1-1-2012

Multicultural Sexuality: Immigrant Seniors' Attitudes Towards Sexuality Post Settlement

Zoe Alyssa Hawkins
Ryerson University

MULTICULTURAL SEXUALITY: IMMIGRANT SENIORS' ATTITUDES TOWARDS SEXUALITY POST SETTLEMENT

by

Zoe Alyssa Hawkins, Honors BA, Laurentian University, 2009

A Major Research Paper

presented to Ryerson University

in partial fulfillment of the requirements for the degree of

Master of Arts

in the Program of

Immigration and Settlement Studies

Toronto, Ontario, Canada, 2012

AUTHOR'S DECLARATION

I hereby declare that I am the sole author of this Major Research Paper. This is a true copy of the MRP, including any required final revisions, as accepted by my examiners. I authorize Ryerson University to lend this MRP to other institutions or individuals for the purpose of scholarly research I further authorize Ryerson University to reproduce this MRP by photocopying or by other means, in total or in part, at the request of other institutions or individuals for the purpose of scholarly research. I understand that my MRP may be made electronically available to the public.

Zoe Alyssa Hawkins

ABSTRACT

MULTICULTURAL SEXUALITY: IMMIGRANT SENIORS' ATTITUDES TOWARDS SEXUALITY POST SETTLEMENT

Zoe Alyssa Hawkins
Master of Arts, 2012
Immigration and Settlement Studies
Ryerson University
ABSTRACT

This comprehensive literature review serves as an exploratory overview of previous research conducted on senior sexuality and the effect on immigrant seniors' sexuality of settlement in Canada. Content analysis was used to systematically uncover similarities and differences among the various sources. The findings show that sexuality and aging are important emerging issues, that healthcare professionals and other care providers need to become more informed about this area and to take a more active role to converse with senior clients about healthy sexuality. Additionally, some cultures and religions, regardless of time of settlement, may be more conservative than Canadian born seniors, with the cautionary note that these cultural differences are not representative of members of immigrant senior populations generally.

Key words: immigrant, sexuality, sex, senior, settlement

DEDICATION

My Major Research Paper is dedicated to my parents for their constant and unwavering support. I would also like to thank my best friend for always listening to me through the frustrations and the triumphs. Finally, I would like to thank my supervisors for their extensive guidance and advice. Without them, this wouldn't be possible.

TABLE OF CONTENTS

INTRODUCTION: SETTING THE CONTEXT

Immigrant senior sexuality is an issue that has previously been ignored and purported as being unimportant. Differences among recent immigrant seniors and long-term immigrant seniors in regards to their perceptions, ideologies, and experiences may depend on time of arrival in Canada and their settlement experience. The cultural invisibility of issues relating to sexuality among all groups of seniors, immigrant or not, is gradually lifting. However, what remains to be explored is how cultural factors have influenced attitudes towards sexuality in immigrant senior populations. The settlement experience may or may not alter values and ideals towards sexuality particularly regarding cultural stigma associated with sexuality. Does length of time in Canada or a new country precipitate a change in cultural values and attitudes to sexuality? Very little research has been conducted on the topic of multicultural sexuality, specifically on the impact of the settlement experience and assimilation into the new cultural community. The definition of sexuality is broad and can mean "looking good, dressing up, feeling pampered, holding hands, cuddling and flirting. It can also include romance, companionship, relationships, sensuality and intimacy, as well as sex, sexual identity and orientation" (Lum et al, 2009). This major research paper (MRP) however concentrates on one dimension of sexuality, namely sex, since most literature available up until now has focused on this aspect. In order to understand this topic within the context of sexuality and aging, I will outline several concrete reasons as to why it is important.

Canada's cultural and demographic landscape is changing, and quickly. After the Second World War, there was an unprecedented increase in fertility rates. This group of baby boomers

is now at the age of retirement and has altered the demographic make-up of Canada and the world. In addition, a decrease in current fertility rates and an increase in life expectancy have led to a population that is older than at any point in reported history. In fact, Statistics Canada reported that between the years 1996 and 2001, the population grew from 1.5 million to 3.9 million among those aged 65 and older. Population projections show that by the year 2036, this age group will increase to 9.8 million (Statistics Canada, July 19, 2011). The baby boomers have had an overwhelming influence on society and culture. Their ideals, values, goals and aspirations have shaped Canada, and will continue to do so as they retire. As they age, this group will shape thinking on a variety of issues, including attitudes to sex. The sixties culture that permeated the Canadian landscape, as created by the baby boomers, will be carried forward into the "golden years." Moses Znaimer, creator of *Zoomer* magazine, focuses primarily on the "zoomer" generation and how "zoomers" (boomers with zip) will define Canada's culture of older adults, including sexuality. His website and magazine target "zoomers" as revolutionary figures who are reshaping and redefining the lifestyles of older people and successfully so. This reshaping redefining is far reaching, as it may now extend to immigrant populations as well.

Older adults are challenging preexisting myths, policies and practices that surround sexuality and aging. For example, there is a growing recognition among health and social care providers, as well as older adults themselves (Gott and Hinchliff, 2003), that healthy aging incorporates a multitude of factors, not just the absence of disease. Mental, physical and social well-being is at the core of aging well, all of which in turn, creates feelings of self worth and a high quality of life. Health Canada on its website on "Seniors and Aging – Sexual Activity" cites a

report on an extensive Canadian survey on Sexuality. The report found that "a large majority of people at age 65 said that sex was important. While one quarter of respondents reported that they had not been sexually active the year before the survey, a majority of those between 65 and 74 considered themselves sexually active. Although the amount of sexual activity generally declines with age, sexual interest and ability can remain fairly constant" (Leger Marketing, 2001). Health Canada underscores a key point: "Sexual activity is a natural and important part of a healthy lifestyle, no matter what your age" (Health Canada, 2006). Recent studies suggest that physicians and other primary care providers can no longer assume that older people are

FAST FACTS [1]

*60% of men and 48% of women aged 60+ believe that sexual activity is a critical part of a good relationship [2]

*52% of men and 52% of women aged 60+ say that sex remains important to them as they age [2]

*69% of men and 55% of women aged 60+ feel that people can still have a sexual relationship even if not married [2]

* 98% of men and 94% of women aged 60+ feel that sex is NOT only for younger people [2]

*44% of men and 18% of women between the ages of 55 to 59 actively date [3]

*13% of men and 2% of women aged 75+ actively date [3]

*In 2006, people over 50+ accounted for 14% of all positive HIV test reports. This is almost double the rate reported in 1985-1998 [4]

1 Lum et al (2009) e?news Issue 20 Spring www.crncc.ca
2 Montenegro, X.P. (2005). *Sexuality at midlife and beyond: 2004 update of attitudes and behaviors*. Washington, D.C.: AARP.
3Connidis, L. (2001). *Family ties and aging*. Thousand Oaks, CA: Sage.
4 Public Health Agency of Canada. (2007). HIV/AIDS Epi updates November 2007. Ottawa: Author.

asexual and need to take the initiative in asking questions to older patients about their sexual health as part of an overall check-up. Gott (2009) talked about the increased rates of STI's among older people in her presentation titled *Sexuality, Sexual Health and Ageing*. Her key point was that doctors and healthcare providers do not deal with the issue of safe sex for seniors the same way as for younger people because of stereotypical assumptions. Healthcare providers interviewed in Gott's research said they presume that older people are in monogamous, heterosexual relationships where a discussion on safe sex is not an issue. Alternatively, primary care providers assume that older people are not interested in, or, are not sexually active. Healthcare providers also expressed a fear of jeopardizing the sanctity of the patient-doctor relationship if the topic of safe sex were broached (Gott, 2009). From a public health standpoint alone, when primary care providers take for granted that older people are asexual, they may miss rising incidences of STIs. More importantly, if healthcare providers do not initiate a dialogue on sexuality among their older clients and patients, they are not attending to the well-being of the whole patient.

Watters and Boyd suggest, "Re-training or initial training of nurses, physicians and mental health professionals" (2009, 313). If healthcare providers communicate their negative attitudes in believing that sexuality is for the young and inappropriate for older populations or are hesitant to ask about client sexual activity, a reaction of equal reluctance to raise the concerns will be the result.

Michael Bauer (2009) in a presentation about older adults and sexuality broaches similar problems that currently exist in long-term care facilities. In his opinion, the dominant

problem is a lack of discussion on the topic which is concurrent with other findings presented in this paper. The attitudes, lack of education and lack of skill perpetuates a lack of understanding that sex is normal for older adults. Additionally, when there is a possibility of discussing sex, providers often do not have the appropriate skills to respond. He adds that personal morals and values play a role in providers feeling uncomfortable with residents' sexuality. Bauer also says that oversensitivity to seniors' sex contributes negatively to a potential discourse. He also mentions environmental surroundings as well as familial reservations as factors which prevent a more positive setting for older people to express their sexuality (Bauer, 2009).

There is increasing discourse about patient centered care, where providers put individuals at the centre. Included in this conversation is the idea that overall well being includes, for some older people, healthy sexuality. As previously mentioned, sexuality can be defined in part as affection, companionship, feeling good and wanting to be pampered, among other things.

Lastly, changes in policy and practice in long-term care facilities offers further evidence in the importance of recognizing and addressing issues surrounding sexuality. Long-term care facilities have implemented policies surrounding the issues of privacy in accordance with the new *Long-Term Care Homes Act, 2007* which was proclaimed on July 1, 2010. Under this legislation, the Residents' Bill of Rights clarified rights that had previously been included and added 8 new rights (Advocacy Centre for the Elderly, 2010). For example, the Bill makes clear that:

- Every resident has the right to form friendships and relationships and to participate in the life of the long-term care home;
- Every resident has the right to have his or her lifestyle and choices respected;
- Every resident has the right to meet privately with his or her spouse or another person in a room that assures privacy;
- Every resident has the right to share a room with another resident according to their mutual wishes, if appropriate accommodation is available (Advocacy Centre for the Elderly, 2010).

These rights will be discussed in more detail in the discussion section of this paper.

What does this topic have to do with immigrant seniors? Aside from aging, Canada's population is becoming more ethnically and culturally diverse. In 2006, Census Canada reported that there were over 200 ethnic groups in Canada, and in 2001, 19.4% of new immigrants in Canada were 65 years old and over at the time of their arrival. Immigrant seniors have varying life experiences when compared to Canadian born seniors, including but not restricted to work, language acquisition, rural or urban settlement and whether the senior has recently settled meaning that there is less time to save for retirement and a decreased likelihood to be eligible for Canadian public pension plans (Statistics Canada, July 17, 2011). A considerable proportion of seniors are immigrants; however, most are long-term, having immigrated to Canada before 1981. Seniors represent a very small proportion of immigrants into Canada every year and the

countries of origin are changing which affects the characteristics of those aged 65+. Are sexuality issues important also for older immigrants?

Changing demographics (both aging and increasingly diverse population) make a study like this informative to improving settlement services and the lives of recently arrived immigrant seniors and long-established immigrant seniors. Pre-existing infrastructures, such as health care, long-term care organizations/facilities and settlement services may need to recognize sexuality issues which are often an unspoken dimension of older immigrant populations' well-being across languages, cultures, religions, and levels of income.

Statistics Canada (2009) outlines four different stages of immigration into Canada. The first is before 1976; the top three countries of origin were Western Europe (63%), Eastern Europe (16%) and Latin America (5%). Between 1976 and 1985; the top three countries of origin were Western Europe (22%), East Asia (21%) and Latin America (13%). Between 1986 and 1995; the top three countries of origin were East Asia (31%), South Asia (18%) and Southeast Asia (12%). And finally, between 1996 and 2006; the top three countries of origin were East Asia (27%), South Asia (22%) and Eastern Europe (14%). These statistics are critical to this particular study because understanding where immigrant seniors come from culturally can potentially inform values, ideals and customs pertaining to sexuality. The dominant religions from these countries of origin are Catholicism, Christianity, Islam, Buddhism, Hinduism, and Taoism. Although one cannot assume the religiosity of immigrants, nonetheless, one can ask whether different cultural and religious backgrounds and values of immigrants to Canada have implications for public health services and programs like healthy sexuality.

This Major Research Paper will focus primarily on the attitudes towards sexuality among immigrant seniors. What are the sexuality attitudes among immigrant seniors prior to settlement? Is it possible to discern the effects of Canadian culture on definitions and attitudes of sexuality among immigrant seniors? How has being in Canada altered thinking and perceptions towards healthy sexuality into the later years of one's life?

METHODOLOGY

This Major Research Project (MRP) relied primarily on secondary sources. I systematically conducted a review of the secondary literature including scholarly writing, journal articles (such as International Migration, Journal of Ethnic and Migration Studies, Canadian Journal of Human Sexuality, Ethnicity and Health, Journal of Immigrant and Minority Health, Gender and History, Culture, Health and Sexuality, International Migration Review, Contemporary Sexuality, Studies in Gender and Sexuality, and Culture Dynamics) in databases such as: Academic Search Premier, EBSCO Host, Proquest Research Library, Sociological Abstracts and Social Services Abstracts). I also examined research reports and the "grey" literature including government documents (Citizenship and Immigration Canada, Human Development Reports). For statistics on population trends in immigrant senior initial arrival, as well as dominant immigrant groups in the Greater Toronto Area and North America I relied mainly on Statistics Canada data. In order to address cultural, generational, ethno racial and age related concerns regarding the relationships of immigrant seniors living in Canada, I used the following key search words: sexuality, immigrants, senior, elderly, cultural, multicultural, diversity, Toronto, North America, generational, attitudes, perceptions, relationships, and older adults. For the purposes of analysis upon saturation of the literature, I conducted a content analysis, which examines the notes taken from the extensive literature review to formulate similarities and differences among all the varying sources. I then compared similarities and differences within the literature to analyze and interpret meanings.

It is important to note key limitations to my methodology. For instance, there are few studies on older people and sexuality and fewer still that are comparative. I relied on secondary sources and therefore, gleaned sensitive information on attitudes towards older people's sexuality from studies that were constructed for a different purpose. Often, studies make general statements about the cultural and religious beliefs of immigrant groups that cannot easily be transposed to all members of an immigrant group. Furthermore, members of a group may or may not behave in the ways that a culture dictates, contrary to ethnic/cultural determinism. Finally, the literature on this topic more often than not focuses on sex, making difficult conclusions about broader sexuality issues. For example, attitudes to sexuality meaning "companionship" and "looking good" may differ from a desire for sexual intercourse. Given these limitations, this MRP focuses on sex and is highly exploratory, opening a dialogue in an understudied and complex research area.

REVIEW OF LITERATURE

I will begin the literature review discussing the challenges associated with migration when examining views towards sexuality looking at specific ethnic groups. I will then progress to the sexual aspects of older age, how gender, family and marriage affect attitudes. I will end by discussing sexuality education within a diverse society and the implications for healthcare providers.

Watters and Boyd believe that the symbolism of sexual normalcy and appropriate attitudes towards sexuality for each individual is formed primarily from education, cultural tradition, familial tradition as well as psychological components (2009). The authors maintain that a person's sexual experience is highly personal and individualized and that identity of self is "interwoven with sexual identity" (Watters and Boyd, 308). How we see ourselves as human entities is created by many things, but among this, is sexuality. Watters and Boyd write: "…being able to remain sexually active often indicates greater self worth, prevents social disengagement and avoids depression" (Watters and Boyd, 308); they add that continuing sexual love can foster a sense of intimacy that has the distinct possibility of furthering overall well-being. It cannot be denied that changes occur with aging, but Watters and Boyd argue that aging does not necessarily mean that the importance of sexuality to one's well-being disappears. In fact, "the expression of sexual needs is not only important at any age but contributes to the ultimate definition of an individual as a valuable and respected human being" (Watters and Boyd, 2009, 308). The belief that sexuality belongs to youth and that older

people are asexual is reinforced by language, media and social relationships. According to Watters and Boyd, cultural attitudes often dictate how a society views older people and often, the predominant cultural view about older people and sexuality is negative. Consequently, older adults, immigrant or not, may internalize this cultural message and see themselves as their culture portrays them.

Tied to this idea is research conducted by Nader in Sweden. The author asked whether immigrants from Iran had changed their attitudes towards sexuality since immigrating. The article looked at how cultural differences could affect sexuality and partner choice. Nader found that the Iranian attitudes and views towards sexuality were shaped by Swedish culture more so than the country of origin. According to Nader "traditional authoritarian patriarchal sexual relationship among Iranian migrants in Sweden is giving way to more egalitarian relationships and a relatively strong tendency towards a similarity of views between the sexes regarding sexuality" (2003, 684). This study prompts questions as to whether North American immigrants' views on sexuality also changes in a similar direction during settlement.

The importance of examining specific ethnic groups as it pertains to immigration and sexuality cannot be overemphasized. The following article looks at a group of Chinese elderly in China. Since China was the second largest source country of immigrants in 2006, studying the sexual attitudes of seniors in China may help inform the attitudes of Chinese seniors in Canada, on the cautionary note that this cannot be generalized. Guan (2004) investigated sexuality among rural Chinese elderly, focusing on sexual attitudes, interests, and activities within spousal relationships. The study confirms the idea that aging itself abolishes neither the need

nor interest in sexual activity. Even though the majority considered sexual life to be normal and good for health, significant numbers of study participants considered sex unsuitable for older people: over one third of the participants considered sex for the elderly as abnormal, and close to one-third said it was not good for health. Guan also found that among the Chinese elderly, sexuality was primarily associated with intercourse and reproduction, while more general sexual needs were deemed unimportant.

Taking into account that China has the largest population growth in those over the age of 65, studying healthy sexuality among older people is important. Guan discusses three frames of thought that have affected the traditional norms and cultural expectations of Chinese elderly, which have previously suppressed sexuality; Confucianism, Taoism and Buddhism. The Confucian belief is that sexuality is only sexual intercourse between married people and for the purposes of producing an heir (Guan, 2004, 105). The Taoist believes that self-control and internal circulation are necessary and that sex is harmful and dangerous to one's health. The Buddhist way of thinking is that in order to achieve "nirvana," one must give up worldly pleasures and be free from desires (Guan, 2004, 105). Perhaps in order to fully understand Chinese thoughts on elderly sexuality, one must look into these historical and cultural traditions. Guan writes that avoiding discussing sex and not participating in regular sexual behavior/activity helped to preserve one's image and self-respect. For older people, feelings of derision, denial and despair are instigated through discrimination and a lack of information. Guan concludes that, "by viewing sex as a natural physiological function, realizing its general effect on the quality of life for the elderly, and facing the fact that a decrease of sexual interest and activity has much to do with social and cultural rejection, we are moving toward a

progressive direction to really care for elderly, respect their full lives, and install their basic entitlement" (Guan, 125).

It needs to be mentioned that it is impossible to generalize to a whole population of immigrant Chinese older people based on one study. Additionally, we do not know the religion, if any, of Chinese immigrants. The study at very least raises the question as to whether sexuality is deemed to be a human need for older Chinese rural people and whether this is the general belief among most Canadians too.

Although Guan's study focused on older Chinese adults, Meston et al.'s study is relevant as it discusses Asian students' knowledge about sexuality. Meston et al. measured how length of residency affected variations in knowledge about sexuality among non-Asian and Asian Canadians. Additionally, the authors compared Canadian-born Asians with Asian immigrants. The findings supported the idea that there is a cultural explanation for conservatism among Asians. Canadian-born Asians did not differ significantly from Asians who had immigrated before 1987 but Canadian-born Asians did differ from Asians who had immigrated after 1987. Meston et al. writes that "information on sexuality has previously shown to influence attitudes toward sexuality" into more liberal thinking (1996, 178), and that ethnicity affects attitudes on masturbation, multiple sexual partners, premarital sex, sex roles and oral sex. Asians who immigrated after 1987 are considerably more conservative than non-Asians in their attitudes and knowledge towards sexuality. An additional cultural explanation would be in the findings on gender differences. Males were more "negative than females in their attitudes toward

homosexuality and females were more conservative than males on all the remaining attitude questions" (Meston et al., 1996, 181).

Wang et al. (2008) found a relationship between sexual satisfaction and "liberal sexual attitudes, intimacy, sexual knowledge, and education among women 50+" (2008, 444). Additionally, psychosocial, socio-economic, religious, ethnic and cultural factors play a role regarding the beliefs, values and attitudes towards sexuality among older people (Wang et al., 2008, 444). Lastly, Wang discusses past studies conducted in Singapore and similar Asian countries that found that physiological, cultural, social and lifestyle factors influence the sex life of older people, as in the West (2008). The Global Study of Sexual Attitudes and Behaviors (GSSAB) surveyed 26,000 middle aged and older adults in 29 countries and found that "sexual difficulties are relatively common among mature adults worldwide and are more associated with physical health and ageing in men and women" (Wang et al., 2008, 448). The GSSAB also found that ethnic, cultural, socio economic, religious and psychosocial factors are determinants for sexual beliefs, attitudes and behavior among older populations worldwide.

When discussing gender differences towards sexuality among immigrants, Hojat et al. (2000) conducted a questionnaire with Iranian adolescents in the United States and found that Iranian male immigrants viewed premarital sex, marriage and family from a traditional stance deeply rooted in culture. However, the Iranian female immigrant attitude was more similar to American society on the same issues. Traditional Iranian culture places the family as most important in bringing people together, and family is stronger than all the other social relationships. When men and women were asked if sex education should be taught in school,

most respondents disagreed. When asked whether sexual intercourse before marriage was wrong, most agreed. When asked if sexual intercourse before marriage was acceptable for boys but not girls, most agreed. The preceding examples perhaps highlight the impact of the cultural, religious and traditional customs and values on the type of knowledge that Iranian immigrant adolescents shared. Hojat et al. postulate that a possible reason for this discrepancy between the sexes is the "heavy restrictions and social pressure imposed on women in traditional Iranian culture" (2000, 429). It can be tentatively and cautiously suggested that Iranian immigrants, whether in the United States or in Canada may also hold traditional cultural views when thinking about sexuality. It is however not possible to make general statements about the attitudes of immigrant older Iranians based on this particular study. However, it may well be possible to compare Guan's findings on rural Chinese older adults with that of the Iranian adolescents and their conservative views on sexuality. There are certain commonalities that exist within conservative cultures regardless of geography or cultural background. For example, Papaharitou et al. (2008) found that more men than women were interested in sex among 60-90 year old married couples in Greece. One of the reasons mentioned for this difference was "conservative cultural norms leading to suppressed sexual feelings and norms" for women but not for men (Papaharitou et al., 2008, 198).

Trudel et al. (2000) conducted a study in Finland and found that attitudes towards sexuality became more conservative with age. Approximately 50 Finnish men and women between 70 to 79 years of age were asked a series of questions regarding their sexuality. Only 20% said that sexuality was natural and healthy in older adults and almost half said that older adults do not have a need for sex. However, they did not generally cite religious beliefs to

support their viewpoints. It appears that older people themselves subscribe to the belief that expressing their sexuality is not "normal." Langer (2009) writes that Judeo-Christian values have been a powerful role in the "repression of sexual thought and conduct and have provided heavy burdens of guilt and shame" (2009, 755).

The final section of this literature review will look at sexuality education among older adults, as well as implications for healthcare providers. Walker and Ephross (1999) focused on the importance of staff in long-term care facilities being aware of the sexual needs and sexual concerns of residents. Sexuality was defined as "intercourse, masturbation, oral sex, sexual conversation, hearing loving words, kissing and hugging" (Walker and Ephross, 1999, 89). Walker et al., found that "...older men and women were interested, active and satisfied with a variety of sexual activities and that declines in sexual activity were more likely to be related to health than age" (89). According to Walker and Ephross, older adults lacked adequate information on issues around sexuality and that this lack of information fostered inappropriate fears and distress (1999). What knowledge and attitude did exist however was often negative especially regarding the sexual behaviors of other elderly individuals. It should be mentioned that the study focused predominately on Caucasian older people, with only one African-American older person and one American Indigenous person.

Langer (2009) found that the socio-cultural context in which one is raised, as well as the cultural stereotypes, misconceptions and humor about older sexuality, can and does affect the older adults' attitudes towards sexuality itself. Society, experience, family, friends, media, religion, law and government influence "sexuality, gender roles and sexual behaviors" (Langer,

2009, 755). Guidelines and taboos perpetuated through generations only negatively affect older people to sexually express themselves. For this reason, Langer writes that all professionals need to take into account cultural values of clients and populations so as to not impose current expectations regarding sex and sexuality, especially when working with individuals who may not wish or be capable of unlearning their cultural attitudes toward sexuality (2009). As other research in the literature suggests, the "current cohorts of older adults grew up during a period when sexual behavior was not discussed, when encouragement of sexual feelings was suppressed, and when instruction in sex education was minimal" (Langer, 2009, 755).

Walker et al. proposed a three-point plan for staff in dealing with sexuality in long-term care facilities. The first point is to make widely available medical knowledge and other factual information relating to sexuality for older people. The second point is to implement a positive outlook toward sexuality and aging and to educate staff that sexual behavior among older people varies just as it does for younger people. The third point is that appropriate staff responses to sexuality among older people must take diverse religious and cultural norms and beliefs into account (Walker and Ephross, 1999, 90). Walker and Ephross's study points to the shortcomings among staff in recognizing and addressing sexuality issues even among mainstream older people.

Concurrent with Walker and Ephross, and Meadus, is Allen et al. (2008) who discussed the satisfaction of a healthy sexuality as being intertwined with a high quality of life and health. Additionally, Allen et al. found that very few older adults spoke with their health care professional about matters relating to sexuality (2008). "Older adults and their physicians may

be unwilling to initiate discussions about sexuality due to sex and age differences; moreover, negative societal attitudes about older women's sexuality may be particularly limiting" (Allen et al., 2008, 238). In their discussion on the lack of openness in long-term care facilities, the authors mention that this is the case specifically among staff, and reiterate the importance of training healthcare providers on issues relating to sexuality and that "…autonomous sexual expression should not be actively discouraged" (2008, 244).

According to Ward and McLean Taylor (1991), "Educators can provide useful sexuality education to students from minority and foreign cultures, but they must first learn from those students how different cultures view sexuality" (Ward and McLean Taylor, 1991, 62). Many programs in the United States offer only programs which are ethnocentric and culturally biased and most do not take into account sexual orientation. Appropriate sex role behavior is highly based on culture and many programs in the United States offer sexuality education from a white, middle class perspective. Ward and McLean Taylor advises that programs should recognize what is culturally permitted. Taking into account the current research conducted on multicultural sexuality among immigrant seniors in their relationships, one may cautiously propose that culture and ethnicity greatly affect the attitudes and knowledge of immigrants towards sexuality, especially within the context of family. Family appears to be a strong unit among immigrants. Therefore, the attitudes they immigrated with may be the attitudes that remain strong within their newly adopted country. However, as noted in the studies cited above, some (perhaps younger) immigrants also tend to adopt the views of the host country. As well, it is necessary to consider that family may also be an important unit for non-immigrants.

Finally, this MRP turns to the role of education on sexuality. In this regard, Diane Richard discusses the increase in sexuality expression among older adults. She highlights that touching and companionship are important aspects to one's quality of life" (2001, 5). The problem, claims the author, is not a supposed decline in interest in sexual activity among older adults but "simply fewer available partners" (2001, 6). On the positive side, Richard talks about the increased attention being paid to senior sexuality and uses the following example to solidify her point: "…this new awareness about senior sexuality has also brought greater political and media attention. For instance, the state of New York financed a video, sent this year to all 677 New York nursing homes, educating aides on the rights of sexual expression for elderly patients, even those with dementia" (2001, 4). The state of New York is leading the way in being proactive in this movement to recognize the rights and needs of older adults.

ANALYSIS OF LITERATURE

This section analyzes the literature through content analysis to uncover similarities and differences among themes in the various studies. To begin, there were a plethora of common words found in the varying sources: ethnocentric, culturally diverse, values, customs, language barriers, religion, ethnic minority, marriage, family, social networks, attitude, knowledge, sexuality, service providers, and religion, to name just a few. Some of the literature used these words for similar purposes in order to portray the information. Other articles had different stances and found different results using the same words.

To examine the content, I will first look at the similarities in the literature. Hojat et al. discussed family as the most important social network; that marriage was the only route to sexual activity; that culture provided a sense of identity; and that sexual attitudes and knowledge were determined by cultural norms, gender roles, ethnicity, and religious beliefs. This was also found to be true in Meston et al.'s findings where length of residency, ethnicity, and culture affected sexual attitudes, knowledge and preconceived opinions. The authors also found that immigrants were consistently more conservative than native born individuals. Additionally, Hendrickx et al. postulated that ethnic minorities were far less informed about sexuality than were members of the dominant culture/society. Many immigrants are bombarded with sexual values/ideals that contradict their original culture/religion which is concurrent with cultural misinformation regarding sexuality. Interestingly enough, Guan felt that Chinese culture looked at sexuality as means of reproduction, suppressed sexual needs and

denied other forms of sexual expression. Guan also found that the sexual and cultural expectations of the elderly significantly and perhaps negatively influenced the attitudes of Chinese elderly toward sexuality. Similarly, Trudel et al. found that attitudes towards sexuality became more conservative with age and that religion played a pivotal role in the inability to express sexuality or even to discuss sexuality issues with a partner, healthcare provider or family member. However, he found that the elderly are at a higher risk of feeling vulnerable due to the dominant society and their views on elderly sexuality. Trudel et al. also suggested that seniors are the carriers of culture, religion, and customs, which has the potential to negatively affect relationships when a discourse is centered on sexuality, specifically with children or grandchildren. Similarly, Walker and Ephross reported that the participants in his study felt sexual decline had more to do with health than aging. They also found that the seniors in the study lacked knowledge and information on sex and consequently, what information they had was often incorrect. Ethnic sameness was strongly emphasized among this particular group of seniors and this presented an attitude that was more generational than anything else. This was found to be true in other sources as well (Walker and Ephross, 1999). Much of the literature reviewed was critical of medical professionals who mostly ignored sexuality issues among older people and were reluctant to initiate discussions about healthy sexuality within a dominant culture, let alone, in immigrant cultures.

Depending on the year the study was conducted, and the journal in which the study was published, differences were found in the literature. Some articles wrote that seniors have no desire for sexuality. Some articles relied on quantitative research, implementing surveys or questionnaires (how the questions were posed is important). Additionally, some of the above

articles focused primarily on one specific culture, which limited the results of the study. The articles I found published in the early 2000s talked about the changes in attitude among older adults and practitioners alike regarding the topic of sexuality, but other articles, in the same years, found the opposite. One possible explanation is that the purposes of the studies were instrumentally different. What then are the similarities among themes in the literature? The following chart visually illustrates the theme similarities found in the varying sources used in this MRP.

CHART 1
Recurrent Themes in the Literature

Theme 1	**Theme 2**	**Theme 3**	**Theme 4**	**Theme 5**	**Theme 6**
Older adults maintain interest	Older adults not interested	Cultural stigma	Religious connotations	Healthcare providers (positive)	Healthcare providers (negative)
Gott & Hinchliff Gott	Guan	Hojat et al. Papaharitou et al.	Guan	Ward and McLean Taylor	Walker and Ephross Gott
Richard	Gott & Hinchliff	Hendrickx et al.	Hojat et al	Meadus	Watters & Boyd
Watters & Boyd		Meston et al.	Trudel et al.	Bailey	Trudel et al.
					Watters & Boyd
		Nader			Bailey
					Bauer

Not surprisingly, the highest proportion of sources had a theme either relating to cultural stigma associated with sexuality or the reluctance of providers to initiate discussions around sex with potentially negative consequences. Several sources emphasized the interest of many seniors towards expressing their sexuality. Fewer sources discussed prohibitions against sexual expression among adults, and seniors within the context of religious principles. Although these results cannot be generalized, they suggest that gradual changes seem to be occurring perhaps also among older people and in the senior services sector. What this necessitates however is a continued need for research on the topic of senior sexuality. As can be seen, few studies have been conducted on senior sexuality, let alone multicultural sexuality. Nonetheless, more information around sexuality and aging is important for the appropriate delivery of services to immigrant seniors. This second chart emphasizes the themes by providing quotes from the various sources.

CHART 2

Examples of Quotes to Illustrate Themes

1.Older Adults maintain interest	"… a large majority of people at age 65 said that sex was important. While one quarter of respondents reported that they had not been sexually active the year before the survey, a majority of those between 65 and 74 considered themselves sexually active. Although the amount of sexual activity generally declines with age, sexual interest and ability can remain fairly constant" (Leger Marketing, 2001).
2. Older adults not interested	" Sexual difficulties are relatively common among mature adults worldwide and are more associated with physical health and ageing in men and women" (Wang, 2008, 448)
3. Religious connotations	"Religion shapes sexual values with sacred law that articulates a range of acceptable sexual behaviors and practices" (Langer, 2009, 755)
4. Cultural stigma	"…our study showed that significantly more men than women have sexual desire and engage in sexual activities. Several explanations may account for that difference: …conservative cultural norms leading to suppressed sexual feelings and norms" (Papaharitou et al., 2008, 198)
5. Healthcare providers (positive)	"…autonomous sexual expression should not be actively discouraged" (Allen et al., 2008, 244)
6. Healthcare providers (negative)	" Older adults and their physicians may be unwilling to initiate discussions about sexuality due to sex and age differences; moreover, negative societal attitudes about older women's sexuality may be particularly limiting" (Allen et al., 2008, 238)

The following will explain the importance of the quotes presented in Chart 2. The first theme is illustrated by Leger Marketing (2001) to demonstrate that older people may well sustain an interest in sexuality as a component of healthy aging. The second theme, illustrated by Wang, expresses the idea that the supposed lack of sexual interest among older adults has less to do with interest and more to do with physical capability. The third theme, illustrated by Langer, represents the force of religious ideas on adults when making informed choices regarding sexuality and additionally, suggesting that those adults who are seniors now may have difficulties letting go of pre-existing religious proscriptions around sexuality. The fourth theme, by Papaharitou et al. demonstrates the strength of cultural norms on sexual decision making, values and beliefs, and is specifically pertinent because of Canada's multicultural population. The fifth theme, aptly illustrated by Allen et al., demonstrates the importance of sexual expression/exploration among older adults, which is slowly being recognized by healthcare providers. Lastly, the sixth theme shows the reluctance of many healthcare providers to discuss matters of a sexual nature with clients and that specifically, women may be viewed differently than men. It needs to be mentioned that this can also be the case for immigrant women, where language barriers, cultural standards (of origin) and gender issues exist.

DISCUSSION

Ceris Metropolis reports that "seniors are the most powerless, least influential and most 'forgotten' segment of the ethnic population "(n.a, 2009). A Ceris Metropolis study (n.a, 2009) writes that "[immigrant seniors] exist as an isolated minority within each ethno-cultural community, depending heavily on younger relatives for financial, social and psychological support." What does this mean for multicultural sexuality? How does this affect the dynamics of the relationships among immigrant seniors post settlement? There is some discrepancy between Canadian-born seniors and immigrant seniors, which additionally needs to be taken into account when medical professionals, gerontologists or settlement services are engaging in discourse and creating "action plans" for both newly arrived and long-term immigrant seniors. What are healthcare providers currently doing to address the issues of sexuality among senior and immigrant senior groups?

Long-term care (LTC) facilities are beginning to recognize sexuality as part of the life of older adults and recognizing the right to privacy. In this regard, some LTC facilities have developed policies regarding sexuality. There are three types of long-term care facilities in Ontario (Nursing Homes, Municipal Homes and Charitable Homes) and each has its own corresponding law; each law then has a Bill of Rights. As previously mentioned, changes to the Residents' Bill of Rights were instituted to ensure that long-term care facilities are homes for the residents who dwell in them. The *Ontario Residents' Bill of Rights*, which governs all of Ontario's long-term care facilities, states that individuals cannot pre-consent to sex but are

assured legally to privacy with persons of their choice without interference. Family members are also not allowed to decide what consenting residents can and cannot do by way of sexual expression (Meadus, 2010). The individual is the only person who can make that decision.

Among the LGBT community, there were concerns that were taken to the Ontario Human Rights Commission regarding allegations in some facilities of heterosexism and homophobia. LGBT older people often rely on facilities providing care because they are more likely than heterosexual older people to be single and have no children (ACE, 2010). Older LGBT people fear discrimination which will affect their overall well-being if healthcare providers do not recognize and affirm gay, lesbian, bisexual and transsexual identities within facilities. *The Best Practice Approach to Intimacy and Sexuality* outlines three relatively positive issues that need to be addressed: 1) awareness of relationships; 2) the ability to avoid exploitation; and, 3) awareness of potential risks (Wright, 2008).

How do LTC facilities assess specific behaviours, assess educational opportunities for residents about sexuality, train staff and react to sexual activity between residents? How do healthcare providers navigate this tricky road? Duty of Care for healthcare professionals dictates that "the hospital may in some cases have a duty to establish procedures to prevent patients from injuring either themselves or someone else, and to protect vulnerable patients from being harmed by others" (Picard and Robertson, 2007). Do LTC homes need to stop residents from sexual activities on the grounds of harm? When does sexuality become a legal issue? What if older people demonstrate that they are interested in exploring and expressing their sexuality? The implication is that healthcare providers and long-term care facility staff

have to know where resident autonomy ends and where legal responsibilities begin when it comes to residents engaging in sexual expression. Furthermore, even though healthcare professionals may affirm residents' right to sexual expression, they also recognize the many challenges posed by cultural values, personal beliefs and their own potentially inadequate training that may result in conflicts among team members providing care. Assessing sexual behavior and relationships must take place within the context of the law, family belief system and practice standards. For example, when considering the sexual relationship or sexual expression of a resident at a long-term care facility, the following must be addressed: clinical assessment and ethics, staff standards of practice, values and beliefs and education, family values and beliefs and comfort level and with regards to the law, the *Health Care Consent Act* and the *Criminal Code* (Bailey, 2006). Several sources discussed in this paper reinforced the idea that personal belief, moral codes and cultural attitudes surrounding sexuality among providers may conflict with professional duties, making it difficult for many residents in long- term care (Bailey, 2006; Bauer, 2009; Gott, 2009). Long-term care facilities need to develop a policy that is standardized and fair in its management and implementation.

Where this relates to the immigrant experience is in the emerging field of ethno-geriatrics. Gradual changes have been made in long-term care facilities to foster culturally competent staff to provide an environment that is free from discrimination. It is generally recognized that cultural beliefs and practices influence individual behavior regarding health. By the same token, cultural norms also influence the attitudes of healthcare providers and hence, patient-healthcare provider relationships. Thus, training for healthcare providers should include self-education on what is culturally appropriate and an acknowledgement of the importance of

ethnicity. If possible, long-term care facilities should implement medical interpreters if language is an issue. However, using family members as interpreters may not be optimal especially if discussing issues surrounding sexuality. Additionally, the level of acculturation with the dominant culture is important to consider (McBride, 2010). Many past studies on aging and sexuality have used participants who were mainly Caucasian, heterosexual, educated and healthy, thereby creating limitations and biases when considering older adult populations with varying cultural and educational backgrounds, mixed sexual orientations and complex health problems (Zeiss & Kasl-Godley, 19). Zeiss and Kasl-Godley (2001) also mention that there are cross-cultural variations in changes in sexual desire, but say that "little is known about how socio cultural or ethnic factors influence older adults' sexual attitudes and activity" (Zeiss and Kasl-Godley, 2001, 20).

Several of the sources researched discussed religion among immigrant seniors. The implication of the studies cited suggests that religious values may affect relationship dynamics in immigrant families (Chinese, Iranian). One interpretation is that immigrant seniors, regardless of ethnicity, religion, culture may have a little difficulties accepting more overt and seemingly liberal sexuality in Canada as compared to more restrictive expressions in their countries of origin. Another interpretation is that immigrant seniors may maintain the religious beliefs, cultural values, norms and customs of their country of origin. As a result, they may adapt to Canadian culture, values and norms on issues other than sexuality. This is evident when looking at large metropolis cities with the varying ethnic and cultural enclaves. By this interpretation, immigration and settlement may have little impact on ideas around sexuality. The story may be different however for those immigrant seniors who came from Europe. The

religious beliefs of Europe are similar to those of North America and the openness in which sexuality is addressed is also similar. Additionally, European immigrants have been in Canada longer, have experienced settlement and have potentially adjusted to, or were a part of, the sexuality evolution within Canadian culture. Canadian culture has changed, and continues to change dramatically with each wave of immigrants.

Baby boomers have the potential to make a positive difference on issues relating to sexuality. They continue to influence the economy, societal attitudes and the healthcare system. In fact, in 2009 those baby boomers aged 45-64 comprised 40.4% of the working population-- the highest from all age categories (www.statcan.gc.ca). What this means is that if baby boomers make a point of voicing their concerns regarding senior sexuality, they will likely succeed in receiving positive attention from healthcare providers and LTC facilities to establish new programs and services directed specifically towards senior sexuality. As evidence, there is a growing industry oriented to senior sexuality including suddenlysenior.com, seniors4seniors.ca, seniorsite.com. Various regions of Toronto have specific centers and sites available for seniors offering a multitude of services. Meetup. Com and Linkedin.com provide opportunities for seniors to meet other seniors in a casual setting. To give another example, St. Paul's L'Amoreaux, a Community Service Agency providing community services and housing to older adults in Scarborough, Ontario (www.splc.ca), was the site of the first Speed Dating for Seniors event in Canada in April 2009.

CONCLUSION

What are the influences of Canadian culture on definitions and attitudes of sexuality among immigrant seniors? Canadian culture may potentially moderate strong religious and cultural beliefs which many immigrant children, adults and seniors hold. The stronger the religious affiliation, and double standards (e.g., regarding gender), the less likely an open discourse on all aspects of sexuality will occur. For many immigrants, family is the dominant social network. Regardless of the host society's views about sexuality, immigrant older people may hold on to the beliefs and attitudes towards sexuality which they brought with them. Thus, Canadian culture can both affect and not affect attitudes on sexuality. Definitions of sexuality also are heavily dependent on a person's country of origin and the dominant culture of that country. Of course, it is important to point of that "Canadian" culture is by no means homogenous regarding attitudes toward sexuality, making this topic very complex and this MRP highly exploratory.

How has this MRP been informative? The literature shows that seniors and senior immigrants, as part of the Canadian community, are interested in their sexuality even into the later stages of their life. Healthcare professionals need to take a more active role and a sensitive approach to conversing with senior clients about issues relating to sexuality. Although immigrants from some cultures and religions may be more conservative in their attitudes and normative behaviours towards sexuality, it is difficult to ascertain whether this is in fact the

case, given that one cannot generalize from the cultural beliefs of a nation to the beliefs of individuals.

Ideas about aging and sexuality are transforming and older people themselves are at the cutting edge of this transformation. Allen et al. (2008) among others suggests a change in theory, practice and attitudes to recognize older adults' sexuality as part of healthy aging. The role of the mass media cannot be underestimated. As Moses Znaimer demonstrates, the media can effectively shift the general population's attitudes of older adults being frail and asexual, to one of "zoomers" with zip, vim, vigor and sexuality. Additionally, The Public Health Agency of Canada created and adopted in 2008, Canadian Guidelines for Sexual Health Education. The new guidelines are to "assist professionals concerned with the development and implementation of new and effective programs, services, and interventions that reinforce behaviors that support sexual health and personal well-being" (Public Health Agency of Canada, 2008, 7). Included in this are guidelines for those professionals working with seniors.

Due to the lack of research on this topic, future considerations are many. Currently, there are extensive knowledge and research gaps. This MRP suggests the following areas for continued research.

1. Tracking the training for health care providers across the continuum of care (physicians, nurses, social workers, personal support workers, etc.) to examine whether sexuality is embedded in routine assessments and the degree to which such assessments consider the linguistic, religious and cultural diversity of the Canadian population.

2. Tracking and evaluating how long-term care facilities in different jurisdictions across Canada are implementing policies surroundings issues of privacy and the extent to which privacy includes expression of sexuality.

3. Tracking the extent to which community agencies that provide supportive services, cultural centers, and organizations that provide settlement services also provide information and supports for healthy sexuality and aging (e.g., information of safe sex for older people in diverse languages).

4. Regular surveys among older adults, including immigrant seniors, of their attitudes towards healthy sexuality and its relationship to holistic health.

5. Tracking images and messages in the mainstream media to map changes in how older people's sexuality is generally portrayed.

6. Mapping the impact of the media on the general population's attitude to older people's sexuality.

7. Creating, tracking and evaluating appropriate training and guidelines for care providers as it pertains to older adults with disabilities, dementia, Alzheimer's etc., in the context of sexuality and consent.

8. Track the changing demographics of care providers as a much more ethnically diverse group and how this affects clients and residents, specifically as it relates to differences in religion, culture and language.

9. Conduct further studies on the multicultural provision of care and how this affects clients and residents.

10. Conduct further studies on the immigrant senior LGBT community, focusing specifically on sexual orientation and the effects of this on both immigrant client/residents and care providers.

Because people are living longer, and because Canada is a multicultural community, and because older people increasingly define healthy sexuality as an integral part of healthy aging, healthcare providers, long-term care facilities and society generally must turn to policy initiatives to affirm and enable healthy sexuality among all seniors including immigrant seniors, where undoubtedly the issues may be complicated by religious and cultural backgrounds. Professionals in the community need to take into account the varying ethnicities and cultures that now contribute to Canada's landscape and recognize culturally sensitive practices which are both mutually comfortable and productive. It is hoped that this Major Research Paper is a step in the direction of continuing research on multicultural sexuality.

REFERENCES

Advocacy Centre for the Elderly. (2010). Every Resident: Bill of Rights for Long Term Care Facilities. Retrieved on October 15 from www.ace.com

Allen, R.S., Petro, K.N., & Phillips, L.L. (2008). Factors influencing young adults' attitudes and knowledge of late life sexuality among older women. *Aging And mental health, 13,* 2: 238-245.

Bailey, J. (2006). *Considerations Regarding the Needs of Long Term Care Residents for Intimate Relationships and Sexual Activity*. Center for Practical Bioethics, 1-10.

Bauer, M. (2009). Older people and sexuality in the institutional setting: penalized pleasure? Retrieved on November 10, 2011 from www.crncc.ca

Guan, J. (2004). Correlates of Spouse relationship with sexual attitude, interest, and activity among Chinese Elderly. *Sexuality and Culture, 8,*1: 104-131.

Gott, M. (2009). Sexuality, Sexual Health and Aging. Retrieved on November 10, 2011 from www.crncc.ca

Gott, M., & Hinchliff, S. (2003). How important is sex in later life? The views of older people. *Age and Aging, 56 (8),* 1617-1628.

Health Canada. 1999. Canada's Seniors. Division of Aging and Seniors.

Hendrickx, K., Lodewijckx., E., Van Royen, P., & Denekens, J. (2001). Sexual Behaviour of second generation Moroccan Immigrants balancing between traditional attitudes and safe sex. *Patient Education and Counseling,* 47: 89-94.

Hojat, M., Shapurian, R., Foroughi, D., Nayerahmadi, H., Farzaneh, M., Shafieyan, M., & Parsi, M. (2000). Gender differences in traditional attitudes towards marriage and the family: An empirical study of Iranian Immigrants in the United States. *Journal of Family Issues,* 21, 4: 419-434.

Langer, N. (2009). Late life love and intimacy. *Educational Gerontology, 35*: 752-764.

Leger Marketing, Canadian Male Sexual Health Council and Pfizer Canada. *2001 Canadian Sexual Health Survey*, June 2001.

Lum, J.M. (2009). *E-News: Volume 20*. The Canadian research network for care in the community. www.crncc.ca

Lum, J. M. et al. (2009). *Keep on Rockin': Sexuality and Aging*. In Focus: Fact sheet. The Canadian research network for care in the community. Retrieved on October 29, 2010 from www.crncc.ca

Lum, J.M. et al. (2009). In Focus: Fact Sheet. *Diversity: Ethnoracial Issues in Home and Community Care.* The Canadian research network for care in the community. Retrieved on September 07, 2011 from www.ryerson.ca/crncc/knowledge/factsheets/index.html.

McBride, M. (2010). Ethnogeriatrics and cultural competence for nursing practice. Retrieved on October 17, 2011 from ConsultGeriRN.org

Meadus, J.E. (2010). *Every Resident: Bill of Rights For People who Live in Long-Term Care Homes in Ontario*. Residents' Bill of Rights under the long-term care homes act 2007. Advocacy Centre for the Elderly.

Meston, C.M., Trapnell, P.D., & Gorzalka, B.B. (1996). Ethnic and Gender differences in sexuality: variations in sexual behavior between Asian and non-Asian University students. *Archives of Sexual Behaviour,* 1, 33-72.

Minister of Health. (2008). Canadian Guidelines for Sexual Health Education. Public Health Agency of Canada, 1-62. https://mail.ryerson.ca/attach/PHAC%20Canadian%20Guidelines%20for%20Sexual%20Health%20Education.pdf

Nader, A. (2003). Migration challenges views on sexuality. *Ethnic and Racial Studies, 26 (4),* 684-706.

Papaharitou, S., Nakopoulou, E., Kirana, P., Giaglis, G., Moraitou, M., & Hatzichristou, D. (2008). Factors associated with sexuality in later life: An exploratory study in a group of Greek married older adults. *Archives of Gerontology and Geriatrics, 46*: 191-201.

Picard, E., & Roberston, G. (2007). *Legal Liability of Doctors and Hospitals in Canada*. Toronto: Thomson Carswell.

Richard, D. (2002). Senior sexuality: sex educators identify new niche in the silver set. *Contemporary Sexuality, 36,* 9: 3-7.

Richard, D. (2001). With age comes wisdom-with wisdom, new lessons. *Contemporary Sexuality, 35,* 3: 3-6.

Statistics Canada. (2009, 2011). Statistics Canada. statcan.gc.ca.

Trudel, G., Turgeon, L., & Piche, L. (2000). Marital and sexual aspects of old age. *Sexual and Relationship Therapy,* 15, 4: 1-26.

Walker, B., & Ephross, P.H. (1999). Knowledge and Attitudes toward sexuality of a group of elderly. *Journal of Gerontological Social Work, 31,* 1: 85-107.

Wang, T., Lu, C., Chen, I., & Yu, S. (2008). Sexual knowledge, attitudes and activity of older people in Taipei, Taiwan. *Journal of Clinical Nursing, 17*: 443-450.

Ward, J.V., & McLean Taylor, J. (1991). Sexuality education in a multicultural society. *Contemporary Issues-Sexuality Education*: 62-65.

Watters, Y., & Boyd, T.V. (2009). Sexuality in later life: opportunity for reflections for healthcare providers. *Sexual and Relationship Therapy, 24,* 3-4: 307-315.

Wright, M.D. *Supporting Sexual Health and Intimacy in Care Facilities: Guidelines for supporting Adults Living in LTC facilities and Group Homes in British Columbia, Canada*. January 2008, 1-26.

Zeiss, A.M., & Kasl-Godley, J. (2001). Sexuality in older adults relationships*. Intimacy and Aging*: 18-25.

(n.a.). Ceris-Metropolis. Retrieved on July 15, 2011 from www.cerismetropolis.com.

(n.a.). St. Paul's L'Amoreaux Centre. www.splc.ca