitive decline and in this chapter we expand further on issues that may emerge at the end of life. Building further on Villa and Fabà's contribution in this volume, I highlight some of the underlying theoretical concepts that forge pathways to improved practice and point to areas in which there are good practice guidance from the current evidence available.

A shift in Western societal perspectives has moved sex as primarily situated within the context of marriage and reproduction, to a more central aspect of health and wellbeing in its own right (Hinchliff and Gott, 2011). With increasing emphasis on wellbeing in later life and on outcome-focused support, in both policy and practice (Glendinning et al, 2007), the workforce requires a culturally competent, curious and authentic approach to engaging with older people on this significant area of their personal lives. As people claim new intimate futures, a step-up in the quality of support and care and leadership of these issues is beginning to emerge (Hafford-Letchfield, 2020; CQC, 2020). At the time of writing the current cohort of older people are less likely to have had exposure to formal sex education yet they would have challenged and changed societal prescriptions of sexual expression and openness (Graf et al, 2020). The baby boomer generation (1946 to 1964) however, may be more permissive,

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outspoken, and varied in their conceptualizations of sexuality (Heywood et al., 2019) and the expectations of these so called 'silver splicers' and 'silver separators' (ILC-UK, 2015) have been impacted further by shifts in equality legislation and human rights in respect of diverse sexual and gender identities.

Sexuality as taboo in care; theoretical perspectives

There has been a growing body of research in health and social care about why the topic of sexuality and intimacy remains a taboo or invisible area. Several studies indicate that lack of knowledge, confidence, and skill prevents practitioners from opening a discussion on what they perceive as a deeply personal aspect of life (Lyons et al, 2018; Taha et al, 2020). Professionals and practitioners report feelings of personal discomfort, fear of offending the person or believe there is somebody else better placed to address the subject. The impact of this on older people has resulted in them reporting distress, disappointment, frustration, shock and fear of failure (Roney and Kazer 2015; Drummond et al. 2013), which can lead to despair, devastation and a sense of hopelessness (Loe 2004). Higgins and Hines (2018) suggest that some clinical practitioners fear transgressing a medico-legal or cultural boundary, should they initiate a discussion on sexuality. Further, reluctance to discuss issues may follow a perception that it is inappropriate due to the age, gender, culture, or religion of the person and wondering whether the person would consider and question sexuality as a legitimate topic for discussion, which would cause further embarrassment (Dyer and das Nair 2013; Simpson et al, 2017). Professionals who reflected on the why and how of their communication about intimate issues with patients recognised the relationship between

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being able to discuss sexual issues with patients and their own life, or their lack of life experiences regarding sexuality (Horden and Street, 2007).

Further, Hinchliff et al (2005), in a study of UK GPs, for example, found that almost half reported that they would be uncomfortable discussing sexuality issues with their lesbian and gay patients and Taylor and Gosney (2011) suggest that GPs may recognise that many older people would prefer discussing sexual issues with a doctor of the same gender and as close as their age range as possible. A large Australian study of a thousand students in allied health (Weerakoon et al, 2004) demonstrated that over half would not be comfortable talking to clients about sexuality. Hafford-Letchfield et al's (2009) intergenerational work with social workers and social work students and older people, revealed everyday double standards in ageing. They found that relatively infrequent contact with older people not in touch with services (as opposed to those who present with complex needs and problems) required active unlearning to combat stereotypes before they could begin to learn new skills to address this area of their practice. When talking about trans ageing, Riggs et al (2018) stress the importance of discussing or including intimacy within professional interactions which enables a more rich and holistic account of transgender lives rather than what tends to happen, which is solely focusing on negative experiences such as their mental health and/or discrimination.

All of the above-mentioned issues are implicated in silencing of older people. Indeed, professionals and practitioners can become even more guarded so as to avoid causing any further fear or anxieties and consequentially, a well-meaning strategy of protecting people from their own distress (Wormel, 2014). Being familiar and confident with the relevant issues

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can be enhanced where professionals and practitioners are given regular opportunities to reflect on and discuss their work in ageing services (BASW, 2019). Without these processes, practice can be configured as simple and straightforward where predominantly surface-level, structural responses to practice shortcomings fail to recognise that a more straightforward and authentic approach is vital in providing good basic care (Ruch, 2011). Further, as many of the chapters in this volume have reinforced, people also need the professionals involved with them to recognise when dysfunctional organisational and societal processes desexualise and create systems of care that impede, rather than support recovery and wellbeing.

Theoretical perspectives

Within the theoretical traditions of health and social care, psychodynamic and systems theories together, are one example of the rich and complex framework that explain this approach. Menzies (1987) seminal work for example, noted that care workers strive to externalise their psychic defence mechanisms through developing real aspects of the organisational 'structure, culture and mode of functioning' (p101), such as the creation of depersonalising rituals of institutionalised care. Menzies asserted that these rituals protect carers against anxiety. Over time, an unconscious, collusive agreement among workers occurs about the form of these defence mechanisms, which then becomes part of the impersonal reality of the organisation and compounds ageism (Gertzitz-Meyden et al, 2018). Within residential or hospital care, the use of humour (Ciccone et al, 2008; Hafford-Letchfield et al, 2008) and the constraining impact of risk-averse policies also protect against the anxiety

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inherent in care work. Together they minimise the possibility of emotional connection and reduce the potential for experiencing intimacy or joy in the work and people they serve.

Services and support which do not enable older people to hold on to their unique sense of self and their humanity are therefore dehumanising, not just disempowering
(Bowers, 2009: 45).

Twigg also talks about 'body work' in care settings where focussing directly on 'assessing, handling, diagnosing, treating and manipulating' the bodies of others (Twigg et al, 2019; 1) becomes the object of the practitioners labour. This influences the contexts, the knowledge systems care workers draw upon, and the status and hierarchies they are embedded in. Bodywork lies on the borders of the erotic, where interventions in personal care mimic sexuality and further ambiguity. Twigg et al (2019) also talk about the emotional aspects of bodywork in which empathy, sympathy can be nurtured, and as noted earlier emotions need to be managed positively as part of the care role.

If we understand sexual relations as social relations however, then this necessitates thinking about the various ways in which bodies and embodiment might figure in care settings (Jackson and Scott, 2010). Jackson and Scott (2010) refer to objectified embodiment as bodies as perceptible entities in physical and social space and their categorisation and recognition is a social act, an act of decoding, that enables us to see a particular body as someone we know as classed, raced, gendered, or disabled and aged. Furthermore our bodies can be objects to ourselves which enables each person not only to see his/her body as object, but also to imagine how it is seen by another and envisage engagement with the embodied actions of

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others. Having an appreciation of these different theoretical concepts and ideas are desirable within professional education to be able to reflect upon how care is practiced and the multiple ways in which desexualising attitudes and behaviours are enacted. As the language of 'function' and 'dysfunction' prominent in past medical discourse is being challenged to support more progressive and rights-based practice about 'normality' and sexuality as normal, this needs to be taken forward in the drive towards person-centred care in which care professionals interact with broader discourses that frame their work with older people.

Pedagogical frameworks that promote knowledge of everyday sexuality (Dunk-West, 2007), without recourse to these deviant or medical discourses, are further congruent with professional ethics and values (Dunk West and Hafford-Letchfield, 2011; 2018) and call for learning opportunities that promote the acquisition of sensitive language and listening skills that enable older people to express doubts, anxieties towards desires and meaningful support. The compartmentalisation of sexuality into specialized areas of practice means that everyday sexuality remains empirically unexamined or under-examined within ageing care. It makes pathological what is a basic human need by denying acknowledgement of an individual's culture and identity. Against this backdrop, a number of studies consistently emphasize the impact of organizational policy and professional power in formulating assessment with older people and their limited involvement and participation in the process (Grenier, 2007; Sullivan, 2008; Gertwitz-Meydan et al, 2018). Those examining the perspectives of older service users and carers portray the disempowerment resulting from the increased amount of set procedures used during professional-user interactions and the lack of choice in decision making (Scourfield, 2007; Higgs and Hafford-Letchfield, 2019;

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Sullivan, 2008). Setting the terms of an assessment or provision are important aspects of professional power. It allows professionals to present with expert knowledge and to seek information from their service users in a prescriptive way (Grenier, 2007). The older person is, thus, objectified or classified to become eligible for services or support. Poststructuralist theorists like Foucault (1993) call this the authoritative gaze that objectifies the user of public services, generating power relationships between professionals and service users. Perspectives that redress this imbalance are those which draw directly on the narratives of the older service-users themselves (Hafford-Letchfield, 2016). The increasing leadership of older people in professional education is embodied in the concept of co-production (INVOLVE, 2019). Key principles involve the sharing of power where people learning about sexuality respects and values the knowledge, skills and perspectives of those who can make a contribution and through reciprocity where a joint understanding and consensus and clarity over roles and responsibilities underpins how unlocking potential to fulfil needs in this area of personal life.

While education plays a critical role in shaping attitudes and behaviours towards diversity, self-awareness remains a powerful influence. Within practice with older people, professionals enter the encounter with a range of understandings and meanings derived from professional, personal, and organizational values. These can be reinforced through professional socialization and extensive government policy and practice guidelines developed for working with older people. These belief systems or frames of reference frequently lead to professionally controlled outcomes in practice encounters with older people, which leaves unchallenged some important areas in the repertoire, such as intimacy and sexuality. More

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recently, sexuality is explicitly recognised within professional standards and frameworks particularly in social care (Skills for Care, 2017; RCN, 2018; BASW, 2019; CQC, 2020). I now turn to some of key transition points in care settings where there is scope for illustrating good practice in working with older people on intimacy and sexuality.

Conceptualising de-sexualisation in care settings

Simpson et al (2017) concept of erotophobia seeks to explain how and why care professionals are remiss in giving advice and support to older people on how to have pleasurable and safer sex and the practice skills needed. Beyond this focus on sexuality and the implications for sexual health policies, societal-level understandings of later life around sexuality needs to be something that older people identify with themselves. When developing institutional local policies and interventions more research could focus on uncovering the nuances of older peoples' lived experiences of ageing and its impact on their sexual lives which engages with their own voices (Gertwitz-Meydan et al, 2018a; 2018b). Providers, for example, need to understand the importance of enabling people to manage their sexuality needs. This includes making sure people have access to sex education and sexual health information to help them develop and maintain relationships and express their sexuality. Inequalities persist, deepen and widen across the life course and age discrimination (and its interaction with other areas of inequality) impacts on older people's access to age appropriate sexual health and advice despite this being absolutely related to contemporary public health challenges. For example in the UK, older heterosexual people in England and Wales are getting married and divorced in greater numbers (ONS, 2017) of whom 92% of these marriage partners aged 65 and over

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were divorcees, widows or widowers, with only 8% getting married for the first time (ONS, 2017).

Further, women are more likely to be living without a partner because of widowhood or divorce but equally demonstrate increasing expectations concerning sexual fulfilment. Self-reported data from the English Longitudinal Study on Ageing (ELSA) of heterosexual men found that they were still sexually active into their 70s, 80s and 90s and challenging heteronormative ideas about sexual relationships (Lee and Tetley, 2017). Ševčíková and Sedláková (2020) study of older peoples perspectives on sexual activity in Czechoslovakia emphasized the role of partnered sex in their fulfilment attributed to a profound change that people experience in later life, a reassurance that they will not be alone and a reorientation from knowledge-related goals to emotion-related goals and to focus on what is most essential, typically meaningful relationships from which they mostly derive greater satisfaction.

Research by Public Health England (PHE, 2019) has also reported increasing rates of sexually transmitted infections (STIs) with the largest proportional increase in gonorrhoea (42%) and chlamydia (24%) in people over 65. There is increasing incidence and prevalence of HIV in older people with one in five UK adults with HIV aged over 50. This is also the consequence both of the expansion in uptake of HIV testing and diagnosis and major improvements in treatments, which are helping, people with HIV to live longer. Despite these trends, sexual health clinics in England are less likely to offer a HIV test to older patients despite a mandate to offer testing to all. These low rates can be explained by clinicians not seeing sexual health

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as relevant in this age group, or expecting older patients to be uncomfortable talking about sexually transmitted infections. Nash et al (2015) has reported the lack of prioritization of older people from the perspective of the National Health Service (NHS) and local Department for Integrated Sexual Health (DISH) services in the UK.

Given the diversification of what we are learning about sexual health and wellbeing in later life, it is now clear that services need to step up to ensure that sexual health and relationship services are age friendly and even targeted for those in later life. As we saw from the detailed examination of sexuality in long-term care in Chapter 9, providers also need to understand the risks associated with people's sexuality needs, recognise and support these needs, so that they do not risk discriminating against people or breaching their human rights (CQC, 2019). This tendency towards conceptualising sexual practices as posing risk is a key site of tension in relation to state governance and surveillance (Jackson and Scott, 2010). Whilst a fulfilling and life enhancing activity it can be seen as potentially problematic where the person is seen as vulnerable, or disabled which are in danger of translating sexual acts as ones that concern sexual abuse, risk and danger. In 2019, the UK care regulator, the *Care Quality Commission* (CQC, 2020) reviewed 661 statutory notifications that described 899 sexual incidents or incidents of alleged sexual abuse that took place in adult social care services, which constituted 3% of all notifications in a three-month period. A snapshot from this data revealed that 45% of all people affected were women aged 75 and over; 46% were from a residential home, 28% from a nursing home and almost half of the incidents reported were categorised as sexual assault, defined as sexually touching another person without their consent.

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Moreover, most incidents were alleged to be carried out by people who use services (60%), and the vast majority of those affected were people using services. 16% of alleged incidents were carried out by employed staff or visiting workers, and in 8% it was friends or relatives, were more likely to be carried out by men (485) than women (126). The CQC noted emerging concerns about the use of social media, mobile phones and the internet in sexual abuse. What was troubling however was that, the 5% of received reports of incidents involved consensual activity indicating ignorance and potentially leading to an infringement in people's human rights. These findings illustrate some situations where providers' unwillingness to talk about sex can be due to uncertainty about the issue, a fear of getting things wrong, or a fear of enforcement or litigation as a result of reporting. I offer the following pointers to help to initiate conversations in practice which concern the following:

- promoting positive messages about personal relationships in later life by service providers through their service information, imagery and general approach;
- Professional re-skilling to ensure that their knowledge is up-to-date on referral procedures and where an older person might go to get advice and resources on sexual health.
- When talking to older people about their personal relationship, questions, pose questions in such a way that avoids making assumptions about their sexuality, sexual or gender identity. Model this by using your own pronouns. Likewise, provide opportunities to support sharing and disclosure by affording privacy and respect.

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- Staff should be assessed for the knowledge and skills needed to confidently advocate for an older person regarding their sexual rights and challenge any ageist discrimination and provision to help them develop and refine these.
- Active consultation with older people about issues concerning their intimate relationships, sexual health and social networks can be included in outreach and engagement work.

Older people are increasingly using the internet to find information about sexual health rather than consulting professionals. Older people might be especially susceptible if they do not have good access to Wi-fi or are confined to their own homes. For those with care professionals coming into the home or living in institutionalised environments, they may require the opportunity to purchase various items in relative privacy, including vibrators, condoms, and lubricants. Some older adults may also have difficulty differentiating between advertising, personal opinions, and professional information on the Internet. Clinicians can provide valuable assistance to older adults who may seek out the assistance of the Internet in finding health and sexually related information. In a scoping review of barriers to older adults seeking sexual health advice and treatment, Ezhova et al, (2019) reported only two interventions related to informing sexual health promotion indicating a need to design, implement and assess effectiveness of interventions that help older adults seeking sexual health advice and treatment.

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Transition and 'vulnerabilities'

In residential care homes, the accommodation, care practice and other arrangements should facilitate the operation of sexual rights, and information and guidance should be available if needed to help service users remain safe and healthy, enjoy pleasurable experiences and take appropriate decisions for themselves in this area of their lives (Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (specifically Regulation 9: Person-centred Care); CQC (2019) Guidance on relationships and sexuality. One of the most common issue professionals are dealing with are the complexities around dementia (see also Villar and Fabà in this volume). Dementia and sexuality, intimacy and sexual behaviour in care homes has been one of the subjects of taboo in long-term care given that cognitive impairment does not erase the need for affection, intimacy and/or relationships. The issues involved can be complex, controversial and sensitive and may be guided by the person-centred approach to dementia care (NICE, 2017). Some people found that becoming a carer in their relationship with their partner either increased a sense of intimacy or changed how they felt about sex with the person they cared for particularly if they have developed dementia (Drummond et al, 2013). A lack of recognition of sexuality diversity is particularly challenging in dementia care where ageing sexualities are minimised, sexuality is seen as a behaviour rather than an identity and seen as a risky behaviour at that, something to be managed and controlled (Bauer et al., 2013; 2014).

While the onset of a dementia or any conditions that affect cognitive ability may change the expression, form and nature of a sexual relationship, this does not mean that older people

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with dementia no longer have any desires of a sexual or intimate nature and each situation and individual will be unique (ILC, 2015). Many people may wish to maintain a sexual relationship, experiencing sexual intimacy as a source of comfort, reassurance and mutual support. Identity work also operates at an embodied level, in terms of dress and appearance (Twigg, 2007). Both are significant in the context of dementia and personhood (Twigg, 2010; Twigg and Buse, 2013). People may also form new relationships in care homes, including where one or both has dementia. Even where established relationships are expected to continue in some way, some care workers and relatives may be uncomfortable and reluctant to acknowledge or support the sexual aspect of their relationship. As explored by Reynolds in this volume, the issues concern autonomy, capacity, competence and protection. The ILC (2015, p17) offers the following advice:

- Establish the role played by the care home in supporting pre-existing relationships.
- Promote a culture of acceptance, dignity and privacy for all residents and remembering not all relationships will be hetero or cis-normative.
- Care home workers and managers should try to include, if possible and if volunteered, the social and sexual history of residents in care plans.
- Facilitate relationships by allowing regular visits either within the care home setting or outside.

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- Promote privacy for residents and space so couples can be together: a simple 'do not disturb' sign can help and provide information and advice if needed.
- Continue monitoring and assessment in terms of the resident's dementia and their mental capacity.
- Maintain good communication with the resident's partner and possibly their close family or friends.

Westwood (2016) further highlights what little attention has been given lesbian and bisexual women with dementia and how their respective sexualities/sexual identities inform their experiences of dementia, how they are supported in that experience – both informally and formally – and how their histories, identities and preferences are (or are not) validated and reflected in dementia care provision, especially residential care. These, she suggests, impact in several ways: under-recognition and hence less social support for carers; carer avoidance due to experiences of prejudice and discrimination; community care provision not geared up to meet the needs of lesbians and bisexual women with dementia; and associated increased risk of premature admission to residential care provision (Westwood,2016: 1502). Further, one of the central ways in which lesbians and bisexual women with dementia are differentiated from heterosexual-identifying women with dementia is subject to heightened surveillance and regulation (Cronin et al., 2011), reducing the possibilities for recognition. It can also complicate possibilities for asserting one's rights in care spaces.

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Matters can become complicated, when one or both of the residents may not have the 'mental capacity' to consent to sexual relations leaving them open to being more vulnerable and in the UK the Mental Capacity Act (2005) will be relevant in assessing the situation. The Mental Capacity Act 2005 (MCA) states that a person must always be assumed to have capacity unless it is established they lack capacity and this is issue specific. The definition of incapacity is outlined in section 2 of the MCA as: 'A person lacks capacity in relation to a matter if at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain.'

The MCA (2005) does not provide any mechanism to allow people to make advance decisions or have decisions made on their behalf about sexual matters and *Best Interest* decisions cannot be made in relation to a person's ability to consent to sex. This is specifically excluded in the Mental Capacity Act 2005 by Section 27 on Family relationships (1) (b) 'Nothing in this Act permits a decision on..... consenting to have sexual relations.' Depending on the circumstances, therefore, the relationship and individual involved could be in breach of the Sexual Offences Act (2003), which prohibits sexual activity with somebody who lacks capacity. Establishing the following principles can help to establishing capacity in relation to sexual activities:

- Does the person with dementia understand that they have a choice around sexual activity and that they can refuse?

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- Are they aware that they can change their mind at any time leading up to, and during, the sexual act and able to act on this?
- Do they understand the mechanics of sex and the associated health and other risks?

Where it is difficult to determine a person's capacity to consent to sexual relations, professional advice must be sought including speaking to the local safeguarding authority, and in some instances, may be referred to the Court of Protection for legal determination. In summary, providers should recognise that people living with dementia will continue to express themselves sexually and enjoy intimacy with their partners and loved ones and all steps must be taken to respect and enable expression with respect and privacy. Providers should have developed policies which reflects the values and principles of respecting diversity, equality, human rights and non-discrimination in line with current legislation such as the Human Rights Act 1998 and the Equality Act 2010 and that demonstrate that no person is excluded from the policy on the grounds of gender or sexual identity

Another area of vulnerability for older people, sexuality and intimacy is during end of life care or palliative care. The majority of people in palliative care belong to the older population. In a recent systematic review of the literature on patient-provider communication about sexual concerns with cancer patients, Reese et al. (2017) concluded that sexuality needs are unacknowledged and unaddressed for many people, particularly women. Similarly, in the few studies involving palliative care patients, a particular concern was the failure of practitioners to provide a context or space to discuss sexuality or acknowledge the loss and grief they were

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experiencing because of changes to their sexual selves and their intimate relationships (Taylor 2014). Loss and grief also has the potential to contribute to “total pain” and total distress and the desire for sex and intimacy has also shown to intensify for some at the end of life (Higgins and Hynes, 2018).

The benefits of sexual expression and intimacy in hospice and palliative care are understated where the strengthening of relationships at the end of life include sexual expression and physical intimacy as a significant part of the process. The act of pleasant physical touch including masturbation can release various neurotransmitters, leading to feelings of warmth, muscle relaxation, pain relief and improved quality of sleep (Redelman, 2008). One of the only available empirical studies of health care professionals’ attitudes toward the discussion of sexuality with their patients in palliative care suggests that recognising different relationships and creating conditions for them to flourish is medicalized (Hordern and Street 2007). Hordern and Street (2007) offer some “opening lines” to help discuss the topic and suggest normalising and giving maximum control of any discussion with the person themselves. For example:

‘Many of the people I see express concerns about how treatment may affect their sex lives. How has this been for you?’

‘How has this experience affected intimate or sexual aspects of your life?’

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“Has your role as parent, partner, spouse, or intimate friend changed since you were diagnosed or treated?”

This may include seeking permission by asking if it's the right time and place to discuss sexual issues and whether people would like to discuss it with the professional or someone else or if they prefer to have some written or practical information.

Stausmire (2004) recommends taking a sexual history regardless of the person's relationship status which also helps to overcome any assumptions about the person's gender or sexual identities and who they may be in a relationship with. Cagle and Bolte (2009) also talk about the need for skills in demonstrating a warm, empathic, and open attitude, providing information that dispels myths and misconceptions speaking without technical jargon and terminology, using open-ended questions, and respecting the values of the patient. Other tips include giving patients and their partners time to come up with questions, or to be able to write them down and give them to the professional can increase confidence and a sense of control, reinforcing the confidential nature of the professional interaction and ensuring permission to speak to intimate partners of any consultation remains essential (Cort et al. 2004). These will be combined with practical challenges such as giving advice about medical equipment such as indwelling catheters, IVs, and oxygen masks can pose clear obstacles to sexual activities. For example, nurses identified many possible efforts that could be made to help (e.g. written information on sexuality, tactile massage, medications for sexual dysfunction, improved ostomy care and relieving fatigue). They also mentioned hygiene so that patients can feel clean, fresh and nice. According to the nurses, this could promote

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intimacy (Hjalmarsson and Lindroth, 2019). The International Council of Nurses (2012) suggest that nurses are well suited to develop, implement and evaluate best practices to include sexuality in palliative care in various global care contexts since it aligns well with global ethical values on holistic and person-centred care (International Council of Nurses, 2012).

Conclusion

Given changes in demography, the increasing diversity of the ageing population and the evidence on what older people want in relation to maintaining their independence and continuing to have fulfilling sexual and intimate relationships as their health and care needs develop, the health and social care workforce will need to respond and develop accordingly. As professionals in health and social care move towards more integrated settings, we need to be able to advocate and support older people and continue to acquire additional skills, knowledge, values and approaches that promote awareness of the impact of diversity and generational inequalities in the area of sexuality, sexual and gender identities. There appears to be a willingness to develop and improve services, set practice standards and adapt as some of the government policy and guidance from advocacy organisations emerges. At the front line, training, supervision and reflection within services themselves should support the workforce. Care work involves consultation with older people, taking the time to listen, understand and respond to the issues, concerns and fears the older person may have, knowing and being familiar with rights and responsibilities in relation to sexuality. Ensuring the voices of older people and their advocates are essential to developing and enhancing this key area of practice where people are supported to live as well as they can until the end of

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life. The medical model is still a powerful tenet in the desexualisation of older people in care settings. Health and social care professionals have a lot to offer, given their knowledge and skills in enablement and engagement. Professional training that encourages a strengths-based approach and evidence-based practice will support the recognition of issues impacting on sexuality such as trauma in earlier life, underlying or unresolved problems such as unhealthy or unsatisfactory relationships, adapting to health, disabilities and adjustments to changes in lifestyle (Higgins and Hynes, 2018). The move towards service integration, and an interdisciplinary approach will draw upon other expertise to develop more holistic and person-centred care alongside advocacy, underpinned by a clearly articulated anti-discriminatory and anti-oppressive stance. These will further support the development of tailored and inclusive services based upon older people's own desires and needs.

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