EDITORIAL

Allowing for Same Sex Preferences

The last day of clinical teaching on the Subacute Unit in our local hospital this past spring I assigned one of our second degree students to a lesbian. The patient’s sexual preference was not known to me, nor would it have made any difference in the student’s assignment. The patient, who had one below the knee amputation, and multiple other health stressors of which one was dementia, required complex care. Although only 41 years old this patient had many physical and psychological needs. The available charts are extremely limited, so that we most often did not know many of the diagnoses.

While checking on the student in the afternoon she stated to me, “Oh Dr. Brower, you just missed all the action.” She went on to explain that the patient’s significant other, who happened to be of the same sex, was visiting the patient behind closed curtains. The student was obviously uncomfortable with the occurrence. It provided an excellent opportunity to discuss sexuality and the older person and include homosexuality during post-conference. One student exclaimed, “Oh, that’s disgusting.” Another stated, “You think they would be able to contain their sexual desires for the short period that they are in here.” The homophobia possessed by nurses and nursing students reflects Western society’s negative stereotyping of the gay or lesbian individual. Eventually the students agreed that they had certain preconceived notions.

The incident gave me pause to reflect how problematic the sexual needs of older persons are, whether they are residing by themselves in the community, in an assistive living facility, or in a nursing facility. The social historical perspective identifies the stereotyping of homosexuality along the progression from sin to crime to illness (Friend, 1989). The health care system and its caregivers is one that postulates a superior-inferior relationship, where the professional knows everything and homosexual patients have no rights to speak for themselves. Nurses often take the position that homosexuality is a sickness that should be cured or abolished (Jay, 1992).

The older gay/lesbian is at particular risk for internalizing ageist ideology as well as homophobic ideology. Sexual needs are with us from birth to death. It is an inalienable right and the sexual person continues to have needs regardless of age, preferences, dementia, and living circumstances. However, society prefers to conceptualize the older person as “sexless.” And those who exhibit a same sex preference are further stigmatized. The processes of heterosexism and ageism are consistent with each other’s bigotry, thereby supporting these twin biases.

When those of us in academia have the opportunity to teach about sexuality and aging do we include anything about those who are bisexual or homosexual? When nursing histories are conducted, does the nurse include a sexual history? When sexual histories are taken is one’s sexual orientation a regular part of the health history of older persons? If not, does the nurse assume that all adult development is heterosexual? As nurses we perpetuate the myth that same sex preference is an extraordinary phenomenon. We should remember not to impose our own values on our clients.

Gays and lesbians are like all humans, they also grow older. If they have positive self images or identities, they will age positively. However, if they belong to the group who have internalized society’s homophobic negative stereotyping they will be doubly jeopardized by the stigmas of their sexual orientation and aging as they grow older. A lifetime of internalizing self recriminations strikes at basic ego integrity. Older widowed homosexuals are likely to lead a lonely, fragmented existence. They desperately need the support of their caregivers.

Since elderly homosexuals grew up in an era when few dared to venture out of
the "closet," they may perpetuate an aura of secrecy. But the aura of secrecy may be forced to disappear when confronted with institutionalization or the incipient symptoms of dementia. If similar proportions of homosexuals are in nursing facilities or assisted living facilities as in society at large, 10% of the residential care population may be assumed to be homosexual. There are few residential facilities that provide for conjugal visits of spouses or significant others. Even rarer are those that expand the availability of shared sexual expression to same-sex coupling. It is time that nursing comes to grips with the issue of allowing sexual expression and the meeting of intimacy needs for older persons regardless of sexual orientation.

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**REFERENCES**


H. Terri Brower, EdD, CRNP Auburn University School of Nursing Auburn, Alabama

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