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## **Bridging the Gap of Age and Awkwardness: Improving Geriatric Sex Education**

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*Abstract:*

Improving geriatric sex education is not a common thought for many Americans, but with a quickly growing population it may soon become a common topic for discussion. Discomfort, awkwardness, and lack of communication often keep health care providers and physicians from discussing sexual health with their elderly patients. These limitations are significantly impairing physicians and health care providers from educating their patients about their sexual health and addressing any concern the patient might have about their sexuality. Sexual health in geriatrics is a growing concern among many health care fields today as the elderly are participating in risky sexual behaviors but are not using safe sex practices. After collecting research from 28 sources, I have concluded that there are many inadequacies that are preventing quality sexual health education for the elderly by examining the history of sex education, discussing the limitations and barriers of adequate sexual health education, and analyzing the training and education methods being used to improve this elderly sexual health education. There are many ways in which improvement for geriatric sexual health education can occur; from enhanced communication to quality training for geriatric health care providers; but in the end the overall change needed will have to come from our society as a whole. The geriatric population is the fastest growing population in today's society and soon this population will have new needs and concerns that will have to be addressed by us and future generations.

*Key words:* sexual health, geriatrics, health care providers, education, training

## **Bridging the Gap of Age and Awkwardness: Improving Geriatric Sex Education**

### *Background:*

Today, the population of the United States is growing and changing in significant ways; in that within a few decades the growing geriatric population will have a drastic effect on the demographics and potentially the education criteria of our future population. According to the 2017 National Population Projections by the United States Census Bureau; “By 2035 there will be 78.0 million people 65 years or older” thus resulting in a higher need for care, environments, and education based on these predictions (Bureau, 2018).

Health care providers and physicians are experiencing problems with discussing geriatric sexuality, in that many times there is little to no discussion of geriatric sexuality with their elderly patients. Sexual Education is extremely important as it can deter the spread of diseases, such as STDS or STIS. Sexuality education provides methods, information, and experiences to those who are learning and developing their own sexuality. Many times the discussion of geriatrics having sexual intercourse is an awkward or weird topic to discuss. This may be true but with a growing older population these topics should be discussed and reviewed. STD’s and STI’s are not affected by age if an older individual has unprotected sex the possibility of contracting an STD is still equal to that of a twenty-two year old (Monteiro, Humboldt, & Leal, 2017).

Sex occurs at all ages and the education about sex should continue across a life time. The human body is continuously changing including how one has and performs with sex. Sex education should not stop after one leaves the classroom, it is a continuous experience that health care providers should have the necessary background in and training. Being considered the age of an older adult does not mean one has stopped having sex. Multiple technological and medical

advances have allowed our geriatric population to remain sexually active. Preparing and discussing sex in geriatrics with training and furthered education for health care providers is and will be extremely important as the United States older adult population grows (Adams, Oye, & Parker, 2003).

Sexual education in geriatrics involves the education pertaining to the sexuality of older adults. Under this individuals are educated on problems or experiences one might encounter when working within the geriatric population. For example, how would a health care employee of an assisted living facility resolve a situation in which multiple residents have been having sexual encounters with each other and now there has been a gonorrhea outbreak? Problems such as these occur quite often and knowing how to solve, prevent, and manage these issues that arise is extremely important. Discussing and learning about these possibilities one may encounter with training better prepares health care providers and physicians who work with geriatrics. (Adams, Oye, & Parker, 2003).

In today's society sexual education is not relevant to one age group but rather to all. The invention of computer technology, medical advances, and changing societal views has helped our older population to navigate the internet, have prolonged enjoyable sex due to the little blue pill, and have open discussions about one's sex life (Adams, Oye, & Parker, 2003). Providing more opportunities to continue learning about geriatric sexual education through facilitated discussion with geriatric residents and continued training for health care professionals has become more pertinent in the current population. Geriatrics sexual education has been increasing but at a less than steady rate. Many geriatric long-term care facilities are providing education modules and training sessions to learn how to solve these sexual encounters and for resident staff to have more education concerning the older population (Taylor & Gosney, 2011).

The United States Census Bureau's 2017 National Population Projections, revealed that 2030 will mark an important demographic change for the population of the United States. This dramatic turning point is going to be a result of "all the baby boomers reaching the age of 65 years or older" (Bureau, 2018) thus resulting in a further expansion of the older geriatrics population. This leaves roughly "1 in 5 residents" being of retirement age while abruptly refocusing the need for development for the elderly population (Bureau, 2018). These changing demographics allow for new research and information to be gained along with new teaching methods and training to be developed for health care providers entering the geriatric field (Bureau, 2018).

The objective of this thesis to understand the lack of training and education with regards to the growing geriatric population. Many do not realize how rapidly the older adult population is growing and why it is important to increase sexual education in geriatrics. In order to understand the increasing need for further sexual education and training within geriatrics, I will first discuss the history of sex education. Next, the inadequacies of geriatric sex education will be reviewed and expanded with discussion of how health care providers can expand their knowledge on sexual health in geriatrics. Finally different training modules and education methods will be reviewed and discussed for their effectiveness in providing quality knowledge to health care providers on the topic of geriatric sexual health.

The factors involved in providing in depth knowledge on geriatric sexuality and sex education include research studies that have been tested and reviewed, along with training modules and education methods that have been analyzed to improve the knowledge of geriatric sexual education among health care providers, care givers, and assisted living/nursing facilities. Finally, the outlook for future sex education training for geriatric caregivers will be reviewed and

discussed for future research with the United States growing older population for health care professionals (Aguilar, 2017).

### ***Discussion of Research:***

This report will first cover a brief history of sex education. I will then discuss multiple inadequacies in sexual health education for geriatrics. Lastly there will be a discussion on the different training modules and education methods that have proved to be successful in improving the sexual health education for staff and the elderly.

### ***Allied Research Section: Brief History of Sexual Education in U.S. History***

#### ***Brief History of Sex Education:***

In today's society sex education is typically a common place discussion within one's middle and high school curriculum, but has only been implemented since the early 1900s. Prior to the early 1900s, sex education was generally a responsibility for an individual's parents and religion. Sex education began to expand and become important in the early 1920s when it was first introduced in high schools due to the belief that higher quality sex education would help soldiers from contracting STIs and STDs (Harris, 2015).

Roughly ten years later, the U.S Office of Education introduced its first educational materials for sex education and in depth training for teachers. Although sex education had begun to become present in middle and high schools all across America. It was not until the late 1930s and early 1940s that this new curriculum became present in colleges. A major milestone for sex education was in the early 1960s, when the Sexuality Information and Education Council for the U.S or SIECUS for short was developed. This council aimed to provide guidelines, criteria, and comprehensive educational information adequate for teachers to use in the classroom (Harris, 2015).



The late 1960s and 1970s began to see an increase in parental protests on the content discussed and taught about sex education in schools. 1975 saw the development of a concise but important definition of sexual health by the World Health Organization or WHO. According to the World Health Organization, the definition of sexual health includes

“...the integration of the somatic, emotional, intellectual, and social aspects of sexual being, in ways that are positively enriching and that enhance personality, communication, and love. Fundamental to this concept are the right to sexual information and the right to pleasure...” (History of sex education in the U.S., 2016).

This new definition provided by the World Health Organization, along with the increase in parental protests towards sex education, would lead to a new reformation of the sexual education program almost a decade later in the 1980s. These new ideals and objections would begin a new development of sexual education based on teaching abstinence and chastity (Organization, 1975). The 1980s also began to see a shift on funding for sex education based programs. For example in 1981 the Adolescent Family Life Act was written in order to start providing funding for abstinence and chastity only sexual education where in two short decades close to thirty one million dollars of funding would be dedicated towards abstinence only sexual education in schools (Harris, 2015).

A crucial decade for U.S. sexual education history was the 1990s, in which there was improvement in sexual education. In the early 1990s, the National Guidelines Task Force was created. This task force would revisit, revise, and republish national guidelines for quality sex education taught to not only middle and high school students but was expanded to kindergarten through twelfth grade (Mather, 2016). These new guidelines sought to improve the previous educational guidelines, while also providing local communities with a framework design for

effective curriculum or to evaluate and improve upon existing curriculum (Cornblatt, 2009). The four key points that resulted from this newly revised sex education model included

1. Provides accurate information about human sexuality, including growth and development, anatomy, physiology, human reproduction, pregnancy, childbirth, parenthood, family life, contraception and sexually transmitted infections.
2. Helps young people develop healthy attitudes, values, and insights about human sexuality by exploring their community's attitudes, their family's values, and critical thinking skills to understand responsibilities to society.
3. Helps young people develop communication, decision-making, assertiveness, and peer-refusal skills for preparation of reciprocal, caring, non-coercive, and mutually satisfying intimacies and using contraception and safer sex when they do become sexually active.
4. Encourages young people to make responsible choices about sexual relationships by practicing abstinence, postponing sexual intercourse, resisting unwanted and early sexual intercourse, and using contraception and safer sex when they do become sexually active (Cornblatt, 2009).

Since the 1920s there have been multiple stepping stones, milestones, and developments made for sexual education within the United States; but there is still an underlying problem in the continued sexual health education over the course of one's lifetime. Although there are inadequacies with continuing sexuality education beyond high school and college; there are improvements being made for the growing adult population (Monteiro, Humboldt, & Leal, 2017).

### ***Critical Research Section: Inadequacies and Training Analysis***

#### *Inadequacies in Geriatric Sex Education:*

Sexual health education is an important piece of an individual's overall health across their lifespan. There are many barriers that have occurred within the sex education realm of the geriatrics population. According to a research study by Ports and colleagues from 2014, "Physicians and health care professionals encounter many barriers attending to and assessing the sexual health needs of older adult patients" (Ports, Barnack-Tavlaris, Syme, Perera, & Lafata,

2014). In other words, sexual health education becomes predominantly learned in adulthood from one's physician or primary health care provider. If one's health care provider is not adequately discussing these sexual health topics then how is one keeping themselves from sexual behaviors that can put them at risk? This study aimed to review and analyze the sexual health discussions older adults were having with their physicians during their periodic health exams. During this study close to 400 PHE's (Physical Health Exams) with adults who are 50 to 80 years of age, were analyzed using a qualitative content analysis (Ports, Barnack-Tavlaris, Syme, Perera, & Lafata, 2014).

The results of this study showed researchers that close to one half of the PHE's were able to include some discussion concerning the patient's sexual health with the physician being the main facilitator of these conversations. This study also concluded that there is a two level regression model between the patient and the physician with gender discordance, race discordance, and the increasing age of the physician was associated with the PHE's and the sexual health discussions. These concluding results show that race, age and gender have a negative or regressive effect on the communication of sexual health between an elderly patient and the physician. An example of this regression can be found in Appendix B on Page 30, in which the gender of the physician and patient had a negative correlation. This is a negative correlation in that if a patient's physician was of the opposing gender then the patient would be less likely to discuss their sexual health than if the patient's physician was of the same gender (Ports, Barnack-Tavlaris, Syme, Perera, & Lafata, 2014).

Overall, the study aided in highlighting that geriatric sex education should focus on helping increase the physician self-efficacy when assessing the sexual health in gender and race discordance, and the age of patient interactions. Similarly, interventions and programs seeking to

improve geriatric sex education will do best if there is a focus on increasing, developing, and implementing improved education on sexual health and sexual risk behaviors. If organizations or educators, such as physicians, are able to develop these programs for the geriatric population, then not only is the sexual health discussion and education improving; but these programs are also empowering individuals to seek information from their health care providers (Ports, Barnack-Tavlaris, Syme, Perera, & Lafata, 2014).

Many of those within the older adult population continue to be sexually active throughout their lives. Seventy-three percent of individuals who are between the ages of 57 and 64 years and fifty-three percent of individuals between the ages of 65 and 74 years have reported that within the previous year they were still engaged in sexual activities (Ports, Barnack-Tavlaris, Syme, Perera, & Lafata, 2014). Sexual activities across one's life span can increase the quality of life and improve long lasting relationships, but the risk of sexually transmitted infections and diseases (including HIV) is becoming an increasing concern among the older population. The geriatric population is more likely to have a significantly limited education and knowledge about sexually transmitted infections, diseases, and HIV/AIDs. The older population is also less likely to participate in safe sex practices than the younger population (Ports, Barnack-Tavlaris, Syme, Perera, & Lafata, 2014). For example, this past decade has displayed a growing and concerning health trend, in that fifteen percent of new HIV/AID diagnoses are those who are aged 50 years or older in the elderly population (Ports, Barnack-Tavlaris, Syme, Perera, & Lafata, 2014).

Another barrier that affects quality sex education in geriatrics is that physicians and health care providers are inadequately identifying and screening individuals within the elderly population who are at risk for sexually transmitted infections and diseases based upon their sexual history. In order for sex education within the geriatrics population to improve, health care

providers must prepare and improve their communication methods. This allows physicians and health care providers to identify geriatric individuals who are at risk for STI's and STD's. These improved screenings also allow for the prevention of disease, mortality, and morbidity in this growing older population (Ports, Barnack-Tavlaris, Syme, Perera, & Lafata, 2014).

There are many components with HIV, STI, and STD prevention that suggest a comprehensive sexual history, sexual activity, and even behaviors that can indicate risk for an individual (Ports, Barnack-Tavlaris, Syme, Perera, & Lafata, 2014). Some of these behaviors can include but are not limited to: the number of sexual partners, frequency of sexual intercourse, injection drug use, types of sex, and history of STI's. A more comprehensive list of these components that indicate risk can be found in Appendix A on Page 29. Although these recommended components are available for health care providers to utilize, the rates in which sexual histories are recorded remains deplorable.(Ports, Barnack-Tavlaris, Syme, Perera, & Lafata, 2014).

A study conducted among 135 physicians discovered that roughly sixty percent of physicians seldom or never discuss sexual health or HIV/AIDS with their patients who are over the age of 50 years old (Ports, Barnack-Tavlaris, Syme, Perera, & Lafata, 2014). This study also found that seventy-two percent of the physicians have spoken about STI, STD, and HIV/AIDS risk factors with individuals who are among the younger population under the age of 30 years. Similarly, thirty-eight percent of men and only twenty-two percent of women typically discuss their sexual activity and sexual health with their physicians past the age of 50 years (Ports, Barnack-Tavlaris, Syme, Perera, & Lafata, 2014).

Sexual health is an extremely integral part of one's overall health, but research has shown that health care providers are underestimating the significance of their patients their sexual

health. Many times physicians are equating sexual health needs and concerns with a younger population, thus leaving the sex education in geriatrics lacking. Physicians have also reported to researchers that there is discomfort and awkwardness when sexual health and sexual activity is discussed with their older patient (Lindau, et al., 2007). According to researchers Gott, Hinchliff, and Galena, “practitioners beliefs about sexual behaviors of older adults were based on stereotypes of aging and sexuality, rather than experience with patients” (Gott, Hinchliff, & Galena, 2004). Not only is there discomfort and awkwardness found in sex education but “the strongest demographic factor correlating with documenting sexual history was the patients age; more specifically a patients increased age has an inverse relationship to documenting sexual history” (Loeb, Lee, Ellison, & Aagaard, 2011).

The interactions and communication between health care providers and patients that have continued dialogue of the sexual history, sexual activity, and risk factors of the patient significantly improve the quality of life of an older adult. Patients who have further in depth discussion about their sexual health, sexual activity, and risk factors are more likely to report issues with their sexual functioning (Loeb, Aagaard, Cali, & Lee, 2010). Although there are multiple barriers, limitations, and inadequacies found in providing quality sex education to the geriatric population, there continues to be an influx of development for new training modules and education methods to assist in improving the sex education for this population today.

#### *Effective Training Modules:*

Providing sex education for the geriatric population is best achieved with focused, targeted, and quality training modules and education methods that have been developed, improved, and are easily attainable for health care providers. There are multiple training modules that have been implemented for the health care providers of the geriatrics population. The ones

discussed and analyzed in this section are those that have gone through multiple trial and error processes but have proven to have high results in effectively training health care providers and educators within gerontology (Pineiro, et al., 2015).

The first training module to be discussed was developed by educators at Duke University. The educators at Duke University wanted to design a program that would develop “quality educational programs and teach medical learners about geriatrics” for geriatrician and non-geriatrician faculty. Duke University and three other leading medical schools offered this program in order to train geriatrician and non-geriatrician students because there is an increasing need to advance geriatrics care. At the time this program was first implemented, in 2005, eighty-three faculty and fifty-two institutions across the United States participated. Participants learned further information on the geriatrics population by participating in a mini-fellowship program with workshops and 1 week campus sessions on curriculum development, and teaching skills that were then implemented in their home institution (Pineiro, et al., 2015).

The program began in 2005 and ran until 2009, in which each year mini-fellowship and weeklong workshops were offered three times per year. These fellowships and workshops had different educational topics within geriatrics. Some of these workshops included further education on geriatrics long-term care, palliative care, and geriatrics general education. The workshops or week long campus sessions also included patient observation, individual mentoring, independent activities, and scholar project presentations. The mini fellowships also included different subspecialties within gerontology and a gerontology focus for medical students (Pineiro, et al., 2015).

The reasons for participants in this program did vary. Many of the participants completed this program in order to learn tools to be better teachers and evaluators. The participants were

encouraged by their institutions to participate because of the experience gained through curricular responsibilities, directing a rotation, and the institutions thought the program would aid faculty in accomplishing these tasks. Other participants stated that they participated in order to solidify secure employment along with obtaining further experience in the geriatric field (Pineiro, et al., 2015).

The efficiency of this program among the participants was gathered through evaluation surveys and a post one year follow up with a faculty of the program. Overall, the survey results highlighted that this four year program was highly satisfying in that the overall mean rating for the mini-fellowships was “4.6 on a 5.0 scale” (Pineiro, et al., 2015). Many of the scholars also agreed that the activities within the mini-fellowship and workshops were well organized, effective, and accomplished the purpose of furthering an education in gerontology. According to Pineiro and associates, “the highest-rated activities were the workshop on designing educational programs (4.9) and the individual mentoring meeting with Duke faculty (4.8)” (Pineiro, et al., 2015).

Although this program provided any effective training and educational models for the geriatrics population, there were some limitations and barriers present too. One barrier cited by participants, was that of a “lack of protected time for teaching and curriculum development” and “limited resources” (DUKE). Most surprisingly, a “learner’s lack of motivation for learning about geriatrics” was also a barrier (Pineiro, et al., 2015). This program may have had some limitations or barriers, but it still remains effective and a quality training module for participants whether they be medical students or future health care providers that are within a nursing home. This program achieved its goal of providing quality and further in depth education on



gerontology and illustrated how improving a program can help our growing geriatric population (Pinheiro, et al., 2015).

A second training model that provided effective education to participants, is that of the PLISSIT model; which can be used by physicians and health care providers to adequately discuss sexual health and sexual education with an elderly patient. This model was originally developed in 1976 by Dr. Jack Annon who was a clinical psychologist. In 2000, there were multiple open ended questions added to this model in order to more effectively guide the physicians or health care provider's assessment of an older adult's sexuality (Folashade, et al., 2014). An example of these open ended questions include "Can you tell me how you express your sexuality?" or "In what ways has your sexual relationship with your partner changed as you have aged?" (Folashade, et al., 2014). Many physicians have only vague and incomplete understanding of the needs and concerns of the sexuality of the elderly. Simply because one is aging does not mean that their sex life is decreasing, but the loss of emotional and physical intimacy is a uniquely profound concern within the older population (Rosen, Kountz, Post-Zwicker, et al., 2006).

The PLISSIT model allows physicians and health care providers to facilitate these awkward and misguided conversations with an elderly patient. The acronym of PLISSIT itself helps aid physicians and health care providers with how to approach discussing sexual health and sexually activity with their patient. P is for seeking (P)ermission from the patient to discuss their sexuality, LI stand for the provider sharing (L)imited (I)nformation about sexual issues that can affect the elderly patient, SS represents how a provider can promote (S)pecific (S)uggestions for the patient to improve their sexual health if needed, and IT correlates with the physician or health care provider recommending (I)ntensive (T)herapy that could be needed if the patients sexual dysfunction or concern is beyond the physicians expertise (Folashade, et al., 2014).

This model provides a foundation for physicians and health care providers to have an in-depth and open communication about the sexual health of an elderly patient and the PLISSIT model has proven to be successful. Elderly patients want to discuss their sexual health with their physicians, but many times do not because the physician does not initiate this important dialogue. According to the Global Study of Sexual Attitudes, “57 percent of 120 geriatricians surveyed routinely took a sexual history, even though 97 percent of them believed that patients with sexual problems should be managed further” (Rosen, Kountz, Post-Zwicker, et al., 2006). The PLISSIT is a simple training method that can allow a physician to bridge the gap of this sometimes awkward discussion with their elderly patients.

This training method, when implemented, highlighted its success in that more physicians were confident in adequately discussing sexual health with their elderly patients. This success was also found for the patients themselves, in that they were more willing to reveal their sexual concerns or possible dysfunctions they may be encountering (Folashade, et al., 2014). This education method had great success, but as always there are one or two limitations. One of the major limitations, is that this model is not provided or used by many physicians who do not have a high magnitude of elderly patients. In other words, this model is more likely to be used by a physician who has a specialty in gerontology rather than a family doctor. Although this limitation is presented, this model could still have availability and use for more than physicians who are in the geriatric field. This model can easily be converted for other uses such as being used by a manager of an assisted living facility with specifically adapted open ended questions (Folashade, et al., 2014).

*Effective Education Methods:*

An education method that was developed specifically to “support the normalization of sexuality in aged care homes and assists facilities to identify where the enhancements to the environment, policies, procedures and practices, information and education/training are required” is the SexAT or Sexuality Assessment Tool (Bauer, Fetherstonhaugh, Tarzia, Nay, & Beattie, 2014). This tool was originally developed using the Delphi Technique in which the SexAT tool methods and criteria were condensed from literature and qualitative interviews with assisted living facility staff, residents, and families. The Delphi Technique aids in helping researchers and developers refine the pool of items while also validating this new developed SexAT tool (Bauer, Fetherstonhaugh, Tarzia, Nay, & Beattie, 2014)

The finalized SexAT tool consists of a twelve page booklet with sixty-nine questions or items, where the first part includes a background of developing the tool, definitions, and the purpose behind this tool. The second part of this tool, is an explanation on the function and implementation of the SexAT tool. While the final section provides information about the scoring of the assessment; the SexAT is designed to be self-administered by a health care provider or manager of the facility who is familiar with the procedures and programs currently in place. The format of this tool consists of “Yes, No, or Sometime” answers in order to provide a simplistic scoring and results. This tool is bridging literature and physical assessments of residential aged care facilities that want to further support the sexual health and sexual activity of their residents. The effectiveness and easy usefulness of the SexAt tool “fills a gap in aged care service delivery” (Bauer, Fetherstonhaugh, Tarzia, Nay, & Beattie, 2014). The SexAT tool provides a framework for facilities and future researchers (Bauer, Fetherstonhaugh, Tarzia, Nay, & Beattie, 2014).

The SexAT tool may have multiple successes for its usefulness and effectiveness, but there still are some limitations. One major limitation is that the tool is not fully in practice. The tool also needs some improvements to be fully functional and translating the knowledge that can be easily understood (Bauer, Fetherstonhaugh, Tarzia, Nay, & Beattie, 2014). Similarly, this tool also has a high quantity of information in the twelve page booklet that can be off putting to complete or utilize due to its length. In the end this tool becoming implemented would make strides in bridging the gap between sexuality concerns among the patients and the health care providers of a facility.

A second education method that also proved effective in improving the knowledge of geriatric sex education for resident care staff consisted of four training modules with seventeen specific objectives for participants which is then evaluated by using the KATES or Knowledge and Attitudes toward Elderly Sexuality tool (Walker & Harrington, 2002). This education method was developed and utilized because “residents of long-term care facilities continue to have the need for sexual expression and intimacy” but “the staff of these facilities often have insufficient knowledge about elderly sexuality” (Walker & Harrington, 2002). The education method was developed by a group of experts from multiple sectors of the health care field, including nursing education, social work, sex education, gerontology, and instructional design in order to present a multifaceted training objective plan for health care providers and geriatric facility staff. Through this program development three goals were identified to help participants build a solid foundation and training for the geriatric population. These three goals were listed as “1. Help staff identify the sexual and intimacy needs of residents. 2. Recognize that those needs vary just as they do for younger people. 3. Identify appropriate caregiver responses to elderly sexuality” (Walker & Harrington, 2002).

The health care staff of geriatric facilities participated in education and training sessions that focused on four main topics. These four main topics included “The Need for Sexuality and Intimacy, Sexuality and Dementia, Sex and Aging, and Family and Personal Issues” (Walker & Harrington, 2002). Each session consisted of an introduction, video footage, and analysis of case studies. The participant’s attitudes and knowledge during these sessions was measured using the KATES tool. The KATES assessment tool consisted of seventy statements where participants responded on paper by circling “agree”, “disagree”, and “don’t know”. The seventy statements consisted of ten common attitudes and information, and then fifteen statements were applied to each of the four main training and education modules (Walker & Harrington, 2002).

The effect of this training and education module was successful and affected resident long-term care staff in a positive way in that their knowledge and attitudes toward elderly sexuality improved. Improvement was found most successful in three of the four training modules which included “Need for Sexuality and Intimacy, Sexuality and Dementia, and Sexuality and Aging” (Walker & Harrington, 2002). One major limitation encountered during this program, is that some instructors did not agree that “Family and Personal Issues” was a critical training module needed for the staff. Only one facility utilized and discussed this last module with its staff. After seeing this program though, many participants indicated that this topic would have been the most important and helpful in overcoming the staff’s previous attitudes of the geriatrics sexuality and intimacy (Walker & Harrington, 2002). Although this education method did have some limitations, it did aid in improving geriatric sex education. As such, this program has proven to be successful and can be applied and utilized in other geriatric care facilities. The goals of this program were reached and helped to increase the long-term care

staff attitudes, knowledge, and provided impactful information in relation to appropriate responses to resident's sexual needs and intimacy expression (Walker, Harrington, 2002).

***Conclusion:***

*Synopsis of Research Findings:*

Overall the American population is significantly changing. There are less children being born and more adults aging. Researchers have predicted that by 2060, the older adult population, those being 65 years and older, will nearly double from forty-six million currently to over ninety-eight million in just 40 years (Mather, 2016). Similarly, by 2030 there will nearly be a seventy-five percent increase in elderly adults who will be required to live in a nursing care facility. Jumping from 1.3 million people in 2010 to 2.3 million by 2030. This growing population raises concerns for researchers, health care providers, nursing care facilities, and physicians in that this population will shift the health needs for society (Mather, 2016).

Sexual health is an integral part of our lives and sexual health does not stop as one ages. Instead, it is shown that sexual activity increases in adults over the age of fifty as many changes are occurring, such as children leaving the home, more free time, menopause, and even a renewed sense of intimacy in their relationship (Lindau, et al., 2007). It is important that with these changes, health care providers and physicians of the elderly are able to provide quality care that encompasses all of the geriatrics needs from physical health to sexual health. Unfortunately, many physicians and health care professionals have an attitude of "I don't want to think about my parents having sex, let alone my grandparents" but this attitude or mindset is detrimental to older adults who need or want to discuss their sexual health and concerns with their primary health care provider (Folashade, et al., 2014).

Ultimately, there are many inadequacies in the health care field that are placing barriers and limitations on the sex education of the geriatric population. From inadequate communication, discomfort or awkwardness, and insufficient knowledge provided to health care providers and physicians, there is much improvement and remodification needed before the growing geriatric population becomes America's biggest population. Although there may be many barriers and limitations to resolve for the geriatric population, headway is being made. Each year there are new health care training modules and education methods being developed and proving to be successful. These training modules are not only focusing on improving the communication, but are providing quality knowledge for geriatric resident staff, health care providers and nursing facilities. Similarly, more health care workers are understanding the sexual needs of their geriatric or elderly patients and finding methods to assist them (Folashade, et al., 2014).

Primary institutions such as Duke University or Johns Hopkins that lead the charge in many medical advances are promoting and focusing some of their programs on the geriatric population in order to provide improved education for their students who plan on being health care professionals. These improvements being made for the geriatric population is the tip of the iceberg but society is not chipping away the ice fast enough. These efforts being made to improve the overall health and more specifically the sexual health of older adults cannot be done by a singular group of people. Instead this is an all-encompassing society change that needs assistance from multiple factors such as the government, small health care providers, and big health care conglomerates.

*Suggestions for Future Research:*

Many elderly patients want to discuss their sexual needs, health, and issues but often feel as if they cannot discuss this important part of their lives with their physician or health care provider. Through this research there have been many topics discussed, but overall the research questions presented on provide in depth, successful area for future research in order to improve the sex education for geriatrics. As stated previously, researchers, medical personnel, and health care providers should focus their interventions and programs on increasing, developing, and implementing improved education on sexual health and sexual risk behaviors (Pineiro, et al., 2015). For future research, sex education for geriatrics should focus on improving physician self-efficacy, improving sexual health discussion, and developing new training and education modules that will continue to provide quality knowledge for health care providers, geriatric caregivers, and physicians not only in the geriatric field but across all health fields (Taylor & Gosney, 2011).

Sex education should not be classified or be only important to one age group in our society. The age of an individual should not prevent someone from continuously learning about their body and sexual health over their life time (Taylor & Gosney, 2011). It is extremely critical that today and future health care providers understand this growing need to provide quality sex education for older adults. Addressing the sexual health of every patient, old or young, should be an integral and mandatory part of a physician's medical assessment of their patient. As listed previously in this document, there are countless training modules and education methods that can aid physicians and health care providers to broach this "taboo" subject (Smith & Schmall, 1983). Old people engage in sex, but they are not engaging in enough sexual health education that can eventually be detrimental to their quality of life. It is crucial that our current and future health



care providers, physicians, nurses, and educators learn to bridge the gap of age and awkwardness in order to improve the sexual health education of the quickly growing geriatric population.

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*Appendixes:***Appendix A:**

Table 1

## Sexual History Taking Components.

Whether patient is sexually active (time since last sexual activity)  
Number of current partners  
Number of partners in a specific time period (e.g., 6 months/1 year)  
Number of partners in lifetime  
Frequency of intercourse and/or sexual activity  
Gender of current partner  
Gender of previous partners in a specific time period  
Gender of previous partner(s) in lifetime  
Type of sexual behaviors (vaginal, anal, oral)  
Partner's sexual history  
Condom use and/or safe sex behaviors (e.g., female condom)  
Birth Control  
History of sexually transmitted infections, general  
History of sexually transmitted infections, specific  
Issues with sexual well-being  
Issues with sexual performance  
History of sexual abuse  
History of intravenous (IV) drug use  
Partner's history with IV drug use.  
Other sexual concerns

## Appendix B:

**Table 5**

Two-level linear model predicting sexual health discussion during period health exam.

Level 1	Estimate	Standard Error	Estimated Standard Error	Odds Ratio	Two-Tailed P-Value
Age	-0.016	0.012	-1.375	0.984	0.169
Married	0.029	0.264	0.110	1.030	0.912
Seen physician in previous year	-0.365	0.365	-0.998	0.694	0.318
Gender	-0.578	0.310	-1.863	0.561	0.062
Education					
High School	0.193	0.458	0.422	1.213	0.673
College	0.403	0.495	0.814	1.497	0.416
Race					
Black	-0.404	0.232	-1.741	0.668	0.082
Other	-1.045	0.375	-2.786	0.352	0.005*
Income	-0.017	0.082	-0.207	0.983	0.836
Gender Concordance	1.000	0.314	3.185	2.718	0.001***
Race Concordance	-0.873	0.269	-3.249	0.418	0.001***
Level 2					
Gender	-0.049	0.362	-0.134		0.893
Race					
Black	0.838	0.440	1.905		0.057
Asian	-0.560	0.440	-1.273		0.203
Other	-0.368	0.463	-0.794		0.427
Specialty	-0.106	0.289	-0.367		0.713
Age	0.039	0.019	2.040		0.041*

Note. Level 2 does not include odds ratios because it predicts the effect of the independent variables on the intercept, not the effect of the independent variables on the log odds of discussing sexual health.

\*  $p < .05$ .

\*\*  $p < .01$ .