Sexual Incidents in an Extended Care Unit for Aged Men

GEORGE SZASZ, MD*

A survey was conducted among the nursing staff of a 400-bed extended-care unit for aged men by questionnaire to find out what patient behaviors were identified as sexual by the staff and how they reacted to these behaviors. Three types of behavior were identified as sexual and as "causing problems": sex talk (e.g., using foul language); sexual acts (e.g., touching or grabbing, exposing genitalia); and implied sexual behavior (e.g., openly reading pornographic magazines). As many as 25 per cent of the residents were thought to create such incidents. Acceptable sexual behavior identified by the staff were limited to hugging and kissing on the cheek, although their answers implied that residents could need more intimate touching and affection. The survey raised questions about the nature and causes of different types of sexual behavior in the institutionalized elderly and about the roles nursing staff, physicians, and administrators can play in recognizing individual needs while safeguarding both the residents and the staff from the consequences of unacceptable incidents.

There is very little information available about the sexual behavior of older men and women living in nursing homes or extended care institutions.

In a recent study, Wason and Loeb[1] interviewed 27 men and 36 women (average age >80 years) living in several Wisconsin nursing homes about their sexual feelings, attitudes, and practices. The respondents said that they were no longer sexually active, but they did consider sexual activity appropriate for other older people. The investigators were told of the occurrence of occasional sexual incidents in the nursing homes. Their impression was that the elderly people in nursing homes do have "sexual thoughts and feelings and do indulge in some acting out behaviors."

In response to our inquiries, staff members at several extended-care units in the Vancouver, British Columbia, area reported that sexual incidents do occur in their institutions and that these incidents often focus on the staff members. Supervisors reported that staff members repeatedly request in-service education on how to deal with these incidents. The very real need of staff support is clear from the following note included in a request for an educational program: "An 82-year-old debilitated man requests that staff 'touch my penis.' Staff finds this very embarrassing. How do you manage such a situation? What can be done to help him with his needs?"

A survey was conducted among the nursing personnel of a 400-bed extended-care unit for aged men by the author to find out what sorts of patient behaviors were identified by the staff as sexual and what their reactions were to these behaviors.

MATERIALS AND METHODS

Anonymous questionnaires were distributed to registered nurses, licensed practical nurses, aides, and orderlies (a total of 90 people) working in the extended-care unit. Two questions were asked:

1. Describe two sorts of sexual behavior or incidents that have caused you problems;
2. Describe one kind of sexual behavior or incident that is acceptable and should be encouraged.

The answers were tabulated, and selected examples were presented to the participating staff at two in-service seminars to derive an impression of their attitudes toward the reported sexual incidents and the patients who cause them. General inquiries were also made about sexual incidents in two other extended-care units that have both women and men as residents. No attempts were made to secure objective data about either the patients or the staff members.

RESULTS

Eighty three of the 90 questionnaires (92 per cent) were returned. Of the 83 respondents, 16 were

* Professor, Department of Health Care and Epidemiology and Director, Inpatient Services, Sexual Medicine Unit, Department of Psychiatry, Shaughnessy Hospital Faculty of Medicine, University of British Columbia, Vancouver, British Columbia, Canada.

Address correspondence and reprint requests to Dr. Szasz: Sexual Medicine Unit, Shaughnessy Hospital, 4500 Oak Street, Vancouver, British Columbia, V6H 3N1 Canada.

TABLE 1
Sexual Incidents Perceived as Causing Problems by Unit Staff

	Reported By				
	RN (n = 16)	LPN (n = 25)	Aide (n = 26)	Orderly (n = 4)	Total Number of Reports
Sexual talk	11	11	13	0	35
Using foul language	2	1	0	0	3
Describing past sex acts	4	4	5	0	13
Lamenting sex losses	0	0	2	0	2
Suggesting sex encounter	5	6	6	0	17
Sexual acts	17	30	22	2	71
Showing of genitalia	0	2	4	0	6
Sexual talk and showing of genitalia	3	4	4	1	12
Touching staff's buttocks and thighs	2	7	4	0	13
Touching staff's breasts	2	5	1	0	8
Deep kiss when hugged	1	1	0	0	2
Grabbing staff's buttocks, thighs, and breasts	3	2	3	0	8
Taking off clothes inappropriately	0	1	0	0	1
Masturbating publicly	4	8	6	1	19
Sexual intercourse with visitor	1	0	0	0	1
Touching another patient's genitalia	1	0	0	0	1
Implied sexual acts	1	2	2	0	5
Reading pornography openly	0	1	0	0	1
Requesting unnecessary genital care	1	1	2	0	4
Miscellaneous responses	1	3	4	3	11
Incidents were seen but were no problem	0	0	4	3	7
No incidents were ever encountered	1	3	0	0	4

RNs; 25, LPNs; 26, aides; and four, orderlies. The answers gave descriptions of 123 incidents or behaviors identified as sexual and as "causing problems," and descriptions of 73 incidents or behaviors identified as sexual and "acceptable," or to be encouraged. One RN and three LPNs reported they had never seen any sexual incidents, and two RNs, three LPNs, and three aides could not identify any acceptable behaviors. The replies are tabulated in Tables 1 and 2.

Sexual Incidents Perceived as Causing Problems

The incidents and behaviors identified as sexual and as "causing problems" to the staff fit into three broad categories: 1) sex talk; 2) sexual acts; and 3) implied sexual behavior. Thirty-five incidents of "sex talk," 71 incidents of "sexual acts," and five incidents of "implied sexual behavior" were described. Proportionally more "sex talk" was reported by RNs (11 reports from 16 RNs, as compared with 11 reports from 25 LPNs and 13 reports from 26 aides). Reports of sexual acts were evenly distributed.

The "sex talk" category includes incidents in which residents were reported to describe their past or present sexual experiences, to use "foul language," to lament loss of sexual abilities, and to request staff members to enter into some form of sexual activity. One aide wrote, "Residents are asking in public very personal questions . . . like sex problems . . . and asking something be done about it." Another aide reported a resident as saying, "Climb into bed with me." An LPN was asked, "You wash me well, but what *else* can you do?" another, "Give me *good* groin care." Other reported comments include "Let me put it into you" and "You give me a hard-on when you are walking by." In one incident an aide was applying a condom drainage device when "one of the residents asked me to have a sexual relationship with him and he would pay me the ticket to go home."

The "sexual acts" category includes incidents of residents exposing their genitalia (with or without suggestive sex talk), touching or grabbing the "private areas" of staff members, inappropriately removing clothing, masturbating publicly, and in one incident, having "intercourse with a prostitute behind the curtains of his bed."

Reporting an incident of this kind, an LPN wrote, "At one time or another a resident had actually exposed himself, showing his penis." Another LPN recalled, "The resident, lying in bed behind the curtain, called out to a staff member to show her his erection, saying 'look what I have for you.' " Other LPNs reported, "Residents are inclined to touch personal parts of your body"; and "residents grabbing at you, e.g., crotch, breast, and buttocks"; or "touching bottom or very private parts of the body"; and "pinching, touching many parts of the body and keep saying they want love badly." Public masturbation was the most bothersome event and was reported by 25 per cent of the respon-

TABLE 2
Sexual Behavior Perceived as Acceptable by Unit Staff

	Reported By				
	RN (n = 16)	LPN (n = 25)	Aide (n = 26)	Orderly (n = 4)	Total Number of Reports
Physical contact	8	14	14	1	37
Hugs, kisses on cheek, forehead	8	12	14	1	35
Same-gender genital care	0	2	0	0	2
Masturbation	3	3	3	1	10
Permit it in private	1	3	3	1	8
Permit it but do not encourage it	2	0	0	0	2
Social arrangements	3	2	5	1	11
Mixed social events	1	1	2	1	5
Visit with women friends	1	1	1	0	3
Expressions of kindness, love	1	0	2	0	3
Ignore whatever happens	0	2	2	1	5
Miscellaneous responses	3	7	3	0	13
No sexual behavior acceptable	1	4	0	0	5
Unable to give examples	2	3	3	0	8

dents. One LPN wrote it was particularly difficult "to see them actually holding their own genitalia and asking you to sleep with them." An aide objected to a patient "stripping and masturbating in staff's presence." Another aide described a "resident masturbating in public hallway, and when requested he do that in privacy, he stated: It's no fun unless it's in public!"

Acts that "imply sexual behavior" included "reading of pornographic magazines with satisfaction"; "some sexual comments on some actors or actresses they see on the TV"; "suggestive compliments"; and requests for condom changes or disimpaction "when there was no need for it."

The majority of the comments by the staff about this type of incident used language such as "not acceptable," "disgusting," "offensive," "embarrassing," "startling," "maddening," "humiliating," and "frustrating" to describe why the incidents caused them problems. Two LPNs said the incidents "keep me from giving patient more attention." One RN and one aide complained about residents who created extra work when "they repeatedly call you over to check their condom." One RN was exasperated because "when they refuse to do anything and continuously say I want to make love to you, and at the same time holding their genitalia" it was impossible for her to do her work. Another RN and an aide wrote that sexual incidents were a problem to them because "I don't know how to refuse advances with tact" and "[I don't know] how to handle the situation."

Acceptable Sexual Incidents

The sexual behaviors or incidents perceived as acceptable and positive by the staff included limited physical contact between staff and patients and masturbation in privacy. Suggestions regarding behavior to be encouraged were mostly about behavior of the staff and not the patients, and included verbal expressions of kindness and love to patients, genital care of patients by staff of the same gender, and the injunction to "ignore whatever happens."

About half of the RNs, LPNs, and aides and one of the four orderlies suggested "hugging," "handholding," and "kissing on the cheek or forehead" were appropriate behaviors between patients and staff. Two RNs cautioned that such contact should be made "only once or twice" and only "when they are sad or hurt." Mixed social events and "visits with women friends" were recommended by a few respondents. One aide wrote, "They should be allowed to have women friends to raise their morale." Genital self-care or care by male orderlies was recommended when the presence of a female staff member would evoke a sexual incident. One RN and four LPNs felt that "sex behaviors are not acceptable in any form."

There were varying comments about the acceptability of masturbation. One RN, three LPNs, three aides, and one orderly felt that masturbation was acceptable when done in private. One aide wrote "when I see a resident masturbating, I pull the curtains and leave." An LPN said, "masturbation in private, but how do we encourage it?" One RN commented, "Masturbation is acceptable but should not be encouraged." Another RN wrote, "Masturbation—considered normal, but *encouraged?*" Two RNs, three LPNs, and three aides had no ideas about what sexual behaviors might be acceptable or should be encouraged. One added, "but there must be a solution." One aide suggested, "Residents, when well enough, could take a taxi downtown to visit a prostitute."

Outcome of the Seminars

Two weeks after the questionnaires were collected a meeting was arranged with staff members to discuss them. Two groups of about 15 staff members were able to attend and offer further comments. The staff members emphasized that sexual incidents and behavior were a daily occurrence, although the majority of incidents were caused by 20–25 per cent of the residents. Certain patients' behavior was well known by most staff members: "Oh, that Mr. D! How he talks! . . . Would I like to have sex! Would I enjoy it!" Or "That Mr. M! He uses a cane to lift up the staffs' uniform!" Or "Try not to get into a corner without a way out from Mr. L!" Revelations about the behavior of other patients came as a surprise to many of the staff members, as if these patients had exhibited certain behaviors to specific staff members only. In comparing their experiences, the staff members observed that, in general, patients who were sex talkers (reciting past experiences, lamenting loss of sexual vigor) usually did not "act," those who exposed themselves did not touch or reach for a staff member's body, and those who touched or tried to caress the female staff members' "private areas" did not grab at their arms, legs, or breasts.

The consensus of the groups was that "touch helps in any treatment or activity" and that "residents demand demonstrations of affection." However, one female LPN who had worked in a mixed ward added, "It is easier to hug ladies than men."

Comments from Other Extended Care Units

To get an impression of the sexual behaviors and incidents in a mixed extended care unit, supervisors of two such units collected data from their staff members in an informal manner about "sexual incidents that have given you negative feelings" and incidents "which you felt good about." The reported incidents concerning men were mostly negative and included "foul language," a "resident asking nurse to wash him in a certain way so that he could have an erection," some "male residents making passes at other resident ladies who could not look after themselves," and "men masturbating in public, upsetting residents, staff, and visitors—it's embarrassing." One staff member commented honestly that "Nurses can't overcome their repulsion toward the residents—even though they feel ashamed about their feelings."

In contrast, sexual incidents about women residents were fewer and more sympathetically reported. "An elderly lady was found across the hall cuddled in a man's arms. These two were friendly during the day. Should she be left there for the night or put back in her own bed?" "A woman, about 65, confused, she was always looking for her husband. One night she crawled in bed with a fellow in the man's four-bed ward. The sad part was that *he* knew what was going on, but she was sure that he was her husband." "I remember an old married couple—they were both confused. They had separate beds, but quite often you would find them both in his with siderails up and their door closed tight with a chair behind it!" One supervisor wrote, in a different tone, "Couples who are in extended care have not been placed in a room together because their medical conditions are usually too disparate. Couples do not seem to desire privacy when one is an extended care patient. They also don't express any desire for a place where they could interact."

DISCUSSION

Wason and Loeb[1] observed in their study of sexuality in nursing homes that "medical and behavioral people showed great reluctance to discuss the subject." In contrast, a majority of staff members in our study freely described the sexual incidents generated by residents of the unit.

Our study indicated that the staff identified a variety of acts and conversations as sexual. Some of the acts, such as taking off clothing in public areas or requesting unnecessary genital care, were considered to be unacceptable because they showed a lack of appropriate self-control of sexual impulses. Other actions were viewed negatively because the intensity or duration of the action changed its implication. So, for example, while hugs, holding hands, and exchanges of kisses on the face are identified as both sexual and acceptable, a deep kiss or a strong and lasting kiss becomes unacceptable. Several overt sex acts, such as masturbation or sexual intercourse with visitors, might be acceptable as long as these acts done in private or an effort is made to make the act private by, for example, closing the curtains around the bed.

To clarify staff attitudes toward the sexual incidents, two discussion meetings were arranged. Presentation of the results provided an approach to in-service education in this area. It appeared to be important to staff members to hear it acknowledged that sexual incidents do occur, that they are not the product of the staff's imagination, and that the supervisors are aware of some of the problems. In-service "sex education" seminars can be successfully integrated into case histories so that staff concerns about the welfare of the patients may surface. This would also give staff members a chance to recognize and talk out their anger toward certain residents. Discussion of experiences, feelings of discomfort, or inventive methods of dealing with situations may give new ideas to some staff members, confirm the wisdom of others, and reassure most.

Alex Comfort[2] suggests that "staff must be educated not to treat normal appetency as evidence of senility. Separation of married couples in institutions should be seen as an outrage . . ." He continues: ". . . petting rooms, permission to hold hands under close chaperonage, mockery or sedation . . . need replacing with dignity." This should

be the ultimate objective of in-service sex education programs. With regard to patient behavior management, sexual counselling is suggested by Eaid[3] and arranged sexual partnerships by Leviton.[4] Similar ideas were brought up by staff members in our study. Some answers to a number of epidemiological, medical, and administrative questions would be of value before such suggestions are implemented.

Examples of Epidemiological Questions

What are the demographic characteristics of the "problem" patients and of the reporting staff? What agreement is there among the staff and between the staff and patients about what is sexual? What are the incidence and prevalence of sexual incidents? When patients are identified as problem-generating, does their sexual behavior become less excusable and more noticeable? Is it true that male patients "act out" more than female patients? Is, therefore, the sexual expression of certain feelings primarily a cultural characteristic of men? Are there requirements for release of certain tensions that go unmet? To what extent are acts of masturbation secondary events to physical conditions such as urinary infections or skin irritations or to psychologic states such as anxiety, depression, or tension? Are the sexual behavior patterns of certain patients a continuation of life-long habits, or are they new developments? Does physical care of male patients by female staff members trigger sexual incidents? Is the staff observation that residents are "specialists" correct—that is, do some limit their sexual behavior to talk only, while others touch only but do not grab, yet others grab, and still others masturbate?

Examples of Medical Questions

What is the responsibility of physicians when the nursing staff reports sexual incidents? What sex-related questions need to be included in the admission history or need to be posed at the periodic medical visits? If a relationship might exist between medical procedures (e.g., TUPR, medications) or medical conditions (e.g., stroke, urinary disorders, etc.) and sexual behavior patterns, then what measures could be taken by the physician to safeguard the patient from the consequences of unacceptable behavior or to forewarn the nursing staff that such behavior is sometimes secondary to the procedure? What methods of treatment are available to help patients with sexual behavior that shows a lack of appropriate impulse controls?

Examples of Administrative Questions

"Privacy" and "dignity" were mentioned repeatedly by the respondents to our survey. How can the administrative responsibility to provide a physical environment that ensures privacy and dignity for patients be implemented? What policies need to be implemented to safeguard the welfare of the staff? The LPNs in our study reported a larger number of bothersome sexual incidents than the other professionals; the number of incidents reported as acceptable, however, was similar among all groups. Perhaps these variations are related to the nature of the work required by different positions (e.g., some jobs involve more physical care than others), to the gender of the staff members in those positions, or to educational or cultural differences between the various job levels. Taking these differences into account, what sort of information, then, should be provided for new staff, and what in-service education would be of value to the staff? What chain of communication is best able to encourage reports of incidents, offer support to staff members, and defuse embarrassing and bothersome situations?

This study brought to the surface many questions about the sexuality of institutionalized aged men and showed the need of health care professionals to discuss and evaluate their responses to the sexual behavior they observe. Further studies are needed to help us understand the natural history of sexuality as people age, and the effects of institutionalization on it. Such studies would help medical, nursing, and administrative staff to respond rationally and effectively to the people in their care.

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