

“ALL THE POWER TO THEM”: EXPLORING PERSPECTIVES AND  
EXPERIENCES OF INTIMACY AND SEXUALITY AMONG OLDER  
LONG-TERM CARE RESIDENTS

by

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Submitted in partial fulfilment of the requirements  
for the degree of Master of Arts

at

Dalhousie University  
Halifax, Nova Scotia  
August 2016

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## **ABSTRACT**

The present study explored the lived realities of LTC residents to gain a better understanding of their intimate and sexual needs. A qualitative descriptive approach gave voice to the experiences of ten residents in a LTC facility in Halifax, Nova Scotia. Participants reported diverse and changing perspectives of intimacy and sexuality. Furthermore, findings revealed that barriers and facilitators to intimacy and sexuality operate at the individual- and system-level. Five system-level factors—staff, rules and regulations, level of privacy, facility neutrality, and residents’ sense of home—are uniquely positioned as both barriers and facilitators to intimacy. These factors may be modifiable and offer promising starting points to create positive change within the facility. Findings may be used by the LTC facility to build on existing strengths and develop a more openly supportive environment for intimate and sexual expression. Implications and recommendations for policy, practice, and future research are provided.

## **LIST OF ABBREVIATIONS USED**

ADLs	Activities of daily living
LGBTQ	Lesbian, gay, bisexual, transgender, queer
LTC	Long-term care
SET	Stereotype Embodiment Theory

## ACKNOWLEDGEMENTS

First, my heartfelt thanks goes out to study participants. Thank you for making the time to share your stories and thoughts with me. Not only did you provide the thoughtful, honest, and meaningful perspectives that are the heart of the study, but you each made a lasting impact on me and the way I see things.

I also want to extend my sincere appreciation to the facility for demonstrating a keen interest in the project and providing me with the opportunity to conduct this study. Special thanks to the facility liaison for his warm welcome, and for ensuring that the logistics of the project could be carried out smoothly. Furthermore, thank you to the staff members for their recruitment efforts—without you, I never would have been introduced to such a lovely group of residents.

To my committee members, Dr. Keri-Leigh Cassidy and Dr. Lori Weeks. Thank you for providing such thoughtful, constructive insights and for challenging me to think about the study in new ways. I appreciate all the time and energy you devoted to this project and to making me a better researcher.

To my thesis supervisor, Dr. Brad Meisner. I could not have asked for a better supporter, mentor, and motivator over the past two years. Thank you for your dedication to this project, for encouraging me to think bigger and worry less, and for all the track changes. I couldn't have navigated this program—or Toronto pedestrian traffic—nearly as well without you.

Sincere thanks also to faculty and staff in the School of Health and Human Performance for being such a great support network and teaching me so many new things. Special thanks to my fellow classmates-turned-friends for showing me that grad school is about more than a degree.

Mom, thank you for being the hardworking, compassionate caregiver that inspired me to start this project, and for being the unwavering voice of support that inspired me to finish it. Dad, thank you for keeping me grounded and reminding me not to sweat the small stuff. Adam, thank you for refusing to let me believe that I couldn't do it. And to the rest of my family and friends, thank you for putting up with my stress and reminding me what is important.

Finally, thank you to CIHR, the Killam Trusts, the Dalhousie Faculty of Health Professions, and the O'Brien Foundation for providing me with the financial support to undertake this research.

## CHAPTER 1: INTRODUCTION

*“Oh yes, yes, yes, I do miss intimacy . . . companionship and love.”  
- 87 year old long-term care resident, as cited in Bauer et al. (2013)*

### **Problem**

Intimacy and sexuality are commonly recognized as taboo subjects for even the most privileged groups in society. But for older adults in particular, discussion or expression of intimate needs are even more of a contentious topic. Older adults experience a series of complex barriers to intimate and sexual expression, and these barriers may be particularly felt by residents of long-term care (LTC) facilities, where institutional policies and practices often create additional challenges to the healthy expression of sexuality (Bauer et al., 2013; Parker, 2006; Tarzia, Bauer, Fetherstonhaugh, & Nay, 2013). These individual- and system-level barriers are problematic, as they effectively deny individuals the health benefits associated with sexual expression among older adults, including positive effects on overall physical and emotional health, as well as quality of life (Bentrott & Margrett, 2011; Hodson & Skeen, 1994).

Given the general agreement in the literature that sexual desires and needs do not cease to exist upon reaching a certain advanced age (Connolly et al., 2012; Elias & Ryan, 2011; Hinchliff & Gott, 2008; Skultety, 2007), it is important that LTC facilities recognize and accommodate this reality. Creating supportive environments for continued intimate and sexual expression is particularly important at this moment in time, considering that the incoming generation of residents is comprised of the same individuals who came of age during the “free love” era of the sexual revolution (Henry & McNab, 2003; Connolly et al., 2012; Katz, 2013). Making positive, proactive changes to

the current system will play a key role in ensuring that LTC facilities provide welcoming homes for the next generation.

While this is by no means a novel concept, the issue begs immediate attention, as Canada has recently undergone an unprecedented age demographic shift. As of July 1, 2015, population estimates showed that the number of older adults (aged 65 and greater) exceeded the population of children (aged 14 and younger; Statistics Canada, 2015). Data from the 2011 census showed that 352,205—or just over seven percent of all older Canadians—inhabited a special care facility (Statistics Canada, 2013a). Given that age is positively associated with the move to a collective dwelling (Statistics Canada, 2013a), it logically follows that as the population ages, older adults will require these facilities in even greater numbers.

Given that LTC is a provincial responsibility, it is useful to examine the provincial context of these demographic changes. The Nova Scotia Department of Health and Wellness (2015a) reports that the province has more LTC beds than the Canadian average (115 beds for every 1,000 adults aged 75 and older), and that wait times have risen from 169 days in 2006, to 333 days in 2015. Evidently, LTC is already in high demand in the province. Notably, government and care providers have taken important steps in response to this demand. Namely, Nova Scotia released a Continuing Care Strategy in 2006 (Nova Scotia Department of Health and Wellness, 2006), and is currently in the process of reviewing and renewing this strategy to meet the current and future needs of an aging population. The five-year strategy will be finalized in 2017, and a recent document was released to seek public input on the proposed plan (Nova Scotia Department of Health and Wellness, 2015a). While the 2006 strategy focused on

increasing the number of beds in LTC facilities, the 2015 document focuses on promoting longer, healthier stays at home, improving access to health services, providing more support to informal caregivers, and improving the quality of existing continuing care services. In light of these demographic changes, and the resulting shifts in the province's approach to continuing care, the need to give voice to the concerns of residents in LTC is more pressing than ever before.

### **Significance of the Study**

Older adults have traditionally been excluded from the discourse surrounding sexuality research, policy, and practice. Indeed, a review of the literature concluded that sexuality is understudied among the aging cohort in general, and that this neglect is particularly notable among older adults in LTC (Elias & Ryan, 2011). Among those studies that do address sexual expression in later-life, first-hand perspectives are decidedly absent. Gott and Hinchliff (2003) comment on this omission, arguing that if we are to refute stereotypes about older adult sexuality, we must seek out the perspectives of older adults themselves. The lack of direct consultation with older adults is also noted in sexuality research conducted in LTC facilities (Elias & Ryan, 2011) and assisted-living settings (Frankowski & Clark, 2009). Furthermore, Cornelison and Doll (2012) recommend future consultation with multiple stakeholders, including staff, family members, and residents, to develop a more diverse narrative on the topic.

Obtaining an in-depth understanding of individuals' perspectives necessitates a qualitative approach. However, the majority of previous studies addressing sexuality in LTC facilities have employed a quantitative, survey-method (e.g. Aizenberg, Weizman, & Barak, 2002; Bullard-Poe, 1994; Mroczek, Kurpas, Gronowska, Kotwas, &

Karakiewicz, 2013). While this methodology allows researchers to account for a greater number of residents, it fails to give voice to the “diversity in late-life sexualities” (Marshall, 2012, p. 341). Doll (2013) advocates for the use of qualitative approaches to “elicit the emotional side of this important issue” (p. 36). It should be acknowledged that the research process can be empowering in and of itself, making space for the views and concerns of a population that may not otherwise be heard. It is imperative that we give voice to these concerns. This matter is particularly significant in Atlantic Canada as the region is home to the country’s highest proportion of older people (Statistics Canada, 2013b). However, there is a marked absence of studies on the topic in Atlantic Canadian care facilities.

The present study sought to address these gaps through a qualitative exploration of the lived realities of intimacy and sexuality among residents of a LTC facility in Halifax, Nova Scotia. There are numerous stakeholders who may be interested in the outcomes of the study. The research findings can be used by decision-makers within the facility of study to produce tangible outcomes such as the development of policies that will reflect residents’ lived experiences. Administrators can make use of recommendations to form the basis of education programs for staff and residents alike, to improve care practices and disrupt common misconceptions. Furthermore, recommendations could be transferred to LTC facilities throughout Halifax and the rest of the province. Importantly, findings should not be transferred to other LTC facilities without careful attention to each local context, nor should it be assumed that the study is wholly representative of the entire LTC population. Nevertheless, the study provides a useful starting point for further study.

Future researchers can make use of in-depth, qualitative findings that identify key themes and priorities according to residents' themselves. Moreover, future researchers may wish to replicate the life review method in other LTC facilities, to shed light on the perspectives of residents in diverse settings. Finally, older LTC residents within the facility of study and in other LTC settings may be interested in the results and whether or not they resonate with their own lived experiences. Ideally, residents will also benefit from the research and action of other stakeholders in response to the present study, as outlined above. At the very least, the present study is significant in that it opens up a safe and respectful arena for much-needed dialogue on a topic that has largely been overlooked.

### **Purpose of the Study**

The purpose of the current study was two-fold: to add to the knowledge base, building on the small but growing body of literature on later-life sexuality in a LTC context; and to have a personal, institutional, and community-level impact on older individuals and the various stakeholders that support them (families, caregivers, administrators, etc.). Ultimately, this study aimed to address the “urgent need for more research that recognizes diversity in late-life sexualities” (Marshall, 2012, p. 341) by examining three research questions:

1. How do older LTC residents define, perceive, and experience intimacy and sexuality?
2. What are the present barriers (if any) to intimate/sexual expression in a LTC facility in Halifax, Nova Scotia?



3. What factors (if any) do residents of this facility experience as facilitators to their intimate/sexual needs?

The primary outcome of the study was to give voice to residents' experiences of sexuality in the context of their living environment, and to determine whether the policies and practices of the LTC facility are reflective of residents' needs. As a secondary outcome, the study (both in content and methodology) aimed to promote person-centred care practices that account for individual needs, desires, and circumstances.

### **Overview of Study Design**

The study was guided by qualitative description, a pragmatic research approach that aims to provide a comprehensive summary of participants' experiences based on "low-inference" interpretation (Sandelowski, 2000). This approach encourages researchers to stay close to the data to provide a "straight description" of participants' experiences, rather than to complicate the meaning through intensive stages of interpretation (Sandelowski, 2000, p. 334). Qualitative description is a good fit for health research because it makes space for the voices of key stakeholders—providers and/or recipients of healthcare (Neergaard, Olesen, Andersen, & Sondergaard, 2009).

The present study benefitted from a qualitative descriptive approach, given that this methodology is amenable to the inclusion of elements from other qualitative methods such as narrative, phenomenology, or grounded theory. These are what Sandelowski (2000) refers to as "hues, tones, and textures" of other methods (p. 337). These overtones are not to be regarded as a limitation of the research, nor should a research project be mislabeled simply because it contains elements of these methods. In this case, the current

study can be broadly defined as qualitative description with overtones of narrative research.

The study's sample consisted of ten participants recruited from one LTC facility in Halifax, Nova Scotia. Data collection occurred in two phases. The first phase involved two informal interviews with each participant to help them compile a life story album (a process known as life review). The second phase consisted of more conventional semi-structured interviews on the topic of residents' experiences with their own sexuality since arriving at the LTC facility.

### **Key Terms**

Prior to engaging with the existing literature, it is important to operationalize some key terms that are relevant to the present study and will appear frequently throughout this report. Due in part to the fact that healthcare is under provincial jurisdiction in Canada and many facilities are owned and operated privately, there is a lack of conceptual clarity about what constitutes 'long-term care.' For the purpose of this study, *long-term care* can be defined in general terms as a facility that "provide[s] living accommodation for people who require on-site delivery of 24 hour, 7 days a week supervised care, including professional health services, personal care and services such as meals, laundry and housekeeping" (Health Canada, 2004).

In Nova Scotia, LTC can be further subdivided into nursing home and residential care facilities. *Nursing homes* provide care for those who require assistance with activities of daily living, such as bathing, dressing, and toileting (Nova Scotia Department of Health and Wellness, 2015b). *Residential care* is appropriate for individuals who do not require the full range of care available in nursing home settings,

but whose needs exceed that offered in home care. Residential care stipulates that residents are capable of evacuating themselves in case of an emergency, but are still provided with full-time supervision and help with personal care (Nova Scotia Department of Health and Wellness, 2015b). The present study was interested in the experiences of those in both levels of LTC, although efforts have been made to distinguish between the two when appropriate.

The terms *older people*, *older adults*, and *residents* are used interchangeably to identify the population of study. In commonplace use, these terms primarily comprise those 65 years and older, as this is the standard age of retirement in Canada (Service Canada, 2015) and is conventionally used as a marker for the older age demographic (Statistics Canada, 2013a; Statistics Canada, 2013b). However, it must be acknowledged that chronological age is not the most useful determinant of one's health status, and that some LTC residents may fall outside of this age bracket. Furthermore, Gott and Hinchliff (2003) suggest that age 50 has a specific connotation in sexual health research, with those over 50 being classified as 'older.' In keeping with this convention, the present study defines *older adult* in broad terms as any person age 50 or above. Additional clarification will be made if there is a need to differentiate between various older age groups.

*Sexuality* is a term that is heavily laden with connotations and often means different things to different people. The World Health Organization (2006) has constructed a working definition of sexuality, identifying it as “a central aspect of being human throughout life [that] encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction” (p. 5). Notably, this definition makes space for the importance of sexuality across the life course,

conceptualizing sexuality as a comprehensive term that includes one's identity, feelings, and behaviours. For the purpose of this study, *sexuality* and *sexual expression* are used to encompass a wide range of constructs—from non-sexual companionship, to feelings of love, to physical acts such as intercourse and masturbation (Bauer, McAuliffe, & Nay, 2007; Tarzia et al., 2013).

It should be noted that when conducting primary research with residents, terms such as 'intimacy' and 'companionship' are recommended over more explicit sexual terms, to reduce embarrassment and elicit more honest responses (Tarzia et al., 2013). With this in mind, the present study borrows from a previous conceptualization of *intimacy* "as close interpersonal interactions of four basic types: social, intellectual, emotional, and [sexual and non-sexual] physical" (Bullard-Poe et al., 1994, p. 232). While sexuality and intimacy are not interchangeable, for the purpose of this study, *intimacy* will often be used as an umbrella term to capture both constructs. These definitions are intended to be as broad as possible, to allow for more expansive examination of a research topic that has been understudied. Furthermore, it should be noted that the definitions of sexuality and intimacy were subject to change over the course of the study, as they are largely based on how these terms resonated with study participants. Further attention is given to these diverse and changing definitions in the reporting of results.

### **Importance & Relevance to Health Promotion**

Too often, sexuality is equated solely with physical acts, when in fact it is about much more than that. Indeed, there is growing criticism in the literature of the representation of sexuality as a distinct and disconnected part of being human, rather than

an integral piece of overall health and wellness across the lifespan (Bentrott & Margrett, 2011). Specifically, Henry and McNab (2003) note that the “absence of attention in the literature to sexuality as a quality-of-life issue for seniors seems to contradict the growing emphasis in health promotion on viewing health from a wellness perspective across the life span” (p. 58).

Doll (2012) emphasizes the importance of considering sexuality and sexual health using a more holistic approach, with the recognition that one’s sexuality is impacted as much by psychosocial and cultural factors—such as feelings, interpersonal relationships, and media—as it is by biological determinants—such as hormones and genitalia. In the context of older adults, it may be even more important to consider sexuality as a multidimensional concept rather than a strictly physiological phenomenon. Older adults may express and experience their sexuality in various ways, including “affection, romance, companionship, personal grooming, touch, and the need to feel attractive and masculine or feminine” (Hajjar & Kamel, 2003, p. 152).

Health promotion as a discipline is well-oriented to the multidimensional approach that must be taken to address sexuality across the lifespan. The Ottawa Charter for Health Promotion defines health promotion as:

...the process of enabling people to increase control over, and to improve, their health. To reach a state of complete physical, mental and social well-being, an individual or group must be able to identify and to realize aspirations, to satisfy needs, and to change or cope with the environment. (World Health Organization, 1986, p. 1)

If sexual and intimate needs are to be understood as contributors to overall well-being, a health promotion framework is key to creating supportive environments and enabling individuals to fulfill these needs.

One of the most notable features of health promotion is its emphasis on prevention rather than treatment (Public Health Agency of Canada, 2010), which has traditionally dominated the healthcare system. Currently, the biomedical model in LTC facilities privileges safety and biomedical needs over sexuality and intimacy (Elias & Ryan, 2011), when in fact the two need not be mutually exclusive. Instead, a preventive approach could be employed to reconceptualise how individuals think about sexuality across the lifespan. Education is needed to reject common myths and misconceptions, and to assert that sexuality can be a positive contributor to wellness and quality of life as one ages (Henry & McNab, 2003). Rather than assuming inevitable decline as one ages, individuals should be informed of the ways in which intimacy and sexuality can enrich their lives in familiar and different ways in later life. Above all, they should be free to continue expressing (or not to express) their sexuality as they so choose. Health promoters have a key role to play in advancing this discourse.

### **Chapter 1 Summary**

Chapter 1 has provided an overview of the present study. Although sexuality can be a positive aspect of health and well-being in later life, this reality is largely neglected, particularly in LTC facilities. The present study is significant relative to the limited research that explores qualitative, first-hand narratives of LTC residents. The study was motivated by the intended purpose of having a personal impact on participants as well as an institutional impact on the facility's policy and practices. It was guided by three central questions that were addressed using a qualitative descriptive approach with ten participants. Finally, Chapter 1 has demonstrated the importance of the topic and its

relevance to the field of health promotion. The following chapter will situate the present study within the wider body of literature on sexuality, aging, and LTC.

## **CHAPTER 2: LITERATURE REVIEW**

There exists a small but growing body of literature on sexuality in later life. This chapter seeks to engage with this literature, demonstrating how the present study builds on this foundation. First, a review of existing research on sexuality and aging in general is undertaken, highlighting the benefits of continued sexual expression and the barriers that impede this expression. Second, common myths and misconceptions about sexuality and older age are deconstructed and the prevalence and importance of sex in later life are examined. Third, the issue is situated in the LTC context with a review of residents' perspectives, needs, and attitudes and an examination of the barriers and concerns that are specific to institutional settings. Finally, the chapter concludes with a discussion of the current gaps in knowledge, and demonstrates the relevance of the current research project in light of these gaps.

### **Benefits of Continued Sexual Expression**

Numerous studies have confirmed the positive relationship between healthy sexual expression and indicators of physical and emotional well-being, as well as overall quality of life. On a physical level, sexual expression in older age is associated with decreased occurrences of health problems such as cancer and cardiovascular disease, as well as longer life expectancy (Lyyra & Heikkinen, 2006; Tenenbaum, 2009). Sexual activity is also shown to act as a useful form of exercise among individuals with arthritis, promoting movement of joints and limbs (Hodson & Skeen, 1994). Some evidence even shows that “a steady sexual life can reduce the physiological effects of aging” (Hodson & Skeen, 1994, p. 226).



In addition to these striking physical benefits, there exists the simple fact that sexual expression can be a source of great pleasure for adults young and old. Pleasure tops the list of benefits uncovered by Doll (2012) in a review of the literature, who also notes that sexual expression can serve as an “affirmation of one’s own body and its functioning” for LTC residents (p. 21). This positive affirmation is significant for older adults who may be experiencing other bodily or cognitive changes associated with aging. Knowing that they are still capable of engaging in sexual acts can serve as an important reminder of their own physical functioning and autonomy, even in the LTC setting. Likewise, Trudel, Turgeon, and Piché (2000) discuss the importance of pleasure for older adults, noting that it can contribute to improved mental and physical health. Denying this source of pleasure for no reason other than chronological age is unnecessary and counterproductive to promoting health among older adults.

As implied, it is not only the body that stands to benefit from sexual expression, but the mind as well. Hajjar and Kamel (2003), in a review of the literature on sexuality among nursing home residents, underscore the importance of sexuality for one’s “self-image, social relationships, and mental health” (p. 152). Given that individuals are often more susceptible to social isolation and loneliness in later life (Dury, 2014), it can be argued that sexual and intimate relationships are of particular importance to older adults. Loneliness, in turn, can impact one’s subjective reporting of health, with decreased feelings of loneliness resulting in self-reports of better health (Roach, 2004). Therefore, not only can continued sexual expression improve health outcomes, it can also help individuals to view their health and life in a more positive light.

Doll (2012) suggests that intimacy is in fact a “buffer in adaptation to stress” (p. 4). Later life, especially when it involves a transition to LTC, may be a particularly stressful phase. Prioritizing residents’ intimate needs could serve to alleviate some of this stress. Research findings also point to the relationship between sexuality and quality of life, asserting that “if intimate interactions are increased, quality of life will improve even for the institutionalized elder” (Bullard-Poe et al., 1994, p. 235). Given this wealth of evidence, it is clear that the freedom to form intimate relationships can have positive outcomes on one’s experience of later life, thereby improving emotional and mental health.

Recognition of these benefits is important, as it helps to deconstruct the common stereotype that positions all older adults as asexual beings. While it is crucial to dispel these damaging myths, critics argue that it is equally important not to use the discourse of healthy sexual expression as a prerequisite for healthy aging (Marshall, 2010; Marshall, 2011; Hinchliff & Gott, 2008). They caution against a biomedical and stereotypical construction of aging and sexuality as a product of the pharmaceutical industry that effectively seeks to pressure older adults into continued sexual activity as “a marker of successful aging” (Marshall, 2010). Marshall (2011) also expresses concern about the series of expectations that this presents for older adults, and the resulting anxieties. The existing paradigms for older people as either asexual or hypersexual are both disempowering in their own ways (Hinchliff & Gott, 2008). Thus, the reality of sexual expression calls for the recognition of a continuum of diverse sexualities in later life.

## **Biopsychosocial Barriers to Continued Sexual Expression**

In spite of the numerous benefits, both community-dwelling and residential older adults face a series of barriers to the fulfillment of their sexual needs. Prior to engaging with this discussion, there is an important distinction that must be made—that is, the difference between chronological age and physical decline. The two are too often conflated, suggesting that one's health outcomes (in this case, one's sexual functioning) can be accurately determined or predicted based solely on the number of years s/he has lived. A surge of research has surfaced to counter this notion. For example, in a nationally-representative survey study of older Americans, researchers stated that “older adults who have medical problems or who are considering treatment that might affect sexual functioning should be counseled according to their health status rather than their age” (Lindau et al., 2007, p. 772). In other words, chronological age is not a particularly useful determinant of a proper course of treatment. Gott and Hinchliff (2003) also found that it was not age alone, but rather “physical problems associated with aging,” that determined the relative importance participants placed on their current sex lives, compared to their younger selves. Evidently, it is best to distinguish individuals based on objective markers of physical health rather than the relatively arbitrary number of years lived. While there are a series of physical and cognitive factors that may limit sexual expression among older LTC residents, age alone should not be considered a primary barrier to engaging in sexual activity.

With that said, Gott and Hinchliff (2003) provide an important caveat to this fact, finding that one's age might also act as a facilitator of coping when faced with the reality of a loss of sexual desire or activity. Some participants who no longer engaged in sexual

activity, due to loss of a partner, poor health, or decreased desire, found that this reality was easier to accept because of their advanced age. For instance, one 77-year old male participant stated: “When you’re 60-odd you can accept it better, nor do you feel as frustrated. I’m not saying you don’t feel frustrated a little bit, but you can deal with it, whereas when you’re younger it’s more important” (Gott & Hinchliff, 2003, p. 1622). Therefore, although it is important not to expect sexual decline simply because one grows older, it is equally important not to negate the experiences of those for whom their age has become a comforting reminder that they have enjoyed many years of sexual fulfillment.

### **Biological Factors**

Popular discourse has framed the aging body as the primary impediment to sexual expression in later life. It is largely assumed that older adults do not participate in sexual activity because they are no longer physically capable. This is certainly the rationale that is touted by the biomedical community, with “hundreds of studies of the negative impact of specific illnesses, medical conditions, or medication on sexual functioning of persons over 55 years of age” (DeLamater, 2012). While it is true that there are a series of physiological changes commonly associated with aging, it is also important not to let physiology overshadow the various other factors that come to bear on an individual’s capacity for sexual expression.

As the body ages, there are a series of physical changes that can be expected. For women, post-menopause brings lower levels of estrogen and other hormones, resulting in a decline in ovarian functioning, reduced vaginal elasticity and lubrication, and thinning of vaginal walls (DeLamater, 2012; Doll, 2012; Zeiss & Kasl-Godley, 2001). Men

typically experience a gradual decrease in testosterone levels, resulting in less penile sensitivity, and less firm erections. Men may also experience shorter or delayed orgasms, less forceful ejaculation, and longer refractory periods (Bartlik & Zucker-Goldstein, 2001; Doll, 2012). However, it must be noted that these changes are not experienced uniformly, and that there is significant variation among individuals (Zeiss & Kasl-Godley, 2001). Furthermore, even with these normal physiological changes, older adults can and do maintain active sexual lives. As Skultety (2007) states: “normal age-related changes should not lead to a decline in sexual function” (p. 33). In fact, older individuals may even experience positive changes in their experience of sexual activity. For postmenopausal women, sex will no longer be associated with the fear of unwanted pregnancy, and may consequently be more pleasurable (Doll, 2012). Older men’s sexual experience may be enriched by a newfound ability to maintain erections for longer periods of time (Doll, 2012). Evidently, older adulthood does not necessitate the end of sexual desire or activity. It will simply bring a series of changes.

When older adults do encounter problems in sexual functioning, these are most often health- rather than age-related. One study of older adults in a Florida retirement community found that sexual inactivity was correlated with a series of health conditions, including cancer, major surgery, and other mental and physical health problems (Bach, Mortimer, VandeWeerd, & Corvin, 2013). Similarly, Doll (2012) identifies a series of illnesses that can influence sexual functioning, including “diabetes, hypertension, heart disease, incontinence, kidney disease, stroke, and neurological and cognitive disorders” (p. 214), noting that prescribed medication for these conditions can also interfere with older adults’ sexual performance. Given that many of these conditions are more common

among older adults, it stands to reason that older adult sexuality would be disproportionately affected by pathological conditions. However, authors have maintained that even severe illness or disease does not preclude older individuals from engaging in various forms of sexual expression (Lemieux, Kaiser, Pereira, & Meadows, 2004; Henry & McNab, 2003). In other words, disease, illness, and medications are not as consequential a barrier as one might expect. Even older people in poor health can and do continue to partake in sexual activities. Therefore, admittance to LTC for health reasons does not necessarily negate one's sexual needs or desires.

### **Need for a Biopsychosocial Approach**

To claim physical functioning as the sole determinant of older adults' sexual expression is to disregard a complex web of psychosocial factors. DeLamater and Sill (2005) are active critics of the medicalization of sexuality, asserting the need to consider psychological and social aspects that contribute to sexual functioning and expression. Likewise, Kontula and Haavio-Mannila (2009) call for a bio-psychological perspective to develop "a comprehensive approach to aging sexuality" (p. 47). In response to this call, the following section will undertake a review of the various psychosocial factors that influence older adults' sexuality, as articulated in existing literature.

### **Psychological Factors**

It is well established that sexuality is more than a physical phenomenon as it encompasses psychological aspects such as "sexual identity, body image, self-esteem, eroticism, [and] imagination" (Badeau, 1995, p. 221). In fact, more often than not, the sexual limitations that older adults face can be attributed more to their psychological outlook than their physical ability (Henry & McNab, 2003). It has been demonstrated that

a person's history of interest in sexuality is an accurate predictor of their interest in later life (Doll, 2012). Interest in sex may be determined more by individual differences such as feelings, beliefs, and attitudes, rather than by how young or old that person is, chronologically.

Specifically, what one thinks about sex and aging can actually impact how he or she will experience sexuality in later life. In a systematic review of the literature, DeLamater (2012) concluded that those who held positive beliefs about sexuality in older age were also those more likely to engage in continued sexual expression. Similarly, Elias and Ryan (2011) found that sex-positive attitudes were associated with more regular sexual activity. Skultety (2007) found that a decline in sexual interest was not determined by one's age alone, but rather by the *expectation* that age would lead to this decline. In other words, individuals did not experience a loss of interest in sex unless they held certain beliefs about the negative effect of aging on sexual behaviours. Notably, these attitudes toward sex in later life do not arise on their own; rather, they are a product of societal beliefs and social expectations.

### **Social Factors**

To understand the origins of these beliefs and expectations, it is important to consider the historical context in which the current generation of older adults came of age. First, religious beliefs have inevitably shaped the social mores surrounding sexuality. In much of North America, the Christian church has historically contributed to a culture of repression and sex-negativity (Doll, 2012). Given that many of today's older adults were raised to uphold Christian values, they may have faced additional pressure to conform to a certain set of rules governing sexual conduct. In older age especially, sex

may be a source of shame as “sexual activity outside of marriage, and not for generative purposes, [has] historically been criticized on moral grounds” (Reingold & Burros, 2004, p. 177). Women in particular are socialized to believe that their participation in sexual activity should be strictly for the purpose of conceiving a child. This belief may contribute to the more pronounced decline in the perceived importance of sex among older women than among older men (DeLamater, 2012). Whether consciously or not, individuals have internalized the belief that sex should be used to facilitate reproduction, rather than as a source of pleasure, or an aspect of health, in and of itself.

Moreover, in much of North America, we have become a youth-oriented culture—one that values the young as beautiful and views older adults as burdensome or amusing. Ageism manifests itself in subtle ways—in television shows and movies that laugh at older adult characters (or exclude them altogether), anti-aging beauty products, and in hospital visits where the physician addresses the younger adult rather than the older adult patient directly (e.g., Malone & Meisner, 2015). These ageist perspectives are intensified when it comes to sexuality, which has been falsely represented as strictly relevant to younger adults. As Hajjar and Kamel (2003) state: “in a youth-oriented culture, sexuality is attributed to the young, healthy, and beautiful, and the myth that the elderly are asexual beings predominates” (p. 152). The widely-held stereotype of the asexual older adult has been corroborated in many studies (Bentrott & Margett, 2011; Bouman, Arcelus, & Benbow, 2006; Parker, 2006).

Not only can these age stereotypes lead to discriminatory treatment of older individuals by younger people, but they can become even more damaging when internalized by older adults themselves. Levy (2009) has developed Stereotype



Embodiment Theory (SET), which posits that older age stereotypes “(a) become internalized across the life span, (b) can operate unconsciously, (c) gain salience from self-relevance, and (d) utilize multiple pathways” (p. 432). The first pathway is psychological, and is supported by study results confirming that older adults who received positive primes (wise, spry, etc.) outperformed those who received negative primes (frail, senile, etc.) on both physical and cognitive tasks. Stereotypes also operate along a behavioural pathway, suggesting that if individuals believe that decline is inevitable, they will be less likely to engage in behaviours to promote and protect their future health. Finally, a physiological pathway, where the negative stereotypes impact the nervous system, causing the body to have an increased cardiovascular response to stress. This stress response can have very detrimental effects on health over time.

Although SET is meant to explain older adults’ health processes and outcomes more generally, it can also be applied to older adult sexuality. The relationship between age stereotypes and sexual behaviour among older adults is well-supported in the literature (Bauer et al., 2007; DeLamater, 2012). Given that accurate information about sexuality and aging is not readily available, people may resort to stereotypes to govern their thoughts and actions (Burgess, 2004, as cited in DeLamater, 2012). To illustrate one potential pathway, of this relationship in accordance with SET, if older adults hold negative age stereotypes, they may expect to stop feeling desire or being able to perform sexually upon reaching a certain age. These expectations may in turn become self-fulfilling prophecies whereby individuals suppress their desire and stop engaging in sexual activity. Consequently, these individuals may be deprived of a valuable source of pleasure, and comfort, reducing quality of life and leading to adverse health outcomes.

Evidently, the social construction of aging and sexuality can become a very tangible barrier to the expression of this sexuality among older adults. As Elias and Ryan (2011) state: “it would appear that a necessary precursor to a more balanced attitude to sexuality in later life is a more positive approach to old age in general” (p. 1673). It is for this reason that we must consider later-life sexuality in the context of a broader set of psychosocial circumstances that influence individuals’ attitudes and behaviours. The present study made use of a biopsychosocial approach, allowing residents to speak not only about their physical experience of sexuality and aging, but also to discuss their attitudes toward sexuality and how these have been shaped by societal environments and social expectations across the life course.

### **The Reality of Sexuality in Older Age**

To deconstruct many of the common stereotypes discussed above, it is important to consider the reality of aging and sexuality, as reported in the literature. This section will seek to critique and clarify many of the common misconceptions, separating the stereotypical from the factual. There is substantial evidence to counter the underlying myth that older adults are predominantly asexual beings. Studies on the prevalence of sexual activity among older, community-dwelling adults tend to reject the common narrative that sex in later life simply does not occur. A nationally-representative survey in the United States found that there was a steady decline in sexual activity after each subsequent decade among those aged 57 to 85 (Lindau et al., 2007). Nevertheless, it is noteworthy that the prevalence of sexual activity of those aged 57 to 64 was 73 percent, and that even in the oldest age group—age 75 to 85—over a quarter of participants still engaged in regular sexual activity. Similar results were obtained in another US study,

which found that over half of men and women aged 50 to 59 reported engaging in vaginal sex, and that men and women noted relatively high rates of penetrative intercourse after age 69—reporting 43 and 22 percent respectively (Herbenick et al., 2010). These statistics alone present convincing evidence that the uniform asexual older adult stereotype is largely unfounded. It is also important to consider that many surveys may define sexual activity as strictly penetrative intercourse, rather than accounting for the full range of intimate behaviours. The prevalence of different forms of sexual expression, such as kissing or touching, may actually be much higher.

Although there are fewer available studies on the prevalence of sexual behaviour in LTC facilities, those studies that do exist serve to dismantle the discourse that sex is a non-issue in these facilities. In fact, the director of one US assisted living facility dismissed this belief outright, saying: “It’s a delicate situation but they still have sex, you know... It’s happened here quite often” (Frankowski & Clark, 2009, p. 29). This point is corroborated by one study of administrators and social workers in Kansas nursing homes, which found that the majority of homes studied reported incidents involving sexual activity (Doll, 2013). In fact, studies have confirmed that there is no difference between the reported rates of desire among nursing home residents, and those of community-dwelling older adults (Cornelison & Doll, 2012). However, the LTC setting may pose a series of additional barriers to the fulfillment of this desire. Rather than regarding sex as an abnormal incident to be reported and treated with caution, there is a need to accept sexual expression as a natural part of life, both inside and outside the LTC setting.

Furthermore, as seen above, there is a gendered difference in the reporting of continued sexual expression, with women consistently reporting lower rates than men

(Lindau et al., 2007; Herbenick et al., 2010). This difference may be explained by the more repressive social mores surrounding female sexuality more generally, as women are typically discouraged from openly expressing their sexuality. Therefore, women may be less likely to engage in sexual activity than their male counterparts, or more simply less likely to report it. This gendered difference may also be explained by men who report higher rates of sexual activity, whether because their estimates are accurate, or because they want to portray themselves as more sexual than they actually are. Alternatively, the lower rates of sexual activity among women might be accounted for by the sheer fact of life expectancy. Given that women live longer than men, heterosexual women will have fewer available partners in later life. This point will be addressed in greater detail in a subsequent section.

In a review of the literature, Elias and Ryan (2011) concluded that although frequency of sexual activity might decrease with age, interest in sex does not. Just because one rarely or never partakes in sexual activity does not mean they no longer consider sex important. Gott and Hinchliff (2003) dismiss this assumption, stating that “only when the barriers to remaining sexually active were seen as so insurmountable as to be completely prohibitive did sex assume no importance, regardless of age” (p. 1626). Interestingly, there are mixed results on the impact of aging on sexual desire. Desire is complex and influenced by various factors. DeLamater and Sill (2005) suggest that sexual desire commonly diminishes with age, but that it is not uncommon for desire to persist into the seventh and eighth decades. Moreover, rates of reported sexual problems in later life are not as high as one might expect if loss of desire were uniformly

experienced by older adults. Indeed, Kontula and Haavio-Mannila (2009) found that only one third of older men and women reported problems related to physical arousal.

### **Lack of Partner**

In fact, the most common barrier reported by older adults is not lack of interest or ability to engage in sexual activity, but rather the practical matter of lack of a partner. This obstacle is well-articulated by a 76-year old widow in the previous literature, who said: “I know for a fact if (husband) was here we would still be having sex ‘cause he was only three years older than me... I can’t see why there should be a sudden stop, you know like I say you get to 75 and that’s it, because I mean it’s just a natural thing when you love somebody isn’t it” (Gott & Hinchliff, 2003, p. 1621). This sentiment has been substantiated by research with community-dwelling older adults and LTC residents alike, and will be given more attention in a later section (Ginsberg, Pomerantz, & Kramer-Feeley, 2005; Parker, 2006).

A lack of partner in older age may be attributed to loss, illness, or simply absence of available partners. For example, Lindau and colleagues (2007) found that the majority of men and women cited the male partner’s physical health problems as the reason for absence of sexual activity. As has been established, the effect is experienced in greater proportions by heterosexual women, as females make up almost 70% of Canadians aged 85 and above, and 80% of those aged 100 and over (Urquijo & Milan, 2011). As a result of life expectancy alone, men are more likely than women to have a partner in later life. This expectation was confirmed by a study which found that 25 percent of men—versus 10 percent of women—reported weekly sexual activity at age 70 (Kontula & Haavio-Mannila, 2009). The absence of a partner is a barrier for many older adults in general,

and will be experienced in equal or greater proportion by LTC residents. Doll (2012) reports that for every available man in LTC, there are four or more available women.

Regardless of gender, residents of LTC have expressed that lack of a partner is a leading deterrent to their sexual activity, with roughly 30 percent of men and 40 percent of women citing this reason (McCracken, 1988). It is also worth considering that residents of LTC may face the additional barrier of being separated from a spouse or partner who lives at home, or who requires a different level of care and therefore lives in a different facility. In these instances, even residents who have partners may not have the opportunity to engage in sexual activity as freely as they would outside of the facility. Granted, it is important to remember that expressing one's sexuality does not necessitate a partner, as sexuality encompasses a wide range of feelings and behaviours, many of which are experienced on an individual level. However, many individuals may associate their sexuality with partnered sexual activity, and therefore will experience loss or lack of partner as a major barrier to fulfilling their sexual needs.

### **Residents' Perspectives, Needs, & Attitudes**

Above all, it is important to dismiss stereotypes and discuss the reality of residents' sexuality from the perspective of residents' themselves. Although research from this perspective has been limited, there is sufficient literature to establish that sexuality is largely valued among this population, and that their needs are not currently being met. Multiple, small-scale survey studies assert that sexual needs and desires are present among LTC residents, and that sexuality and/or intimacy are identified as at least moderately important (Aizenberg et al., 2002; Bullard-Poe et al., 1994; Mroczek et al., 2013). For example, Aizenberg and colleagues (2002) focused on attitudes toward

sexuality and found that residents, particularly males, rated sex as at least a moderately important need. Bullard-Poe et al. (1994) studied male residents of a Veteran's Affairs facility, and found that all types of intimacy were considered at least moderately important, except for sexual-physical intimacy, which fell between somewhat and moderately important. Finally, Mroczek and colleagues (2013) found that only a quarter of residents were satisfied with their sexual life, and just under 40 percent reported that they were able to fulfill their psychosexual needs in the nursing home environment.

Notably, these surveys do not claim to be representative of the national population, as each was undertaken in a single facility in different countries—Israel, United States, and Poland, respectively. They also varied in scope, and had varied study samples. However, it is interesting to note that the relative importance of meeting sexuality/intimate needs was confirmed by studies in such different contexts.

An existing qualitative study provides a more nuanced understanding of these needs, as articulated by residents (Bauer et al., 2013). Although the views voiced by these participants are not transferable to all other facilities in other countries, they contribute to a growing narrative of residents' sexual realities. More specifically, Bauer and colleagues (2013) conducted their study with 16 residents in six Australian LTC facilities, and residents' views were compiled into four categories. First was a resounding assertion that sexuality still matters. For example, an 80-year old man with dementia stated: "I don't see anything wrong with it (*sex*). It's happened since time began. These people (staff) can't alter it" (p. 301). Second, many residents reported that they no longer felt the need for intimate or sexual expression, as their sexual lives were part of their past. This sentiment was held by an 82-year old woman who had lost her husband: "I don't require

any sort of help with that sort of thing at all [intimacy] because I had a wonderful life with my husband and nobody would be able to replace him in any shape or form” (p. 302). Third, residents expressed the desire for their sexuality to remain a personal and private matter. For example, one woman insisted that staff should “keep out of it” (p. 302). Finally, LTC facilities were largely represented as environments that were uncondusive to sexual or intimate expression. The specific barriers that these environments present will be discussed in the following section.

### **Long-Term Care-Specific Barriers**

Although LTC facilities are intended to fulfill both health care (e.g., nursing) and social service (e.g., income-supported housing) functions (Banerjee, 2007), residents’ physiological and medical needs are often prioritized. Specifically, “because they are geared toward the demands of basic body care, nursing homes are not inclined to create an environment conducive to the fulfillment of sexual needs” (Bauer, 1999a, p. 37). Care tends to revolve around regimented schedules of feeding, medication, bathing, and toileting, leaving little time and energy for the consideration of sexual or intimate needs. Indeed, there is overwhelming consensus in the literature that LTC facilities impose a series of barriers on the sexual expression of their residents. These barriers can be attributed to structural or institutional factors such as privacy concerns, lack of proper infrastructure and resources, facility policy, and staff practices. Individual-level barriers such as family dynamics, cognitive functioning, and sexual orientation, can also play a major role in the regulation of sexual expression within the LTC setting. Each of these barriers will be discussed accordingly in the following section.



## **Privacy Concerns**

Lack of privacy has been identified as perhaps the most significant impediment to the fulfillment of residents' sexual needs. Residents have limited physical space that is private, and living in a communal facility also generates concerns about the privacy of personal information. Each of these privacy concerns will be discussed accordingly in the subsequent sections.

### **Lack of Physical Privacy**

Bauer (1999a) notes lack of single rooms, curtains in place of walls and doors, and poor adherence to knocking policies, as features that largely designate nursing homes as public rather than private spaces. Doll (2012) attributes this design to the monitoring nature of nursing homes—the spaces are constructed to facilitate the staff's role of keeping a watchful eye on residents. While this design is presumably used in the name of safety and care, it is important to ensure that this aim is not entirely at the expense of residents' privacy and autonomy. However, in most cases, privacy concerns are regarded as secondary in importance. In fact, it has been found that staff consider it acceptable practice to jeopardize a resident's privacy if they are contributing to residents' physical care (Litz & Arnold, 1995, as cited in Hajjar & Kamel, 2003).

Residents' privacy is further compromised by inconsistent policies and practices surrounding the cohabitation of partners. These breaches of privacy not only present an issue for new partners. Even when long-term couples are admitted to LTC at the same time, they are often not allowed to share a bed or even a room, and many facilities fail to make additional accommodations for intimacy (Skultety, 2007). Recently, facilities have begun to make special allowances for married couples, but the same privileges are often

not granted to unmarried partners (Henry & McNab, 2003; Mroczek et al., 2013). Furthermore, if both partners require care, it is probable that they will have a different set of care needs, and may therefore be placed on different floors or even in different facilities altogether (Doll, 2012).

In some cases, nursing homes provide a designated private space that residents are entitled to use. However, Cornelison and Doll (2012) report that many residents are not well-informed about this option, or are reluctant to use this space for fear of what others will think or say. This particular circumstance was encountered by participants in the Bauer et al. (2013) study, as one 79-year old man stated: “they told us, you know, that they’d made a room especially for us if we want to use it. But who wants to go in there and enjoy themselves? No” (p. 303). Likewise, an 85-year old man with dementia specifically referenced the fear that others would talk about his use of the room: “everybody would know about it and they’d be ‘yap yap yap’” (p. 304).

### **Lack of Information Privacy**

As these quotations illustrate, physical privacy is not the only concern in LTC facilities. Residents are also apprehensive about the privacy of their information and the discretion of their activities. One study demonstrated that care providers will frequently share information among one another, further diminishing residents’ sense of privacy and confidentiality (Bauer, 1999a). Parker (2006) notes that residents who recognized this type of staff gossip would be more hesitant to express their sexuality for fear that they would become the subject of this gossip. To combat this pejorative activity, Hajjar and Kamel (2003) emphasize the importance of developing and implementing stringent guidelines regarding reporting and discussion of residents’ sexual behaviour. They note

that only essential information that is pertinent to resident care should be recorded in his or her chart and that “this information may be relayed to other providers in a professional and confidential manner, devoid of sensationalism” (p. 154). Enforcing this policy would contribute to a culture that acknowledges most resident sexual activity as a natural behaviour, rather than a problem activity that warrants discussion and action on the part of staff.

Privacy concerns are not unique to nursing homes, but are also present in other forms of LTC. Frankowski and Clark (2009) point out the contradiction between the mandate of assisted-living facilities, which claims to value privacy and autonomy, and the practice within these facilities. They describe regular check-ins, monitoring and reporting of behaviour to staff and family members, and failure to wait for permission to enter upon knocking, arguing that the value of privacy is “more ideological than practical” (p. 33). There is an urgent need to bridge this gap and establish practices that value privacy as much as practicality.

### **Infrastructure & Resources**

In the vast majority of cases, facilities are not physically equipped to handle residents’ sexual needs. The infrastructure is not designed to allow for the safe and healthy expression of sexuality, and there are a number of resources that are not readily available in most facilities. These barriers will be discussed in the following sections.

#### **Furniture**

Single beds, though typically present for safety and care reasons, also make partnered sexual activity difficult. As described in a previous study, a 90-year old married woman expressed her frustration at the choice of furniture: “We’ve tried to lie on the one

(*single*) bed and there just isn't room” (Bauer et al., 2013, p. 303). Similarly, in one study, the majority of nursing homes furnished common areas with high-backed armchairs rather than sofas, which would allow for residents to sit close together if they so desired (Ward, Vass, Aggarwal, Garfield, & Cybyk, 2005). Although it is important to ensure staff and resident safety—when lifting residents out of bed, for example—surely there is a means of designing furniture that can accommodate both safety and intimacy.

### **Sexual Materials**

Other frequently cited physical barriers to sexual expression in care facilities include an absence or regulation of sex-related resources such as condoms or pornography (Scherrer, 2009). As such, Doll (2012) advocates for the provision of resources such as condoms, drugs to enhance sexual performance, and lubricants. These may be provided upon request, or made available in an accessible location. When separated from socially-constructed connotations of obscenity or moral unacceptability, providing these resources is really no different than the supply of other care items, such as shampoo or medication. They are simply materials used to enhance well-being and quality of life.

### **Protection**

Most residents of LTC will no longer need to use contraception for the purpose of preventing pregnancy. However, many of these resources are also essential for the prevention of sexually transmitted infections. Research shows that older people are less well-informed about STIs and the use of protection than their younger counterparts (Bouman et al., 2006). Furthermore, medical practitioners are often hesitant or poorly trained on discussing sexual health concerns with older patients (Doll, 2012). These

circumstances put residents at even greater risk for contracting STIs, providing additional justification for the provision of condoms and other barrier methods for STI prevention. Provision of these resources may also be paired with education for residents on sexual health and wellbeing more generally (Doll, 2012).

### **Beauty Products & Care**

It is established that an individual's self-perception of his or her physical/sexual attractiveness will play a key role in his or her experience of sexuality. With this in mind, it is important to provide residents with resources and care to help them look their best. Wasow and Loeb (1979) were among the first to recommend the provision of beauty salons and other cosmetic services within the facility itself (as cited in Hajjar & Kamel, 2003). An 85-year old resident in the Bauer et al. (2013) study confirmed the importance of personal appearance and attractiveness, suggesting that this was not enough of a priority in the facility: "When I went to taking young ladies to balls I had tails. Oh my god. You know, white tie, tails, the lot. I used to enjoy that. (*Now*) I've got nothing to get dressed up in" (p. 304). Another woman lamented that she hadn't "worn perfume in years" (p. 304). This evidence shows that even attention to seemingly minor details can make an important change in older residents' experience of sexuality.

### **Policy**

Although the physical infrastructure and resources are arguably the most visible barriers to residents' sexual expression, the facility's policy on sexuality can have equally tangible impacts. Indeed, it is the role of policy to govern all related practice and protocols. Existing policies on sexuality in LTC have been heavily criticized in the literature, mainly due to their absence (Bauer, Nay, & McAuliffe, 2009; Doll, 2013;

Kirkman, Kenny, & Fox, 2013; Shuttleworth, Russell, Weekaroon, & Dune, 2010). On a broad scale, it is demonstrated that aging is missing from national sexuality policies, and sexuality is missing from national aging policies, at least in the United Kingdom.

According to policy-makers, it seems that ‘aging’ and ‘sexuality’ are mutually exclusive (Gott & Hinchliff, 2003). Notably, this phenomenon is not restricted to the UK. For instance, Kirkman and colleagues (2013) compared Australia’s health policy with those in the UK, USA, and Canada to determine that older adults’ sexual health is neglected in federal policies across the board.

At the level of individual facilities, policies are not any more comprehensive. In their review of the literature, Cornelison and Doll (2012) conclude “that sexuality training and policies for staff are not the norm in LTC; thus, it is unclear how sexual expression is managed overall” (p. 782). Where relevant policy is present, it is typically couched in terms of privacy rather than explicitly referencing sexuality or intimacy (Doll, 2013; Bauer et al., 2009). Such is the case in assisted-living facilities as well. In one facility, staff were informally encouraged to “leave quietly” if they happened to come across any incidents of sexual expression, but were not given any formal training or proactive strategies for addressing residents’ sexuality (Frankowski & Clark, 2009, p. 31). This absence of policy directive creates, at best, a culture of ignorance or avoidance and, at worst, one of shame and embarrassment for engaging in natural and healthy sexual expression.

Fortunately, there is one nursing home that can provide a best-practice example of effective policy in this area—The Hebrew Home at Riverdale in New York—that has been heralded as a leading facility in the careful and intentional development of policy

related to residents' sexuality. Their policy was first developed in August of 1995 (Dessel & Ramirez, 2013), has undergone two subsequent revisions, and is touted by many other authors (e.g. Bentrott & Margrett, 2011; Doll, 2013) as an example of what LTC sexual expression policy *should* be. This policy is premised on "the importance of emotional and physical intimacy in the lives of older adults. Such close human interactions are viewed as a normal and natural aspect of life" (Dessel & Ramirez, 2013, p. 2). It outlines residents' sexual rights, staff responsibilities, and organizational responsibilities. Furthermore, acknowledging that cognitive impairment is often part of the reality of sexual expression in LTC, the policy is accompanied by practical guidelines that staff can use to assess residents' ability to give consent (Hebrew Home at Riverdale & Weinberg Center, 2011).

In fact, the Hebrew Home's policy is well-suited to overcome many of the aforementioned barriers. Notably, the policy places high value on residents' privacy and autonomy, and the organization as a whole takes responsibility for making "arrangements which facilitate sexual expression, e.g., a private room for one member of a couple" (Dessel & Ramirez, 2013, p. 5). There is also written policy in place to allow a visiting partner to partake in sexual activities with a resident, as long as it is a "legal arrangement" and does not involve "the solicitation of other residents" (p. 3). This would alleviate the challenges faced by many LTC residents in the existing literature who did not feel comfortable engaging in sexual activities due to a lack of private space for them and their partners. Furthermore, the policy advocates for residents' private use of resources such as "materials with legal but sexually explicit content: books, magazines, film, video, audio, pictures, or drawings" (p. 3). Staff are encouraged to refer residents to

a professional (upon resident request) for counselling about sexual concerns. Importantly, the policy details staff responsibilities but does not place responsibility solely on the care provider's discretion. Instead, the policy demonstrates the organization's commitment to providing staff with necessary training and skill development. The Hebrew Home's model should be used as a foundation for the development of future policies in LTC facilities.

### **Staff**

Without sufficient direction from institutional guidelines, staff are left to make decisions based on their own personal beliefs and value-systems (Elias & Ryan, 2011). This practice can result in inconsistent and even punitive responses that do not reflect the viewpoints of the residents themselves (Bentrott & Margrett, 2011), nor the mandate of the facility at large. Indeed, care providers' attitudes and behaviours in response to residents' sexuality have been extensively examined in the literature (Bauer, 1999b; Bauer, MacAuliffe, Nay, & Chenco, 2013; Gilmer, Meyer, Davidson, & Koziol-McLain, 2010; Roach, 2004) and, while a full analysis of the issue is beyond the scope of this review, attention must be given to some of the key findings.

One of the most troubling viewpoints held by staff is that sexual behaviour is inherently problematic rather than natural and healthy. This is a perspective that is widely reported in the literature (Archibald, 2003; Bentrott & Margrett, 2011; Cornelison & Doll, 2012). Rather than fostering and encouraging healthy sexual expression, staff often conceptualise sexuality as a behavioural problem that must be addressed accordingly. In extreme cases, medication is used to inhibit residents' sexual drive and eliminate 'problem' behaviours (Archibald, 2003; Hall & O'Connor, 2004). Notably, the



medicalization of the body and the problematization of sexual expression positions resident sexuality as an individual liability and negates staff's responsibility to treat later-life sexuality with respect and compassion.

Research has shown that staff attitudes are shaped by a set of personal values and beliefs. It is demonstrated that younger and/or less experienced staff hold more prejudicial attitudes toward residents' sexuality (Bouman, Arcelus, & Benbow, 2007), and therefore are more likely to respond inappropriately. Doll (2012) explains that staff's prejudices may be rooted in a desire to separate themselves from the aging process by claiming sexuality within the domain of younger people. Additionally, staff members may associate residents with their own parents or grandparents and wish to distance themselves from the image of their family engaging in sexual acts (Doll, 2012). Whatever the reasoning for their discomfort, Roach (2004) demonstrates that such attitudes will inevitably shape staff members' responses to resident sexual expression. Depending on the individual, and their sex and aging attitudes, responses may take many forms.

It has been noted in the literature that staff frequently use humour to diffuse the situation if they encounter sexual behaviour. Although humour may be considered a relatively harmless response, it can serve to dismiss the real lived experiences of residents' sexuality and deny the residents' sexual expression. Bauer (1999b) notes that while it might be intended to mask underlying feelings of discomfort among staff, humour can also be used "as a form of social control" to restrict residents' sexual expression (p. 152). Furthermore, Both Gilmer et al. (2010) and Roach (2004) signal on care providers' discomfort with sexuality and the tendency to use reactive rather than proactive strategies to deal with incidents. If staff are unprepared to face the reality of

sexual expression among their older care recipient(s), they may react with disgust, anger, or disbelief (Doll, 2012). Finally, in both assisted-living settings and LTC homes, the treatment of residents as children (i.e., infantilization) is identified as a pressing concern, particularly in the context of sexual expression (Frankowski & Clark, 2009; Parker, 2006). For instance, a staff member in an assisted-living facility documented in Frankowski and Clark (2009) described her instinctive response to a relationship between two residents: “Millie was getting herself ready to go to bed in Mr. Rove’s room— and being the mother I am, I said, ‘You go to your room and he stays in his room’...it sounded like I was talking to my children” (p. 32). This type of patronizing language is a damaging form of stigmatization experienced by older adults in general (Salari, 2005), but is particularly relevant in the context of sexuality, which is already so heavily stigmatized.

Luckily, there are ways to reduce this stigma and inspire positive and constructive responses. Researchers have found that education can serve as an effective intervention to change some of the damaging attitudes of LTC staff (Bauer, 1999b, Bauer, McAuliffe et al., 2013). Doll (2012) suggests that these training programs should be targeted toward deconstructing myths and stereotypes of sex and sexuality and validating sexual expression as a natural part of being human. Also, staff should learn to confront and contest some of their own misconceptions and be provided with accurate, up-to-date information on how to approach residents’ sexuality in a proactive manner. It is not simply a matter of learning to suppress one’s personal beliefs and ignore residents’ sexual activity, as ignorance can present a barrier in and of itself (Bauer, McAuliffe et al., 2013). Instead, staff should be encouraged to speak openly with residents about their sexual

needs. There is a clear need for this type of training, as it is not readily available in most LTC facilities (Cornelison & Doll, 2012).

### **Family**

It should be noted that staff are not the only ones whose views influence resident sexuality. In fact, in some cases, their views are among the more progressive. For example, one study found that both residents and spouses expressed less accepting attitudes than staff when asked about various forms of resident sexual expression, such as masturbation and use of pornography (Gibson, Bol, Woodbury, Beaton, & Janke, 1999). This finding is significant, as the opinions held by spouses and other family members are often very influential in governing care practices and establishing acceptable behaviours of residents in institutional settings (Bentrott & Margrett, 2011).

Family members are often very invested in the care of their loved ones. In many ways, this involvement can be a positive thing, as their engagement in the development of a care plan can help to make standard care more personalised. However, when it comes to residents' sexual expression, family members' views may not always align with those of the residents themselves. Cornelison and Doll (2012) report that a resident's sexuality may elicit a lot of discomfort for family members. This hesitance may arise from a variety of sources. For instance, adult children may feel threatened if their parent develops a new relationship within a facility, particularly if their other parent has passed away (Doll, 2012). In one study, family members (60 percent) were largely supportive of residents' sexual freedom (Doll, 2013); however, one quarter of respondents expressed a lack of support for their loved one's sexual expression, and a minority (7 percent) considered the resident's sexual expression to be a source of disgrace (Doll, 2013).

Bentrott and Margrett (2011) report that family members who are unsatisfied with the allowance of sexual expression in LTC may confront administrators in an effort to restrict such behaviours. This dialogue goes both ways—facilities frequently report sexual activity of residents to their family members, even when residents are cognitively and physically capable to give consent to sexual activity (Doll, 2013). Perhaps most problematically, the views of family members are often privileged over those of residents’ themselves (Doll, 2012). This effect is magnified in facilities that rely on the financial support of family members to continue operating. For example, in an assisted living setting context, “management often perceives residents’ children, not residents themselves, as the consumers of their service, [therefore] residents’ children are the ones who need to be mollified” (Frankowski & Clark, 2009, p. 33). The heavy involvement of family members stands in stark contrast to the belief shared by many residents in Bauer et al.’s (2013) study. Residents expressed that the involvement of their family in sexual matters should be decided on a case-by-case basis. Considerations might include the resident’s cognitive capacity, as well as the circumstances surrounding the resident’s sexual expression. If residents are consenting adults, the behaviour occurs in the privacy of their own room and does not disturb other residents, there is no apparent need to mention it to, or involve, family members.

### **Cognitive Impairment & Psychopathology**

As already alluded to, dementia and other forms of cognitive impairment can complicate the expression of sexuality in LTC facilities. However, it should be made clear that dementia should not be regarded as a barrier to sexual expression in and of itself. Different forms of dementia can impact sexual expression in different ways, and

much of this impact is highly variable between individuals—some may experience higher levels of sexual desire and expression than they did prior to the onset of dementia, whereas others may experience a loss of sexual drive (Badeau, 1995). In a review of the literature, Tsatali, Tsolaki, Christodoulou, and Papaliagkas (2010) confirm these findings, stating that while some individuals may become hypersexual in the initial stages of dementia, others may lose interest altogether.

Therefore, rather than generalizing all forms of cognitive impairment as a barrier to sexuality, it is important to consider the complex ways in which impairment can interact with one's sexual functioning and needs. In terms of barriers, it *can* be readily stated that the presence of people with dementia in LTC makes it more difficult to establish this population's ability to consent (Hajjar & Kamel, 2003). However, the Hebrew Home at Riverdale maintains that a cognitive impairment does not preclude an individual from participation in sexual activity (Hebrew Home & Weinberg Center, 2011). In fact, intimate and sexual relationships are associated with important benefits for those with cognitive impairments, such as coping with loss and greater self-esteem (Parker, 2006). Rather than denying sexual expression altogether, there is a shared responsibility between organization administrators, staff, family members, and residents to develop and participate in an ongoing process of assessing consent among cognitively impaired individuals. As Frankowski and Clark (2009) note, "it is possible to differentiate between healthy and unhealthy or wanted versus unwanted sexual behavior" (p. 27). This differentiation is the goal of the Hebrew Home's guidelines, which include questions and observations that staff can use to determine the resident's ability to articulate choices, to establish whether or not s/he appreciates sexual/intimate activity, and to determine

whether sex is an important part of the his/her reality (Hebrew Home & Weinberg Center, 2011). These guidelines help to ensure the safety of all residents, taking caution to distinguish healthy, consensual relationships from abusive, coercive behaviour.

In some cases, dementia can cause individuals to exhibit ‘inappropriate’ sexual behaviour. This term should be used carefully, as sexual behaviours in general are too often classified as inappropriate. In this context, *inappropriate* is meant to designate behaviour that is intrusive or exhibited at an improper time or place (Doll, 2012). This classification might include behaviours such as masturbating in common areas, public nudity, or making sexual remarks or advances toward others without consent (Doll, 2012). Although residents with dementia are often stereotyped as sexually aggressive, this type of behaviour is relatively uncommon (Hall & O’Connor, 2004). Burns, Jacoby, and Levy (1990) found that among a sample of residents with Alzheimer’s disease, less than ten percent engaged in inappropriate sexual behaviour. Notably, there is a gendered element to disinhibited sexual behaviour among those with cognitive impairment—men are either more likely to exhibit sexually inappropriate behaviours, or their behaviours are more often problematized by care providers (Ward et al., 2005). Tsatali et al. (2010) also discussed the inherent difficulty of disentangling patients’ current expressions of sexuality from those expressed prior to the onset of dementia. In other words, how are caregivers to determine whether these forms of sexual expression are “consistent with the patient’s premorbid personality” (Tsatali et al., 2010, p. 146), and what should be done in light of inconsistency? Hajjar and Kamel (2003) provide an important reminder that these individuals’ “sexual needs are real and that the way these needs are expressed may be altered as a result of their disease process” (p. 155). Although these behaviours are

inappropriate and may make other residents and staff uncomfortable, it is important to consider the ways we can help people with dementia meet their sexual needs, without compromising the needs or safety of others.

These issues are further complicated by the lack of research in this area, as people with dementia are commonly excluded from sexuality research (Parker, 2006). The present study sought to address this gap through broadly defined inclusion criteria. Although the sexual needs and lived experiences of individuals with dementia and other forms of psychopathology were not the explicit focus of the study, these individuals were purposely not excluded. In the event of cognitive impairment, informed consent from a third-party representative would have been obtained, as outlined in a subsequent section on ethical considerations.

Finally, it is important to consider the implications of other forms of psychopathology, including depression, on sexual functioning and expression among LTC residents. In a systematic review of the literature on the prevalence of psychiatric disorders in LTC facilities, Seitz, Purandare, and Conn (2010) found that dementia, depression and anxiety were the most prevalent disorders in the facilities reviewed. Furthermore, the prevalence of these disorders in LTC residents was higher than in community-dwelling populations. Although the relationship between higher levels of depression/anxiety and lower sexual functioning have been examined in younger populations (e.g. Kalmbach, Pillai, Kingsberg, & Ciesla, 2015), it remains to be seen whether this finding is supported in research with older adults. Furthermore, Torkelson and Dobal (1999) examined the complexity of sexual relationships among adults in residential care who experience serious and persistent mental illness. These findings

suggested a series of clinical implications, including the need to recognize that “(a) residents with SPMI may be sexually active; [and] (b) residents have a right to be protected from sexual assault, sexual exploitation, or sexually transmitted disease” (Torkelson & Dobal, 1999, p. 157). These findings are similar to the implications in the above research on residents with dementia. In both cases, there is a need to recognize diverse sexual needs and protect against sexual harm or exploitation. Evidently, those with dementia and other forms of psychopathology represent important sub-populations that warrant nuanced consideration in the development of intimacy-related policy and practices.

### **Sexual Orientation**

Another barrier that emerges in the existing literature and warrants discussion in the LTC context is the additional stigma faced by individuals who identify as LGBTQ. Sexual orientation and gender identity are key parts of an individual’s sexuality. Sadly, many older adults entering LTC do not feel comfortable disclosing that they identify as LGBTQ due to popular and known systemic prejudice and discrimination that exists in institutional settings (Stein, Beckerman, & Sherman, 2010). These experiences may come in the form of homophobic or transphobic comments from staff or other residents, the lack of recognition that an individual of the same sex is one’s life partner, and the failure to allow same-sex partners to make care decisions on a resident’s behalf (Doll, 2012).

There is a notable dearth of research on this topic (Bauer et al., 2007). This may be at least partially attributed to the fact that many LGBTQ residents feel compelled to go back into the closet upon entering LTC (Johnson, Jackson, Arnette, & Koffman, 2005). Indeed, individuals who identify as LGBTQ have expressed many anxieties about



entering LTC, including: “fear of being rejected or neglected by healthcare providers... fear of not being accepted and respected by other residents; fear of having to go back into the closet if placed in long-term care; and a preference for gay-friendly care” (Stein et al., 2010, p. 421). Evidently, there is a distinct need to foster LTC communities that are inclusive and accepting of the full range of sexual orientations and gender identities, and to conduct research that substantiates this need. The present study did not seek to recruit or identify participants based on sexual orientation, but remained open to discussion of LGBTQ-specific needs if the topic arose organically.

### **Importance of Person-Centred Care**

Older adults entering LTC are already faced with a series of changes that compromise their autonomy and personhood. Rather than contribute to this loss, residents’ sexuality should remain as much a part of their identity as it was before, if desired—a reminder that not everything must change. As is evidenced by the multitude of barriers represented in the literature, this is not the case in many facilities.

Instead, there exists a contrast between the values of independence and autonomy that many care facilities seek to uphold, and decision-making regarding sexual expression. Nowhere is the contradiction more apparent than in assisted-living facilities, which were originally intended to “[promote] the ideals of dignity and independence, [provide] a homelike environment, and [encourage] long-term residency even as clients’ needs increased” (Frankowski & Clark, 2009, p. 25). If we are to make this vision a reality, we must consider, first and foremost, the complete health- and health care-related needs of the individual.

There is a recent call for change in the way the healthcare system operates—a shift away from a focus on specific disease processes as isolated entities, to one that considers “the needs, values and perspectives of the whole person in their life context and course” (International College of Person-Centred Medicine, 2014). That is, rather than treating a medical condition, we treat the person who happens to have that condition. The Alzheimer’s Society of Canada (2011) defines *person-centred care* as “a philosophy that recognizes that individuals have unique values, personal history and personality and that each person has an equal right to dignity, respect, and to participate fully in their environment” (p. 10). Furthermore, person-centred care seeks to prolong older adults’ independence (Perez-Merino, 2014).

With these outcomes in mind, the person-centred care model is well-positioned to address the sexual needs and desires of LTC residents. It emphasizes understanding individuals in the context of their entire life history, rather than solely as residents who are functionally dependent. In other words, residents may be understood as people with diverse experiences of sexuality and intimacy who happen to have grown older.

To practice person-centred care, it is important that staff and administrators are able to relate to residents as complex individuals, to become acquainted with them as people. Such is the mandate of biographical or life review approaches (Clarke, Hanson, & Ross, 2003; Guse et al., 2000; Lubarsky, 1997; Reichman, Leonard, Mintz, Kaizer, & Lisner-Kerbel, 2004). This method involves one-on-one consultation between staff members and residents to compile a visual record of central moments in their lives. In this way, staff’s subconscious age stereotypes are corrected or clarified and they develop a deeper, more realistic understanding of individuals’ experiences over time (Clarke et

al., 2003). In keeping with the commitment to understanding residents in the context of their life course, the present study made use of a life review approach.

### **Gaps in Literature & Relevance of Present Study**

Upon review of the existing literature, it becomes apparent that there are a series of gaps that warrant future study. As discussed, quantitative studies predominate the research on aging and sexuality, with most studies of LTC focusing on the collection of survey data (e.g., Aizenberg et al., 2002; Bullard-Poe et al., 1994; Mroczek et al., 2013). The current research employed a qualitative approach to provide first-hand narratives of the broader conclusions that have been drawn from quantitative data.

To the researcher's knowledge, no other research study on older adult sexuality has used a life review approach. This approach is crucial to situating sexual and intimate experiences in the context of an individual's life course (Clarke et al., 2003). In effect, the present study provides a novel methodological contribution in that it employs life review as a research method rather than to inform care practices, as it has been used previously. Furthermore, this method will allow the researcher to give "careful attention to disentangling age and cohort effects," as DeLamater (2012) has called for (p. 138). Exploring the full range of circumstances that have shaped an individual's experience of sexuality in later-life can help to deconstruct the notion that chronological age is a meaningful indicator of the value placed on sexual expression.

Furthermore, residents with cognitive impairment have traditionally been excluded from studies on sexuality (Parker, 2006). As established, to exclude this group is to deny the perspectives and opinions of a substantial portion of the LTC population, and fails to account for the importance of a diversity of perspectives within the LTC

setting. Although the present study did exclude those with *moderate* or *severe* cognitive impairment by nature of the study's methods—the requirement to participate in the life review and interview sessions—efforts were made to keep the inclusion criteria as broad as possible. In this way, the study sought to give voice to the lived experiences of those with a wide range of cognitive and physical functioning.

The present study's setting aimed to address the relative absence of older adult sexuality research from a Canadian, and especially Atlantic Canadian perspective. The majority of literature that is readily available on the topic is conducted in other countries, namely Australia, the United States, and the United Kingdom. Although certain experiences are bound to transcend country boundaries, LTC settings are also highly contextual given their lack of federal regulation and their affiliation with the larger healthcare system. It is interesting and important to establish how the perspectives of LTC residents in Halifax, Nova Scotia compare with those in other parts of the country and the world.

Many studies are limited by a preoccupation with sexuality as a biomedical phenomenon that revolves around physical functioning, or lack thereof (DeLamater, 2012; Marshall, 2011). The present study avoided this oversimplification by defining sexuality and intimacy in broad terms, and consulted with participants to ensure that the meanings they attributed to intimacy and sexuality were reflected in these definitions. The study adopted a health promotion focus with a view toward the various biopsychosocial factors that influence an individual's experience of sexuality and intimacy across the life course. Particularly, the study was interested in the way in which

the LTC setting, as a social environment, impacts residents' experiences of sexuality and intimacy, and in turn their health and quality of life.

### **Chapter 2 Summary**

Chapter 2 has provided an overview and critique of the literature on sexuality and aging in the LTC context. According to the existing literature, there are a number of benefits associated with the continued expression of sexuality in later life. These include the prevention of disease and illness, the provision of a source of pleasure and affirmation, and positive impacts on mental health and adaptation to stress. In spite of these well-established benefits, even community-dwelling older adults are impacted by a host of biopsychosocial determinants that impede their freedom of sexual expression. Although the common stereotype of older adults is that they are asexual beings, studies have shown that there is a relatively high prevalence of sexual needs and behaviours among older adults. These needs are not unique to independent-living or community-dwelling older adults, as LTC residents have also identified sexuality as a moderately important need. However, the literature demonstrates that LTC residents face additional barriers to their sexual expression—both systemic (e.g. privacy concerns, lack of infrastructure/resources, absence of policy, ineffective staff practices) and individual (e.g. family dynamics, cognitive functioning, and sexual orientation). Ultimately, the existing literature points to the need for person-centred care to address this issue. The present study was designed to fill some of the gaps in the current literature by a) employing a life review method, b) broadly defining the inclusion criteria, c) conducting the study in an Atlantic Canadian context, and d) making use of a flexible definition of sexuality that resonates with the experiences of LTC resident participants. The following chapter will

underscore how the present study fits within the existing body of literature by providing a detailed description of the guiding methodology and research design.

## **CHAPTER 3: RESEARCH DESIGN & RESEARCH METHODS**

### **Introduction to Research Approach**

As previously mentioned, the current study employed a qualitative approach. Qualitative research is well-suited to this project, as it is useful “for exploring and understanding the meaning individuals or groups ascribe to a social or human problem,” in this case older adult sexuality (Creswell, 2014, p. 4). The project was informed by a social constructivist worldview. Importantly, a central tenet of constructivism is that realities are multiple (Guba & Lincoln, 1994). As Creswell (2014) notes, “individuals develop subjective meanings of their experiences” which are “varied and multiple, leading the researcher to look for the complexity of views rather than narrowing meaning into a few categories or ideas” (p. 8). With this in mind, the researcher acknowledged that the meaning individuals attribute to sexuality is shaped by their previous interactions and experiences, and open-ended methods were used to allow participants to construct meaning out of these past experiences (Creswell, 2014). Notably, Bauer et al.’s (2013) study employs qualitative methodologies to explore residents’ sexuality through in-depth interviews, and is also rooted in constructivist assumptions. To uncover this meaning, the study was guided by three research questions:

1. How do older LTC residents define, perceive, and experience intimacy and sexuality?
2. What are the present barriers (if any) to intimate/sexual expression in a LTC facility in Halifax, Nova Scotia?
3. What factors (if any) do residents of this facility experience as facilitators to their intimate/sexual needs?

The process of finding answers to these questions was guided by qualitative description, an approach that is used to describe a subject matter or phenomenon as articulated by research participants, with minimal interference of researcher interpretation (Neergaard et al., 2009; Sandelowski, 2000). Sandelowski (2000) notes that qualitative description is a useful solution to the problem of “methodological acrobatics” (p. 335). That is, rather than stretch and alter a project to conform to rigid tenets of other qualitative approaches, a researcher can borrow certain ‘hues’ of these approaches while accurately designating the project as qualitative description. With this detail in mind, the first phase of data collection in the present study borrowed from narrative research by employing a method known as life review. This phase involved the collection and consolidation of life stories from each participant.

Narrative research is broadly defined as “a design of inquiry from the humanities in which the researcher... asks one or more individuals to provide stories about their lives” (Riessman, 2008, as cited in Creswell, 2014, p. 13). While narrative research is typically conducted with only one or two participants, broader participation is sought in some cases to “develop a collective story” (Huber & Whelan, 1999, as cited in Creswell, 2007, p. 126). The present study followed the latter approach to consolidate the lived experiences of participants into a larger story of intimacy and sexuality in LTC.

The narrative approach within this qualitative descriptive study lends itself well to work with older adults, as it helps to contextualize their present within the stories of their past (e.g., Lee, Simpson, & Froggatt, 2013). However, unlike a typical narrative research study that only consults with one or two participants, the researcher for the present study recruited a greater number of participants to speak to the shared experience of residents



on the specific topic of intimacy and sexuality. As a secondary consideration, the use of a life review method also facilitated the relationship-building process that is essential to candid discussion of such sensitive matters as one's sexuality and intimacy. Phase 2 of data collection consisted of more conventional, semi-structured interviews on the topic of residents' experiences of sexuality and intimacy within the LTC facility. The following sections will detail each stage of the research process, and will provide justification for these methodological decisions.

### **Site Selection & Recruitment**

The first stage in the research process necessitated the identification of a suitable LTC facility and recruitment of willing participants. Given that sexuality is a relatively taboo subject, especially with respect to older adults, this stage required particular care and attention. The following sections will describe the strategies that were employed to select a facility and seek out residents who were interested in participating.

#### **Selecting the Facility**

Purposeful sampling was used to target a LTC facility that was, first and foremost, keen to participate in the study, and secondly, that would allow for a diverse representation of resident perspectives. Purposeful sampling can be defined as the intentional selection of "information-rich cases for study in depth. Information-rich cases are those from which one can learn a great deal about issues of central importance to the purpose of the research" (Patton, 1990, as cited in Coyne, 1997, p. 169). This sampling method allowed for the selection of an engaged facility that expressed an interest in the research topic, therefore increasing the likelihood that findings will be used to inform practice. With these considerations in mind, a larger LTC facility in Halifax, Nova Scotia

was selected as the study site. This facility was purposefully selected for the study due to their interest in the study topic, their commitment to research in general, and the size of their facility. Given the large number of residents in the facility's care, there was more opportunity to recruit interested participants, and confidentiality concerns were further mitigated.

First contact was made with a manager at the facility who also sits on the facility's internal ethics board. The project was presented as an opportunity to increase awareness and understanding of residents' lived experiences surrounding intimacy and sexuality, and the manager confirmed the organization's keen interest in the research question. After receiving ethics approval from both the Dalhousie Health Sciences Research Ethics Board as well as the facility's internal ethics board, participant recruitment was set to proceed.

### **Recruiting Participants**

Unlike research on community-dwelling older people, where more traditional recruitment methods (e.g. newspaper advertising, posters, radio announcements) can be used, the environment in a LTC facility is much more controlled and necessitates cooperation from a contact person within the organization. When conducting a similar study, Tarzia and colleagues (2013) found that "the only effective recruitment strategy... was having a reliable and enthusiastic 'insider' at a facility management level who was prepared to provide residents with information about the project, [and] gauge their interest" (p. 4). This "insider" has been referred to as a "community liaison" by Kelly and colleagues (2001), who stress the importance of this mediator role, particularly in the foundational stages of a project (as cited in Minkler, 2004). Fittingly, this "community

liaison” is built into the existing research process at the facility of study. A liaison is carefully selected by the facility for each research project they are involved with. In recent research projects, the liaisons have predominantly been managers or directors employed by the facility. In the case of the present study, the aforementioned manager was assigned to the project and acted as the main contact person for the duration of the project.

The primary recruitment strategy for the present study involved regular communication with the facility liaison. An initial meeting was held with the liaison to determine the best approach for recruitment. In addition to the initial proposal submitted to the facility, the liaison was provided with the study details, including study title and description, the inclusion criteria for each group, the level of time commitment required by participants, details regarding compensation, and researchers’ contact information. The liaison enlisted the help of three staff members to assist with recruitment, as they had more regular, one-on-one interaction with residents and would be better suited to approach potential participants. An additional meeting was held with the liaison, the staff members, and the researcher to go over the details of the study, and address any questions. After this meeting, staff were provided with recruitment handouts to be distributed to potential participants upon initial contact (see Appendix A).

As per the standard recruitment process for research projects at the facility, the liaison and staff members approached potential participants, provided them with information regarding the research study, and determined their level of interest. With permission from potential participants, their names and contact information were given to the researcher, who then followed up with each participant to set up an initial meeting

time. At this meeting, the researcher went over the study details once more, determined whether the resident was still interested in participating, and obtained informed consent.

Given the anticipated difficulty of recruiting interested resident participants, and in the name of inclusiveness, the participation criteria for the present study were broadly defined, as follows: participant must be: a) a resident of the chosen facility in Halifax, Nova Scotia; b) aged 50 or older; c) capable of providing informed consent (or assent with informed consent from a third party); and d) have capacity (e.g. hearing, cognitive ability, etc.) and desire to participate in a 45-60 minute interview in English. The liaison and staff were responsible for determining which residents satisfied these inclusion criteria, as well as identifying any participants who would require third-party consent from a substitute decision-maker. Efforts were made to recruit an equal number of men and women, with the caveat that in Nova Scotia, female residents make up roughly 71% of the nursing home population, with a ratio of three women for every man over age 85 (CIHI, 2007, as cited in Banerjee, 2007).

The age criterion is not meant to imply that chronological age (specifically age 50) is an accurate predictor of physiological or sexual functioning, nor overall health outcomes. However, Gott and Hinchliff (2003) found that age 50 has a specific connotation in sexual health research, with those over 50 being classified as ‘older.’ Notably, the scope of the present study is *older adult* residents’ sexuality, rather than sexual expression of LTC residents of all ages. It is for this reason that age 50 has been selected as the minimum age for residents to participate in the study.

Also, it is important to note that in Nova Scotia, 61% of LTC residents are identified as having moderate to severe cognitive impairment (Canadian Institute for

Health Information, 2011). To exclude this group is to deny the perspectives and opinions of a substantial portion of the LTC population, and fails to account for the importance of sexual and intimate expression in the lives of many older adults with cognitive impairment. Nevertheless, residents with cognitive impairment are traditionally excluded from studies on sexuality, based on a set of valid concerns regarding ability to consent—to participate in research and to engage in consensual sexual activities (Parker, 2006). With this probable participant demographic in mind, the inclusion criterion regarding cognitive impairment was broadly defined for the present study. It was stipulated that informed consent had to be obtained from either the resident, or from an appropriate third party with assent from the resident, when appropriate. Furthermore, by nature of the study methods (i.e., the need to participate in life review sessions plus a 45-60 minute interview) those with severe cognitive impairment were likely to be excluded. Determinations of cognitive ability were made by the liaison and staff who had sole access to residents' health records. Information from these records were not shared with the researcher. It should be noted that all participants who were recruited for the study were able to give consent independently, with no need for a third-party delegate. Therefore, although the option for third-party consent was made available in an effort to be more inclusive, no participants required this option as a result of the cognitive functioning of the participants who happened to be recruited by the liaison and staff.

Over the course of ten weeks, a total of fifteen residents were approached by staff. Of these, ten participants were successfully recruited for the study, and five residents ultimately declined to participate. Interviews with the first participants began the week

after they agreed to participate, therefore recruitment and data collection occurred simultaneously until all participants were recruited.

### **Data Collection**

Data were collected in a two-phase process over the course of two and a half months (from February to April, 2016). The first phase employed a life review method, and the second phase followed a more conventional semi-structured interview process. Each phase is detailed in the sections that follow.

#### **Phase 1**

This phase employed aspects of narrative research to collect and consolidate the life stories of participants, using a life review method. Researchers have noted that interviews with older people can often be time-consuming due to storytelling that can become discursive or off-topic (Robertson & Hale, 2011). However, rather than viewing these tendencies as problematic or frustrating, the stories offered by older participants can be valued and built into the strengths of a qualitative descriptive process. In fact, one study found that “taking time to listen provided a better relationship and ultimately developed richer responses to the researchers’ questions” (Robertson & Hale, 2011, p. 6). Likewise, Tarzia and colleagues (2013) offered lessons from a previous qualitative research project on older adults in LTC, and identified relationship-building as an important feature of eliciting more honest answers from participants: “an older person—or any person, for that matter—will be much more likely to feel relaxed when speaking about a sensitive subject like sexuality if they feel they have established some form of connection with the interviewer” (p. 8). To build necessary rapport and data trustworthiness, the researchers recommended one or more informal meetings with the

resident prior to the interview, with the purpose of ‘getting to know’ one another (Tarzia et al., 2013).

Given these recommendations, the researcher arranged two meetings with each participant prior to the semi-structured interview. These sessions lasted between 20 and 85 minutes, with an average of 48 minutes. They involved introductions and casual conversation about the resident’s life history, particularly the role of sexuality and intimacy across the life course. These stories will be documented in a life story album, which Guse et al. (2000) defined as “a collection of selected memorabilia, photographs, and archival and other material that describes an individual’s life in a photograph book format” (p. 34). Residents were encouraged to supply photographs or other artifacts that could be duplicated and added to the album. It should be noted that, given time and feasibility constraints, the process of encouraging reminiscence and compiling the life story album was not as extensive as found in other studies (e.g. Guse et al., 2000; Reichman et al., 2004; Stinson & Long, 2014). In these studies, older adults’ biographies and the process of reminiscing were the primary focus. However, this work was consulted to develop an abridged version of the life story approach.

The first life review session revolved around general introductions and discussion about the resident’s life more generally. Topics included childhood memories, schooling, past employment or volunteering, hobbies, travel, personality, and family, and discussion was guided by a series of questions (see Appendix B). The second session was structured around residents’ stories of companionship, relationships, and intimacy more specifically. Discussion was focused on close friends, first dates, happy relationship moments, and recollections of the sexual revolution. When photos were provided, these were also used

to prompt conversation about significant people in the participant's life (for guiding questions, see Appendix B). Residents were encouraged to speak openly, but were also reminded that they could choose not to share stories if they so desired. Life review sessions were audio-recorded and stories were transcribed for inclusion in the life story albums.

The life story albums are not meant to be exhaustive by any means—indeed, it is impossible to record 50 or more years of stories in two, one-hour sessions. Rather, they are intended to capture the moments and memories that have particular meaning to residents, providing a snapshot of their lived experiences. Moreover, as recommended by Guse et al. (2000) some pages will be left blank to leave room for the addition of future life stories. This approach may also provide a useful opportunity for caregivers or family members to partake in the process of reminiscence and reflection.

As a result of this approach, participants will be left with an album that they can choose to share with caregivers and/or administrators. Staff could then make use of these resources to enhance person-centred care that is sensitive to each individual's life experiences. In this way, the life story album represents the researcher's commitment to reciprocity. As Robertson and Hale (2011) state, "usually reciprocity was related to returning the stories that the older person told in a format that could be easily read" (p. 5). Moreover, as has been noted, this approach served to build a trusting relationship with residents, so that they would feel more comfortable responding to interview questions openly, thereby "yield[ing] richer data" (Tarzia et al., 2013, p. 8).

Life review was chosen for this study because of its effectiveness in previous work with older people and LTC populations. Even when this approach is not used



formally, researchers have noted the value of remembering and reflecting on past life events. For example, Lubarsky (1997) emphasized older adults' ability to "somehow see the connections that exist among a multitude of experiences" in order to understand the meaning in their lives (p. 143). Furthermore, in the context of qualitative research, Robinson (2000) asserted that making space for reminiscence in the research process is important for storytellers and listeners alike, but also "pay[s] off in terms of gaining better understanding of respondents, their value systems, and data that are reported" (p. 22).

Finally, this approach has had promising implications on care practices. The process of recalling and discussing life events has been used as a therapeutic intervention for older people to improve quality of life (Stinson & Long, 2014). Furthermore, compiling and listening to the stories of residents has been shown to improve caregivers' attitudes toward residents (Clarke et al., 2003; Reichman et al., 2004), allowing them to conceptualise residents as individuals with life histories, rather than simply as patients.

## **Phase 2**

A semi-structured interview method is well-suited to interviews with older people on the topic of sexuality. Authors have noted that the informal style of these interviews encourages a greater comfort-level when discussing sensitive subjects (Tarzia et al., 2013) and that open-ended questions tend to empower participants, giving them more control over the direction of the research process (Corbin & Morse, 2003).

With these considerations in mind, the researcher conducted one-on-one interviews with resident participants that were loosely based on a predetermined interview guide (see Appendix C). Questions and prompts were prepared in advance, but

strict adherence to the interview guide was not enforced. Overall, an effort was made to keep the tone as conversational as possible, and questions that appeared to be distressing for participants were circumvented as quickly as possible. Each interview session lasted between 30 and 70 minutes, with an average of 44 minutes per interview.

Former qualitative researchers recommended speaking in generalities about other residents or using hypothetical situations to encourage participants to speak more openly on the topic of sexuality (Tarzia et al., 2013). The latter study found that when asked directly about personal experiences, residents tended to be more reluctant to respond. Similarly, these researchers suggested using terms such as “companionship” in place of more explicit or academic terms such as “sexuality” throughout the interview process (Tarzia et al., 2013). These recommendations were taken into consideration during the development of the semi-structured interview guide (see Appendix C).

The interview opened with demographic questions to determine participants’ age, gender, relationship status, and duration of stay in the LTC facility. Next, questions were asked to address the three primary research questions. The first set of questions revolved around residents’ general knowledge and perceptions of the sexual and intimate needs of older adults in their facility. For example: “How would you describe the opportunities for companionship between residents in this facility?” and “Generally, do you think this environment encourages intimacy/sexuality among residents?” The second set of questions were directed more specifically at the residents’ personal experiences with and opinions about sexual expression and desire. It included inquiries such as: “How has the value you place on intimacy changed over time?” and “Do you feel that your intimate needs are being met in this facility?” The third set of questions aimed to get a sense of

potential barriers that the facility may present and any positive efforts the facility may be making to address residents' sexual and intimate needs. This topic area was addressed using questions such as: "How would you describe the level of privacy in this facility?" and "How do you think a staff member would behave if they were to walk in on a resident engaging in an intimate activity?" The interview concluded with questions targeting participants' experiences with the research process generally and the life review sessions more specifically. At the end of the interview process, participants were encouraged to ask any questions. Audio-recording was a required component of participating in the study, as all interview data were audio-recorded and transcribed verbatim.

This data collection procedure is well-supported by Robinson's (2000) phases for conducting qualitative interviews with older people in institutions (see Figure 1).

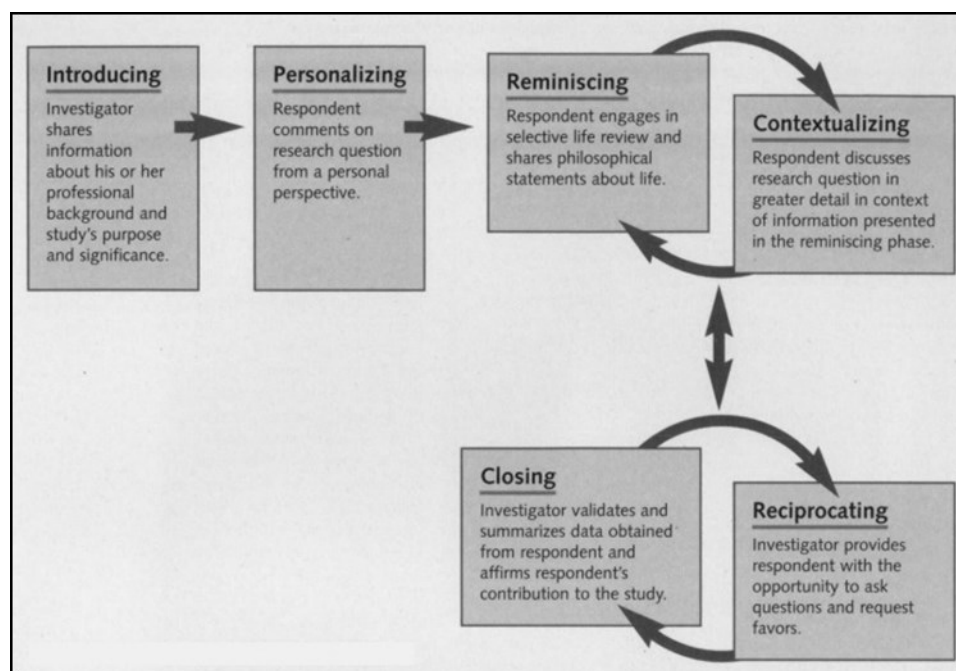


Figure 1. Phases of qualitative research interview with older adults in institutions (Robinson, 2000, p. 20).

Robinson's (2000) approach is based on the trends observed while conducting in-depth, open-ended qualitative interviews with ten nursing home residents. These phases play out in a linear and cyclical order in almost every interview, and were recommended as a means of obtaining richer data and increasing benefits for interview participants. While these phases are guidelines for a single 30-90 minute interview, they also have utility for conducting research over a longer period of time. In the case of the current research project, the introducing, personalizing, and reminiscing phases largely took place during Phase 1 of data collection, whereas the contextualizing of these memories occurred place in Phase 2, throughout the interview on sexual and intimate experiences. Finally, the interview concluded with an opportunity for questions, as well as the reciprocating gift of the life story album, which will coincide with the closing of the dissemination process. Extending these phases over a longer period of time served to

strengthen the process, as it allowed for more time to reminisce and develop a trusting research relationship.

### **Data Management & Analysis**

As advised by Creswell (2014), data collection, data analysis, and preliminary reporting of findings occurred simultaneously. Initial stages of data analysis began soon after the first interviews were transcribed, and this was an ongoing process until all interviews were completed, transcribed, and analysed. Furthermore, analytic memos were used to keep track of significant thoughts and ideas, and to document “how the process of inquiry [was] taking shape” (Saldaña, 2013, p. 41). These memos comprised the initial stages of reporting on the data.

### **Thematic Analysis**

Thematic analysis was employed to actively extract central themes from the interview narratives offered by participants. This approach has been described by Braun and Clarke (2006) as a flexible “method for identifying, analysing, and reporting patterns (themes) within data. It minimally organises and describes your data set in (rich) detail” (p. 6). The subsequent description of thematic analysis will rely heavily on Braun and Clarke (2006), as they provide a comprehensive guide for conducting this type of analysis. Saldaña (2013) also offers valuable instruction on the specifics of coding transcripts.

The data set of primary interest was the transcripts from the semi-structured interviews, although the analysis process was inevitably informed by the researcher’s interactions with participants prior to the interviews, during the life review stage. The researcher took an inductive approach to coding the data and identifying the larger

themes, so that findings were as rich as possible and accurately reflected participants' lived experiences. First, de-identified transcripts were printed in hard copy to allow for more hands-on analysis. These hard copies were formatted with extra space in the margins for notes, as well as line numbers for reference. Transcripts were read and reread, and first cycle coding was done by hand, in the margins of the transcripts. Strauss and Corbin (1998) identified initial coding as an effective method for "breaking down qualitative data into discrete parts, closely examining them, and comparing them for similarities and differences" (as cited in Saldaña, 2013, p. 100). In addition to initial coding, particular attention was also given to descriptive coding, to summarize recurring topics or ideas in simple words or phrases, as well as In Vivo coding, to capture words and phrases as voiced by participants (Saldaña, 2013). These coding methods provided a useful starting point, as they produced a wealth of detailed codes that represented the data set.

Once all ten transcripts had been undergone first cycle coding, second stage coding methods were employed (Saldaña, 2013). During this stage, codes were highlighted based on which research question(s) they addressed. Using axial coding, codes within each research question were merged and reconstructed into broader codes based on the higher-level ideas they represented (Saldaña, 2013). Furthermore, over the course of second stage coding, regular meetings between the researcher and her supervisor were held to discuss codes, patterns, and emerging themes. This allowed for peer examination, thereby improving data trustworthiness. Finally, throughout the coding process, the researcher wrote a series of analytic memos to note significant ideas, patterns, and preliminary themes in the data (Saldaña, 2013). This process also allowed

for constant comparison of data within and across transcripts. These memos became the foundation of reporting on study results and discussion of these results.

Once these two stages of coding were complete, the process of identifying overarching themes began. It involved the creation of various ‘mind-maps’ to conceptualize codes, and understand how they intersected with one another. Once a list of tentative themes was established, it was reviewed and refined until it best captured the voices and stories of participants. These themes were given appropriate labels, and data were reviewed once again to extract supporting narrative for each theme. Ultimately, the themes were used as the foundation for the “collective story” (Huber & Whelan, 1999, as cited in Creswell, 2007, p. 126) that was created by weaving together the voices of residents. Above all, efforts were made to demonstrate how these voices spoke to and against one another in the context of each theme, highlighting the diverse experiences of participants.

### **Ethical Considerations**

It is important to note that research conducted with a vulnerable population, within a care institution, and on a sensitive subject, has a host of important ethical concerns that merit attention. The following considerations are by no means a comprehensive list of the anticipated ethical issues associated with the present study; however, they provide insight into the wide range of factors that were addressed, with safeguards, to protect the identity, rights, and dignity of each research participant

## **Risk & Benefit Analysis**

Overall, the present study can be defined as a minimal-risk study in a higher-risk setting. It was minimal-risk in that that the “probability and magnitude of possible harms implied by participation in the research [was] no greater than those encountered by participants in those aspects of their everyday life that relate to the research” (Tri-Council, 2010, p. 23). The potential risks associated with participating (i.e., three interview sessions) did not exceed the general risks encountered in day-to-day life even within the context of living in a LTC facility. The degree of risk associated with the life review process was equivalent to that associated with reflecting on past memories with a family member or caregiver, for example. The level of discomfort with the interview topic of sexuality was expected to vary based on each participant’s personal beliefs and values surrounding sexuality. However, the risk associated with discussion of matters related to sexuality was considered to be comparable to that associated with discussion of these matters with a healthcare provider, friend, or family member.

Given that the topic of the study is considered relatively taboo, it was expected that participants would experience a certain level of discomfort when discussing their experiences related to the sexual expression of older adults in the LTC setting. The topic of the interviews was personal in nature, and therefore it had the potential to elicit emotional responses from participants. Topics related to intimacy, companionship, and sexuality can be sensitive or highly emotional for anyone, but this is particularly likely for older adults whose “point of reference about sexuality may often relate to a partner who has died” (Tarzia et al., 2013). Additionally, these types of intimate discussion may prompt recollection of traumatic events such as past or current sexual abuse. Moreover,



this type of emotional content may be particularly difficult for participants who experience depression or other mood-related disorders. Therefore, it is important not to understate the importance of being sensitive to residents' responses and needs throughout the interview process. There was also a chance that residents would feel embarrassment during open discussions about sexuality, especially when the terms 'sexuality' or 'sexual expression' were used explicitly, as found in a similar study (Tarzia et al., 2013).

To mitigate these emotional risks, the researcher approached each interview with empathy and compassion, progressed at the participant's pace, and offered to stop the interview altogether if necessary. Ample time was provided for questions and clarification prior to beginning the interview, and participants were assured that they could skip any questions, take a break, or withdraw from the study at any time.

Additionally, the life review method doubled as part of the risk mitigation strategy.

Although sharing life stories caused many memories to surface, the process also had the potential to alleviate or prevent some of the emotional distress during the interview, as it has been demonstrated that recalling and discussing past events with older adults can often have a cathartic or therapeutic effect (Latorre et al., 2015; Stinson & Long, 2014).

Prefacing interviews with this approach may have allowed residents to reframe these memories in a more positive light.

Furthermore, the informal sessions prior to the interviews were designed to allow the researcher to establish whether there were any topics that were particularly distressing for the resident. In the event that a participant disclosed sensitive or distressing experiences during the life review phase that could be triggered in subsequent sessions (e.g., the recent passing of a spouse or partner, memories of sexual assault/abuse),

additional steps were prepared to determine whether or not it was advisable for the participant to continue with the study. If the distressing topic(s) (a) came up in passing, and were not central to the research questions, the researcher would make a note to avoid these topics altogether in future sessions. If the topic(s) (b) were directly related to the line of inquiry and could not be reasonably avoided, the researcher would consult with the participant, reminding them of the types of questions that they could expect from the interview, and inquiring about whether these questions would be too difficult in light of past experiences. In either scenario (i.e., a or b), the researcher would offer to seek out a long-term care staff member. Upon agreement of the participant, the researcher would find a staff member who could provide additional and ongoing emotional support, or who could refer the participant to an appropriate professional.

In addition to providing an opportunity to identify potentially distressing topics for the participant, the life review method helped to establish a relationship of trust and rapport with the researcher, with the goal of eliminating residents' embarrassment or discomfort discussing such a personal matter. Finally, to mitigate the risks associated with participation, study participants were provided with a list of resources available within the facility (see Appendix D). This list was developed in consultation with the facility liaison to remind participants of the resources available to them in the event that—following the life review and/or interview sessions—they needed to address any emotional distress, or wanted to follow up on physical/sexual health concerns with a professional upon completion of the study.

Additionally, every effort was made to ensure that knowledge of who was participating in the study was kept private. Given that the interviews and life review

sessions took place within the LTC facility, there was the potential risk that other individuals within the facility would become aware of who was participating. Residents may have been concerned about the level of care they would receive or treatment by fellow residents if their participation was made known. As a result, participants were given the choice between using their private room or another private, neutral location in the facility for conducting interviews. When another location was used, the purpose of the meeting spot was not made public knowledge within the facility. Efforts were made to vary the meeting places for different participants so that one room did not become known among the participants as ‘the interview room.’ Furthermore, the researcher used discretion during her visits to the facility, not disclosing the purpose of the visit to staff or other residents.

Additionally, participants may have experienced a series of benefits as a result of their participation in the study. Participation may have produced a sense of accomplishment for having made a meaningful and personal contribution to the understanding of research, policy, and practice related to intimacy/sexuality in the LTC setting. Also, at the end of the dissemination phase, participants will be left with a tangible benefit in the form of their life story album that they can choose to share with caregivers and/or administrators. Whether these albums are used to strengthen care practices, or whether participants choose to keep their albums private as a personal collection of memories, the creation of these albums represents an important element of reciprocity—providing residents with a visual compilation of their life stories as a token of thanks for their participation.

Another tangible benefit existed in the form of monetary compensation. Using funding from a Faculty of Health Professions Research Development Grant, participants were offered an honorarium as a token of appreciation for their participation in the study. This honorarium was offered in the form of \$15 per meeting with a researcher, amount totaling to \$45 per participant. This number was chosen as it is higher than minimum wage, but is not too large a sum to create incentive for residents to participate. Participants were assured that if they chose to withdraw from the study at any time, they would still receive the honorarium based on the number of sessions completed, including the one at the moment of withdrawal. Upon acquiring the honoraria in cash, or as a deposit to their trust fund at the facility, participants were asked to sign a receipt as a record of the transaction (see Appendix E). These signed receipts were stored separately from de-identified transcripts.

Furthermore, although sexuality is often considered a highly sensitive topic, it must be stipulated that discussions of sexuality and intimacy have proven cathartic and enjoyable for previous older adult research participants (Doll, 2012). For instance, Gott and Hinchliff (2003) reported that “despite concerns about causing offence,” no participants were upset by the experience, and many actually found it enjoyable, having “never spoken about sex to anyone before” (p. 1619). This knowledge informed the researcher’s attitude throughout the data collection process. Although it was important to remember that sex is laden with socially-constructed notions of shame and silence, and to address it with appropriate sensitivity, it was equally important to remember that these *are* social constructions. In other words, stereotypes about sexuality and aging should not

lead to undue fear about broaching the subject in the first place, for this would exclude older individuals from an experience that was likely to be refreshing and valuable.

### **Facility Arrangements**

As already noted, the institutional setting presented a unique set of ethical considerations and challenges that would not have been present if the study were undertaken with community-dwelling older adults. For this reason, there were a series of safeguards and arrangements that were made with, and by, the LTC facility, in addition to those associated with the standard ethics protocols for academic research.

It is important to note that in an institutional setting, the recruitment process in and of itself could pose a significant ethical dilemma if not handled carefully. The *Tri-Council Policy Statement* (2010) emphasizes the importance of ensuring that an individual's consent to research is completely voluntary. It states that "in particular, how, when and where participants are approached, and who recruits them are important elements in assuring (or undermining) voluntariness" (p. 28). The reality is that access to populations in institutions is usually controlled by administrators or other staff members who hold positions of authority. Because these individuals are 'gatekeepers' to the community, the recruitment process will almost inevitably involve someone in a position of power. This concern has been identified in former studies, where potential participants "may feel coerced into becoming participants, with a fear of losing services if they do not agree" (Robertson & Hale, 2011, p. 2).

Given that recruitment was conducted internally by the facility liaison and staff, concerns about voluntariness of participation were paramount. Safeguards were taken to ensure that any coercive influences were mitigated. Individuals were well-informed that

their decision to participate—or not to participate—would in no way influence the level of care that they receive. The facility liaison and staff associated with recruitment were asked to assure prospective participants that participation was completely voluntary, and that they could choose to withdraw at any time. These details were reiterated and confirmed by the researcher during the ongoing informed consent process to ensure that no coercion—real or perceived—had occurred.

Finally, every effort was made to maintain participants' privacy during the data collection process. The researcher worked in tandem with the facility liaison to ensure that residents' privacy and dignity was protected. Interviews were conducted within the facility, in a private, safe, and comfortable environment for the participant. The choice of a neutral location minimized the likelihood of others knowing that the resident had chosen to participate in the study.

### **Informed Consent**

Informed consent was obtained using a written consent form for each participant (see Appendix F). In most cases, participants were provided with a copy of the consent form via the facility liaison or recruiting staff member in advance of the scheduled meeting time for the first life review session, so that they had the opportunity to read it over and assess their interest in participating. At the first meeting, the researcher went over the details of the consent form, and responded to any questions the participant had about the study. Once it was clear that the participant fully understood and had given his/her approval, the signature page was completed. At each subsequent life review session and prior to the interview session itself, discussion occurred to ensure that participants wished to continue participating in the study. There was opportunity for

questions and clarification. Participants were asked to provide written consent by signing the consent form prior to each data collection session. Thus, this study employed an ongoing informed consent process. In the event that visual, cognitive, or other impairments had presented a barrier to providing written consent, the participant would have been asked to provide oral or third-party consent instead. In all cases, data collection did not proceed until informed consent was obtained.

Based on the study's inclusion criteria, it was possible that the liaison and staff would identify prospective participants with mild cognitive impairment, or other forms of impairment that would compromise the resident's ability to make his/her own informed decisions. A detailed informed consent procedure was developed in the event that this occurred. In these instances, the facility liaison was to indicate that the participant required third-party consent, without yielding any specific details to the researcher about the reason(s) for this requirement. Based on the facility's policy on research, the liaison would then identify an appropriate substitute decision-maker to give third-party consent. In these cases, the researcher would obtain both informed consent from the designated individual, as well as assent from the resident participant, using a consent form with two separate signature pages (see Appendix F). Signatures would be obtained from both the resident participant, as well as the individual responsible for decisions regarding the resident's health and health care. In the end, this procedure was not required, as all prospective participants identified by staff and the liaison were able to consent to the study independently.

## **Confidentiality & Anonymity**

Because of the inherent power differential between residents and their caregivers/administrators, the importance of protecting residents' identity in the reporting of findings was paramount. If staff were able to attribute residents' identities to the voices in the final report, it could mean differential treatment, whether intentional or unintentional. Given this potential risk, every effort was made to ensure that data remained strictly confidential. The purposeful selection of the facility of study was one factor that helped to protect participants' confidentiality, given the facility's large size and multiple residents.

Life review sessions and interviews were conducted in face-to-face, one-on-one meetings with the researcher, therefore complete anonymity was not possible. However, a series of safeguards were employed to ensure that participants' identities remained confidential. Qualitative data were collected using a secure-audio recording device and the digital files (i.e., .mp3) were transferred from this device onto a secure, firewalled computer. Interviews were transcribed verbatim and all identifying information was removed from transcripts, which were stored in password-protected file folders. Hard copies were stored in a locked box separate from signed consent forms and receipts so that the identifying personal information could not be paired with collected raw data. Data will be retained for five years after the conclusion of the study, after which all digital and hard copies will be destroyed. These protocols apply to both data collected during Phase 1 and 2 of data collection, with the exception of the life story album. This album, while a product of data collection, will remain with the participant upon completion of the project.



## **Ethics Approval**

Given that this project was conducted at an institution with its own ethical procedures, ethics approval for the present study required a two-step process. First, the Dalhousie Health Sciences Research Ethics Board granted their approval of the project on October 27, 2015 (see Appendix G). Following this approval, a project proposal and ethics application was submitted to the facility for internal review. Approval was granted by the internal ethics board on January 8, 2016. This letter of approval has not been attached, as it discloses identifying information about the chosen facility.

## **Researcher Positionality**

As much as qualitative description strives to minimize the impact of the researcher on the interpretation of data, proponents of the approach have asserted that “descriptions always depend on the perceptions, inclinations, sensitivities, and sensibilities of the describer” (Sandelowski, 2000, p. 335). It is impossible to separate one’s own feelings, ideas, and social locations from the process of conducting research. Given that it cannot be separated, it is important to recognize my positionality and how this may have intersected with the research process. Robertson and Hale (2011) have alluded to this recognition in their preparation steps for interviews with older people, stating that “individuals bring different backgrounds to an interview. Consider what background you bring and what influence this might have” (p. 7). With this in mind, I entered this research project with an awareness of my own positionality as a younger, female researcher who is inevitably affiliated with ‘the academy’ and all of the related positive and negative connotations.

My liberal arts education has fostered a sex-positive attitude—I value the importance of discussing sexuality honestly and openly, without fear of shame or ridicule. This attitude was cultivated at Mount Allison University where I completed my undergraduate degree in English and sociology. The sociology background was particularly helpful as it familiarized me with critical discourse surrounding sexuality. For example, in a second year Sex and Gender Studies class, I partook in various coffeehouse-style discussions which encouraged frank, open discussion of topics that would commonly be considered taboo. This class sparked my initial interest in the topic of sexuality, which I continued to foster throughout my coursework. In my final year at Mount Allison, I took an elective Human Sexuality class, and chose older adult sexuality as a topic for the final term paper. This project provided a useful introduction to the body of literature on later-life intimacy and sexuality, a topic which I continued to explore as I developed the proposal for my Master’s research project.

Importantly, my interest in the topic was also borne from my personal and family relationships. My mother has worked in a nursing home for over 30 years, and she has always encouraged us to treat older people with compassion, respect, and most importantly, as people. My respect for older people and their stories has only been intensified through second-hand accounts of my mother’s experiences.

Even with a personal motivation for engaging in this research, my age and gender may have impacted residents’ willingness to share their stories with me, particularly on the topic of sexuality. Former researchers have noted diverse effects of these demographics, suggesting that the ability of residents to identify with a researcher as a granddaughter can be beneficial for encouraging trust, but may also make older

individuals more reluctant to share their true opinions on certain matters (Grenier, 2007). Every effort was made to consider the impacts of my positionality on the outcomes of the research, and to mitigate these where possible.

By virtue of my age, it may not have been possible for me to fully understand the range of life experiences that study participants reported. As demonstrated in other studies (Guse et al., 2000; Lubarsky, 1997), life review serves as an effective method to bridge the age gap by eliciting stories that help the researcher to understand and empathize with participants' experiences. Furthermore, throughout the interview process, I was committed to listening respectfully and without judgement. Finally, the research project involved a constant process of self-reflection and re-evaluation of any ageist assumptions that I uncovered within myself.

### **Dissemination Strategy**

#### **Academic Dissemination**

Findings from the present study have been presented at local and national conferences. In March 2016, preliminary results were presented at the Crossroads Interdisciplinary Health Research Conference. Furthermore, in June 2016, findings related to barriers and facilitators were presented at the Public Health 2016, the Annual Meeting of the Canadian Public Health Association. Study findings pertaining to the utility of the life review method have been accepted for presentation at the 2016 Annual Scientific and Educational Meeting of the Canadian Association on Gerontology in October 2016. An abstract has also been submitted to IAGG 2017, the World Congress of Gerontology and Geriatrics. If accepted, this presentation would occur in July 2017 and would address findings related to the residents' definitions, perceptions, and experiences

of intimacy and sexuality. Finally, findings on the topic of residents' experiences with sexuality in LTC will be prepared and submitted to a scholarly journal with a focus on care practice, whereas findings related to participants' experiences with the life review approach will be submitted to a scholarly journal with a more methodological focus.

### **Community Dissemination**

General study findings will also be presented to members of the LTC community through a presentation organized in collaboration with the facility liaison. This presentation will be open to all residents, staff, and managers, and allow for the community—including participants, if they wish to attend—to hear and engage with the study's findings and implications. Additionally, a community report will be prepared for the facility liaison, who may distribute this report to the appropriate managers and staff within the LTC facility of study. This report will contain information on key findings that may be used in future development of policy and practices and as a foundation for future research. Precautions will be taken to ensure that residents' voices cannot be attributed to them in the presentation of these findings. Moreover, residents will be left with a life-story album that they can choose to share with family members or staff in order to facilitate further discussion about their personal life histories. These albums will be completed and distributed by October 2016.

### **Chapter 3 Summary**

Chapter 3 has provided a comprehensive and descriptive explanation of the research methodology and methods for the present study. A qualitative descriptive approach with a constructivist worldview served as the methodology to address three central research questions. Qualitative description is a flexible methodology that

minimizes the influence of the researcher's interpretation, so as not to misrepresent the original meaning of participants' words. A single LTC facility was selected as the study site, ten participants were recruited by the facility liaison and designated staff based on a predetermined set of inclusion criteria. Data were collected in a two-phase process that combined life review and semi-structured interview methods. Data were analysed for key themes using thematic analysis. A series of ethical concerns were taken into account, including the risks and benefits associated with participation, specific arrangements that must be made within an institutional setting, the process of obtaining informed consent, and the maintenance of participants' confidentiality/anonymity. It must also be noted that the researcher's positionality—including personal experience, age, and gender inevitably impacted the research process and thus must be acknowledged. Upon completion, study findings will be disseminated to the academic community, as well as to interested managers, staff, and residents at the LTC facility of study. The following chapter includes the presentation of study findings.

## CHAPTER 4: RESULTS

### Participants

Participants were recruited from a single LTC facility in Halifax, Nova Scotia. A total of 10 residents participated in the study, with five identifying as male and five as female. Participants ranged from ages 59 to 98, with an average of 71.5 years. Three participants reported that they did not currently have a partner, whereas seven did have a spouse or partner. Of those, five participants had partners who lived in the same LTC facility, and two reported having community-dwelling partners. Participants reported a wide variety of lengths of stay in the facility, ranging from as few as five months to more than a decade. Five participants reported living in the facility for less than one year, and five for more than one year, with an average length of stay of 3.2 years. Eight participants were recruited from nursing home care (Level 2) and two from residential care. The names used in the reporting of results are pseudonyms, chosen by participants in collaboration with the researcher, to protect their true identities. For a summary of participant details, organized to maintain participant anonymity, see Table 1.

Table 1. Summary of participant details.

<b>Pseudonym</b>	<b>Age Group</b>	<b>Gender</b>	<b>Length of Stay</b>
<i>Alexandra</i>	65+	Female	> 1 year
<i>Bill</i>	55-64	Male	< 1 year
<i>Eileen</i>	65+	Female	< 1 year
<i>Hazel</i>	65+	Female	< 1 year
<i>Jason</i>	55-64	Male	< 1 year
<i>J.D.</i>	55-64	Male	> 1 year
<i>Lefty</i>	65+	Male	> 1 year
<i>Marlene</i>	65+	Female	> 1 year
<i>Mary</i>	65+	Female	> 1 year
<i>Paul</i>	65+	Male	< 1 year

## Presentation of Results

Interviews with participants uncovered an abundance of rich data on intimacy and sexuality in later-life, as well as the challenges and supports to this phenomenon in the context of the LTC environment. Emergent themes from participant interviews are categorized into two sections according to the research question that they address. Section one discusses residents' perspectives on intimacy and sexuality in response to research question one: how do older LTC residents define, perceive, and experience intimacy and sexuality? Section two outlines the current barriers and facilitators to intimacy and sexuality in LTC, addressing research questions two and three, respectively: what are the present challenges (if any) to intimate/sexual expression in a LTC facility in Halifax, Nova Scotia?; and what factors (if any) do residents of this facility experience as facilitators to their intimate/sexual needs?

### Section 1: Residents' Perspectives on Intimacy & Sexuality

#### *How do older LTC residents define, perceive, and experience intimacy and sexuality?*

Findings revealed a wealth of participant responses pertaining to their definitions, perceptions, and experiences of intimacy and sexuality in the LTC setting. These diverse and varied responses were consolidated into several key themes to capture the essence of study participants' narratives. Given the length and richness of the present section, these themes have been represented in the following table for conceptual clarity (see Table 2).

Table 2. Themes pertaining to residents' perspectives on intimacy and sexuality.

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#### **Definitions of Intimacy and Sexuality: "Know Where the Starting Point Is"**

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##### *Defining intimacy*

- Intimacy as personal and private
- Intimacy as physical
- Intimacy as partnered

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**Definitions of Intimacy and Sexuality: “Know Where the Starting Point Is” (cont’d)**

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***Defining sexuality***

- Sexuality as (primarily) physical
- Sexuality as a label
- Sexuality as a dynamic construct

***Contextualizing definitions of intimacy and sexuality***

- Conflation of intimacy and sexuality
- Diverse and difficult definitions

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**Perceptions of Intimacy and Sexuality: Does Age Matter?**

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***Age matters***

- “Age appropriate” relationships
- Depends on the individual

***Age doesn’t matter***

- Subjective age
- Generational differences
- Intimacy in older age as normal
- Intimacy in older age as power

***Perceptions of intimacy and sexuality as dynamic***

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**Experiences of Intimacy and Sexuality: “It Changed but We Work It Out”**

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***Intimate acts as present and varied******Significance of language***

- Direct vs. indirect language
- Words of innocence and experience

***Dynamic experiences of intimacy and sexuality***

- Heightened experience of intimacy
- Decline in sexual expression
- Accepting and adapting to changes

***Relevance of appearance and attractiveness***

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**Definitions of Intimacy & Sexuality: “Know Where the Starting Point Is”**

Intimacy and sexuality resonate differently with each individual and at different stages of the life course. This is evidenced by the diversity of ideas articulated by participants when asked to define these terms. Simply put by one participant: “you’re going to get a variance there. But as long as you know where the starting point is then you can work from there” (Lefty). In other words, prior to discussing residents’



perspectives of intimacy and sexuality, it is important to clarify what these terms mean to them. Thus, this section provides this “starting point,” consolidating participants’ definitions of intimacy and sexuality into key themes.

**Defining intimacy.** Participants provided varying definitions of intimacy, which can be grouped into three major themes: intimacy as personal and private, intimacy as physical, and intimacy as partnered. Each of these themes is well supported by participants’ narratives, which are represented in the following sections.

***Intimacy as personal and private.*** The first theme that emerged from residents’ responses was an understanding of intimacy as a personal and private phenomenon. For instance, Eileen asserted that intimacy was “a personal thing” that was not “anybody’s business.” This statement suggests that intimacy shouldn’t be widely shared with just “anybody.” Instead, intimate thoughts or acts should be kept private, as Bill stated outright in his definition of intimacy: “I don’t know really, I mean private stuff I guess, you know, you might be with your wife or significant other.” Notably, Bill indicated that “private” does not necessarily mean solo activity, as intimacy can extend to being with a partner as well.

***Intimacy as physical.*** As a second theme, many residents understood intimacy as a physical experience. For example, when asked to define intimacy, Jason simply stated: “Sex... two good partners together.” This allusion to the act of sexual intercourse suggests that Jason understands intimacy first and foremost as a physical experience. Mary broadens this definition, saying: “Well it doesn’t actually have to be sex, it can be hugging, or just talking to each other, holding hands, and being with one another.” She also mentioned sexual touching when elaborating on her definition. According to these

perspectives, intimacy can include physical acts ranging from hugging and hand-holding to touching and intercourse; but it can also simply involve “being with” and “talking to” a partner.

***Intimacy as partnered.*** This leads well into the third theme, which represents intimacy as partnered or shared activity. When defining intimacy, participants mentioned interacting with one or more others in various capacities. This partnership can be further divided into four sub-themes: companionship, closeness, comfort/caring, and confidant. For some, intimacy was as simple as finding *companionship*, one or more people to spend time with. This might involve outings or opportunities to “get to know more and more people” (Hazel). For instance, Lefty described intimacy as spending time with a resident with whom he had common interests. Others placed more emphasis on the *closeness* inherent in these relationships that involve “feelings for another person” (Hazel). Marlene specified that intimate relationships should be both healthy and enjoyable. These relationships could be with romantic partners, but could also include close relationships with family or friends. As Alexandra clarified: “I could say he or she in that situation too [because intimacy is] not necessarily romantic at all.” J.D. corroborated this view, defining intimacy as “a relationship with your sons, your daughters... with family.” Participants also mentioned that partnered intimate relationships involve some level of *comfort* and *caring*. Bill described holding hands as a way to comfort his partner, and Hazel emphasized the importance of respect and caring in her relationship: “As long as he treats you with respect and shows that he cares...” Finally, intimacy was often equated with having a *confidant*, “someone that you can trust and confide in, someone you can bounce things off of so to speak” (Lefty). Alexandra emphasized that an intimate

relationship should allow for sharing information with no fear of judgement. She defined this relationship as “one in which you can tell very personal things to... things that you would tell very few people but you would feel trusting enough of that person to tell him and expect him not to scoff.” These participants valued the element of supportive, trustworthy, and stimulating conversation as defining features of an intimate partnership.

**Defining sexuality.** Residents had equally varied views on what constitutes sexuality. These definitions can be best understood as three themes: sexuality as (primarily) physical, sexuality as a label, and sexuality as a dynamic construct. The following sections provide evidence for each of these thematic understandings.

*Sexuality as (primarily) physical.* First, and perhaps unsurprisingly, participants understood sexuality as a predominantly physical experience. For example, Lefty referred to “the actual act of sexuality,” implying that the “actual” physical act of intercourse is somehow a more real or legitimate understanding of sexuality than any other definition. However, Lefty also acknowledged that sexuality does not always necessitate intercourse, but could also encompass other shared activities such as “being outside enjoying the weather... and maybe holding hands.” Alexandra provided a similar two-tiered response, initially stating: “sexuality always seems to me to have an ultimate goal of sexual relations.” She went on to stipulate that sexuality does not strictly mean intercourse, but may also involve the process of desire and attraction that precedes a physical act: “sexual relations can simply be attraction and thought... the chemical attraction, almost like a crush, has to come first.” For both participants, sexuality was partially, but not exclusively, a physical phenomenon.

***Sexuality as a label.*** A second distinct theme emerging from the data was the understanding of sexuality as a label. Some participants conceptualized sexuality as synonymous with, or related to, sexual orientation and/or gender. When asked what word came to mind upon hearing the word sexuality, J.D. replied: “Straight, I guess.” Whereas this connotes sexual orientation, Bill indicated that sexuality was more closely tied to gender: “I mean it’s all according to what gender you are I guess... sexuality is sexuality.” Jason seemed to understand sexuality as an umbrella term for sexual orientation, gender, and possibly individual sexual preferences: “like what sexuality are you, like you’re male, female... what kind of sex do you like and sexuality... do you like men or women.” In these cases, sexuality was not related to physical acts, but rather how one identifies and who they are attracted to.

***Sexuality as a dynamic construct.*** A third theme that was reflected in participant responses was an awareness of sexuality as a dynamic construct. In other words, the definition of sexuality was likely to change over time or at different stages of the life course. This was first hinted at when residents defined sexuality, and made a point of clarifying whether they should provide a current or past definition. Questions such as “you mean now?” or “at this stage in my life?” revealed that residents did not understand sexuality in the same way now as they had at an earlier point in their lives. This changing nature was made more explicit in some cases. For example, Lefty commented: “You know I would have a different answer if you asked me that question when I was 25.” He noted that while in the past, his definition would have been more physical, now “it just means someone you can depend on, someone you can say hey let’s go here or let’s go there.” Marlene also implied a change or loss of the definition, as to her sexuality “means

diddly, nothing.” Therefore, it is important to be attuned to the possible variance in sexuality’s meaning, not just from person to person, but within each person over time.

**Contextualizing definitions of intimacy and sexuality.** The above six themes clearly emerged from participants’ definitions of intimacy and sexuality. In spite of the clear evidence for these themes, participants’ responses also demonstrated that these can be complex constructs that are not easy to define. Results show that intimacy and sexuality were not always understood as distinct concepts. Participants’ responses illustrated the diversity present within definitions of intimacy and sexuality, as well as the difficulty of operationalizing these terms.

***Conflation of intimacy and sexuality.*** Importantly, some residents did not see a distinction between intimacy and sexuality, and used the terms interchangeably. Such was the case for Bill, who defined sexuality as “just being intimate with your wife.” Likewise, as in the example given earlier, Jason defined intimacy plainly as “sex.” Evidently, for some, these words can be used synonymously. Other residents, including Hazel, only provided a definition for intimacy and then indicated that their understanding of sexuality is similar and need not be defined again.

***Diverse and difficult definitions.*** Definitions of intimacy and sexuality were highly individualized, therefore resulting in a fairly diverse understanding of the terms. In Eileen’s case especially, it is apparent that the definition of intimacy was intricately tied to her own experience. When asked for a definition, she immediately recounted her personal experience: “Well we see each other every day and at night...” Lefty showed a particular interest in the diversity of residents’ definitions, repeatedly mentioning the “wide variance” that should be expected from the results and stating that

intimacy/sexuality “has to” mean something different to everyone. He gave an example: “you may find that what one person considers to be intimate, another person may consider to be vulgar.” Bill seemed to be aware of these individualized differences, providing a caveat to his definition that makes it clear he is only speaking for himself: “Right? As far as I’m concerned anyway.” Bill’s response signaled a desire for approval of his response, suggesting some uncertainty related to defining these terms.

Bill was not alone in this sentiment, as initial uncertainty became a relatively common theme within the subtext of residents’ definitions. This is evidenced by the appearance of phrases such as “I don’t know,” “I never really gave it much thought,” or joking “Oh God!” when asked to define the terms. Language itself may be a source of uncertainty for some residents. For example, J.D. began his definition of intimacy with “Mmm, I can’t even pronounce the word.” This suggests that in some cases, it may not be the content that participants are reluctant to discuss, but rather that the language used to define these terms is unfamiliar or intimidating. Participants’ use of language will be represented in greater detail in a subsequent section.

### **Perceptions of Intimacy & Sexuality: Does Age Matter?**

In addition to understanding how residents define these terms, it is equally important to consider how they perceive intimacy and sexuality for older people in general. This section explores participants’ thoughts, views, and beliefs related to intimacy and sexuality in later life. This goes beyond participants’ individual definitions of intimacy and sexuality, emphasizing how they understand and perceive sexuality and intimacy in the *context of aging*. These perceptions may be related to first-hand insights on sex and aging, or to their impressions of intimacy among other older adults.

Specifically, this section seeks to address the underlying question: when it comes to sex and intimacy, does age matter?

**Age matters.** When asked if age is a factor that impacts a person's ability to be intimate or sexually active, Marlene responded: "some people think it is." With this statement, Marlene demonstrated her awareness of the common belief that age determines an individual's desire or ability to be intimate. Although Marlene did not subscribe to this view herself, data analysis revealed that some residents' perceptions corresponded to this idea; certain participants perceived that age does matter, at least to some extent. For example, Hazel immediately identified a chronological age marker associated with the end of intimate or sexual activities: "I'd say as soon as they hit early 50." She went on to normalize loss of sex drive in middle to older age, saying "most of us lose that [urge] at 45 or 50." Evidently, for Hazel, loss of sex drive is firmly associated with a numerical age. Similarly, Eileen attributed a change in intimacy to increasing age, acknowledging that even before entering LTC, "when we were still home you know it wasn't like it was when you were younger." The implication here is that a "younger" chronological age means more intimate activity, and that a decline in intimacy is expected with increasing age.

***"Age-appropriate" relationships.*** Participants also discussed chronological age in the context of "age-appropriate" relationships. J.D. noted that age should be considered in relationships, saying "for a man and a woman I don't think there should be an age gap or anything." Alexandra seemed to share this view, expressing disapproval of relationships with significant age gaps and marked approval for a couple who was close in age: "nobody can believe they met in here, they're age appropriate, they're both 80... and they

seem to have a very loving relationship.” In this context, chronological age is viewed as an important determinant of a successful relationship. It is important to note that not all participants perceived an age gap to be a negative thing. As Marlene said: “He’s a lot younger than me. I like it that way.” Similarly, Jason mentioned that his wife is ten years older than him and that age difference does not matter to him. This discrepancy in perspective suggests that, especially for those who have personal experience with age differences in couples, age may not be as much of a factor.

***Depends on the individual.*** When asked to what extent age determines a person’s ability to be intimate or sexually active, Lefty emphasized the role of the individual: “I think it does for some people, I think it doesn’t to other people. I think there are different factors involved but I think that, I think age itself no.” Lefty’s consideration of individual differences is significant here, suggesting that stereotypes about sex and aging cannot be generalized to everyone. Furthermore, attention should be drawn to the mention of “age itself.” According to Lefty, age as an isolated phenomenon is not responsible for a change in intimacy. Instead, there are “different factors” to consider.

***Age doesn’t matter.*** Lefty’s view resonates with many other participants who vocalized that age alone is not the determining factor. These residents expressed the belief that there is no predetermined age for intimacy, a view stated by Bill: “I don’t think age makes one damn bit of difference.” Similarly, J.D. expressed that age should not be a factor at all: “I don’t think there should be any age involved.” Mary provided support for this argument as well, asserting: “I don’t think there’s any age limit. If you’re healthy, I’ve heard people getting married in their 80s and stuff like that.” With these words,



Mary implies that it is not as much about age as it is about level of health, and that people should not feel restricted or confined by an arbitrary “age limit.”

***Subjective age.*** The data also suggested that chronological age is not as important as how old one *feels*. When discussing the impact of age on intimacy and other factors that may be involved, Lefty referenced a song lyric, explaining that “they’re not saying you’re not getting older chronologically it just says you don’t get old mentally.” About his own attitude toward the aging process, he said: “I don’t necessarily feel old and I know there are things that I used to be able to do that I probably can’t now but I try to make up for it as much as I can.” He seems to suggest that attitude towards aging may impact one’s desire or ability to engage in intimate activities. Paul also acknowledged that subjective age may be more important than chronological age when it comes to continued intimate expression. He said: “Your mind is as young as you want it, that’s right.”

***Generational differences.*** The data also lend some support to the idea that age itself is not as significant as the generation in which one was raised. Lefty touched on this point when he described “the real older women in here, like maybe in their late 80s or 90s, they’re much different than women even 10 years, 20 years younger than them because they look at things differently.” The important distinction here is that he perceived this different viewpoint as a product of the women’s cohort rather than their age alone.

***Intimacy in older age as normal.*** Some participants also voiced the perception that intimacy or sexual expression in older age should be regarded as normal. Lefty recounted a story of a friend who was interviewed for a position at a LTC facility. When

the friend was asked how he would respond if he were to walk in on a resident masturbating, he responded that he would leave the room immediately. Lefty offered his commentary on this response: “And that was the answer they were looking for I guess. What are you going to do? Tell someone that has a normal activity and criticize him? I mean, it’s life, it’s what happens in life.” With these words, the participant is effectively normalizing masturbation, asserting that it is a regular part of life that should be accepted rather than “criticized.” He also stated that as long as the intimate activity is not causing harm or discomfort to others, it should not be considered a problem. Similarly, Bill asserted that the need for intimate or private time with his partner should be obvious: “They’ve got to remember I’m a man, she’s a woman, we’ve been together [for over 40] years right? Obviously we’d appreciate a little bit alone time.” The use of the word “obviously” is significant, implying that making space for residents’ intimate needs should be a standard, normative practice.

***Intimacy in older age as power.*** However, participants also acknowledged that when intimacy does occur in later life, it is regarded as a source of power—an exceptional circumstance that merits praise. “All the power” was a common catchphrase spoken by Jason when referencing other residents who expressed interest in sexuality despite their age: “I say if two adults, grown adults needs to have it, all the power, yes.” Jason also expressed his support for the acceptance of intimate desires expressed by those with dementia, as long as no harm is caused: “all the power... you know as long as they’re not hurting nobody.” Similarly, Hazel affirmed that older adults deserve a right to privacy to engage in intimate activities if they so desire: “I mean at their age if they can still get the urge, all the power to them.” Here, there is also the underlying assumption

that this is not considered the norm for older adults. Therefore, somewhat contrary to the above sub-theme on intimacy as normal, maintaining a sex drive in later life seems to be understood by these participants as an exception rather than a common occurrence, and as something that can be regarded as powerful rather than shameful.

**Perceptions of intimacy and sexuality as dynamic.** Finally, participants expressed a change in the value they placed on intimacy over time. Notably, this change went both ways. Some residents expressed that intimacy was less important to them at this stage of their life than it had been previously. This was the case for Bill, who said: “It was at one time, it’s not now.” Conversely, Mary noted that physical intimacy was currently a very valuable part of her life, whereas during her previous marriages, she had considered intimacy more as a product of marital obligation: “Well it’s just, you know when you’re married it’s, your husband is there and you know you have to you know.” Evidently, perceptions of intimacy are not constant, but change based on personal experiences and over time.

### **Experiences of Intimacy & Sexuality: “It Changed but We Work It Out”**

The study was not only interested in how participants perceived intimacy for older people in general, but also how they themselves experienced intimacy and sexuality at this stage in the life course. While some of these experiences are captured in the definitions and perceptions offered by participants, this section focuses exclusively on the range of intimate acts participants report, the language they use to describe these acts, how their experiences have changed over time, and the role of attractiveness in residents’ experiences of sexuality.

**Intimate acts as present and varied.** Data revealed that participants' current experiences of intimacy and sexuality are present and varied; that is, participants reported engaging in a wide spectrum of intimate and sexual acts, ranging from casual companionship to sexual touching. This range of experiences is reminiscent of the diversity apparent in participants' definitions of intimacy and sexuality. When asked what sort of intimate behaviour people may engage in at the facility, Hazel implied that options were endless: "Anything." For some, intimacy constituted being in the company of another person, eating lunch together, or even sharing food with a fellow resident on outings: "that's what we do and that's what, you know couples do that actually... that's kind of an intimacy thing when you're sharing food" (Lefty). Others' intimate experiences involved daily or nightly rituals with a partner who also lives in the facility. This is the case for Eileen, who said: "Well we see each other every day... and when we're parting for the night well we'll give each other a kiss and a hug or something."

Experiencing enjoyment from looking at sexualized materials or talking about sex was a sub-theme that arose from a couple of interviews. For instance, one resident described his experience watching television advertisements with women in bikinis, saying: "it was fun just watching the ads." This suggests that he still experiences some level of desire or pleasure as a result of sexualized images. Similarly, the oldest female participant revealed that she enjoyed talking to others about sex as a source of humour: "but naturally I like, you know, talking to people about sex and we have a laugh, you know, once in a while." This statement is particularly interesting in light of the assumption held by a relatively younger male participant (age 63) regarding older people's aversion to talking about sex: "am I going to talk to [a 75-85 year-old woman]

about my sex life and how good it was last night?” Although his question was meant to be rhetorical, it seems that for some older women, the answer would be yes.

Notably, residents’ intimate experiences extend beyond spending time with and talking to one another. Participants also described a variety of physical acts as part of their intimate and sexual experiences. These included holding hands, hugs, back rubs, placing an arm around a partner’s shoulder, and cuddling or the desire to cuddle. J.D. spoke to the benefits gained from a physically intimate relationship: “when me and this lady were involved... I think it really helped her psychologically and helped me psychologically.” For some residents, sexual expression goes beyond cuddling. For instance, Mary alluded to sexual touching, saying: “I try to please him right... I know men like to be touched and I do that once in a while for him and he thanks me. I say you don’t have to thank me.” This is significant in that it demonstrates that the participant perceives sexual touching as a normal part of sexual expression, not requiring any special thanks.

Interestingly, none of the participants discussed sexual intercourse as a part of their current intimate experience. Some openly expressed that they no longer engaged in sex, which will be addressed at greater length in a subsequent theme. For instance, Bill referred readily to hearsay of another couple’s sexual encounter, saying “they were locked up hard,” but denies that he himself masturbates: “Or if you’re asking me if I play with myself? No, I don’t.” Others neglected to mention sex entirely in the context of their own experience.

**Significance of language.** In addition to the types of intimate and sexual experiences that participants described, it is important to consider the language

participants employed to discuss these experiences. There was a significant difference in the words used by participants; some participants spoke in direct terms, whereas others used more indirect language or avoided certain words altogether. Furthermore, an interesting theme emerged from participants' recurring use of words connoting innocence to describe or defend the intimate behaviours of themselves or others.

***Direct vs. indirect language.*** There was a clear dichotomy in the types of language used by participants to describe experiences of intimacy and sexuality. Some participants used more direct language, whereas others relied on indirect euphemisms or obscenities to get their point across. For instance, Alexandra referred to "sexual relations," "oral sex," and "petting sessions" at different points during the interview, exemplifying the use of direct language. Conversely, Lefty jokingly referred to intercourse using euphemisms such as "completing the transaction" and "making the sale," and Bill used equally colourful language to describe different sexual acts, including "lay her down and knock her off," "bend her over the sink," and "get a little frisky."

In other cases, participants fell outside of this dichotomy by trailing off or avoiding sexual or intimate terms altogether. For example, when asked about whether his experience of sexuality had changed over time, Jason responded with a series of unfinished sentences: "No, I'd say it's less but it's still going, like you know we, you know but it's not as much, but that's part..." In other instances, participants would allude to intimate acts without explicitly stating what they meant. For instance, when discussing a spare room in the LTC facility for occasional use by family members, Marlene said: "it's for family members that want to stay for a few hours overnight if the relative is real sick. Other than that, and it is not for *that*." She emphasized the word "that" to imply

intimate or sexual activity, without stating it outright. It should be noted that each participant did not necessarily subscribe wholly to an indirect or direct use of language—instead, each participant tended to use some combination of the two.

*Words of innocence and experience.* An additional, significant theme related to language was participants' tendency to couch their experiences in terms that connote innocence. Sexual or intimate acts were often prefaced by the word "just" to minimize or justify these actions. For instance, Mary expressed a desire to "just cuddle," J.D. described evenings where he and a partner would "just snuggle here on the bed" and Jason defended an older resident who "just gave a kiss, that's it."

Indeed, it seems this language is often used to defend or validate the innocence of residents' intimate acts, especially when they occur in the presence of others. This defensiveness was present in Lefty's interview. He described a situation in which a fellow resident expressed distaste for a public display of affection between him and a friend, saying "it wasn't like we were gyrating on the floor... she gave me a peck on the cheek." Similarly, Bill expressed anger at the need to justify his intimate activities to staff. He repeatedly mentioned the types of innocent activities that he engages in with his partner (e.g., hand holding, comforting, arm on shoulder) and contrasted this with more explicit, hypothetical situations that he could be engaging in: "And God forbid that either I'm or both of us weren't the type to say you know 'f' it and go at it right, that would never, ever happen in a million years." This signals on somewhat of a dichotomy; participants are aware of a category of intimate/sexual activities that are less 'innocent,' but they also firmly distance themselves from that category with 'it's not like we were...' or 'it could be worse' statements. This suggests that there is a continuum of sexual

activity, and that residents may only be willing to admit to activities on one end of the spectrum, as the others are perceived as too private and/or shameful to discuss.

Interestingly, the language of innocence also feeds into an implied infantilization of older adults. This is apparent in Lefty's observations of another couple in the facility: "I'm not sure what kind of relationship it is other than a little touchy-feely going on or something... You know something that I used to do in seventh grade." Although the participant spoke in a joking tone, his words—particularly the use of "a little touchy-feely"—suggest a trivialization of the depth of older residents' intimate relationships.

**Dynamic experiences of intimacy and sexuality.** Not all participants made the connection between intimacy in youth and in older age. However, almost everyone spoke about significant changes in their experience of intimacy and sexuality over time or at different stages in the life course. These changes emerged as three distinct sub-themes: a heightened experience of intimacy, a decline or absence of sexual expression, and the importance of adapting to and/or accepting change.

***Heightened experience of intimacy.*** A minority of participants reported a heightened experience of intimacy compared to earlier in their life or before they entered LTC. For example, Lefty spoke about how he was more likely at this stage in his life to compliment people openly on their appearance: "I don't expect anything to come of it but I tell them. Whereas I might not have done that years ago." Given that Lefty's definition of intimacy related to conversation and getting to know others, this change is significant as it demonstrates less hesitance or reluctance to make this type of outright intimate comment.



Mary's heightened experience of intimacy was more related to physical intimacy. She reported that her current relationship was more physical than her previous marriages:

I never felt, I mean I had [multiple] husbands and when I met [current partner] I want to be with him almost all the time and I can't go in without holding his hand, like I have to touch him if I go near his bed, I have to touch his hand or his arm.

In this quotation, the participant represents physical touch as a more immediate need than in her previous experiences. This physical contact with her current partner is something she "wants," "has to" do, and "can't go" without. Notably, the physical touch she described is not inherently sexual, but suggests a desire for closeness and intimate contact.

***Decline in sexual expression.*** Conversely, other residents reported a sense of decline or absence of physically intimate experiences. Most of those who experienced decline were referring specifically to sexual acts rather than intimacy more broadly. For some, these changes were as a result of physical conditions that precluded them from engaging in sexual activities. This notion was expressed by a male participant, who reported an absence of sexual activity due to physical inability: "Once [health condition] affects your libido and you may want to, but want to got nothing to do with it" (Bill). Others did not seem to experience a persistent desire for "anything sexual," expressing instead a desire for "closeness" or some other form of intimacy (J.D.). Furthermore, Lefty discussed how he would be content with less physical intimacy now than when he was younger, using the following example to illustrate:

Let's say just laying on a bed and watching a movie on TV, I mean that would be cool for me at this point. Whereas in the old days, you might want to set up that way but you want to end up, you know, completing the transaction, making the sale...

He went on to explain that sex was no longer a priority, saying: “as far as anything goes sexually, I’ve had my run.” Instead, sex was associated with an earlier stage in his life.

Eileen shared a similar view, specifying that sexual relationships were no longer important.

***Accepting and adapting to changes.*** The importance of accepting and adapting to changes also arose as a sub-theme in the data. Change was largely perceived as the norm—something that was natural and could be expected. This view is apparent in Eileen’s clear-cut statement: “Oh well, you know we no longer have sex, naturally, and I don’t know it [is] just, the way it is now.” It is clear from these words that Eileen had no expectations for sexual activity at this stage in her life, nor did she seem upset by this fact. Instead, it is stated as an objective, natural reality, perhaps demonstrating her acceptance of this reality. Jason also addressed the process of change and coming to terms with that. He said: “It changed, oh, it changed, yeah. For some people and me yeah, it changed but we work it out. You know we can work it out and make sure that everything is still good in one way you know.” This statement demonstrates a willingness to adapt to change and “work it out” with his partner. In this way, change does not necessitate negativity; instead, things can be different, but “still good.”

***Relevance of appearance and attractiveness.*** Residents offered extensive perspectives on the role of appearance or attractiveness as it pertained to their experience of sexuality. Many participants described rituals that they engaged in to maintain their desired appearance. Notably, most participants took responsibility for maintaining their own appearance, rather than attributing this responsibility to the facility or staff care practices. For example, Mary described her personal ritual as follows:

I go down and get my hair done which I did today... and I get my clothes ready at night, what I want to wear the next day, yeah. I can still do that, hopefully I can do that for a while yet. And I've never worn make-up in my life so I don't wear any of that stuff, no.

For others, wearing makeup was also an important part of helping them to feel attractive:

"I always put on lipstick but I've had some friends that put on lipstick the day they died you know" (Alexandra). While women's preferences for makeup differed, most female participants mentioned doing their hair or having their hair done as an important part of keeping up with their appearance. Picking out her own clothes was identified as an important process for Mary, allowing her to make independent decisions regarding her own appearance. She also noted that she does not wear makeup now because she never did, suggesting that her appearance-related rituals have been consistent over time.

Alexandra also mentioned this notion of continuity over time, specifically in relation to who one is attracted to. She posited that everyone has a "type" and that that type stays the same over time: "that's always been the type of person that you were attracted to forever and that doesn't seem to change." In this case, Alexandra touches on the relevance of her partner's attractiveness for her own experience of sexuality.

Others expressed similar views, although these were interestingly gendered. Most often, when a woman was asked about the importance of attractiveness to her experience of sexuality, she would discuss her own appearance first, suggesting that it was important for her to feel attractive. This was best articulated by Mary: "I don't care what he looks like 'cause I love him, but I want to look good for him." Conversely, when men were asked about their appearance or the importance of attractiveness, they would often revert to discussing the importance of their partner's appearance. For example, Lefty responded

initially with: “you don’t want to feel like you’re butt ugly you know...,” but then quickly considered the importance of female attractiveness: “...I would say too with any woman I’d want her to be good looking too, at least not embarrassing.” Likewise, when asked if feeling attractive was important to his sexuality, Bill responded: “yeah there’s got to be something about the person you’re with that attracts your, you know...” This suggests that Bill is less concerned about his own appearance than he is about his feelings of attraction toward his partner.

However, some residents noted that looking or feeling attractive was not relevant to their experience of sexuality at all. J.D. stated: “I don’t think attraction has anything to do with it,” instead focusing on whether a person’s words and personality appealed to him. Similarly, Marlene responded that “[feeling attractive has] got nothing to do with it. Take it or leave it.” For these residents, attractiveness—of oneself or one’s partner—did not factor into their individual experience of sexuality.

## **Section 2: Barriers & Facilitators to Intimacy & Sexuality in the LTC Environment**

***What are the present barriers (if any) to intimate/sexual expression in a LTC facility in Halifax, NS? What factors (if any) do residents of this facility experience as facilitators to their intimate/sexual needs?***

Participants identified a wide range of factors that contributed to their experience of intimacy and sexuality. These ranged from individual- and system-level barriers, to system-level factors, to system- and individual-level facilitators. Again, these findings produced a large quantity of themes that may be difficult to conceptualize. These themes are represented more succinctly in the following table (see Table 3).

Table 3. Themes pertaining to barriers and facilitators of intimacy and sexuality.

<b>Individual-Level Barriers</b>
<p><i>Biological barriers</i></p> <ul style="list-style-type: none"> <li>Physiological changes</li> <li>Functional changes</li> </ul> <p><i>Psychological barriers</i></p> <ul style="list-style-type: none"> <li>Relationship history</li> <li>Background/religious upbringing</li> </ul> <p><i>Social barriers</i></p> <ul style="list-style-type: none"> <li>Family influence</li> <li>Availability of partner</li> </ul>
<b>System-Level Barriers</b>
<p><i>Facility infrastructure</i></p> <p><i>Facility culture</i></p> <p><i>Facility care</i></p>
<b>System-Level Factors</b>
<p><i>Staff influence</i></p> <ul style="list-style-type: none"> <li>Negative staff influence</li> <li>Positive staff influence</li> </ul> <p><i>Facility rules and regulations</i></p> <ul style="list-style-type: none"> <li>Restrictive rules and regulations</li> <li>Reasonable rules and regulations</li> <li>Permission-seeking as problematic</li> </ul> <p><i>Privacy</i></p> <ul style="list-style-type: none"> <li>Lack of privacy</li> <li>Privacy available upon request</li> </ul> <p><i>Facility neutrality</i></p> <ul style="list-style-type: none"> <li>Facility neutrality as negative</li> <li>Facility neutrality as positive</li> </ul> <p><i>(Nursing) home?</i></p> <ul style="list-style-type: none"> <li>Facility as not home</li> <li>Facility as home</li> </ul>
<b>System-Level Facilitators</b>
<p><i>General contentment with facility practices</i></p> <p><i>Shared environment</i></p> <p><i>Fostering new relationships</i></p> <p><i>Accommodating policies and practices</i></p>

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## Individual-Level Facilitators

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### *Self-advocacy*

- Securing privacy
- Addressing concerns with staff

### *Adaptation and activities*

- Maintaining connections
  - Organizing peer groups
- 

## Individual-Level Barriers

Study participants reported a series of complex barriers to intimate and sexual expression, some of which were experienced at the individual level. These are the barriers that occur independently of the living environment; those that older adults would be likely to encounter regardless of whether they lived in the community or in the LTC setting. Individual-level barriers manifest themselves in different ways and have been divided into three distinct sub-themes: biological, psychological, and social barriers. The following section details each of these categories, respectively, as they were experienced and expressed by study participants.

**Biological barriers.** Many of the individual-level barriers discussed by participants operated at the level of biology or physiology. These were challenges that presented themselves as a result of changes, health conditions, and functioning of participants' bodies. In some cases, these biological factors were the cause of participants' admission to LTC in the first place.

**Physiological changes.** Some participants attributed decreased sexual expression to physiological, age-related changes. For example, although she acknowledged that these changes are not experienced the same way for everyone, Alexandra associated her loss of sexual desire with the natural changes associated with menopause: "For me it was

very much related to menopause. Before menopause there seemed to be you know an obsession with sex. After menopause it simply was not.” Alexandra described this barrier very matter-of-factly, demonstrating that sexual expression may be hindered as a result of normal bodily changes that can be expected as a person ages.

However, it is important to note that these normal age-related changes were not addressed by many participants. Instead, prevalent health-related changes emerged as a more significant theme in the data. For some, health was the first factor that came to mind when asked about barriers to older adults’ sexual expression. For example, Mary noted that a person’s ability to be intimate was entirely dependent on “the health of the person and how they can, if they can still do it.” Here, Mary signals on the fact that one’s health may impact “how” he or she engages in sexual activity, or “if” s/he is able to at all. Bill would agree with this last point, arguing that health conditions often negate sexual functioning altogether: “If you’ve got health problems there’s no way you can do it. Most men can’t get it up.” In his view, health conditions preclude individuals from engaging in sexual acts.

Other participants also discussed health conditions as a barrier to their intimate or sexual expression. Stroke, heart conditions, and other chronic illnesses were among the most common health issues addressed by participants. Two of these conditions are highlighted in the following quotation from Jason:

When I had my stroke I couldn’t do it for a long, long time but yet I wanted but I couldn’t do it. I couldn’t get a rise... [And] there’s a guy in here he was telling me that he hasn’t had sex for over 12 years. I said ‘why?’ He said ‘I just, I’m scared to.’ I said ‘why?’ He said ‘well I’ve got a bad heart.’ So I said ‘wouldn’t you be happy to die, you know, with a happy heart?’

In this example, Jason contrasts his and a friend's experience. Whereas he experienced a continued desire to engage in sexual activity in spite of his stroke, but was not physically able to perform, his friend opted for an extended period of abstinence in order to prevent further health complications. The friend's attitude is supported by another resident, who described her experience navigating opportunities for sexual activity after contracting a sexually transmitted infection: "so as far as I've always been concerned, it's just not worth it." For her, the health risks associated with continued engagement in sexual activity outweighed the benefits of this activity. In other cases, residents expressed that health concerns could overshadow the need for sexual activity, making sex less of a priority. For example, J.D. indicated that after having a stroke, "it took me eight months just to get to know who I was," therefore sex and intimacy were not a top priority upon arrival to the facility.

Some participants explicitly predicted that their sexual lives would have been more active if they had not encountered health problems. As Lefty stated:

I can tell you if I hadn't had this stroke I mean my life of course would be completely different but I'd be, I would be walking around here, buzzing around here and doing all kinds of stuff. And who's to say what would happen then, I don't know.

Based on these words, it is clear that Lefty associates his stroke with a loss of activity and possibility, both sexual and otherwise. For others, it is not the health condition itself but rather the medication taken to treat the condition that results in this loss. Such was the case for Hazel's husband, who was told to expect a loss of sex drive as a result of his prescribed medication.



**Functional changes.** In addition to these physical and health-related changes, residents may also experience functional changes in ability as a significant barrier to intimacy. Participants discussed both physical ability and cognitive ability as factors that influenced their intimate experiences, although it is worth noting that participants had more first-hand experience with physical impairment rather than cognitive impairment. For example, Mary mentioned a desired activity that was significantly impeded by her and her partner's loss of mobility: "Don't get me wrong, I would like to be able to lay on his bed and cuddle with him but I can't... get up and he can't get on my bed." Similarly, loss of mobility impacted Marlene's intimate relationship in a major way. Given that her partner was "a very active man," she felt compelled to end the relationship when she could no longer participate in the same level of activity, a feat that she termed the "hardest thing." Evidently, whether one or both partners experience changes in physical functioning, it can present a barrier to intimacy.

Likewise, dementia and other forms of cognitive impairment are discussed as factors that complicate intimate relationships. Alexandra gave the example of a "very good-looking man" who had developed dementia and been moved to a dementia floor. Alexandra explained that although the man has a wife outside the facility, "there's about three women up there that are fighting constantly and I mean really physically fighting over this man" and that "he doesn't know what's going on at all." This example demonstrates that in some cases, cognitive impairment does not impede intimate or sexual desires. Instead, it may intensify those desires, cause individuals to express those desires when they may not have otherwise, or to forget about their spouse or other intimate partners. When this occurs, Jason emphasized the importance of privileging the

needs of the individual with dementia: “her needs are more important right, and even, like I said, sickness you can’t help.” Based on these perspectives, it is evident that cognitive impairment is not exclusively a barrier to intimacy writ large, but it can complicate the intimate relationships of those who experience cognitive decline.

**Psychological barriers.** The data also show that an individual’s psychology—specifically their beliefs and attitudes—will impact their experience of intimacy in later life. Participant responses indicated that each individual’s psychology is informed by a series of factors, including their relationship history, as well as their background and religious upbringing.

**Relationship history.** Continuity with one’s past self is an idea that surfaced at various points throughout the interviews; that is, the idea that an older person thinks or acts a certain way because that is the way they have always been. Alexandra discussed this notion as it pertains to intimacy when she suggested that one’s personal history will shape his/her current expectations and experiences of intimacy: “like this one woman that... found somebody new, she obviously expects that there’s always going to be men in her life. I suspect that there probably was you know.” Conversely, an individual who was not as accustomed to being in a relationship throughout his/her life may be less likely to desire a relationship in older age. In other words, a person’s past experiences with relationships may impact his/her current desire for one. In this way, one’s personal history could serve as a barrier or facilitator for intimate relationships in the present.

**Background and religious upbringing.** It is not only an individual’s relationship history that may influence their current experience of intimacy. Residents beliefs and attitudes toward sexuality in later life may also be influenced by the culture in which they

were raised. Or, as Lefty eloquently put it: “You know something truthfully, your upbringing, your background. Some people are very prudish. You know they wouldn’t say shit if they had a mouthful.” For some residents, this “upbringing” involved fostering religious beliefs, including restrictions on premarital sex and intimacy, or beliefs about sex solely for reproductive purposes: “there are people out there that think the only time you should have sex is when you want to procreate” (Lefty). These beliefs may have resonated more with some residents than with others. For example, whereas Lefty termed many of these beliefs religious “guilt trips,” other residents often discussed intimacy in the context of marriage, or gave the impression that marriage should grant more legitimacy to intimate relationships. For example, Hazel expressed discontent with the facility’s policy restricting bed-sharing, especially for married couples: “I can’t see if you’re a married couple, I mean I suppose if you’re just going together...” Evidently, the values instilled during a person’s upbringing, whether religious or otherwise, will impact his or her beliefs and attitudes about sexuality in the present.

**Social barriers.** There are also social factors operating at the individual level that may present barriers to residents’ intimate needs. In other words, the people who surround a resident will inevitably influence that resident’s experience of intimacy. Data show that study participants had experience with social barriers including perceived disapproval from family members, as well as lack of available partners.

**Family influence.** Family members play a large role in the lives of many residents. While family involvement can be a positive influence (as will be presented in the individual facilitator section), if family members are disapproving or unsupportive, family influence can become a barrier to intimacy. For example, Jason spoke of an

instance when he overheard family members vocalizing their disapproval of a resident's recent intimate experience: "one resident said 'oh I'm having fun and I kissed this woman,' and they weren't happy about it." As a fellow resident, Jason expressed his disbelief at the family's lack of support, saying: "I mean they just gave a kiss, that's it... why would they be scared or afraid or you know mad that their parent is going to have something with a woman?" In his mind, the resident's intimacy is harmless and should not be a source of fear or anger.

In some cases, family influence may go beyond expressing disapproval, and may actually involve family members intervening in intimate relationships. Such was the case for Hazel, who recounted her experience as that family member when her father was in a LTC facility and his partner asked to spend the night: "she wanted Dad to ask if she could stay overnight and I went behind his back to the nurse and I said no, no way. I didn't tell Dad I did that..." Interestingly, Hazel did not express any regret about her decision to intervene in her father's relationship, as she asserted that she was acting to protect him from a "gold digger." Similarly, with regard to the resident with dementia (discussed above), Alexandra referred to his wife "who comes in fairly frequently so probably whatever is going on she manages to keep the lid on things." In other words, the spouse is able to restrict the resident's intimate involvement with other residents. These examples illustrate the complexity of family influence, as it becomes clear that family members may present barriers while trying to act in the resident's best interest.

***Availability of partner.*** Finally, residents' intimacy may be limited, not by the people who make up their immediate social circle, but because of those who *do not*. In other words, lack of available partners presents a barrier for many older adults, especially

those in LTC. Some residents discussed loss of partner or divorce as a significant barrier to maintaining an intimate relationship in later life. Although she herself has a partner that lives in the facility, Eileen mentioned death of a partner as a barrier experienced by “most of the people” on her floor. As Alexandra noted, although some women move on to new partners after death or divorce, many choose not to:

A lot of women will say to me well since my husband died I haven't been the least interested or since my last divorce I haven't been in the least interested you know. And they mean it, you know. It's not like the opportunity hasn't rolled around but they really do mean it.

Indeed, loss or lack of a partner may be an experience that is particularly felt by heterosexual women in LTC, given that there is a much larger population of women than men in the facility. One resident described the demographics in the facility: “as far as I know it's 98% women” (Bill). While this percentage is an exaggeration, another resident also commented on the lack of male residents on her floor: “On this floor especially there's only three men” (Hazel). Therefore, simply by virtue of an unequal gender ratio, finding a partner may be difficult for some older adults in LTC.

Others expressed difficulty finding a partner simply because of a lack of available and compatible individuals. As Mary noted, it depends on “if they found someone.” In other words, simply finding a partner can be a challenge to a person's ability to be intimate, let alone someone who shares common interests. This lack of compatibility was mentioned by Lefty, who said: “to be honest with you there are very few, very few residents that I would really be interested in sexually.” Evidently, participants are keenly aware that the limited availability of partners is a reality that many LTC residents face.

## **System-Level Barriers**

Although many of the biopsychosocial barriers presented above are likely to be experienced by community- and facility-dwelling older adults alike, the present data shows that the LTC facility presents its own unique set of challenges to intimacy and sexuality. These are the environmental factors that compound any of the above individual factors, and that study participants identified as barriers to their intimate and sexual expression. These barriers can all be understood as falling into one of three sub-themes, which will be presented as follows: facility infrastructure, facility culture, and facility care.

**Facility infrastructure.** Data suggest that the LTC facility is not built for intimacy. That is to say, the facility's physical environment often presented challenges to residents' sexual or intimate needs. Specifically, participants identified the absence of locks on doors, lack of designated space for intimacy, and no double beds as significant barriers.

The lack of locking doors was often the first physical barrier that came to mind for participants. Lefty indicated that the absence of locks could "intimidate people if they don't want to be in the middle of something and have someone walk in." As a result of this intimidation, participants might avoid engaging in intimate activity entirely. To prevent residents' discomfort at the prospect of intimacy, Bill was adamant about the need for locks on doors stating: "Put locks on the door. If you come on the door and it's locked you know that it's locked for a reason." And even in residential care, where the doors could be locked, one participant expressed discomfort that all staff had a key to her

room. She voiced a desire for “a lot of big zippers with locks to them and the only one that can undo the lock would be me” (Marlene).

However, some residents were quick to acknowledge the complexity of the issue, identifying potential safety risks if residents were the only ones who could unlock their rooms. For example, Lefty objected to the idea of putting locks on the doors, saying: “you can’t do it, you can’t. People lock themselves in their room then you’d have to get in to help them. They’re going to stroke in their room and you can’t get through the door.” In addition to the possible safety risk, Alexandra expressed that the facility encourages an open door policy in order to improve opportunities for socialization among residents, and that some residents may misinterpret that to mean they are not allowed to close their doors at all.

Given this complex reality, participants also offered suggestions for ways to improve privacy in spite of the absence of locks. Hazel proposed using Do Not Disturb signs to alert staff to intimate activity and prevent unwanted interruptions. Similarly, Lefty recommended speaking to staff directly to inform them of plans for intimate activity during a certain time period. And Alexandra described a facility policy that allowed residents to request “yellow strips” for their doors to prevent unwanted visitors in wheelchairs from entering their room.

Other participants expressed the need for a designated space for occasional use by couples who desired more privacy: “Well, it would be nice to have a, just a separate room somewhere where two people wanted to go and say hi or something” (Mary). Marlene mentioned that she was aware of a room that could serve such a purpose, but that it was only rented out to family members. In fact, when she had inquired about it, she said that

she was “told that they weren’t running a whorehouse.” These strong words illustrate that recommendations for making infrastructure more accommodating are not always well-received.

Finally, participants noted a lack of double beds in the facility. Participants were either unaware if double beds were available, or stated confidently that “they don’t do that” (Mary). Moreover, couples who expressed a desire to put their single beds together were told it was against facility policy to do so (Hazel, Bill). Again, this demonstrates a lack of flexibility when it comes to modifying facility infrastructure. For some residents, the rationale behind this lack of flexibility was either not well-understood or not supported.

**Facility culture.** In addition to the tangible, physical environment, participants also identified the culture of the facility as a barrier to intimacy. There was general consensus among participants that the facility does not encourage intimacy or sexuality, with only two participants indicating that they were unsure if intimacy was encouraged, and the rest stating that it was not. Granted, some participants were more adamant than others that the facility was not encouraging. For example, Bill asserted: “We would no more try to be intimate with one another in here than getting booted in the mouth.” J.D. expressed his impressions on the topic, indicating that not only does the facility not encourage intimacy, but “they pretty much shun it.”

It is important to note that this disapproval—or at the very least lack of encouragement—might not operate at an overt level, but may be experienced or felt by some residents as a more intangible, subtle phenomenon. Some participants indicated that they could not identify individual barriers to intimacy, but instead just discussed an



overall feeling of disapproval. Along these lines, Alexandra referred to “unwritten rules” and aptly stated: “Yeah there are barriers, that’s definitely, even if they’re not written down, they’re felt.” Similarly, although J.D. reported that he himself had a positive experience with an intimate relationship in the facility, he also indicated that this is not the perceived norm in the facility. When asked what gave him this impression, he stated: “I got the feeling that, for the staff, they couldn’t bother with it.” Of particular import is the mention of this “feeling” of discouragement of intimacy, in spite of his own experience. This “feeling” indicates an intangible perception, something that is unspoken but can be felt by residents. It is also worth mentioning that this subtle feeling of disapproval may emanate from staff and fellow residents alike. For example, when discussing some residents’ disapproval of intimate relationships, Lefty said: “I mean you can almost see it and they don’t say it but they’re thinking it.” This provides further evidence for that notion that the facility culture is one of disapproval or discouragement, even though that disapproval may not be expressed openly or intentionally.

Residents may also get the impression that the facility’s culture is unsupportive as a result of a lack of receptiveness to complaints and concerns related to intimate needs. This was touched on earlier regarding the harsh dismissal of Marlene’s request for a designated space, but it was also experienced by some of the other participants. For instance, Bill recounted how the facility was not receptive to his complaints about a lack of confidants or appropriate activities for him and his partner: “I brought it up and they get mad as hell. There’s nothing here for us, neither one of us to do.” Alexandra also mentioned that rather than addressing unwanted or inappropriate behaviour by fellow residents, the facility would use cognitive decline as an excuse for that behaviour:

“there’s always the excuse here, well they don’t really know what they’re doing, bullshit you know.” It should be noted that not all participants experienced this lack of receptiveness, as will be discussed in the system-level facilitator section. However, these few examples illustrate participants’ dissatisfaction with how the facility responded to their concerns, again feeding into the perception that the broader culture of the facility is one of dismissal rather than encouragement.

**Facility care.** In a minority of cases, participants indicated that care practices themselves may be perceived as intimate or sexualized by residents; in other words, some residents conflate routine care practices with intimate or sexual acts, which can cause significant discomfort or distress. The process of undressing in particular may present a problematic or confusing situation for residents, particularly those who only associate undressing with very intimate relationships. For example, Hazel reflected on an incident when a staff member was taking her into the washroom to wash and dress her, prompting feelings of discomfort for her husband:

I could see his point, he was sitting there and he says is she okay, is she okay, does she feel uncomfortable? And when, with him and I, it took me what... we were married for twenty-five years before I could even undress in front of him and then he thought, she’s willing to go in with, you know.

In this case, the participant juxtaposes her reluctance to undress in front of her husband with the expectation that she will undress readily for staff. Although Hazel herself seems aware of the distinction between care and intimacy, she also sympathizes with her husband’s discomfort.

In some cases, the conflation of care and intimacy can lead to more overt anger or resistance to care altogether. For instance, Bill recounted his first interaction with a staff

member who was trying to undress him to get him ready for bed. He indicated that he felt rushed and unorganized, and recalled saying: “I’d want some six-foot blond with big hooters to do that, not you [the staff member].” This seems to suggest that Bill equates undressing with a sexual or intimate encounter, and he does not want the caregiver to be involved in the act. Later, Bill expressed further objections to washing by staff, indicating that he did not want her to wash his private area: “I said you don’t turn me on that much [that] I’m going to let you play with my junk.” Again, care practices have been conflated with sexual acts, causing the resident significant distress.

It should be noted that not all residents feel this way. Other participants indicated that they feel more comfortable with undressing and other care practices, rationalizing that it is the staff’s job and is not the same as intimacy between partners. This type of attitude was espoused by Eileen, who indicated that she was more comfortable with female caregivers but that she did not object to care by male staff when women were not available: “I prefer female staff when I’m having a shower but if it’s not available well you know sure, ‘cause it’s just their job, sure.” Finally, Paul expressed no objections to being undressed by staff, indicating that he was not bothered by the process whatsoever: “in the condo I’d strip off in the tub and some of the ladies... they’d come in and wash me and I never thought anything about it.” Both Paul and Eileen demonstrate an awareness of the distinction between care practices and intimate acts, which in turn seems to mitigate their discomfort or resistance to care.

### **System-Level Factors**

While some system-level factors, such as those above, present very clear barriers to residents’ desired intimate expression, other factors are more ambiguous. That is to

say, some factors can be categorized as both barriers *and* facilitators to intimacy and sexuality. This dual classification can be explained by conflicting resident perspectives, as well as positive and negative aspects of each factor. The system-level factors that emerged as major themes are as follows: staff attitudes and actions, facility rules and regulations, privacy, facility neutrality, and residents' sense of the facility as home. This section will present each of these factors, with attention to the qualities that make them both barriers and facilitators to intimacy.

**Staff influence.** There was general agreement that the facility's staff made a significant impact on residents' experience of sexuality. However, participants expressed somewhat conflicting views about whether the staff had a positive or negative effect on their intimate needs. The following results will demonstrate both perspectives, outlining the staff-related factors that were perceived as barriers, as well as the context in which staff were identified as facilitators to intimacy.

**Negative staff influence.** Participants' narratives often suggested that staff could present a barrier to intimacy. Some participants held negative perceptions of staff's attitudes and actions, which in turn led them to expect negative responses from staff when encountering intimate behaviour. These negative perceptions and expectations could be attributed to a lack of personal connection with staff. Lack of uniformity among staff members also arose as a major sub-theme, and some participants mentioned a lack of staff training on these issues as the root cause of unsupportive staff attitudes or actions.

**Unsupportive attitudes and actions.** Some participants discussed previous encounters with staff that demonstrated a lack of support for or knowledge of residents' intimate concerns. Perhaps the most adamant proponent of this view was Marlene, who

identified “nurses that are so ignorant” as a primary barrier to her intimate needs. As an example of this “ignorance,” Marlene stated that staff tend to assume that *all* residents are cognitively impaired and are not able to consent to intimate activity:

They think that we’re not able to, how would I say this and be dignified? That we have not got the marbles as you would say, to know whether we want to or not. Which is absolutely wrong... It’s different for every person. I have all mine but not everybody here does.

With this statement, Marlene illustrates how these types of assumptions and attitudes may falsely represent each resident’s experiences of intimacy. Instead, there is a need for more case-by-case, individual consideration.

Even Mary, who perceived staff as largely supportive, discussed one incident that demonstrated that staff may not be active facilitators of intimacy when their assistance is required. She described a situation where her partner had attempted to join her on her bed, but was at a risk of falling without staff assistance: “we had to phone the nurse... and the nurse had to help him back, they didn’t help him back in my bed, they put him back in his room.” Notably, the nurses did not encourage the intimate behaviour by assisting him into the bed. Instead, they offered their help to “put him back in his room,” effectively separating the couple. Although it is important to note that the nurses’ attitudes in this case were described as “pleasant” and “laughing,” their actions suggest a reluctance to make intimate acts easier for residents who may require some level of assistance. This reluctance could present a subtle barrier, particularly for residents with mobility issues.

*Expectations of embarrassment.* Even participants who had not had direct experience with staff and intimate encounters offered speculation on what would occur if

a staff member walked in on residents engaging in intimate or sexual activity. Results showed that, thankfully, not many participants had encountered this situation. However, many of the responses indicated that this would be a negative, or at the very least uncomfortable experience. Variations of the word “embarrassment” were repeatedly used in reference to this hypothetical. Participants indicated that this would be a source of embarrassment for residents (Jason, Hazel, Paul), as well as for staff (Eileen) and Mary described it as “a nervous situation” that she hoped to avoid. Others expected more extreme, negative reactions, stating that if staff were to walk in on residents being intimate, they would act “like you chopped off their leg... and then screaming and hollering, no you’re not allowed here” (Marlene). Evidently, those who held more negative perceptions of staff also anticipated more negative responses from staff.

*Lack of connection with staff.* Participants also expressed a lack of personal connection with the majority of staff members, which could be a source of their negative perceptions and expectations. For some, this lack of connection manifested itself as a general unawareness or unfamiliarity with staff members. For example, when referring to a specific nurse, Bill stated: “I don’t know who she is, some bullshit LPN or whatever they call them. I don’t know what their names are.” This illustrates that even on the basic level of name recognition, Bill was unfamiliar with staff members at the facility.

Not only do some participants not know staff, but there is also the implication that staff do not know the residents. Indeed, some participants expressed that they felt misunderstood by staff. At one point in her interview, Marlene stated that staff had “the wrong idea about [her]” and was upset that staff had asked her personal questions when “they don’t know me.” She went on to describe her response to staff: “So you get to

know me and if you feel like you need to ask the question, I will answer it.” Similarly, Bill expressed the sentiment that staff could not relate to his experience: “They don’t know what it’s like probably to take their partner’s hand or boyfriend’s hand... in public. They have no clue.” Evidently, this feeling of misunderstanding only deepens the divide between staff and residents, particularly in terms of discussing or addressing their intimate needs.

*Lack of uniformity among staff.* Importantly, participants noted that staff perceptions of and responses to intimacy were highly dependent on the individual staff member. This idea was brought up by most participants. This is the case for Eileen who stated: “Well it just depends on the person you know.” Furthermore, Mary noted that she could not generalize all staff members’ attitudes toward intimacy among residents, asserting: “some of them are okay with it, some aren’t... You know I can’t say everybody you know.” Other residents discussed varying comfort levels at the prospect of speaking to staff members about intimate concerns: “It depends on who the staff member is. In some cases, yes, other cases maybe you want to keep it to yourself” (Paul). Generally, participants reported discomfort with the majority of staff members, indicating that there were only a limited number of staff they could confide in. This was evident in Alexandra’s assertion that of the twenty or so staff on her floor, “there might be one of the CCAs that I would feel comfortable talking about that... just one. That’s not a lot.”

From participants’ perspectives, staff members’ responses or attitudes toward intimacy were likely to be influenced by their own personal or religious beliefs. For instance, Lefty commented that upon encountering an intimate act, “some of the staff would probably be appalled” and Marlene suggested that a staff member’s religious

background would govern her attitude toward intimacy: “one of the ladies I like she’s a very religious lady so with her she wouldn’t approve.” Therefore, the lack of uniformity among staff may be related to individual differences in the beliefs, attitudes, and experiences of staff members.

*Lack of staff training.* However, it is also important to consider the role of effective training, or lack thereof, on policies and practices related to resident intimacy and sexuality. In other words, if staff are thinking or behaving differently, it may be because they have not received consistent training on facility policy for addressing resident intimacy. For example, Hazel suggested that Do Not Disturb signs should be provided, noting that it would be equally important that “all the staff knew a Do Not Disturb sign means that they’re engaging in something.” This points to a need, not only to change policy, but to ensure that these policies are carried out uniformly by “*all the staff*.” Marlene explicitly referenced the need for staff training. When asked what would make residents more comfortable discussing intimacy with staff, she stated: “new staff... that are trained.” Furthermore, Bill demonstrated that a lack of knowledge on how to deal with a situation can lead to uncomfortable or inappropriate responses from staff members: “they’re looking and gawking and staring and they don’t know what to say so they say stupid shit.” Based on these responses, there is a perceived lack of adequate training to guide staff’s words and actions surrounding residents’ intimate expression.

*Positive staff influence.* Contrary to the points outlined above, many residents discussed staff as a positive influence on their experience of intimacy. This section will highlight the strengths of staff as facilitators to residents’ intimate and sexual needs. Participants discussed the positive qualities of those staff members they viewed as



facilitators, and many expected that staff would respond reasonably to incidents of intimate or sexual expression in the facility. The importance of developing rapport with staff members also emerged as a significant sub-theme in the data.

*Supportive attitudes and actions.* Many participants expressed positive impressions of the staff in general. For example, J.D. stated: “well the staff we have on here right now, they’re pretty good.” Eileen also offered positive reviews, demonstrating her compassion for the work the staff did in the facility:

The staff here sometimes you feel like giving them a hug you know, some of them and it might take them a bit longer getting them around doing things for people which is understandable because there’s only a few here, they’re short-staffed.

This passage also confirms Eileen’s understanding of the pressures staff face in their day-to-day work.

In addition to these positive perceptions of staff, some participants discussed the staff qualities which made them more accommodating of intimacy in the facility. Mary mentioned that she would be comfortable discussing her intimate needs with one staff member because she is informative, friendly, upbeat, well-liked, and a good leader. Furthermore, Jason highlighted the professionalism of one staff member, saying: “She’s very professional this woman is, very, very professional. That’s why I said... I’m glad I’m in here. I’m not sorry I did sign myself in here.” As evidenced by this quotation, staff can have a major influence on residents’ comfort level regarding discussion of intimate needs, as well as their satisfaction with the facility in general.

It is not only staff qualities that impact residents’ experience, but also their actions. Mary gave the example of one nurse who never interrupts Mary’s time with her partner, even when care practices are involved: “I know the nurse that gives out pills, and

she always says ‘stay there’ if I’m visiting and ‘I’ll... get your pills later, don’t leave.’” This relatively simple action meant a lot to Mary, who noted: “she understands, right.” Similarly, J.D. experienced this level of understanding from staff who helped him through a difficult personal matter: “I know when my wife and I got divorced I talked to staff and they were pretty understanding... They probably went through the same thing.” In this case, the participant felt that staff could relate to what he was going through, and this level of understanding helped to facilitate intimate discussion.

*Expectations of “excuse me.”* Whereas negative perceptions of staff attitudes and actions tended to be associated with negative expectations about staff’s responses to intimate or sexual acts, the opposite can be said for those with positive perceptions of staff. Many participants expressed hope or confidence that if staff were to walk in on residents engaged in intimate acts, they would likely leave calmly, quietly, and politely. For example, Paul speculated that “they may open the door and say ‘oh excuse me,’ and keep going on their way.” Similarly, Alexandra posited that “they’d just tiptoe out of the room.” Lefty had similar expectations, adding that staff may use humour to deflect any discomfort felt by the residents: “They would probably do that, ‘oops, sorry,’ or they’d make some comment, they’d say something like ‘I thought I was the only one,’ you know.” These responses demonstrate participants’ faith that staff members would respond reasonably and respectfully if the situation were to arise.

*Value of rapport with staff members.* Given the lack of staff uniformity presented above, it is not surprising that participants emphasized the value of developing close relationships with individual staff members. In other words, although participants did not feel comfortable talking openly about intimacy with staff at large, many discussed the

significance of one or two staff members with whom they had built a rapport. For some, this rapport is built based on personal connections outside of the facility. For instance, Marlene described her relationship with a nurse in the facility who was related to her through marriage: “she is the only person that I can get what you would call down and dirty talk with.” Similarly, Lefty indicated that although it might be a problem to address intimate concerns with some staff members, it “would never be a problem” with those he had “built a rapport with.”

In fact, some participants suggested that this rapport with staff members could fulfill a need for intimacy to some extent. For instance, Alexandra discussed the open conversation that occurs between her and a staff member:

A level of intimacy has developed in terms of what she tells me you know and then... in turn what I will tell her. And the fact that I could tell her about some affair that I've had, I don't know if I even have, but I could and I would expect her not to be shocked. Yeah you can kind of sense that sometimes with people.

The relationship that Alexandra describes sets a precedent for the possibility that staff and residents can share a “level of intimacy” that is mutually beneficial. Similarly, Lefty touched on the benefits of these relationships for residents: “I’m not saying it on a physically, sexual thing but it can be a mentally sexual thing you know. Like some staff members they say ‘hey good looking how are you doing?’ It makes you feel good.”

Importantly, Lefty emphasizes the appropriateness of these relationships, stipulating that they are not “physically sexual.” Therefore, data suggests that not only does rapport with staff facilitate intimacy and sexuality among residents, but that relationships with staff can be a source of intimacy in and of themselves.

**Facility rules and regulations.** Participants also discussed their understanding of and experience with facility rules and regulations. For some, these rules were perceived as negative and restrictive, whereas other participants understood the regulations as positive and/or necessary. In either case, results suggest that participants' awareness of the need for permission may be significant. Therefore, facility rules and regulations can be identified as another system-level factor that may present itself as either a barrier or a facilitator to residents' intimate and sexual expression.

***Restrictive rules and regulations: "Not allowed to..."*** Words related to permission surfaced frequently in the data. Participants consistently referred to activities that facility or staff "let [them]" engage in versus those that residents are "not allowed" to partake in. For example, participants discussed how residents were "not allowed to put the beds together," (Hazel) "not allowed to have that curtain around," (Bill) "not allowed to let somebody sleep in their bed at night," (Alexandra), a married couple "not allowed to stay in the same room," (Alexandra) and so on. Similarly, Marlene used this restrictive language when she described staff's typical response to encountering an intimate situation in a resident's room: "And then screaming and hollering, 'no you're not allowed here!'" Bill went on to reveal his impression that "they don't condone I guess two people even touching one another." Based on these perspectives, it is clear that participants are keenly aware of facility rules and regulations that restrict their intimate or sexual activity.

***Reasonable rules and regulations: "They let us..."*** Other participants perceived the facility's rules and regulations as both accommodating and understandable. For example, Mary expressed her contentment with rules allowing certain public displays of affection: "they let us hug at the tables in the dining room and I thought that was nice of

them.” Specifically, Mary’s perception that the rule was “nice of them” indicates that this is an unexpected but welcome facilitator to intimacy. Similarly, Jason made a point of emphasizing that the facility grants permission for residents to leave at any time: “We’re allowed to go home anytime we want.” This is significant in the context of Jason’s intimate needs, as he had previously indicated that most of these needs were met at home. Therefore, it makes sense that Jason perceives this lack of restriction as a facilitator to intimacy.

Furthermore, some participants expressed their understanding of the need for certain rules related to intimacy. This was most apparent in discussions about the facility’s rule forbidding intimate relationships between residents and staff members. For example, Jason was insistent that this restriction was necessary and no different than regulations at other workplaces: “a resident can’t go with anybody who works here though, that’s the only thing... but I can see that cause it’s sort of like jeopardiz[ing] of the job... which of course, that’s all over really.” Evidently, Jason perceives this as both a standard and reasonable rule. Similarly, Lefty expressed his understanding for rules and regulations related to staff-resident relationships: “You don’t want somebody getting special treatment, and that’s understandable.” However, it should be noted that he also saw the value of close rapport with staff, and felt that these rules should not prevent this rapport-building.

***Permission-seeking as problematic.*** As a final consideration related to facility rules and regulations, it is significant that even when discussing things that they are “allowed” to do, the subtext of participants’ words reveals that they are conscious of the need for approval from a facility authority. For example, Mary described the process of

obtaining permission from staff to be physically intimate with her partner: “like if I asked the supervisors they would let us get together... our last supervisor said that, not this one, so I don’t know.” This illustrates the perceived need to involve staff in the conversation to ensure that they were not breaking any rules by “get[ting] together.” It also indicates some degree of confusion regarding what the facility allows and does not allow.

Therefore, whether or not residents are “allowed” to engage in certain intimate acts may not be as noteworthy as the participants’ heightened awareness of the need to obtain permission in the first place.

**Privacy.** Privacy is a top priority for LTC residents. In fact, according to study participants, it is often the primary concern. As Paul stated: “the best thing to have in here is to keep to yourself and keep out of trouble.” Participants also described privacy as a crucial prerequisite to intimacy: “To have intimacy, number one is privacy.” Therefore, it is not surprising that privacy (or lack thereof) emerged as a significant factor that impacted residents’ experiences of intimacy and sexuality. Some participants reported a lack of privacy, both physically and in terms of privacy of information. However, participants also noted that privacy was respected and available in the facility, particularly if it was explicitly requested by the resident. This section will present results on privacy as a prominent barrier and occasional facilitator to intimacy in the LTC setting.

**Lack of privacy.** As with many of the other factors, lack of privacy is experienced more acutely by some residents than others. Participants generally described the level of privacy offered by the facility as minimal to nonexistent. For example, Lefty reported that the facility was “as private as someone opening that door” and J.D. confirmed this

view, stating: “Don’t have much. Everybody’s got a key to the door.” Similarly, Paul commented that he was unaware of any privacy in the facility, Marlene identified lack of privacy as “our worst” barrier, and Bill plainly stated: “there’s no such thing as [privacy] here and I hope you put that in your report.” Of relevance to this study is the fact that participants perceived this lack of privacy as a major barrier to intimate expression.

*Lack of physical privacy.* This barrier operated at the level of physical privacy, including the need to share physical space with a roommate, the difficulty of obtaining a shared room for married couples, and unnecessary or unwanted breaches of privacy from staff and fellow residents. Each of these sub-themes will be addressed in the following section.

*Roommate as barrier.* Of those interviewed, six participants currently inhabited a single room in the facility, and four shared their room with a roommate. For those participants who shared a room with someone other than their partner, or whose partner had a roommate, limited space often presented a barrier to privacy. It is apparent from the data that roommates can pose challenges that are unrelated to intimate or sexual expression. Participants indicated that different sleep schedules could be a source of “friction” between roommates (Jason). Lefty expressed aversion to the idea of having a shared room: “not from an intimacy standpoint, but... if I had a roommate, I would have to be considerate of that person and maybe they’re sleeping... that would be a horrible thing to me.” Therefore, Lefty enjoys his privacy, not for the sake of intimacy, but for the sake of practicality. Similarly, Paul politely expressed that “there may be times you’d say I’d rather have a room of my own and I can do what I want.”

From an intimacy standpoint specifically, roommates can be a major barrier. Mary described the difficulty and discomfort of being intimate with her partner, who shares a room with another man: “you know you don’t want to express yourself if there’s someone laying there you know so it’s hard.” In this way, Mary’s intimate or sexual expression is impeded by the presence of another person. She went on to describe the impact the roommate has on her relationship: “Sometimes I feel like I’m dating two people because [of] his roommate, [and] the curtains are open.” This quotation highlights the sense that her romantic relationship feels overly crowded as a result of her physical living space. It also illustrates the ineffectiveness of curtains as dividers between roommates. In practice, it seems they do not offer much privacy to couples who wish to engage in intimate acts.

Although the majority of participants represented shared rooms as barriers to intimacy, it should be noted that this is not the case for everyone. For some, having a roommate may actually be a positive experience. Such was the case for Eileen, who said: “I’m in a room with another lady... and I like her very much.” In this example, Eileen benefits from the company and shared activity with her roommate. Therefore, in the event that roommates are compatible, it is possible that they could be a valuable source of companionship and friendship, a relationship that some may even describe as intimate.

*No room for couples.* For partners, limited physical space may pose a different set of barriers to intimacy. Namely, when individuals want to share a room with someone, the facility may not always be able to accommodate them. Participants discussed the difficulty of finding shared rooms for married couples upon arrival to the facility. For instance, Hazel spoke about her experience with this barrier:



I mean I don't know if we were the first married couple or not but we were given quite a bit of grief at first. I don't know if we can find a room together and so forth and so on.

And while some couples, such as Hazel and her husband, were eventually given the opportunity for a shared room, some couples are still on a waiting list: "I had suggested to both have the same room, like man and wife usually do, but for some reason no, can't do that" (Paul). Here, Paul indicated that he was unsure of the reasoning for the facility's decision.

Eileen suggested that sharing a room with her partner would make it easier for her intimate needs to be met: "maybe if we had a room together it would be a little different, not sexually but like I, you don't like giving people hugs... and things like that too much when you're in a group." This is evidence of the participant's discomfort showing affection in the presence of others. But even those who shared a room with their partner expressed difficulty finding "alone time so you can talk" (Bill). Bill went on to say: "There's nothing. What am I going to do? Go and hide in the bathroom with her?" Evidently, this participant felt that he had run out of options for securing private space with his partner.

With these perspectives in mind, it should be noted that sharing a room is not necessarily preferable for every couple. For instance, Mary expressed doubt about how marriage would work within the facility, stating: "I like my own room and my own space." Mary also suggested that being able to have alone time, watch what she wants on TV, etc. is important to maintaining her independence: "it's better to be independent... when the situation is like that." Therefore, it is important to consider how space might be tied into residents' perception of their independence. Maintaining a sense of

independence from one's partner is likely important in any relationship, but this may take on a new significance for LTC residents who have likely already experienced substantial losses of independence. Lefty spoke to the importance of independence at this stage in his life: "there is some [independence]. I lost a lot, but there's some I still have and I'm clinging to it." Finally, couples may not be able to share a room because of different care needs. For instance, Mary noted that her partner does not require the use of a lift and can walk short distances, whereas she requires staff to help her with these activities. All this to say that individual needs and desires may impact their preference for certain rooming arrangements.

*Unnecessary and unwanted interruptions.* Frequent interruptions by staff and fellow residents are also presented as significant barriers to residents' privacy. In other words, even when residents are in a private space, that space is often entered without apparent cause or sufficient warning. As a result of these interruptions, Bill described attempts at intimacy as futile or hopeless: "You're in a 6 x 8 room with people beating the door down steady. You may as well forget about it. Unless you hide in a closet." Of particular significance is his perception that there is a "steady" stream of interruptions, implying there is no respite from them. Building on this idea of futile attempts, Marlene suggested that efforts to keep staff out of her room only intensified their visits: "If I put stay out on my door, every staff member with a key will be in here. So what's the use?" In her view, it was easier to expect these interruptions than to try and prevent them.

Furthermore, residents did not always feel that these frequent interruptions were necessary. In fact, Alexandra seemed to imply that they were related to staff's curiosity about visitors, particularly male visitors:

We can sit here and no nurse has ever walked in and they won't unless I ring my bell. But you bring a man into your room and all of a sudden they're in, they're busying themselves doing this and that, you know, that kind of thing.

These staff visits may be interpreted as innocent checking in, to assure resident safety.

However, Alexandra and others perceived them as largely unnecessary, as if staff were creating excuses to enter residents' rooms.

Some participants also objected to *the way* staff entered the room. The words "barging in" came up in more than one interview, and participants suggested that staff would enter unannounced or without knocking. The most apt example of this phenomenon occurred during one interview when a participant was recounting a previous experience with a staff member who had entered unannounced:

'What would you have done,' I said, 'if you had barged in that door, you don't knock, you don't say can I come in, you just boot the door wide open.' [Staff enters.] What's I tell you? Do I need to say anymore? Do I need to say anymore?

The staff member's quick entrance at that moment may have been entirely coincidental and unintentional. However, the fact that it occurred seemed to make the participant feel validated in his experience, as if his stories of unannounced entry were now confirmed.

But staff were not the only ones who reportedly entered residents' room with little to no warning or invitation. Alexandra described an incident with another resident:

I saw him sitting out in the hall looking at me so I pulled the curtain across and the next thing I see is his black shoes coming underneath the curtain right. And you just go 'oh my god' and press the buzzer really quickly and then somebody came pretty quickly and wheeled him out.

In this case, Alexandra experienced a breach of privacy by a fellow resident, which prompted a sense of urgency and fear. Fortunately, the staff seemed responsive to her call

for help in this instance, helping her to restore some level of privacy (at least temporarily) by removing the resident from her room.

*Lack of privacy of information.* Participants also described an absence of privacy of information, indicating that they felt wary of monitoring and gossip, perceived judgement or disapproval from others, and that an impervious attitude was necessary in order to continue intimate relationships without being affected by what others thought.

*Monitoring and gossip.* Given that the LTC setting is a communal living environment, it is perhaps not surprising that residents expressed awareness and concerns about other people monitoring their activities and discussing their personal matters. These concerns may deter residents from fulfilling intimate needs. As Lefty noted, people “would be nervous about sharing intimacy with someone else and they think ‘what will someone say?’” Similarly, Marlene suggested that if staff were to find out about her intimate activities, it would be “all over the floor [because]... they’ve got the biggest mouths.” Both of these perspectives demonstrate a preoccupation with what others are saying, as well as a lack of faith in the discretion of staff and fellow residents.

Some residents may feel a heightened sense that they are always being watched or listened to. This is evident in one participant’s suspicion that a staff member was eavesdropping by the door during the interview and that the staff member fabricated an excuse to enter the room: “I don’t think she could get enough information listening through the crack in the door.” He also suggested that the staff are displeased when people come to visit with residents and they do not know who they are or much about them. Marlene expressed a similar resentment toward “nosey” staff members who were too curious about her visitors. This is yet another example of residents’ perception that

their privacy has been compromised. Whether or not staff are actually or intentionally listening in or monitoring residents' information, the important piece is that residents *think that they are*; moreover, residents may interpret this as a breach of privacy, rather than an act that serves to help or protect them

*Perceived judgement and disapproval.* Not only did participants comment on the fact that others were aware of their private business, but some perceived that their intimate relationships were a cause of judgement or disapproval from others. Some participants perceived other residents as the perpetrators of this disapproval. For instance, Lefty described an incident in which a fellow resident witnessed a kiss on the cheek between himself and a friend. The resident was "appalled" and reported what she saw to a staff member, who was supportive of the kiss. Lefty discussed how each resident's personal characteristics and belief system would influence their judgement:

I want to relate back to some of the things you're up against here and it's still the residents that get jealous or envious maybe or they're appalled, oh my god, you know maybe you're supposed to have a ring on your finger because you kiss somebody, you know things like that.

Here, Lefty presents the resident's disapproving attitude as a barrier to intimacy, one of the "things you're up against."

Conversely, Bill recounted an experience where the roles were reversed. He perceived that the staff were disapproving of his desire to hold his wife's hand in public, and fellow residents came to his defence: "decent people, older people... said well you go ahead bud hold her hand if you want to... aw look he's holding her hand." In both cases, residents' intimate activities were being watched by two parties: staff and

residents. And in both cases, one of these parties exhibited judgement of intimate acts whereas the other voiced their support.

*Necessity of no-care attitude.* In light of the lack of privacy of information and resulting gossip and disapproval, participants emphasized the necessity of a no-care attitude. Namely, they indicated that it was important to become impervious to others' judgement. As Lefty eloquently stated: "you've just got to be with a person who doesn't give a shit." J.D. exhibited this no-care attitude when he was asked what would happen if a staff member were to walk in on an intimate encounter: "That's their tough luck, the way I look at it. They want to walk in, fine." Although this attitude may not be possible for everyone to adopt, it seemed to work as an effective coping mechanism for some, enabling them to engage in their desired level of intimacy without worrying about what others would think or say.

*Privacy available upon request.* Given that privacy was not exclusively perceived as a barrier to intimacy, it is important to highlight the perspectives of those who felt that their privacy was respected in the facility, thereby allowing for intimacy if desired. Some residents were very content with the level of privacy in the facility, citing door-knocking, and respect for resident's wishes as facilitators. Notably, this sense of privacy may have been especially felt by those who explicitly asked for it. Furthermore, it became apparent from participant responses that privacy and safety need not be mutually exclusive; in some ways, the facility can and does accommodate both needs simultaneously.

*Contentment with privacy.* Jason was perhaps the most vocal supporter of the facility's privacy accommodations. He spoke very highly of the privacy offered by the facility, noting that staff respect door knocking policies, "don't charge in" and do not

enter the room without permission. Similarly, Hazel indicated right away that “they always knock before they come in and if you wanted to [be intimate] you could.”

Although this conflicts with what other participants have said, it is equally important to consider that some participants report positive experiences with staff who consistently knock before entering.

Participants responses also indicated that privacy needs may be better addressed when they are requested outright by residents. This is apparent in the following statement from Jason:

If you ask they give it to you, yeah. That’s one thing, if you ask the head nurse or even your worker on the floor and tell them what’s what, they will close the door, and when that door close usually nobody should come in, and they have to knock before, and [if] I say stay out, they will.

Of particular import here is the phrase “if you ask.” This is evidence that privacy is available, but that it may be contingent on residents’ initiative to arrange that privacy with staff in advance. Nevertheless, Jason’s confidence in the staff’s respect for his privacy indicates that he is content with the level of privacy he receives. At the very least, he does not perceive it to be a barrier to intimacy.

Hazel expressed a similar perspective:

We have a lot of privacy. Just shut your door and they know, the door is shut... I don’t know if it’s just us or if it’s that way for everybody but I was talking to [a friend] the other day, she said the same thing. They learned to knock at her door.

It is clear from this statement that Hazel also enjoys substantial privacy in the facility, and that staff respect closed doors as a sign that they should not enter. However, Hazel also expressed some uncertainty about whether this is the case for everyone, or whether her and her partner are simply granted this level of privacy because they asked for it.

Furthermore, the suggestion that staff “learned to knock” at the door is significant, demonstrating that staff learn to accommodate privacy needs over time and based on residents’ individual responses.

*Balancing privacy and safety.* Although privacy and safety in LTC settings are often understood as a dichotomy, these results showed that the residents can experience both safety and privacy simultaneously. For example, Jason explained that staff would check in on him every couple of hours, but would maintain a respectful distance: “That’s what I like about it, they’d rather make sure that everybody’s okay in here so yeah it’s, I’ve got quite a bit of nice privacy in here.” Jason clearly does not see the privacy and safety as mutually exclusive, suggesting that the facility has achieved an effective balance between the two. They check in on residents regularly, every “couple hours or so” but also respect residents’ wishes if they ask staff not to enter or to leave. Alexandra brings to mind another instance when safety and privacy are not mutually exclusive. She speaks of the “yellow strips” that she requested to prevent unwanted intruders in wheelchairs from entering her room. In this instance, the strip serves to improve her level of privacy, maintaining her personal space, which in turn makes her feel safe from “perverse” or unwanted sexual “attacks.” This may not be everyone’s experience, but according to Jason and Alexandra, safety and privacy can go hand in hand.

**Facility neutrality toward intimacy and sexuality.** Results show that, from participants’ perspectives, the LTC facility largely takes a neutral stance on intimacy and sexuality. Lefty may have articulated this best when he said: “I would say, they don’t encourage it but they don’t discourage it either, they stay neutral. They’re neutral and



they're not going to stop you." This section will discuss both the negative and positive implications of the facility's neutral stance, as expressed by participants.

*Facility neutrality as negative.* A major theme in the data represented the facility's neutrality as a negative thing. Participants indicated that the facility does not consider intimate needs a priority and signaled on a lack of openness and transparency that unnecessarily places the onus on the residents to advocate for their intimate needs. The following section will represent each of these arguments in turn.

*Not a priority.* Some participants mentioned that residents' intimate or sexual needs were not considered a priority by the facility. Bill expressed discontent with this fact. When asked what the facility could change about their policy or practices in order to facilitate intimacy, he said: "They don't want to do it and they don't want nothing to do about it. Nothing." Evidently, Bill had the impression that the facility was not only removed from the topic of intimacy, but that they *did not want* to be involved in making changes or finding solutions. Lefty gave insight into the possible rationale for the facility's reluctance to get involved. He was the first to discuss the concept of liability in the context of intimate relationships: "I think they're kind of afraid to get sued or something. Truthfully, liability is something they're more concerned with than a lot of things in my opinion." He gave the hypothetical example of an assault accusation within an intimate relationship between two residents, suggesting that the facility would "have to defend it" if they had condoned or been involved in this relationship. Lefty did not seem perturbed at the implication that liability may be a primary concern for the facility. However, other residents might be upset by the suggestion that the facility is more concerned with liability than with the needs of their residents.

*Lack of openness and transparency.* The facility's lack of openness and transparency regarding intimacy is a recurring sub-theme that emerges from participants' narratives. There is general consensus that residents are provided with little to no information on their rights to intimate or sexual expression when they arrive. Alexandra was confident that such information was not outlined in the resident handbook: "I'm sure there isn't anything in the handbook 'cause I helped re-write it, nothing about sexuality in that." Similarly, Lefty did not recall receiving any information upon arrival to the facility, saying: "I don't think that's part of their program to give that information out." This lack of upfront information left some residents uncertain about available options or resources for intimacy. For example, J.D. said that he was "not aware of any" resources, and Eileen reported a similar lack of awareness: "Well I never asked, I don't know." Evidently, this lack of transparency feeds into a general lack of awareness about any options or resources that the facility may offer to meet intimate needs.

Those participants who were aware of these options reported that they found out about relevant policies or information on an individual basis or as needs arose. Bill stated that rather than being provided with information on their rights to intimacy/sexuality upon arrival, "they kind of told you in bits and pieces." Similarly, Mary noted that she "found out as [she] got interested in [her] honey." These perspectives suggest that in the absence of transparent information on intimacy, residents are left to seek this information out as they need it, or find out about it gradually over time.

Although some residents may be content with this system, others feel that the facility should be transparent about their stance on intimacy and sexuality from the beginning. This is best articulated by Alexandra, who stated:

I think people should know where they stand... the ones that are interested, they shouldn't feel 'hey it's all over,' you know. I don't know what you'd do, whether you'd say look if you're down there having a dance with a few people and you want to bring them up to your room for a little petting session or whatever, feel free. You know there should be something, why not? Why not, you know?

With these words, Alexandra makes three important points. First, that the facility should be open about “where they stand” on the issue. Second, that residents who are still interested in sexual expression should not be made to feel that their intimate lives have come to an end upon entering LTC. And third, that making accommodations for intimacy is relatively easy, and there is no valid reason not to do so.

It is possible that the facility is only forthcoming about their policies relating to intimacy/sexuality when it comes to things residents are not allowed to do. In other words, rather than inform residents of opportunities for intimacy, the facility informs them only of limitations. For instance, Hazel mentioned that she did not receive any information about her right to engage in intimate activities upon entering the facility, aside from being told that “we couldn't put the beds together, you know couldn't share a bed.” The reasoning given for this restriction was because it was facility policy.

Similarly, Bill discussed how the “first thing they said” upon his arrival was that “you're not allowed to put your beds together.” Bill expressed anger at this restriction. This type of restriction without balanced information about what *is* available may set the stage for the perception that the facility is not open to allowing or encouraging intimacy among residents.

*Onus on the individual.* With a lack of clear, transparent direction from facility, data suggest that the onus is often placed on the individual to facilitate intimacy within the LTC environment. As Lefty said, in order to make space for intimacy in the facility,

“you’ve got to be innovative.” Notably, the emphasis here is on “you,” the resident. Participants spoke about making spaces more private, seeking out resources, asking questions, requesting that staff give them space for a period of time, demanding staff attention, and so on. While the specifics of these efforts will be discussed in the individual-level facilitator section, it is important to note here that many residents objected to the notion that it was their sole responsibility to advocate for and facilitate intimacy, without support from the facility. For example, Bill perceived the right to intimacy as a continuous point of struggle between himself and the facility, and announced that he no longer wanted the onus to be on him. He directed his thoughts on the matter to staff, saying: “you want to come in that door without announcing that you’re coming in, be prepared to see whatever... I said I ain’t pulling no punches no more. As long as [my wife] don’t mind, I don’t mind.” It is apparent from his words that Bill perceives intimacy as something that needs to be fought for, but that he does not intend to continue “pulling punches.” Instead, he seems to suggest that the facility should accept and allow intimate activity to happen.

Alexandra took this one step further by suggesting that intimacy should not only be *allowed*, but it should be *facilitated* within the LTC setting:

To spend the night... I think that that should be allowed. I mean I don’t want it, but I think it should be allowed. I think [in] these cases for sure, you know, whether it be the woman that just lost her dance partner or the older couple that have gotten together in here, I think it should be allowed and it should be facilitated... One nurse told me of a nursing home when if two people are having an intimate relationship they would even make their room a little romantic you know so that it would just seem kind of nice for them and I think that that can be done without invading anybody’s privacy... nobody else needs to know.

Alexandra does not see it as sufficient that the facility simply allows intimacy to happen if individuals take the initiative. Instead, the implication is that the facility should be an active part in making intimate relationships easier or even “kind of nice” for residents who desire those relationships. Facilitating intimacy need not be limited to romantic or sexual activities, but may also include opportunities for intimate friendship and companionship. For example, Hazel pointed to the need for more facilitated co-ed outings: “say we all went to Walmart and then went to lunch somewhere, you get to know more and more people.” With these perspectives in mind, it is clear that some participants would urge the facility to move beyond their neutral stance.

*Facility neutrality as positive.* However, some participants also considered the neutral stance as a positive thing. They emphasized that it is not the facility’s responsibility, nor their business, to be involved in intimate matters. These individuals used language that removed the blame from the facility and focused on other limiting factors.

*Not “in the business” of intimacy.* When asked if his intimate needs were being met in the facility, Lefty struggles to conceptualize the question, asking: “What do you mean my intimacy needs being met? What is being met mean?” He was stuck on this idea, and found it almost laughable that the LTC facility would have anything to do with his intimate needs. He went on to say: “I don’t think they’re in the business of having your intimacy met. I think it’s available out there but it’s available on the street too.” In other words, Lefty seemed to suggest that intimacy can occur in the LTC environment, but that it is not the responsibility of the facility to meet these needs. Instead, the onus is on the individual to seek it out if they so desire. Importantly, Lefty is not upset that these

needs are not explicitly targeted by the facility. Instead, he seems content with the fact that intimacy is not a leading priority for the facility. He does not expect them to meet his intimate needs, therefore he does not seem upset that they do not.

In fact, for some residents it may be preferable if intimacy is not openly discussed by the facility. Participants indicated that it is a personal topic for some, to be discussed only by those within an intimate relationship. For example, when asked if the facility provides any facilitators to intimacy, Eileen replied: “No, that’s a personal thing, I don’t think that’s anybody’s business.” Eileen also indicated that upon arrival to the facility, the option was available to “ask questions if you wanted to” but that this was “up to the people themselves.” She noted that people at the facility “don’t talk about it or anything like that” and that there was “nothing out of the way that I have seen that would make you feel embarrassed or anything.” In this view, a lack of open information and discussion about intimacy was perceived as a positive thing because such discussion could lead to discomfort or embarrassment.

*Removal of blame from facility.* Even in the language used by some participants, it is apparent that they do not hold the facility responsible for the barriers to intimacy that they may face. For example, when describing a negative roommate situation, Jason specified that he was discontent with his privacy not because of the facility, but because of the roommate: “but that was his doing you know what I mean, he was a night hawk.” Similarly, Mary did not attribute blame to the facility when discussing her desire to spend more time with her partner: “this can’t be helped by anybody ‘cause I would like to see more of [partner] but he sleeps a lot.... That’s nothing to do with you guys [the facility].” Finally, Hazel emphasized the efforts that had been made, suggesting that there was not

much else that could reasonably be done to change intimacy-related practice: “They try that we all get along and they have tried, I mean you can’t really push people together.” This supports the idea that some residents are content with the facility’s neutral position on intimacy, believing that the facility is doing enough as it is and that there are other factors which prevent the fulfillment of residents’ intimate needs.

**(Nursing) home?** Results show that home is a meaningful concept for LTC residents, particularly in the context of intimacy, as the topic of home came up organically in many interviews. Given that intimate and sexual expression are often associated with ‘the privacy of one’s own home,’ it is important to consider the role of the LTC facility in residents’ perceptions of home, and how that relates to their experiences of intimacy in the facility. For those residents that did not identify with the facility as home, the LTC setting was understood as more of a barrier to intimacy, whereas those who felt at home in the facility tended to see it more as a facilitator to intimacy. The following section will present these two contrasting perspectives.

***Facility as not home.*** Some participants opposed the notion of calling the facility home. Bill expressed the most blatant rejection of this idea, saying: “I’ll never call this shack home as long as I live... it’s the most filtiest, degrading goddamn place I’ve ever been.” For Bill, these feelings of degradation were tied up in his discomfort expressing intimacy in the facility. The concept of home also came up in this interview when Bill commented on a confrontation with staff, in which he alluded to intimate activities at home with her “old man” after she interrupted his and his wife’s intimate time. He reported that the staff member justified her actions by saying “well... I’m home” to which Bill responded “and what do you call this for me?” Therefore, although Bill

adamantly rejected the label of LTC facility as home, he pointed out that this was supposed to be his home now. This provides evidence for the importance of considering how the LTC facility substitutes as a home for many residents. In other words, activities that might typically be considered at-home, private activities may occur in the facility because some residents may have no other home to relate to.

Although she does not explicitly mention the term ‘home,’ Marlene discussed leaving the facility to spend time with her partner, as she is decisively opposed to the idea of being intimate in the facility. Leaving the facility is more of a necessity for her: “We’d have to go out.” She opts to go to a hotel because it is “more relaxing” for both her and her partner and “more fun that way.” Furthermore, Marlene implied that she was not herself in the facility and that there is no opportunity for intimacy there: “Myself I would never... Staff or a resident, I would never be with, ever. But outside, I’m me.” Evidently, Marlene does not feel at home in the facility, particularly when it comes to engaging in intimate activity.

***Facility as home.*** Finally, as with the other system-level factors, there was not unanimous agreement on the role of the facility as home. Indeed, some responses showed strong support for the idea that they were made to feel at home in the facility, which was in turn related to increased comfort being intimate within the facility. Jason was a proponent of this view on more than one occasion. At one point, he discussed the relief associated with removing the burden of his care from his partner at home, praising the “24-hour care” and the fact that “they make you feel like you’re at home here.” Later, he also referred to the facility as his “second home,” and described the support network that was provided by friends, staff, and fellow residents in the facility. Although Jason



indicated that he would frequently leave the facility to fulfill his intimate needs, he does not seem discontent with the opportunities available in the facility, noting that he and his wife will also engage in intimate acts “here in [his] own room.” Perhaps it is simply more convenient or comfortable for Jason and his wife to be intimate at their home, given that this space is still available to them.

Mary also associated the facility with a sense of home. Specifically, she made the connection between the facility’s accommodations for intimacy and that feeling of home: “I think it’s [facility]’s policy to accommodate people if they want to be together, yeah... They say it’s just like our home, you know and they try to accommodate us any way they can.” Based on these words, it is evident that policies that accommodate and facilitate intimacy can be major contributors to helping residents to feel at home in LTC settings.

### **System-Level Facilitators**

Just as the LTC facility presents unique challenges to intimacy and sexuality, the living environment also provides unique supports to residents’ intimate and sexual expression. Many participants revealed a general sense of contentment with facility practices. They identified the shared environment, opportunity to meet new people, and accommodating policies and practices as key facilitators to their experience of intimacy in the LTC setting. These system-level facilitators will be presented in the following section.

**General contentment with facility practices.** In spite of the barriers outlined in the previous sections, many participants implied that they were generally content with the way things were run in the facility. When asked about recommendations for changes to practices related to intimacy, or to name specific barriers to their intimate needs, more

than half of participants had very few or no criticisms. For example, Jason struggled to think of barriers to intimacy when he was asked: “No, not that, no, I can’t say anything about that there ‘cause no, no.” This lack of complaint was a relatively common theme within certain interviews, illustrating a general satisfaction with the current system.

Not only did participants describe an absence of barriers, but they also discussed the presence of available opportunities in the facility. For example, Hazel repeatedly stated that the opportunities for intimacy were “good, if you want to.” For those who desired intimacy, those opportunities could be sought out. Similarly, Jason was confident about the opportunities for intimacy, and described his perception that the environment fostered courtship among residents. When asked if opportunities exist, he said: “Sure there is, yeah, believe it or not there is. Yeah, like... I saw girls going after other guys and guys going after girls in here.” Interestingly, the phrase “believe it or not” suggests that Jason was making a concerted effort to convince the interviewer of these opportunities, as if he is aware that the norm would be *not to* believe that the setting could facilitate intimacy.

Furthermore, Alexandra made an interesting point about the particular value of intimate story-sharing within the LTC setting:

I think that there’s quite a lot of opportunity to get to know people intimately you know because at this age, and at this stage, people... just sort of want to tell their story to you, which is a very intimate thing and some of their stories are extremely intimate, you know stories that they may be have not even told their families in some cases right.

Evidently, Alexandra attributes this increased desire to share intimate stories to the “age” and “stage” of the resident population, suggesting that the sheer number of people at that stage of their life course would create unique opportunities for this type of intimacy in the

facility. She went on to suggest that the facility offered more opportunity for intimate story-sharing “than when you’re going through your day-to-day life.” This is significant, as it suggests that living in LTC is an active facilitator of this particular type of intimacy, compared to living in the community.

Participants also cited interactions with people in the facility as positive contributors to their intimate experience. Eileen commented on the sense of community in the facility, saying: “Well we all seem to get along and... I like most of them.” Jason also commented on the supportive community in the facility, describing a person-centred culture: “it’s the person that counts and that’s what I like about it, you know people who look past our disability.” It is apparent from this quote that Jason was made to feel like a valued part of the community.

Finally, some participants were content with the facility’s efforts to facilitate intimacy, and happy that they were receptive to addressing problems. This was apparent in Hazel’s statement: “They try that we all get along and they have tried.” Similarly, Jason expressed his gratitude for the facility’s efforts:

And so far my, things... I’ve been saying to them have been dealt with and I’m really appreciative of that and like I said, they try everything in their power in this place to help you, whatever they can do for you, they’re right there for you.

Both participants emphasized what the facility was “trying” to do, suggesting that these attempts do not go unnoticed by residents. In other words, participants felt supported, not necessarily because the facility’s efforts were always successful, but because it demonstrated that they were doing “everything in their power to help.”

**Shared environment.** Simply by virtue of living in a communal living environment, participants experienced valuable opportunities for intimate interaction.

Mealtimes, for instance, presented regular occasions for residents to socialize and get to know one another. For example, Eileen spoke at length about her tablemate, suggesting that mealtimes have presented her with the opportunity to get to know her fellow residents on a personal or intimate level. These times may be particularly significant for those who do not have many other opportunities to socialize. As Eileen stated: “unless there’s something going on, we just see the people around us and at... meal time we’re down in the dining area and we see the other residents on this floor.” Evidently, mealtimes stuck out for Eileen as a time when residents would come together. Although the primary goal of mealtimes is to provide residents with food, their social benefits should not be overlooked.

Alexandra discussed other opportunities for social gathering within the LTC environment. She mentioned a bar that is open in the evening for a happy hour. Although she viewed this as a positive opportunity, she had some suggestions to make it even more amenable to meeting residents’ intimate needs:

[For] most people a happy hour for a half hour before supper would be better, it would be better and would fulfill their needs for intimacy especially when the groups are small. You know when you get a group of eight or ten that’s too big, but if you’re four or five, that’s perfect.

With these recommendations in mind, the bar could transition from a feature of the environment for residents to take advantage of if they so choose, to a more intentional, active setting for intimate interaction between residents.

The facility’s recreation programs were identified and praised as a key facilitator for this type of intimate interaction. Alexandra called the department “absolutely excellent” and attributed the success of the program to small group interaction: “And

those people get to be quite intimate you know, they know stuff about each other, they talk more freely. If you're eating or you're doing an activity you enjoy, you get to see another side of somebody." Here, the participant speaks to the value of shared activity to help people get to know one another on a more intimate level.

**Fostering new relationships.** In addition to the facilitators offered by the facility's physical environment and recreation programming, participants also discussed the value of meeting new people as a result of moving into the facility. For some, these relationships were strictly platonic. For instance, Hazel referred to the many female friends that her husband had acquired since arriving at the facility, indicating that she was not bothered by these friendships because of a marriage based on trust. Similarly, Jason also spoke about the friendships he had developed since entering the facility:

Since I've been here... I have got about four or five female companions that are very good friends of mine and yes I tell them I love them, but in a different way. And my love for them is like a brother and sister.

Similarly, Lefty spoke of a platonic relationship with a fellow resident, describing how they enjoyed spending time together because of their shared interests and good conversation.

The facility has also been a starting place for romantic relationships. For instance, Alexandra referred to the "loving relationship" of a certain couple, saying that "nobody can believe that they actually met in here." Given that the couple seems as though they have known each other for much longer, this example demonstrates the facility's potential to be the catalyst for deep and meaningful relationships. Similarly, J.D. described his own experience with romance in the facility. For him, meeting a new partner made a significant impact on his experience in the facility at large. Whereas he

had initially had difficulty transitioning, he identified meeting his partner as a turning point: “that’s when things changed for me. ‘Cause I met this lady and everything.”

Although this is somewhat of an unintentional facilitator, simply by virtue of bringing people together, the facility allows people to meet friends and romantic partners that they may not have met otherwise.

**Accommodating policies and practices.** While the majority of the facilitators so far have been related to companionship, friendships, and relationships in general, participants also discussed policies and practices that were available to accommodate intimate and sexual expression. Some individuals reported that they had not yet encountered the need for this type of accommodation, but they were confident that they would be supported if the situation arose. For instance, Jason said: “when I have my wife, and you know I bet you they would find a place for me maybe, I don’t know, who knows, they’d probably give me somewhere where it was quiet or give us advice.” Although the participant was unsure of the specifics of what would be done to ensure that he and his wife could have intimate time together, the important piece is that he was sure something would be done. Lefty expressed similar confidence when discussing how intimate needs could be met in spite of the lack of locks on doors:

Although I think you can work around it, in fact I know you could. If you had, I’ve never done this, but I suspect that I could do it if I wanted it. Certain of the staff here, you could go up to one of them that you’ve developed a friendship with and say hey you know [name] is coming down to my room at four o’clock, do me a favor and don’t come in for about two hours. They would not come in I mean. They’d honor that request.

Even without first-hand experience with this type of accommodation, Lefty is assured that securing private, intimate time would be possible if a resident needed or wanted it.

Those who had had experience with accommodating policies and practices also offered their perspectives. For example, J.D. spoke about regular “cuddle nights” that he had with another resident. The participant described how the staff helped to “make arrangements” for these events, and how they developed a discrete system to notify staff not to disturb them: “that went over pretty good, yah, and I would tumble up to her room, they’d have a sheet of paper up, I’d put it over to say basically... Yeah and they were pretty good about it.” It is clearly apparent that J.D. felt supported by staff in this instance. However, it should be noted that he also stated that he did not perceive this type of accommodation as the norm in the facility. Conversely, Mary was under the impression that it was facility-wide policy to “accommodate people if they want to be together.” She also had the sense that resources were available to help with intimate and sexual expression, but that the resident would have to seek them out. This is similar to Hazel’s understanding that arrangements could be made if residents so desired. These slight discrepancies illustrate that the facility’s policy on accommodating intimacy may be understood differently by different people. But at the very least, some residents reported positive experiences with these policies and practices.

### **Individual-Level Facilitators**

Although these system-level facilitators are a positive sign, there are also a number of factors that operate at the individual level in order to make these facilitators a reality. In other words, opportunities for intimacy are available within (or in spite of) the facility, as long as residents make them. This is reminiscent of the onus on the individual theme, discussed above, which described how individuals needed to advocate for their own intimate needs in response to a neutral stance from the facility. Participants

discussed the crucial role of self-advocacy in ensuring that their intimate needs were being met. Similarly, participants also described various adaption strategies and activities that allowed them to fulfill intimate and sexual needs in spite of the numerous barriers they encountered.

**Self-advocacy.** Although most participants did not self-identify as advocates for their own sexual/intimate needs, the role of self-advocacy emerged as a significant theme in the data. Participants described multiple, sometimes subtle forms of advocacy that they used on a regular basis.

**Securing privacy.** For instance, some participants described steps they had taken or would take in the future to make their space more private. Such was the case for Alexandra, who took the initiative to put a “sign on [her] door for them not to come in at night.” As previously noted, Alexandra also sought out a facility policy that allowed her to request “yellow strips” to prevent the unwanted entry of certain residents in wheelchairs. Some residents preferred to find space outside of their room that would offer more privacy. For instance, Paul noted that when his family came to visit, they would “go to a place to get away from people [and] have a little privacy.” Furthermore, even with a roommate sharing her partner’s room, Mary proposed a plan for obtaining more privacy: “from now on I’m going to just ask, or tell [his roommate] I want a little private time with [my partner], is it okay if I close your curtain a little bit? Yeah that’s what I’m going to start saying.” In this instance, Mary resolved to advocate for privacy on behalf of herself and her partner.

Another couple presented an example that suggests that one partner may often be the advocate for these types of needs, whereas the other partner may not be aware that



such advocacy is occurring. For example, it is noteworthy that Hazel expressed such contentment with the level of privacy that she has, when her husband was so discontent with the privacy offered by the facility, even though they share the same room. Perhaps the difference lies in the fact that the husband is the advocate for their privacy, therefore she does not experience the persistent need to assert and maintain a private space because he does so on their behalf. Hazel acknowledged that everyone may not experience the same degree of privacy, saying twice: “I don’t know if it’s just us.” And she mentioned that the staff will hear her husband’s “bark.” In this case, perhaps the most privacy is granted to those who advocate the most loudly for this privacy. This point is supported by Hazel’s suggestion that the staff are responsive to her and her husband’s needs because “they all know it by now. If they don’t come they’re going to get a tongue lashing.” In this case, the staff’s response is shaped by the individual’s behaviour.

*Addressing concerns with staff.* In other cases, participants described addressing intimate concerns with staff directly. Examples of this have been discussed in previous sections, such as Lefty’s suggestion to request uninterrupted time with a partner, and Mary’s conversation with the floor supervisor about what types of intimate behaviour were permitted. Bill gave another example of addressing concerns with staff. He described an instance when staff were pushing his partner in a wheelchair and unintentionally put too much space in between her and Bill:

They didn’t bother to slow up so finally [my partner] said ‘I want you to stop right now, I want [Bill] to catch up to me.’ She said ‘I don’t want to be separated. If you’re going to separate us, take me back to my room.’

Based on these examples, it seems that this type of direct, straightforward communication is also an effective form of self-advocacy.

**Adaptation and activities.** Related to self-advocacy were the factors and strategies that helped residents to adapt to the barriers to intimacy that they faced. These adaptation strategies included maintaining a social circle outside of the facility with long-term social connections, as well as gathering in small groups for support, conversation, and to build new relationships.

***Maintaining connections.*** For some participants, adapting consisted of maintaining contact with supportive friends and family outside of the facility. For instance, Alexandra spoke about weekly phone calls, lunch dates, and activities with friends that she had known for many years. Alexandra described this as “a really meaningful connection” and discussed how these connections were integral to her experience of intimacy: “we’ve known each other for so many years that it’s very comfortable and it does increase your sense of intimacy for sure.” Similarly, Lefty was looking forward to a lunch date with “one of the residents from the other place” that he had known for an extended period of time.

Some participants also mentioned continued contact with supportive family members as a form of adaptation. For example, Marlene talked about spending time with her family outside of the facility, and reported that they were supportive of her intimate needs:

My family know that I go out to a hotel and [my sister] says, she’s got a perfectly good room... she’s the only one that I really, really told what goes on here and she goes... nowadays that’s what they’re doing?

This illustrates Marlene’s ability to confide in her sister, which could itself be a source of intimacy. It also demonstrates her sister’s sense of disbelief about the facility’s barriers to

intimacy, which seemed to act as a form of validation for Marlene, legitimizing her intimate needs and the fact that she should be able to use her room for sexual expression.

Lefty also reported a supportive family network, particularly with regards to his intimate needs: “now if I went out tomorrow and ended up getting married to some woman that, they’d be happy as a pig in shit, they’d say dad good for you... they want me to live a stress-free life.” While it should be acknowledged that not everyone is fortunate enough to have such encouraging family members, Lefty’s experience is evidence of the value of maintaining supportive connections outside of the facility whenever possible.

***Organizing peer groups.*** Alexandra also spoke at length about the benefits of peer groups. Specifically, she mentioned a happy hour group, an optimistic group, and a book club, which all helped to facilitate trust and relationship-building as well as to alleviate loneliness among residents. Alexandra described the close relationship that had developed between members of the happy hour group:

And you know we know each other well enough now that we talk about the way we feel about politics, or religion or art or literature or the nurses, you know. Things of that kind and you have a definite feeling that if it goes outside the room it would be very judiciously... it wouldn’t be spread all over.

Evidently, these groups provided a sense of privacy of information and intimate conversation that were not as readily available elsewhere in the facility. Importantly, Alexandra also discussed how these groups were inspired and/or organized independently by residents themselves. She emphasized that these types of small group gatherings could benefit even more residents if they were facilitated at the system-level: “those kinds of things should be encouraged. I know [other facility] has it. Thursday afternoon there’s a

happy hour and residents just get together and talk and I think that that really, that should be part of the program.” Based on Alexandra’s testimony, it is apparent that these types of facilitators are relatively simple to organize, but that they have the potential to make a big difference in residents’ experiences of intimacy. Given these findings, it is encouraging to know that some residents are finding ways to facilitate intimacy and sexuality within the LTC environment, at least until these types of facilitators become “part of the program.”

### **Chapter 4 Summary**

Chapter 4 has provided a thorough account of study results. In section one, participants reported varying definitions of intimacy and sexuality. They defined intimacy as personal and private, physical, and as shared or partnered activity. Sexuality was conceptualized as primarily physical, as a label, and as a dynamic construct. Participant perspectives provided additional context for understanding the diversity within these definitions. Participants also reported conflicting and changing perceptions of sex and aging. Some participants indicated that age was a limiting factor in a person’s ability to experience sexual or intimate expression in later-life, whereas other participants maintained that age alone was not as consequential as other factors. They asserted that intimacy in older age was both normal and a source of power. Furthermore, residents discussed their own experiences of sexuality and intimacy, indicating that these experiences were both present and varied. Findings demonstrated significant language choices used by participants to describe their experiences of intimacy, and there was a notable emphasis on how those experiences changed over time. Section two provided an in-depth account of the barriers and facilitators encountered by study participants.

Participants reported individual-level barriers that manifested as biopsychosocial factors, as well as system-level barriers including aspects of facility infrastructure, culture, and care practices. Results uncovered five system-level factors that presented as both barriers and facilitators. These included staff influence, facility rules and regulations, privacy, facility neutrality, and participants' sense of the facility as home. Finally, participants also discussed factors that they experienced exclusively as facilitators to intimacy and sexuality. Some facilitators operated at the system-level (e.g. general contentment with facility practices, shared living environment, the development of new relationships, and the presence of some accommodating policies and practices), whereas other opportunities for intimacy were initiated at the individual level through self-advocacy and adaptation. The following chapter will situate study findings within the current literature and discuss their significance and implications for future research, policy, and practice.

## **CHAPTER 5: DISCUSSION**

### **Introduction to Discussion**

The following chapter will discuss the major findings of the present study. It will explore the significance of participants' diverse and changing perspectives on intimacy and sexuality, situating these perspectives within the relevant literature. Furthermore, individual- and system-level barriers and facilitators will be explored, with particular attention to their potential for creating a more supportive system for intimacy in LTC. Finally, practical recommendations for initiating positive change will be provided, and study limitations will be discussed.

#### **Section 1: Residents' Diverse & Changing Perspectives on Intimacy & Sexuality**

##### ***How do older LTC residents define, perceive and experience intimacy and sexuality?***

Older adults living in LTC settings have diverse and changing perspectives on intimacy and sexuality. Study findings reveal varied definitions of intimacy and sexuality, conflicting perceptions about intimate and sexual expression in the context of aging, and a wide variance of intimate and sexual experiences in later-life. Not only does this variation appear from one person to the next, but change occurs at the individual level over time.

The following section will highlight these two constructs—diversity and change—as underlying themes of results related to the first research question. Findings will be situated within the literature to discuss the relevance of the study to current knowledge base, as well as new meanings and novel contributions that arise from the findings.

## **Diverse Perspectives of Intimacy & Sexuality**

Study findings demonstrate that there is significant variance in the way participants define, perceive, and experience intimacy and sexuality in later life. This diversity suggests that these perspectives are highly individualized, and may vary from participant to participant. Given this diversity, the findings are consistent with a social constructivist worldview. As Guba and Lincoln (1994) state, constructivism “assumes multiple, apprehendable, and sometimes conflicting social realities” (p. 111). This section will discuss the “multiple” and “sometimes conflicting” realities of sexuality and intimacy, as expressed by study participants. Specifically, the section examines the diverse ways that residents operationalize these terms, opposing attitudes about sex and intimacy in the context of aging, as well as the presence and variance of sexual and intimate behaviours reported by study participants.

**Diverse definitions.** Diversity was immediately apparent in the way study participants defined intimacy and sexuality. There was a very apparent lack of consistency in these definitions, resulting in three themes for each construct. Intimacy was represented by such varied themes as personal/private, physical, and partnered, which was further subdivided into varying degrees of shared activity. Sexuality was also defined using a wide range of terms, and was ultimately conceptualized as (primarily) physical, as a label, and as a dynamic construct.

The variance in operationalizing these terms is not unique to this study, but has been supported by other research on intimacy and sexuality. For instance, Moss and Schwebel (1993) acknowledged the complexity of the intimacy construct in the context of family relations. They studied the diversity of definitions of intimacy in scholarly

publications in an effort to formulate a “widely applicable definition of intimacy in romantic relationships” (p. 31). The authors uncovered 61 unique definitions and distilled these into a singular definition that included five constructs: commitment, affective intimacy, cognitive intimacy, physical intimacy, and mutuality. Similarly, Diorio (2001) discussed two diverging understandings of sexuality as either a reproductive or a non-reproductive phenomenon, arguing that privileging one over the other in sex education practice has ethical and moral implications.

Failure to recognize and represent this diversity also has implications in the context of research on sexuality and aging. This is not a new concept, as Deacon, Minichiello, and Plummer (1995) addressed this concern more than two decades ago: “There is far more variability and fluidity in people’s sexual patterns as described in popular culture than current research appears to capture. This suggests that current researchers need to scrutinize their definition of human sexuality more closely” (p. 501). Ignoring individual variability and fluidity is still a concern in more recent research, as evidenced by a study of older Chinese adults’ understanding of sexuality (Yan, Wu, Ho, & Pearson, 2011). The study took a qualitative approach, and argued “that research into sexuality that does not take into account how participants define sexuality cannot be complete” (Yan, Wu, Ho, & Pearson, 2011, p. 984).

The present study provides evidence for this argument, emphasizing the importance of representing the individual differences in participants’ definitions of intimacy and sexuality. Without an initial understanding of how these terms resonate with study participants, it would be difficult to determine exactly what attitudes and behaviours they were referring to throughout the remainder of the interviews. As Lefty



said, without identifying the “starting points,” it would be hard to situate individual perspectives within the wide range of possible meanings. Making space for older adults to voice their own definitions also provides participants with a source of agency and ownership. It creates an opportunity for participants to control which constructs they will discuss throughout the interview process. Similarly, Corbin and Morse (2003) noted the importance of using open-ended questions to grant participants a level of control within the research process.

Using standardized definitions of intimacy and sexuality that do not adequately represent participants’ understandings is equally flawed. For instance, many studies are informed predominantly by biomedical definitions of sexuality that focus exclusively on sexual functioning (DeLamater, 2012; Marshall, 2011). Similarly, close-ended surveys that focus only on partnered activity, or penetrative intercourse neglect the wide range of other concepts that residents defined as intimate or sexual, including hugging, holding hands, spending time with a partner, or confiding in another person (e.g. Herbenick et al., 2010; Lindau et al., 2007). Although using a consistent definition of sexuality is important for quantitative work, overly rigid definitions present a limitation in that they may not accurately represent the full range of constructs that fall within older adults’ understanding of intimacy. The present study moves beyond these rigid definitions by showcasing the diversity of residents’ responses. This provides support for the idea that qualitative methods are necessary for elucidating more nuanced, personal understandings of complex terms.

**Paradoxical perceptions.** In addition to the diversity in the definitions of the terms, there were equally conflicting perceptions regarding the relevance of age as a

determining factor for intimate or sexual expression. Whereas some participants clearly viewed chronological age as a significant factor in their understanding and experience of intimacy, others were adamant that age alone is irrelevant. In other words, participants' beliefs about aging and sexuality/intimacy were firmly placed in one of two contradictory camps: age matters, or age does not matter.

Those participants who understood age as a determining factor discussed the relevance of chronological age for sexual expression, and expressed disapproval of significant age differences between romantic partners. They attributed significance to chronological age, hinting at an understanding that loss of sexual desire is normal and should be expected upon reaching a certain age. Notably, this expectation is supported by studies that identify normal, physiological changes associated with age (Bartlik & Zucker-Goldstein, 2001; DeLamater, 2012; Doll, 2012; Zeiss & Kasl-Godley, 2001). In one study, researchers found that chronological age actually served as a form of coping when sex occurred less frequently (Gott & Hinchliff, 2003). In other words, it was easier to cope with a decline in sexual frequency or activity in older age if that decline had been expected.

As shown in the current results, one participant explicitly recognized that perceptions about sexuality and aging are more dependent on "individual factors" than on "age alone" (Lefty). This finding is consistent with Frankowski and Clarke's (2009) conclusion that interest in sex is not generalizable to the entire study population of residents in assisted living facilities. Instead, "interest in sex is resident dependent" (Frankowski & Clarke, 2009, p. 29). This confirms the need to consider perceptions of

sex and aging at the individual level, rather than making assumptions about a population at large.

The present study makes a strong case for the fact that chronological age alone is not as consequential as other factors, such as health, subjective age (how old a person feels), and the generation in which one was raised. These generational differences have been explored in other studies. For example, Hinchliff and Gott (2008) discussed the sexual diversity among older female participants, and found that some of this diversity could be attributed to older women being “raised in an era where sex was taboo and women were not expected to enjoy it” (p. 74). In this case as well, it is not necessarily the age difference itself that results in different perceptions, but instead the cohort differences.

The influence of non-age-related factors is also well-supported in the literature (Lindau et al., 2007; Gott & Hinchliff, 2003). For example, the latter study found that although older participants (age 70-90) placed less value on sex than their younger counterparts (age 50-70), this was not necessarily as a result of age. Instead, authors indicated that “the prevalence of those barriers that resulted in the reprioritisation of sex increased, and became more insurmountable, with age” (Gott & Hinchliff, 2003, p. 1626). This is consistent with the present study’s finding that age alone should not be viewed as the primary limiting factor to intimacy; instead, there is a need to account for diversity between individuals. Some participants in this study advocated for the view that intimacy in older age should be considered normal. However, other participants’ responses implied that expressions of intimacy among the LTC resident population were exceptional circumstances that warranted praise. These results suggest a contradiction

between what *should be* occurring and *what is* occurring, indicating that normalization of these activities is not widely accepted.

Evidently, results demonstrated diverse perceptions regarding whether or not age impacts an individual's desire or ability to engage in intimate or sexual activity. Previous research has shown that whether older adults believe that it does or it does not, they are probably right. In other words, an individual's beliefs and attitudes about aging and sexuality will in turn impact their experiences of sexuality in later life (DeLamater, 2012; DeLamater & Koepsel, 2015; Elias & Ryan, 2011; Skultety, 2007). These diverse experiences will be discussed in the following section.

**Elaborating on experiences.** Popular belief about older adults' intimate experiences often rely on stereotypical understandings of older people as asexual beings (Bentrott & Margett, 2011; Bouman et al., 2006; Parker, 2006). The present study rejects that narrative, as findings demonstrate that participants not only experience intimacy and sexuality, but that these experiences vary from one individual to the next. In other words, the reality of participants' experiences cannot be adequately captured by stereotypes that negate individual experiences.

Participants in the present study reported a wide variety of intimate and sexual behaviours. These included spending time together, talking, hugging, kissing, cuddling, and sexual touching. This is consistent with other studies whose findings demonstrated an emphasis on "less physically intense expressions" of intimacy (Fransowski & Clarke, 2009, p. 29; Ginsberg et al., 2005). The present findings were also supported by the Ginsberg et al. (2005) study in that participants did not explicitly discuss experiencing or desiring masturbation or sexual intercourse. Most participants did not mention

intercourse at all, or only in the context of general or others' experiences. This is noteworthy given that in a US survey of older adults, Herbenick and colleagues (2010) concluded that more than 50 percent of those in their 50s engaged in vaginal sex, and that the rates of intercourse remained relatively high after age 69, with men and women reporting 43 and 22 percent respectively. This discrepancy can be understood through a series of possible explanations. First, the Herbenick et al. (2010) study was conducted with a nationally representative sample of *community-dwelling* older adults. Therefore, this population may engage in more physically-demanding forms of sexual expression as a result of differences in the health and/or mobility of the LTC population. Furthermore, it is possible that residents in the present study were engaging in intercourse, but they were not willing to speak openly about it with the interviewer. They may have been more likely to indicate this information in an anonymous survey format, such as that employed by Herbenick et al. (2010). In other words, it is possible that participants are actually not engaging in sex, but it is equally possible that they were not sufficiently comfortable discussing sexual acts that are traditionally more taboo, at least in the context of their own personal experience.

Indeed, there was also diversity present in the language used by participants to describe their experiences. This language was categorized into a clear dichotomy: direct vs. indirect language. Frankowski and Clarke (2009) alluded to the indirect type of language usage, which they described as “metaphoric” or “figurative” (p. 29). The authors commented on the methodological difficulty associated with the lack of consistent language usage among participants. The present study takes this one step further by recognizing the value that can come from paying attention to this diversity. For

instance, word choices could be indicative of participants' levels of comfort discussing the topics of intimacy and sexuality; those who are more comfortable may be more likely to use direct language, whereas those who are less accustomed to talking openly about these issues may be more likely to use indirect euphemisms or to imply sexual/intimate acts without stating them outright. Furthermore, analysis of participant language revealed a recurring use of innocent language to describe intimate experiences. This is significant, as it suggests a perceived need to validate or defend their actions to the interviewer. Furthermore, participants' language use implies that, whether consciously or subconsciously, they are aware of which types of intimate acts (e.g. hugging, holding hands) are defensible as 'innocent,' and which are too taboo to defend or discuss at all.

Finally, participants in the current study reported diverse experiences related to appearance and attractiveness. Some participants indicated that their own feelings of attractiveness comprised an important part of their sexuality, and described various routines to maintain their appearance. This was also the case for participants in a study by Bauer and colleagues (2013) who described a lack of attention to these appearance-related care needs in the LTC setting. Notably, participants in the current study indicated that they took responsibility for maintaining their appearance on their own, implying that the facility did not have a role to play in this type of care. The present study also found a gendered element in the perceived importance of attractiveness, as women were more likely to express concern about their own appearance, whereas men were more likely to discuss their female partner's appearance. This discrepancy may be evidence of gendered expectations of beauty and societal pressures on women that persist into older age. For example, Winterich (2007) studied the perspectives of a diverse group of older women,

and found that many of these women—particularly white, heterosexual women—felt pressure to prevent or treat weight gain, greying hair, and facial hair as they aged. More representative research is needed to determine whether this claim can be generalized to the broader older adult population. Finally, the fact that some participants did not see any relationship between physical attractiveness and sexuality is further evidence of diverse experiences, and suggests that the topic of attractiveness may not have been mentioned at all had it not been addressed in the interview guide.

### **Changing Perspectives of Intimacy & Sexuality**

Seemingly in (delayed) response to Deacon and colleagues' (1995) call for research that recognizes the “variability and fluidity in people’s sexual patterns,” Bouman and Kleipatz (2016) recently wrote an editorial for a special issue of *Sexual and Relationship Therapy*. The issue showcases research aimed at “exploring and understanding greater diversity and fluidity of sexual expression of older people” (Bouman & Kleipatz, 2016). Both statements indicate a previous absence of research on older adult sexuality that recognizes “diversity and fluidity.” It has already been established that the present research findings contribute to a diverse understanding of older adult sexuality/intimacy. Fittingly, the study also recognizes intimacy and sexuality as fluid concepts. Not only do the study findings demonstrate variance between individuals, but also change within each individual over time. This change is apparent at the level of definitions, perceptions, and experiences.

**Developing definitions.** As previously mentioned, one of the central themes identified in residents’ definitions was that sexuality itself is a dynamic construct. This was evidenced by participants need to clarify whether they were required to provide their

current or previous definition of sexuality, as well as one participant's more explicit assertion that his definition would have been different when he was younger. Although previous studies have considered that different people will define sexuality in different ways, few have recognized that the same person might define sexuality differently at different stages in their life. In this way, this finding represents a novel contribution to the research on sex and aging.

Interestingly, the idea of change was not present in participants' definitions of intimacy. This may be due to the fact that intimacy is a broader, less explicit term with fewer connotations of sexual intercourse. Given that no participants described engaging in sex at this stage, it follows logically that they may define sexuality differently now than when they were younger. But given that intimacy encompasses such diverse constructs as companionship, confiding in a partner, and other less sexually explicit behaviour, it is more likely that at least some of these activities will resonate with residents' past *and* current experience of intimacy.

**Progressing perceptions.** Results also indicated a change in the perceived importance of intimacy over time. Some participants indicated that sexuality and intimacy were no longer important, or were less important than they had once been. This is consistent with a major theme in the Bauer et al. (2013) study, which associated sex and intimacy with "reminiscence and resignation" rather than identifying it as an important part of the present. A second theme presented in this study was that "sex still matters" for many older adults (Bauer et al., 2013). The sustained importance of sex and intimacy was also apparent in the present study. In fact, one participant identified that it was not only *still* important, but it was now *more* important than it had been when she



was married and associated sex with obligation. This finding is significant in that it demonstrates that there are more than two options for the importance placed on sex and intimacy over time. It may not simply stay the same or become less important, but actually may become more important in later life, depending on other factors such as investment in the current relationship. The perceived importance of sexuality is meaningful, as it is associated with the frequency and experience of sexual behaviour (Gott & Hinchliff, 2003; Kontula & Haavio-Mannila, 2009).

**Evolving experiences.** The emphasis on change was most readily apparent in the way participants discussed their experiences of sexual and intimate expression. Unsurprisingly, the participant who placed more value on intimacy in her present than she had in her past also described a heightened experience of intimacy. She experienced a more immediate need for physical contact with her current partner than she had experienced in previous relationships. While this goes against the dominant stereotypes of sex and aging, it is not unprecedented in the literature. For example, Gott and Hinchliff (2003) found that “a minority of participants reported that sex had become more pleasurable, and assumed greater importance for them, as they had got older” (p. 1626). Doll (2012) offered possible explanations for this increased enjoyment, positing that women might experience more pleasure from sexual activity after menopause, as pregnancy is no longer a possible consequence. Likewise, men may be able to sustain erections for longer periods of time (Doll, 2012).

Although this positive change is possible, a decline in sexual expression was more representative of residents’ experiences in the present study. It should be specified that this decline was associated with explicitly sexual behaviours, rather than with intimate

expression more broadly. This decline is consistent with the literature. For instance, a nationally-representative survey found that sexual activity decreased steadily by decade among those aged 57 to 85 (Lindau et al., 2007). While some participants in the present study associated this decline with health problems, others reported that sexual expression was simply no longer a priority for them. This demonstrates that sexual decline may occur for various reasons, depending on the individual and their circumstances.

Although there is a biological basis for sexual decline, it has been proven that physiological changes will not be experienced uniformly by all older adults (Zeiss & Kasl-Godley, 2001). Therefore, it is equally important to consider the ways in which participants' expectations about sex and aging are shaped by stereotypes. Levy's (2009) Stereotype Embodiment Theory (SET) provides an alternative explanation for why some participants in the present study attributed decline in sexual expression to their chronological age. The SET posits that if individuals subscribe to stereotypes about aging, they will internalize and subsequently experience those stereotypes. In order to explore this possible explanation, future studies on aging and sexuality should incorporate questions that target age stereotypes more explicitly, in order to determine whether participants' perceptions are informed by these stereotypes, or simply by their own experiences.

Finally, accepting and adapting to changes in intimate and sexual expression emerged as a significant theme in participants' experiences. This was apparent in the way participants normalized changes or loss of intimacy in later life. In other words, if change was expected, it was easier to accept. One participant spoke about adapting to change more directly, indicating that his experience of intimacy was different, but that it could

still be fulfilling in a different way. This offers insight into the value of adaptive practices for older adult sexuality, and for aging more generally.

### **Significance of Findings**

Upon examining residents' definitions, perceptions, and experiences of intimacy and sexuality, study findings have emphasized the importance of diversity and change. Much can be learned from recognizing the variance that occurs between and within individuals, and these lessons have significant implications for research, policy, and practice in LTC settings.

**Diversity matters.** First, understanding diversity is important in order to create inclusive, supportive environments. In other words, there can be no 'one-size-fits-all' approach to intimacy and sexuality in LTC. Instead, there is a need to recognize and accommodate varying levels of intimate and sexual needs. In practice, accommodating this diversity may be challenging. If everyone is not experiencing, perceiving, or even defining intimacy and sexuality in the same way, how will LTC facilities ensure that their policies and practices reflect this diversity? According to previous best-practice research, a focus on person-centred care may be an important first step toward addressing this challenge. This type of care emphasizes putting the person first, understanding each individual in the context of their past and present experiences, and tailoring each resident's care practices to their individual needs (Crandall, White, Schuldheis, & Amann Talerico, 2007). In this way, person-centred care presents a promising approach to addressing the wealth of individual diversity inherent in residents' sexual and intimate needs.

Furthermore, the present study adds support to the knowledge base on recognizing diversity among older adults in order to dismiss negative age stereotypes. The study findings emphasize that not all older people have the same views or experiences of intimacy and sexuality, therefore such assumptions should not be made. Dissemination of these results to facility staff and administrators, as well as members of the general public, will contribute to a discourse that encourages people to deconstruct their own assumptions about later-life intimacy, and move away from stereotypical understandings of the topic.

These findings are also meaningful in the research context, as they reiterate the importance of using qualitative methods to give voice to this diversity. The aim of quantitative research is to generalize findings to a broader population, but qualitative methods are valuable in that they provide greater insight into the complexity of individual perspectives. In other words, had this study been conducted using quantitative surveys, it would be missing the first-hand accounts that demonstrate how each individual's perspectives are shaped by their own thoughts and experiences. Therefore, future studies that aim to recognize this diversity should consider the merits of a qualitative approach.

**Change matters.** The second major lesson that can be learned from study findings is that—when it comes to aging and sexuality—change is inevitable, but it is not necessarily bad. In order to understand individual change over time, there is a need for research methodologies that effectively capture this change. The present study's use of a life review approach was a useful method to contextualize individuals' present perceptions of sexuality and intimacy within their past experience. However, this approach is also premised on the importance of recalling past experiences, therefore it

depends on participants' memories of these experiences. With this in mind, future studies might benefit from a more longitudinal approach in order to capture individuals' experiences of sexuality and intimacy at various points throughout the life course.

Furthermore, in the context of implications for LTC settings, the emphasis on change signals on the need for flexible policies and practices. In other words, it should not be assumed that an individual's intimate/sexual needs and desires will remain the same throughout their stay in the facility. These needs and desires may change based on a range of individual factors (e.g. health conditions, availability of partner, etc.). For instance, a resident may not value intimacy upon entering the facility, but may develop a newfound interest upon meeting a fellow resident. With this in mind, facility should be attuned to the possibility of changing needs, and ensure that policies are significantly adaptive to ensure that these changes are not met with adversity.

Ultimately, given the diversity of resident perspectives and the changing nature of these perspectives over time, it is critical to make space for first-hand accounts, and to use these accounts to inform policy, practice, and future research. These recommendations will be outlined in greater depth in a subsequent section.

## **Section 2: Moving from the Present Reality to the Possible Reality for Intimacy & Sexuality in the LTC Environment**

***What are the present barriers (if any) to intimate/sexual expression in a LTC facility in Halifax, NS? What factors (if any) do residents of this facility experience as facilitators to their intimate/sexual needs?***

Older residents in the LTC facility of study currently experience a series of individual- and system-level factors that influence their intimate and sexual expression.

Study findings demonstrate that many of these factors are exclusively experienced as barriers to intimate and sexual needs, while others are strictly identified as facilitators to intimacy and sexuality. A third category of factors—those that are experienced simultaneously as barriers and facilitators—signals on an important opportunity for system-level change. Understanding these factors as modifiable provides a useful starting point for moving from a present system where barriers and facilitators overlap, to a future system where facilitators overshadow barriers to intimacy and sexuality.

The following section will discuss the present reality of barriers and facilitators as experienced and articulated by study participants. This reality will be contextualized and compared to relevant literature through discussion of each category of barriers and facilitators. Finally, study results will be discussed in terms of their significance for moving from the what is presently occurring in the LTC facility to what can be made possible in the future.

### **Present Reality**

As represented by the study findings, the present reality of sexuality and intimacy in LTC is complex. Barriers and facilitators to intimacy operate across two levels and are experienced in varying degrees by each participant. This complex reality is illustrated in the diagram below (see Figure 2). As represented by the two sets of circles, many of these factors can be distilled into four categories: individual-level barriers, system-level barriers, system-level facilitators, and individual-level facilitators. However, it is important to note that these categories are not distinct from one another, but instead are overlaid and overlapping. Factors experienced at the individual-level are influenced by and have an influence upon the broader system level, therefore the individual-level

barriers and facilitators are situated within the system-level barriers and facilitators (see Figure 2). Furthermore, study findings clearly demonstrate that several factors act as both barriers and facilitators to intimacy, thereby creating a fifth category—system-level factors—where the two overlap (see Figure 2). This visual is not only a way to conceptualize the present system, but also offers useful insight into the implications of study findings.

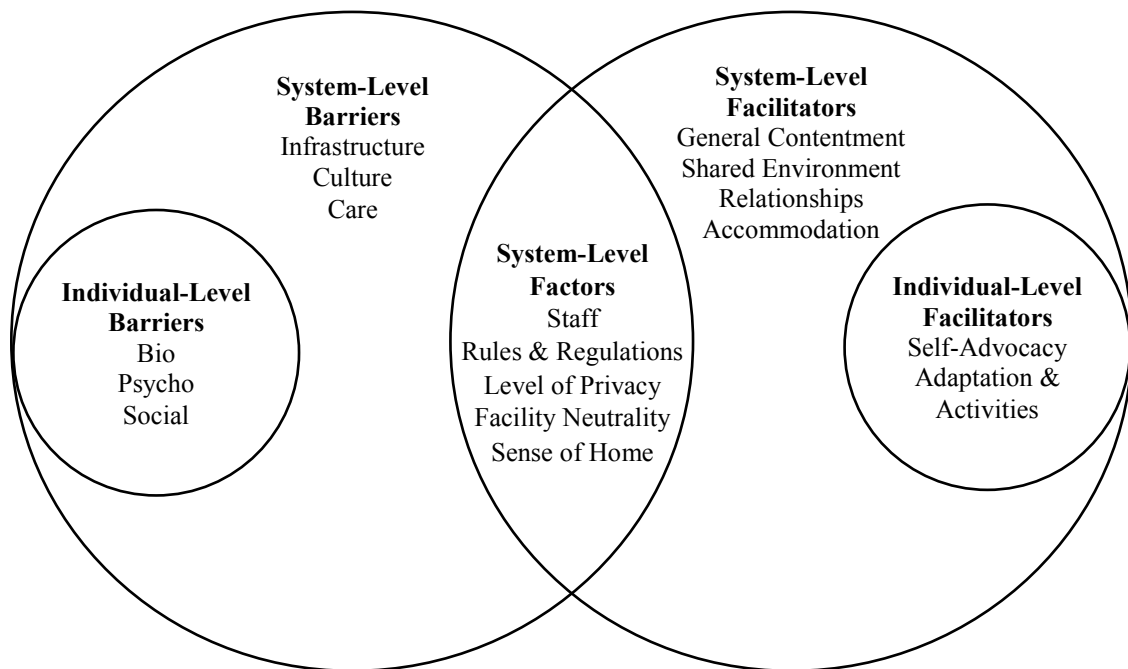


Figure 2. Present reality of barriers and facilitators in the LTC facility of study.

**Individual and system levels interact.** Study results confirm that barriers and facilitators operate at both the individual- and system-level. These levels are represented by the smaller circles positioned within the larger circles (see Figure 2). This placement is significant, as it indicates that the individual is constrained or encouraged by the broader system, and also that s/he may help to inform that system. This is important from a health promotion perspective, given that the interplay between the individual and the broader system is a key area of interest for health promoters.

This interplay was first established in the Ottawa Charter for Health Promotion, which emphasized the importance of creating supportive environments. The Charter specifies that health promotion initiatives should produce “living and working conditions that are safe, stimulating, satisfying and enjoyable” (World Health Organization, 1986, p. 1). Of particular relevance here is the role of the living environment in contributing to individuals’ health. Similarly, McLeroy, Bibeau, Steckler, and Glanz (1988) wrote a foundational piece on the importance of taking an ecological approach to health promotion. They critiqued health promotion programs that solely focused on advocating for individual-level behaviour change, instead positing that “appropriate changes in the social environment will produce changes in individuals, and that the support of individuals in the population is essential for implementing environmental changes” (McLeroy et al., 1988). This reciprocal relationship between the individual and the social environment is understood as a key feature of effective health promotion interventions. The above diagram (Figure 2) represents a somewhat simplified version of the ecological model discussed by McLeroy and colleagues (1988), as it primarily focuses on the role of the LTC facility as the broader social environment that interacts with individual-level factors.

Harris, Grootjans, and Wenham (2008) offer insight on the specific application of an ecological perspective in the context of aging and care settings. They advocate for the use of a settings approach to health promotion in LTC and other living environments for older adults. Extrapolating these findings to the present study provides further evidence for the fact that an individual’s sexual and intimate needs cannot be facilitated without appropriate support from the system, and a system cannot effectively facilitate intimate



needs without consideration of individual-level factors. In other words, initiatives to support intimacy and sexuality should be understood as a shared responsibility between the individual and the facility.

**Not all barriers and facilitators are mutually exclusive.** Whereas some factors (e.g. individual health conditions and functional changes, facility infrastructure) were experienced exclusively as barriers and others (e.g. accommodating policies and practices, self-advocacy) were represented exclusively as facilitators to intimacy, other factors were not so clear-cut. The overlap is significant (see Figure 2), as it suggests that these factors can be exhibited or expressed as both barriers and facilitators. For example, according to some participants, staff attitudes and actions had negative effects on participants' intimate needs, whereas for others, staff actually facilitated intimacy. Similarly, some participants praised the opportunities for privacy in the facility, whereas the majority of participants discussed lack of privacy as a barrier to intimate and/or sexual expression. Participants also had conflicting views about facility rules and regulations, facility neutrality, and the sense of the facility as home. The fact that these factors are present in both camps may indicate that they are modifiable.

Typically, modifiable factors are discussed in health promotion literature relative to their implications for individual-level change. For example, Marquez, Bustamante, Blissmer, and Prohaska (2009) identify the psychological and behavioural factors that can be modified by individuals to promote successful aging. Notably, these authors also mention environmental factors such as “a supportive interpersonal environment, [and] having physical resources” as key factors to promoting healthy aging in general (Marquez et al., 2009, p. 14). Importantly, these environmental factors can be applied to the living

environment, suggesting that modifiable factors can have implications at the system level and in the context of promoting healthy intimate and sexual expression. Therefore, analysis of factors that appear as both barriers and facilitators provides a useful starting point for making supportive changes at the system level. In other words, examining when and how these overlapping factors appear as facilitators can help us to determine how to make the necessary changes to ensure that they are experienced as facilitators more frequently. This concept will be explored in greater depth in a subsequent, detailed discussion of system-level factors.

### **Barriers to Intimacy & Sexuality**

Prior to engaging with these more versatile factors, it is useful to examine the factors that do not overlap; those that participants identified as either entirely problematic or entirely helpful to the fulfillment of their intimate/sexual needs. The following section will focus on the former category—factors that were reported as a hindrance to desired intimate expression, whether at the individual or system level.

**Individual-level barriers.** Study findings show that some barriers to intimacy are experienced as a result of individual differences in biology or physiology, psychological outlook, and immediate social circle. This section explores each of these individual-level barriers in turn, with particular attention to how they have been represented in former research and what the current study can contribute to the existing body of knowledge.

**Biological barriers.** Biological and physical factors featured heavily in participants' discussion of issues that prevented them from engaging in intimate or sexual activity. Interestingly, participants' narratives placed much more emphasis on health- or function-related changes rather than natural, age-related changes. It is well-supported in

the literature that there are a series of physiological changes associated with later-life that may impact individuals' physical experience of intimacy and sexuality. These include hormonal changes resulting in decreased vaginal elasticity and lubrication, less firm erections, shorter or delayed orgasms, and so on (Bartlik & Zucker-Goldstein, 2001; DeLamater, 2012; Doll, 2012; Zeiss & Kasl-Godley, 2001). Given the wealth of evidence supporting these physiological changes and their impact on sexual functioning, it was expected that these changes would feature more heavily in participants' discussion of barriers. Instead, only one participant mentioned the impact of menopause on her sexual drive, whereas health problems (e.g. stroke, heart conditions, chronic illness) and functional decline (e.g. mobility issues) emerged as much more significant impediments to intimacy. This finding is significant, but it is not unprecedented. Numerous studies have confirmed that health problems pose significant challenges to intimate and sexual expression. For example, Bach and colleagues (2013) found that cancer, major surgery, and other mental and physical conditions were deterrents to sexual activity. Similarly, Doll (2012) confirmed that sexual functioning can be impeded by many conditions, including stroke, diabetes, and heart disease. Notably, all three of these conditions were mentioned by participants in the present study.

There are three possible explanations for participants' emphasis on health conditions over natural changes as a leading barrier to sexual expression. As residents of a LTC facility, participants in this study may represent a relatively less physically-healthy sample compared to studies of older adults in general. It can be logically reasoned that many of the study participants experienced one or more health problems, given that they required LTC placement in the first place. Moreover, given that all participants in the

present study were capable of giving informed consent, it can be safely assumed that they required care due to physical health problems rather than cognitive functioning.

Alternatively, the increased emphasis on health could be attributed to the wording of interview questions. Although the topic of health came up organically in many interviews, the researcher also made a point of asking a probing question about health if it had not already been addressed. An equivalent, explicit probing question was not posed for other physiological changes, so these topics would only have been addressed if the participant brought them up independently in response to a more general question (e.g. To what extent does a person's age determine his/her ability to stay sexually active? How has the value you place on intimacy changed over time?). Finally, it may simply be the case that health conditions *are* more detrimental to individuals' experience of sexuality in later life than any normal age-related changes. This corresponds with one author's assertion that "normal age-related changes should not lead to a decline in sexual function" (Skultety, 2007, p. 33).

Study results demonstrate that declines in cognitive functioning can also impact intimacy. Findings show that dementia and other forms of cognitive impairment do not always present a barrier in a straightforward sense. Those with cognitive impairment may still desire and engage in sexual or intimate activity, but this may not be expressed in the same way or with the same partner as it was prior to the cognitive decline. This idea is supported in the literature, which indicates that different types of cognitive impairment will effect intimacy and sexuality in different ways, resulting in variance from one person to the next (Badeau, 1995). Importantly, although they were not excluded from the participation criteria, the present study did not interview any participants who required

third-party consent. Therefore, the study sample had relatively high cognitive functioning compared to the standard population in Nova Scotia LTC facilities (Canadian Institute for Health Information, 2011). In this case, participants' discussion of intimacy and sexuality was based on their perceptions or observations of other residents, rather than their own experiences with cognitive impairment and intimacy. While this information is useful as a starting point, future research should seek to actively recruit participants with cognitive impairment in order to capture these first-hand accounts and contribute to this existing gap in knowledge (Parker, 2006).

***Psychological barriers.*** Results show that it is not only residents' health and functioning, but also their psychological outlook that can present a barrier to intimate and sexual expression. Indeed, in a review of the literature, Garrett (2014) identified a series of psychological factors that influence older adults' experience of sexual intimacy, including the perceived importance of intimacy, attitudes toward sexuality, level of desire, and ageist stereotypes. In the context of the present study, discussion of psychological barriers revolved around individuals' beliefs and attitudes about sexual and intimate expression, and how these beliefs and attitudes originated. One participant emphasized the role of previous romantic involvement in determining an individual's current interest in a relationship. She argued that if a person had become accustomed to being in a relationship, s/he would be more likely to seek one out at this stage in the life course. The argument is supported by Doll (2012), who identified past sexual interest and behaviour as a determinant of sexual interest in the present. This finding is significant, as it provides further evidence for the fact that some barriers to intimacy may be highly individualized, and therefore should be considered in the context of an individual's life

history. This in turn strengthens the case for using a life review method in order to gain a better understanding of and appreciation for each participant's personal and relationship history.

However, it is also important to note that an individual's attitudes toward sexuality are not entirely premised on their individual or relationship experiences. Instead, results show that these attitudes are at least partially influenced by individuals' religious and personal upbringing. Doll (2012) referenced the Christian church as a source of repressive attitudes about sexuality. Similarly, Reingold and Burros (2004) cited religious or moral disapproval of sexual expression that occurred outside of marriage or reproduction as a source of negative attitudes toward sex in later life. This explanation was echoed almost word-for-word by one participant, and other participants' words demonstrated that they had internalized some of these beliefs. Therefore, while this is not a new finding, it lends further support to the notion that attitudes about sexuality in later-life are do not arise from nothing; instead, they are developed at various stages throughout the life course and shaped by different institutions and influences.

***Social barriers.*** As will be discussed in the following section, the LTC facility represents the broader social environment that contributes to residents' experience of intimacy and sexuality. However, social barriers also present themselves on a more micro level, in each individual's immediate social circle. In other words, these are the social factors that may vary from one participant to the next, in spite of their shared living environment. The two main individual-level social barriers that were discussed by participants were negative family influences and lack or loss of an intimate partner.

Although many participants identified their own family members as either impartial to or supportive of their intimate or sexual needs, participants also reported witnessing or being involved with non-supportive family influences. In these cases, family involvement presented a barrier to intimate needs or wants. The present study associated some family members' responses with fear and anger. Previous studies have confirmed that sexual and intimate expression can be a source of discomfort for family members, particularly if the resident has developed a new intimate relationship in the facility with an unfamiliar partner (Cornelison & Doll, 2012; Doll, 2012). However, family influence is not simply a matter of disapproving or concerned words. Results from this and previous studies have shown that when family members do not approve of a resident's intimate or sexual behaviour, they may play a more active role in consulting with facility staff in order to restrict these behaviours (Bentrott & Margrett, 2011). Such was the case for one participant, who described a situation when she instructed her father's caregivers not to allow his new partner to spend the night. Notably, this participant did not see a problem with her actions, even with the added perspective obtained from being a LTC resident herself.

These findings demonstrate that family involvement is complex, as family members often act out of concern or fear, with good intentions, or with the aim of protecting the resident. Although the attitudes and actions of family members are highly individualized and beyond the control of the facility, there is evidently a need for system-level policies and practices that value resident autonomy as much as they value resident safety and protection. Residents should be the authority on their intimate and sexual needs, with input or assistance from family members only when requested, or when

necessary. This view is supported by resident participants in the Bauer et al. (2013) study, who expressed that family members should only be involved in residents' intimate relationships in certain circumstances (e.g. if the resident's ability to consent is clearly compromised, or if the behaviour is harmful to the resident or others).

Another social barrier that prevented some participants from engaging in intimate relationships was an absence of available partners, whether due to death, divorce, or lack of compatible partners in their immediate social circle. This reality is well-supported in the literature (Gott & Hinchliff, 2003; Ginsberg et al., 2005; Parker, 2006). In fact, McCracken (1988) identified lack of partner as the leading cause of decreased sexual activity. Notably, there is an anticipated gendered difference in the experience of lack or loss of partner, given women's higher life expectancy (Doll, 2012; Urquijo & Milan, 2011). This gendered discrepancy was felt by some participants in the present study, who perceived the female population in the facility as much larger than the male population. Moreover, one participant shared her impression that many women were no longer interested in intimacy after their partner's death or divorce. These findings are significant for two reasons. First, they indicate that intimacy and sexuality are largely understood as partnered, heterosexual activities among older LTC residents. Second, they provide a nuanced understanding of a significant challenge faced by single adults who do wish to engage in partnered intimate activity in later-life.

**System-level barriers.** As has been shown by study findings and confirmed in existing literature, many barriers to intimacy and sexuality among older adults operate at the individual level. That is to say, these are individual challenges that participants may have faced regardless of where they lived. However, due to facility infrastructure, facility



culture, and aspects of facility care, study participants experienced additional barriers that were specific to the living environment.

***Facility infrastructure.*** Perhaps the most readily identifiable barrier to intimate expression in the LTC facility is the way the facility is built. Participants expressed discontent with the inability to lock doors, absence of a designated private space for intimate activities, and the lack of double beds in the facility. Other studies have corroborated these infrastructure-related barriers. For example, Ward and colleagues (2005) commented on the use of high-backed armchairs rather than sofas that would allow residents to sit side by side. Likewise, Bauer and colleagues (2013) discussed the difficulty of being intimate with a partner in a single bed, and stated that “an uncondusive environment” was a major theme articulated by study participants. Previous work has attributed this uncondusive design to the precedence of monitoring and care-related concerns (Doll, 2012). And while one participant acknowledged the potential danger associated with residents locking themselves in their room, this was not a common concern expressed by participants. This suggests a discrepancy between the priorities of those who designed the facility and those who inhabit it, and may warrant future study in order to determine what infrastructure would be best-suited to meet care- *and* intimacy-related needs. In light of this discrepancy, participants offered suggestions for small improvements that could be made within the facility (e.g. Do Not Disturb signs, optional use of a designated space for intimate activity). Although changes to facility design and infrastructure may be long-term projects, these suggestions are worth considering as short-term, relatively minimal effort accommodations in the interim.

***Facility culture.*** In addition to the readily observable structure of the LTC facility, participants also discussed various, less tangible aspects of the facility's culture as barriers to their intimate and sexual expression. The facility culture was generally perceived as unsupportive of intimacy and sexuality, although the source of this disapproval was sometimes difficult for residents to pinpoint. Participants described subtle, unwritten rules and lack of receptiveness to complaints as factors that gave them the impression that the facility did not wish to encourage residents' intimate expression. These findings represent a novel contribution to the knowledge base on intimacy and sexuality in LTC settings. Whereas many studies have detailed barriers that operate at a more overt, observable level, this finding implies that barriers are not always easy to see, but this does not mean that they are not perceived and felt by residents. This is important information, as it calls for closer attention to implicit messaging about intimacy and sexuality that may be present in facility policies and practices. Particular attention should be given, not only to how these policies and practices are delivered, but to how they are received.

Renewed or increased emphasis on person-centred care may offer a promising opportunity for culture change within the facility. Given its emphasis on "personhood," "maximizing choice and autonomy," and "creating a supportive physical and organizational environment," it makes sense that person-centred care has been heralded as "a key concept in the culture change movement" (Crandall et al., 2007, p. 48). As has been previously noted, person-centred care may have particular relevance for considerations of residents' intimacy and sexuality as it aims to consider the full range of needs across the life course (International College of Person-Centred Medicine, 2014).

The current facility of study should be recognized and praised for its existing commitment to person-centred care. However, previous research has shown that even well-intentioned facilities that commit to a person-centred approach are not always able to translate this philosophy to residents' experiences in practice (Donnelly & MacEntee, 2016). In other words, there is always room for improvement. Re-evaluating, strengthening, and extending the existing person-centred care approach to residents' intimate needs may be an important first step toward changing the existing culture in the facility from an ambiguously unsupportive culture to an openly supportive one.

***Facility care.*** Perhaps as an effect of the current culture in the facility, some study participants expressed discomfort with certain care practices, perceiving them to be sexualized or intimate in nature. It should be specified that this is not to say that care practices were intentionally sexualized by staff, but that *some* care practices (e.g. undressing, washing, etc.) were perceived by *some* participants as overly intimate or sexual to be completed by a relative stranger. For those who did conflate care and intimacy, these care practices were a source of discomfort and occasionally resulted in objection, confrontation, or other forms of resistance to care. In this way, the confusion about the relationship between care and intimacy presented a barrier to participants' healthy or familiar experience of sexuality.

Resistance-to-care behaviours in LTC facilities have been extensively examined in the literature, though typically in the context of residents with dementia and cognitive impairment (e.g. Konno, Sun Kang, & Makimoto, 2014). The latter study was a review of the literature, which used an existing definition of resisting care: "any patient behaviour which prevents or interferes with the nurse performing or assisting with activities of daily

living (ADLs) for the patient, including bathing, toileting and grooming” (Potts et al., 1996, p. 11, as cited in Konno et al., 2014, p. 2168). This definition is useful to contextualize the participant’s resistant behaviour within the broader literature. The reporting of these behaviours by one participant in the current study may also suggest that further research should be done on the possible causes of and appropriate interventions for resistant behaviour in individuals without dementia.

Given this gap, there are many possible explanations for the conflation of care and intimacy and the resulting resistance to care in the present study. First, it is possible that participants who expressed discomfort with care practices were also those who resisted the idea of requiring care at all. Research has demonstrated that being able to maintain self-care practices was an important part of residents’ sense of independence in assisted living facilities (Ball et al., 2004). Therefore, those residents struggling to maintain independence and experiencing difficulty transitioning to LTC might be more likely to object to care practices in general. Furthermore, in the context of sexuality, the fact that some participants could not clearly distinguish between care practices and intimate acts suggests that, whether consciously or not, they still perceive parts of their own body as sexualized. Importantly, this was not the case for all participants, as two participants expressed comfort with care practices, citing an awareness that it was part of caregivers’ job to undress and bathe them. Interestingly, this level of comfort was found among the two oldest participants in the study (age 90 and 98) whereas the discomfort was expressed by the two of the younger participants (age 64 and 67). Although correlations cannot be made from this study, future research could examine the possible relationship between age and acceptance of care practices.

In light of this barrier, it is important to consider how the facility and staff could help residents to distinguish between sexualized activity and non-sexualized care practices. This may be as simple as more open discussion and communication with residents before, during, and after care practices, or may require more intensive policy development and staff training to help address residents' concerns. Again, person-centred care may play a role here in helping the resident to become an active, autonomous part in his/her care (Crandall et al., 2007).

### **Facilitators to Intimacy & Sexuality**

As has been demonstrated, many of the barriers found in the present study have already been identified in previous research. However, this study provides a novel contribution in that it also uncovered a series of facilitators at the system- and individual-level. These are strengths that should be maintained in the present facility and fostered in others, as they were associated with positive experiences of intimacy and/or sexuality among residents.

**System-level facilitators.** The majority of literature on sexuality and intimacy in LTC settings focuses on the barriers that these facilities present to residents' desired expression, and what should be changed in the future to address these barriers. While it is important to identify these challenges and propose solutions, it is equally important to recognize existing supports to intimacy in the facility to ensure that these are not neglected or forgotten amidst future changes.

Specifically, participants identified four categories of system-level facilitators to their intimate or sexual needs. First, many participants expressed a general contentment with facility practices, indicating that opportunities for intimacy were available if desired,

that the LTC facility provided a unique setting for intimate story-sharing, and that positive interactions with individuals at the facility improved their intimate experience. Second, participants discussed the inherent value of sharing an environment with others, citing mealtimes, the bar, and recreation programs as highlights of this shared environment. Third, some participants discussed opportunities to foster new relationships—platonic and romantic—in the facility. And fourth, some participants expressed confidence that their sexual needs would be accommodated, if needed, although it was clear that details of accommodation policies and practices were not understood in the same way by all participants.

In spite of the well-established barriers to intimacy in LTC settings, it is significant that participants still identified positive facilitators to their intimate and sexual needs. It is important to pay attention to these strengths, and to build on them wherever possible. Previous research has called for a need to adopt a strengths-based approach in health promotion interventions targeting individuals (e.g. Hirst, Lane, & Stares, 2013; Lind & Smith, 2008). This approach is defined by the notion “that people and environments interact and change each other in the process. It is an alternative to the historical deficit approach found in the fields of mental health and social services where deficits, problem behaviors, and pathologies are the focus.” Focusing on strengths, rather than deficits, of individuals and communities has been identified as a promising approach for individual-level change.

Furthermore, there is some evidence to support the use of this approach at the system level to promote culture change within organizations. For example, Johnson and Leavitt (2001) have identified appreciative inquiry as an approach that organizations can

use to build on existing strengths and successes within an organization. Similarly, Slocombe (2003) identified the utility of strengths-based practice to mobilize and motivate positive culture change in long-term care settings. With this in mind, and in light of the existence of system-level facilitators, future research should examine the utility of a strengths-based approach or appreciative inquiry as a means of addressing intimacy and sexuality in LTC settings.

**Individual-level facilitators.** In spite of these strengths, study findings reveal an apparent need for individuals to respond to or contend with the various barriers that manifested at the system-level. These factors can be understood as individual-level facilitators to intimacy and sexuality, as they represent efforts taken by *some* participants to advocate for intimacy or adapt their intimate needs and activities within the LTC environment. These facilitators included self-advocacy, (e.g. actions taken by residents to secure their own privacy, addressing intimacy-related concerns with staff), as well as adaptive activities (e.g. maintaining social connections outside of the facility and organizing peer gatherings from within the facility).

It is significant that the majority of the data regarding individual-level facilitators came from two or three participants, and that many participants did not mention these types of self-advocacy and adaptation techniques at all. This absence in and of itself could be an indication that not everyone has the knowledge, ability, or access to these types of individual-level facilitators. Therefore, the ability to advocate and adapt is likely to vary from one person to the next. Indeed, previous research has explored the factors that make individual residents more or less adaptive to the LTC environment. For example, Chao and colleagues (2008) found that various factors impacted LTC residents'

psychosocial adaptation to the LTC setting, including personal characteristics such as level of education and voluntariness of admission to the facility, as well as perceived family support and personal life attitudes.

It is also possible that the ability to adapt to system-level barriers is related to an individual's resilience. The role of resilience in later life is receiving increasing attention in the literature. Resilience has been defined as "the ability to adapt positively to adversity" (Marquez et al., 2009, p. 13) and studies have confirmed a relationship between resilience and successful aging (Jeste et al., 2013). Based on this research, it may be inferred that more resilient LTC residents will be better equipped to adapt to their environment and facilitate intimate and sexual expression within that environment. Future research is needed in order to explore this possibility. Moreover, Jansenn, Van Regenmortel, and Abma (2011) explored sources of strength among older LTC residents that contributed to their resilience. They identified multiple influential factors, including:

...the positive beliefs older persons have about their competence, the efforts they make to exert control over their situation, their capacity to understand their situation, the positive and empowering social formal as well as informal interactions they have with others, the accessibility of health and social care service, the availability of material resources such as medical devices and the presence of an enabling context like a supportive social policy. (Jansenn et al., 2011, p. 153)

While many of these factors (e.g. availability of resources, accessibility of health and care services, policy) are likely to be experienced uniformly by many residents in the LTC facility, the more individual-level factors (e.g. beliefs, efforts, capacity to understand) are likely to result in significant variance in the levels of resilience among LTC residents.

Given the expected variance in individual capacity for adaptation and resilience, it may not be the best option to place the onus on the individual to advocate for themselves,



adapt to facility barriers, and create their own activities to facilitate intimate interaction. While results show that only select residents—those who took the time and initiative to organize peer group meetings—experience intimacy-related benefits from adaptive efforts, results also suggest that these types of activities could be incorporated into facility programming. Fittingly, previous researchers have provided a guideline for creating and facilitating current events groups in LTC settings, emphasizing the psychosocial and health-related benefits of such groups (Vacha-Haas, Archibald, Brescian, Martin, & Fitzpatrick, 2009). This type of programming may provide a useful starting point for reducing the dependence on individual-level facilitators in the LTC setting. In other words, striving to decrease the need for self-advocacy and adaptation would create a more equitable environment in which all participants would have equal access to facilitators of intimacy and sexuality.

### **Barrier-Facilitators to Intimacy & Sexuality**

Arguably one of the most significant findings of the present study is the existence of system-level factors that cannot be labelled solely as barriers or as facilitators to intimacy. Results show that many factors fall into both categories, including: staff attitudes and actions, facility rules and regulations, level of privacy, the facility's neutral stance, and residents' sense of the facility as home. Participants either had conflicting perspectives about whether these factors were experienced as barriers or as facilitators, or they identified both positive and negative aspects of each factor. As such, these factors deserve particular attention. The fact that all factors do not present strictly as barriers (as much of the current literature seems to suggest) may indicate that each of these factors fall along their own barrier-facilitator continuum. In other words, it suggests that they are

modifiable, with the potential to facilitate intimacy if conditions are supportive. The current section will discuss each of these factors, and the possibilities they present for creating a more supportive environment for intimacy and sexual expression in LTC.

**Staff attitudes and actions.** One of the major findings that emerged from the data on staff attitudes and actions is that not all staff are the same, and not all residents reported consistent experiences with staff members. In this way, staff were represented as both negative and positive influences on resident intimacy and sexuality.

The lack of uniformity among staff is well-represented and explained in the literature. Previous research has shown that staff attitudes and actions are often variable because of individual beliefs about sexuality and aging. For example, Bouman and colleagues (2007) found that staff who were younger or less experienced at the facility tended to harbour more negative attitudes about older adult sexuality. Similarly, Doll (2012) explained that staff attitudes may be informed by a desire to maintain that sexuality is a youthful phenomenon that does not occur among residents, or among their similarly-aged family members. Similar differences in staff attitudes were reported by participants in the current study, who suggested that staff attitudes were informed by personal or religious beliefs. Importantly, these attitudes do not simply influence staff members' personal thoughts, but they usually manifest in the way staff respond to expressions of resident intimacy (Roach, 2004). This may have been the case in the present study, as participants identified real and hypothetical instances where staff exhibited unsupportive actions toward sexual expression.

Above all, previous research has emphasized the need for effective facility policy to ensure that staff actions are not governed by their own values or prejudices (Elias &

Ryan, 2011). Therefore, the lack of uniformity represented in study findings could signal upon an absence of effective policy that clearly outlines the facility's support of resident intimacy and sexuality, or a lack of implementation of such policy by staff members.

This implementation point signals upon another staff-related barrier identified by some study participants, which is a perceived need for more staff training on supportive responses to intimate and sexual needs. Again, this finding is not surprising, as it has been corroborated by many studies (e.g. Cornelison & Doll, 2012; Roach, 2004).

Importantly, Roach (2004) suggests that "training should incorporate staff examination of personal values and beliefs related to sexuality" (p. 378). Indeed, studies have proven that educational interventions can be effective in improving staff knowledge, attitudes, and beliefs about resident sexuality (Bauer, 1999b; Bauer, McAuliffe et al., 2013). For instance, the latter study demonstrated the effectiveness of a three-hour workshop on fostering more permissive attitudes among staff participants of the workshop (Bauer, McAuliffe et al., 2013). This is an encouraging finding, although it remains to be seen whether these changed attitudes persist in the long term, and whether they result in improved care practices. Nevertheless, this and similar education interventions represent a promising starting point to ensuring that staff are trained to respond to resident intimacy in consistent and supportive ways.

It is also important to emphasize that some participants reported positive staff influences. They spoke of supportive attitudes and actions, and revealed expectations that staff would be polite and courteous upon encountering intimate expression. This is significant, as it provides evidence for the fact that staff have the potential to be facilitators of intimacy among residents. Moreover, it outlines existing staff qualities that

should be built into training as exemplary behaviour for other staff members. This is not to say that individual differences among staff should be banished altogether, as findings also show that many residents valued the unique relationship and rapport-building that occurred with certain staff members. In fact, results show that these relationships with staff may even be perceived as a valuable source of intimacy for some residents.

However, facilities should outline and implement explicit standards regarding staff's approach to intimacy and sexuality, and these guidelines should be carried out uniformly by *all* staff members.

**Facility rules and regulations.** Findings also showed divided opinion regarding the role of facility rules and regulations. Whereas some participants viewed these rules as restrictive barriers to intimacy, others perceived them as reasonable and accommodating, or necessary in order to manage intimacy in a communal living environment. It is unclear whether these rules were communicated to residents purposefully, or whether they remain unspoken and are simply gleaned from residents' previous experiences with the facility. In either case, the need to obtain permission to engage in intimate acts may be regarded as inherently problematic, as it connotes a level of authority held by the facility and experienced by residents.

Everett (2007) argues that there are very limited circumstances when a facility should intervene in residents' intimate and sexual behaviours. These circumstances should only be determined "based on an ethical analysis of harm to self (and participating others), harm to others and offense to others" (p. 26). For instance, a case where a staff member or fellow resident is offended by a public display of affection will likely not be sufficient to require intervention, whereas a case where a resident does not consent to

sexual advances by another resident will require intervention (Everett, 2007). Putting this philosophy into practice will be challenging. However, this argument is still important, as it demonstrates that imposing unnecessary rules and regulations to intimacy in LTC is unethical.

This suggests a need to evaluate rules to ensure they are supportive of intimacy whenever possible. It is apparent that such supportive guidelines already exist in the facility, and that they have been perceived by or communicated to residents. For example, participants cited the allowance of hand holding in public and the ability to leave the facility at any time as positive facilitators to their experience of intimacy. Furthermore, if rules pertaining to intimacy and sexuality are necessary—such as in the case presented by Everett (2007)—it is important that the facility is transparent about the rationale for such rules and regulations. In other words, ‘restrictive rules’ should not be the norm, and ‘reasonable rules’ should be clearly communicated so as not to lead to the perception that the facility largely condones intimate acts.

**Privacy.** In the results and the literature alike, privacy (and lack thereof) is a major influence on residents’ experience of intimacy and sexuality. In fact, participants in the present study identified privacy as the primary concern for facilitating intimacy. Unfortunately, most participants discussed privacy with a focus on its absence, referencing both a lack of physical privacy and a lack of privacy of information. Importantly, Bauer (1999a) identified the same dual threat to privacy in LTC settings. Participants identified roommates, lack of shared rooms for couples, and unnecessary or unwanted interruptions as barriers to their physical privacy. Moreover, participants expressed concerns about monitoring and gossip between staff and residents, and

perceived judgment or disapproval as threats to their privacy of information, indicating that an uncaring attitude was required in order to maintain intimate relationships in the face of these threats. Many of these findings are supported by the literature. For example, authors have confirmed the difficulty couples face obtaining a shared room in the facility, particularly if they are unmarried or require different levels of care (Doll, 2012; Henry & McNab, 2003; Mroczek et al., 2013; Skultety, 2007). Furthermore, research has shown that facility staff may unnecessarily share information with one another, and that residents' awareness of staff gossip will decrease their likelihood of engaging in intimate acts (Bauer, 1999a; Parker, 2006).

Bauer (1999a) attributed this lack of privacy to the emphasis placed on safety and care concerns in LTC facilities: "because they are geared toward the demands of basic body care, nursing homes are not inclined to create an environment conducive to the fulfillment of sexual needs" (p. 37). This view was supported by Litz and Arnold (1995) who found that staff prioritized residents' physical care needs over residents' privacy (as cited in Hajjar & Kamel, 2003). This may offer explanation for the reporting of unnecessary or unwanted interruptions by staff in the present study. In light of this reality, Kane (2001) discusses the importance of considering the equal importance of many determinants of quality of life—including privacy—rather than considering safety "the be-all and end-all of LTC" (p. 296). The author posits that "embedded in most of our rules and regulations is the idea that LTC should aspire to the best possible quality of life *as is consistent with health and safety*. But ordinary people may prefer the best health and safety outcomes possible *that are consistent with a meaningful quality of life*" (Kane, 2001, p. 296). In other words, residents' safety should not be maintained at the expense

of privacy and other important contributors to residents' quality of life (in this case the quality of their intimate life). Instead, the facility should aim to strike a balance between the two. Study findings suggest that the facility may be moving toward this balance. Privacy and safety may not be entirely at odds with one another, as some participants understood them as interconnected. This finding is significant, as it suggests that space can be made for residents' privacy and autonomy, without compromising basic care and safety concerns.

Finally, as with the other system-level factors, privacy was not understood wholly as a barrier to intimacy and sexuality. Some participants indicated that privacy was available in the facility upon request. They expressed contentment with the level of privacy available in the facility, especially when they specifically requested this privacy. Although the responsibility should not be placed solely on the individual to make this request, it is worth noting that this type of individual initiative and open communication was effective for achieving the desired level of privacy among select participants. Above all, attention should be given to the perspectives of those who indicated contentment with their experience of privacy as a model for improving privacy in the facility at large. Strategies should be developed in order to ensure that respect for privacy is the default for all residents, whether or not they request it.

**Facility neutrality.** The facility's neutral stance on intimacy and sexuality emerged as a significant theme in the data. It became apparent that residents did not perceive the facility as openly supportive of intimacy, but many also expressed that the facility did not actively discourage intimacy either. Many participants perceived this neutrality as inherently negative, as it suggested that intimacy was not considered a

priority, manifested as a lack of openness and transparency about intimacy in facility policies and practices, and that this lack of transparency placed a disproportionate amount of responsibility on the individual to advocate for their intimate needs. Previous studies have confirmed a lack of facility transparency, particularly as it relates to the provision of resources such as condoms, sex-enhancing drugs, lubricants, and pornography (Doll, 2012; Scherrer, 2009). Notably, participants in the present study mentioned an absence or lack of awareness of resources or information generally, but did not go into the specifics of these resources. In any case, information and/or resources were provided on a needs-basis, rather than being made available to everyone from the outset. It is also important to note that some participants perceived facility neutrality as positive or understandable. These participants considered intimacy to be a private activity that fell outside of the facility's jurisdiction, and used language that removed the blame from the facility.

These conflicting views point to important considerations for developing, presenting, and implementing facility policy on intimacy. Above all, this policy should be openly supportive, and should be detailed in introductory materials and orientation programs. This would ensure that those who are interested in continued sexual or intimate expression will be made aware that the option is available to them, rather than wondering how to seek it out. These materials should be distributed without alienating or causing embarrassment for those who feel that intimacy is a personal matter or who are not interested in engaging in intimate acts. Finding this balance should not be difficult, as individuals could simply be informed that these options are available, but that they need not take advantage of them or seek out more information unless they desired to do so. By adopting a more open, transparent, and supportive stance, the facility would simply be



making interested residents aware of their options, so as not to alienate those who may still be interested in pursuing their sexual and intimate needs.

**(Nursing) home?** An unexpected but interesting finding is the way that the notion of home featured in participants' discussion of intimacy and sexuality. Indeed, the idea of home, and the facility's place in that idea, came up in four interviews in spite of the fact that it was not addressed explicitly in interview questions. Although unexpected, this finding makes sense, given the importance of feeling at home in order to be comfortable enough to engage in intimate or sexual activity. As Everett (2008) argued: "it is discriminatory not to allow long-term care residents to use the private areas of their homes, like the rest of us can, as appropriate places to engage in sexual activity." Indeed, the relationship between home and sexuality may not be unique to residents of LTC, but may also resonate with adults who live in their own homes. However, the emphasis on feeling at home may be of particular importance to residents of LTC, as the transition to LTC may prompt a reconceptualization of their understanding of home.

Cooney (2011) developed a theory to understand factors that help older adults "find home" in LTC settings. This theory emphasizes the importance of "continuity, preserving personal identity, belonging, and being active and working" as factors that contribute to residents' sense of home in the facility, with the potential to improve overall quality of life (p. 191). The researcher also offered strategies to apply this theory in the LTC environment. These include a focus on getting to know each person's "life story" to promote continuity, encouraging "small group activities" to promote belonging, making use of "reminiscence" and "biographical interviewing to promote understanding of the person and his/her life" and integrating residents into the process of "selecting, planning,

and running activities” to encourage resident activity in the facility (p. 196). Interestingly, many of these strategies coincide with recommendations for facilitating intimacy in the present study. This suggests that encouraging a sense of home goes hand in hand with encouraging intimacy in the facility.

In the case of the present study, two participants reported feeling at home in the facility, whereas two adamantly opposed the idea of the facility as home. Furthermore, those who did identify the facility as home generally reported more positive experiences of intimacy and sexuality in the facility, whereas those who objected to the facility as home reported largely negative intimate experiences. While the association between feeling at home and facilitating intimacy cannot be generalized, it provides an interesting possibility for future research. Furthermore, the finding suggests that some residents are more readily able to adapt to the idea of the facility as home on their own, whereas others may require more concerted efforts from the facility. The strategies outlined by Cooney (2011) may present a promising starting point for these efforts.

### **Possible Reality**

The above sections have provided a thorough discussion of the present reality of intimacy and sexuality in LTC. As evidenced by study findings, supported in the literature, and depicted in the previous diagram (Figure 2), the present reality consists of a series of barriers to sexuality, facilitators to intimacy, and five factors that manifest as both barriers and facilitators. It has also been demonstrated that given their unique, overlapping positions, these system-level factors merit particular attention as potentially modifiable. In other words, the current approach to intimacy and sexuality in LTC offers opportunity for change that can be cultivated at the system-level. This change presents

the possibility of a future system that is more supportive of intimacy and sexuality, in which the facilitators overshadow the barriers (see Figure 3).

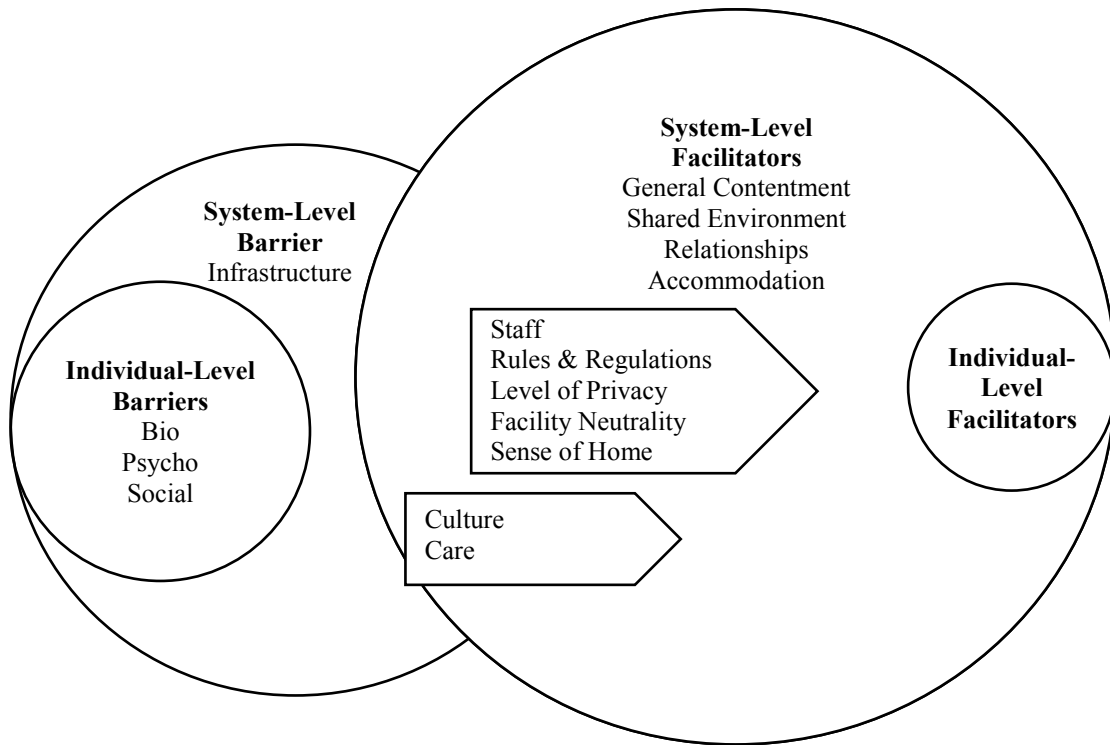


Figure 3. Possible reality of barriers and facilitators in the LTC facility of study.

As represented in this diagram (Figure 3) and in study findings, some factors (e.g. individual-level barriers and facility infrastructure) are more difficult to change. These factors have remained in the same position, with the individual-level barrier circle remaining the same size. Although adaptations can be made to account for these factors, and long-term change is possible, these factors may not be the best places to start. For example, making major changes to the design of the current building may not be a practical solution in the short term. Likewise, individual-barriers are just that—individual—and are likely to vary from one person to the next. Furthermore, many of

these barriers, such as individual health and functioning, are much more difficult to change significantly in the short term.

With this in mind, attention should be focused on the five system-level factors—staff, facility rules and regulations, level of privacy, facility neutrality, and residents’ sense of home—as promising starting points to initiate change. These are the factors that have already been partially identified as facilitators by some participants, therefore it logically follows that their strengths could be built upon, moving them from barrier-facilitators to exclusively facilitators (see Figure 3). It should also be noted that facility culture and facility care have been positioned in a smaller arrow (see Figure 3). This is to signify that, with positive changes to the five system-level factors, there will likely be improvements to the overall culture and care practices, prompting forward momentum in these factors as well. For example, if the facility moves beyond its neutral stance and exhibits openly supportive policy on intimacy, it is likely that residents will experience the effects of this culture change. Or if staff are trained to respect the intimate needs of residents, there may be less conflation of intimacy and care practices. The movement of these factors from system-level barriers to system-level facilitators would effectively decrease the space inhabited by barriers in the possible system compared to the present system (see Figures 2 and 3).

Furthermore, study findings have identified and commended certain factors of the present reality as positive facilitators of intimacy and sexuality. These include general contentment with facility practices related to intimacy, benefits from inhabiting a shared living environment, fostering relationships among residents, and accommodating policies and practices, which are all represented in the larger circle (see Figure 3). The increased

size of this circle represents the need for continued emphasis on and attention to existing strengths, as well as the addition of new facilitators.

Finally, in light of the increase in system-level facilitators, it can be expected that the need for individual-level advocacy and adaptation would diminish. This is demonstrated by the decreased size of the individual-facilitator circle (see Figure 3). This is not to say that the individual does not still have a role to play in achieving their desired intimate and sexual expression. Instead, it is meant to suggest that positive changes at the system level would result in a more equitable system that would not necessitate individual action in order to make intimacy possible. Instead, opportunities for intimacy would be more readily available to all, not just those who were able to vocalize their concerns and actively create those opportunities. In the possible reality, individual-level facilitators would not be *necessary* to fulfilling basic intimate needs, but they would foster *additional* opportunities that may vary from one individual to the next. In light of the differences between the two diagrams (Figure 2 and Figure 3), the following section will summarize concrete recommendations for how to transition from the present to the possible system.

### **Summary of Recommendations**

The findings of the present study point to a need for a series of recommendations to minimize barriers and maximize facilitators to intimacy and sexuality in the LTC setting. These are the recommendations that should be considered by LTC providers in order to build on existing strengths and for the development and delivery of future policy, programming, and practice in the facility. These recommendations have been integrated

at various points throughout discussion of study findings, but will be rearticulated and summarized in the present section.

### **Recognizing Diversity & Change: “It Changed but We Work It Out”**

Results of the research demonstrate that the resident population is made up of individuals who have diverse and changing perspectives of sexuality and intimacy. This suggests a need for the facility to recognize the diversity between individuals and the change within individuals over time. As has been demonstrated, person-centred care may represent a promising strategy to acknowledge individual diversity and changes to intimacy-related care needs over time. It is encouraging that the facility of study has already adopted the person-centred care philosophy. Further attention should be given to this philosophy to ensure that it extends to residents’ experiences of intimacy and sexuality as part of their personhood, and that the philosophy translates well to resident experiences in practice.

Furthermore, life review or similar biographical methods may offer a promising approach to adopt in care practices. While the present study employed the life review approach as a research method, it can and has been used with equal or greater effectiveness in care settings. Making space for staff and/or administrators to engage in life review with residents may help them to deconstruct and reconstruct assumptions related to sex and aging. Further, this would allow staff an even greater understanding of residents as complex, unique individuals with rich life histories.

### **Moving Beyond Neutrality: “It Should Be Allowed & It Should Be Facilitated”**

Study findings also demonstrated a need for the facility to move beyond its perceived neutral stance toward intimacy and sexuality, and to adopt an openly supportive position. Importantly, it is possible that this neutrality is not known or intended by the facility, in which case they may wish to evaluate implicit messaging in their policy or practices that may be interpreted by residents as discouraging intimacy. The facility may also wish to consider building upon their existing recreation programming and further integrating intimate peer group activities (e.g. book clubs, current event groups, happy hour groups) into their programming to facilitate intimate interaction between residents. Furthermore, the facility should be upfront about their supportive stance. This may mean being transparent about available opportunities for intimate interaction or sexual resources from the outset—in resident orientation materials or programming. It may also consist of instructing staff on how to engage in open, honest, and respectful conversation about intimacy with residents so that the onus is not placed on the resident to seek out such support.

### **Clarifying Rules & Regulations: “People Should Know Where They Stand”**

Although a review of existing facility policy on intimacy and sexuality was beyond the scope of this study, it was inferred from the perceived lack of uniformity among staff that there may not be a set of clear guidelines on the issue for staff to follow. Therefore, results point to the need to strengthen existing policy or develop new policy rooted in residents’ perspectives and best-practice research. Moreover, in keeping with the last point, the facility should ensure that residents are made aware of this policy. As has been noted, the Hebrew Home at Riverdale has been identified as a leader in the field

of policy development on intimate and sexual expression in LTC, therefore their policy may provide a useful tool for policy development (Dessel & Ramirez, 2013; Hebrew Home & Weinberg Center, 2011). Particular attention should be given to developing practical, ethical guidelines pertaining to consent for residents with dementia and other forms of cognitive impairment.

### **Changing Staff Attitudes & Actions: “Some... Are Okay with It, Some Aren’t”**

Findings also illustrate the need for ongoing staff education that is meaningful and effective in order to ensure that supportive facility policy is carried out uniformly by all staff. Importantly, staff training programs should focus on changing attitudes, not just levels of knowledge. Training should prompt staff members to reflect critically upon their own attitudes about aging and sexuality, and how these align with the broader facility policy. It is important to note that this may be easier to achieve in theory than in reality, as attitude change is a difficult and ongoing process. Incorporating resident perspectives and interaction with residents into this training may provide a useful starting point for these attitude shifts. Furthermore, the life review approach may have utility here as well for encouraging staff to conceptualize residents as people with diverse needs.

### **Prioritizing Privacy: “To Have Intimacy, Number One Is Privacy”**

Findings represented privacy as one of the most—if not *the* most—important factor influencing resident intimate and sexual behaviour. Given that many perceived privacy as the leading barrier to intimacy and sexuality, there is a clear need to strengthen policies and practices surrounding privacy. The facility should be encouraged to conceptualize privacy and safety/care needs as equally important and mutually beneficial. This reprioritization of privacy should be communicated to staff in order to prevent



unnecessary or unannounced interruptions to intimacy and encourage door-knocking policies. Furthermore, while many facilitators of privacy may necessitate longer-term changes (e.g. redesigning facilities with more private space, locks on doors, provision of double beds), findings also indicate shorter-term improvements to privacy, as recommended by participants. These include the distribution of Do Not Disturb signs for residents' usage, as well as the availability of a designated private space for intimate or sexual activities.

### **Making the Facility a Home: “That’s Why I Call This My Second Home”**

The final recommendation is less directly related to intimacy and sexuality, but is still worth noting as a means of encouraging residents' level of comfort being intimate in the facility. Namely, administrators and staff may wish to consider ways to make residents feel more at home within the facility. Although this is a large task, Cooney (2011) has identified a series of strategies that may promote residents' sense of “continuity, preserving personal identity, belonging, being active/working” in the facility (p. 191). Importantly, many of these strategies align with the above recommendations (e.g. biographical interviewing, encouraging group activities) therefore addressing intimacy and sexuality may provide an important first step toward strengthening residents' sense of home more broadly.

### **Study Limitations**

As with any research project, the present study was confined by a set of limitations. First, although the inclusion criteria were broadly defined to allow for the participation of residents with varying levels of cognitive functioning, the internal recruitment process resulted in the selection of residents who were all able to give

informed consent without a third-party delegate. Therefore, the study population consisted of ten, non-cognitively impaired participants. This indicates that these residents had relatively high cognitive functioning compared to the majority of LTC residents in Nova Scotia (Canadian Institute for Health Information, 2011). In this way, the study population may present a limitation to the trustworthiness—more specifically, the transferability—of findings. In other words, study findings do not represent the views of LTC residents with cognitive impairment, therefore these findings are not transferable to the overall LTC population. Nevertheless, the findings *are* readily transferable to similar populations in LTC and to other health care settings, including assisted living and residential care facilities. These findings can be used to inform policy and practice for individuals living in these facilities who are not cognitively impaired.

It should also be noted that although transferability is somewhat limited by a circumscribed study sample of the overall LTC population, strategies were consciously employed to strengthen other indicators of data trustworthiness—including dependability, credibility, and confirmability (Lincoln & Guba, 1985, as cited in Krefting, 1991). For example, study methods were reviewed and revised based on expert advice from the researcher's thesis committee, as well as the LTC manager. Also, the life review sessions allowed the researcher to build rapport and encouraged participants to feel more comfortable speaking truthfully. These sessions are an excellent example of “prolonged engagement,” a strategy recommended by Lincoln & Guba (1985) to enhance credibility (as cited in Krefting, 1991, p. 217). Finally, peer examination was conducted through regular meetings with the supervisor throughout the data analysis process. This provided

a second opinion to ensure that the codes and themes were representative of participants' experiences.

Second, given the self-reported nature of these data, self-report bias presented another possible limitation. This is noted as a common limitation within sexuality research (Lindau et al., 2007) as individuals' responses may be influenced by deeply ingrained social norms and expectations. In turn, participants may strive to present themselves favourably to the researcher, rather than report honestly on their experiences. With this possibility in mind, elements of the current study were designed to minimize self-report bias. Specifically, efforts were made to establish a trusting relationship with participants in the first phase of data collection so that they felt more comfortable speaking candidly on the subject. The interviews were conducted face-to-face, which allowed for more open discussion rather than less personal, close-ended surveys. Finally, participants were assured that their identity would remain confidential in the reporting of results.

Third, the recruitment process may have presented a limitation to study findings in that recruitment was conducted by staff in the facility, introducing the possibility for selection bias. In other words, given that study participants were not determined randomly, but instead were selected deliberately by staff who knew them, it is possible that this selection may have influenced the results in some way. For example, staff may have—knowingly or unknowingly—selected participants who would provide data that would reflect more favourably on the facility. However, given the wealth of findings related to barriers and negative system-level factors, this did not appear to be the case. As Tarzia and colleagues (2013) noted, this limitation may have been unavoidable, as

seeking help from staff to recruit LTC residents for this type of study was identified as “the only effective recruitment strategy” (p. 4). Furthermore, the researcher strived to mitigate the effects of this possible limitation by meeting with staff prior to recruitment, encouraging the selection of residents who would report diverse views on and experiences of intimacy and sexuality, and communicating with staff recruiters regularly via email. Notwithstanding these limitations, the study represents an important contribution to the growing body of literature on intimacy and sexuality in LTC settings.

### **Chapter 5 Summary**

Chapter 5 has provided a nuanced discussion of study findings relative to the existing body of literature. Results demonstrated that participants define, perceive, and experience intimacy/sexuality in diverse and changing ways. This diversity is significant, as it highlights the need to recognize and value individual perspectives when developing policy and practices to address intimacy in the LTC setting. Moreover, the emphasis on change is important, as it points to a need for new and different research methods (e.g. life review, longitudinal studies) to capture individual variance over time. This also confirms the need for flexible, adaptable policies and practices that make space for changing intimate/sexual needs among LTC residents. Furthermore, this chapter has provided a useful conceptual model for moving from the present reality of intimacy and sexuality in LTC, to a possible reality in the future. This possible reality is premised on the need to build on current strengths and target system-level factors that may be modifiable. In this way, the overlapping barrier-and-facilitator-model could be replaced by a system where barriers are overshadowed and negated by facilitators. Practical

recommendations for making this system a reality have been presented, and study limitations have been discussed.

## **CHAPTER 6: CONCLUSION**

Although it has been well-established that continued sexual and intimate expression can contribute to overall health and well-being, it has also been demonstrated that older adults often face particular challenges to the fulfillment of their intimate and sexual needs. Previous research has demonstrated that older LTC residents may experience additional, system-level barriers to intimacy/sexuality as a result of their living environment. The present study was designed to gain a nuanced understanding of this issue from the perspectives of older LTC residents. Guided by a qualitative descriptive methodology and using life review and one-on-one interview methods, the study sought to address three primary research questions:

1. How do older LTC residents define, perceive, and experience intimacy and sexuality?
2. What are the present barriers (if any) to intimate/sexual expression in a LTC facility in Halifax, Nova Scotia?
3. What factors (if any) do residents of this facility experience as facilitators to their intimate/sexual needs?

### **Summary of Main Findings**

These research questions elicited a series of study findings, which can be summarized as follows. With regard to research question one, study findings confirmed that a) recognizing diverse perspectives on intimacy and sexuality is important in order to create inclusive, supportive environments, and b) when it comes to later-life intimacy and sexuality, change is inevitable, but it is not necessarily bad. In response to research question two, findings demonstrated that barriers to intimacy and sexuality are

experienced at the individual level (in the form of biopsychosocial factors) as well as the system level (facility infrastructure, culture, and aspects of care practices). Findings pertaining to research question three confirmed that facilitators to intimacy and sexuality are also experienced at the individual level (self-advocacy, adaptation and activities) and the system level (contentment with facility practices, shared environment, fostering relationships, and accommodating policies and practices). Furthermore, it is important to note that some findings addressed both research questions two and three. These system-level factors (staff attitudes and actions, rules and regulations, level of privacy, facility neutrality, sense of the facility as home) cannot be considered wholly barriers or facilitators, which positions them as important starting points for mobilizing change in the facility.

### **Significance & Implications**

The present study represents a significant contribution to the current knowledge base on later-life sexuality, and has implications for future research and practice within the facility of study. By conducting this research in a LTC facility in Halifax, Nova Scotia, the study provides a unique, local perspective that is particularly relevant giving the aging population in Nova Scotia and Atlantic Canada at large. Furthermore, the novel use of the life review method in this study represents an innovative methodological contribution that warrants future investigation. This approach appears to shed light on the utility of this method for future research with older adult participants to strengthen rapport between the researcher and participants, and put participants at greater ease when disclosing sensitive information. Notably, much of the existing research on this topic has been quantitative and survey-based (e.g., Aizenberg et al., 2002; Bullard-Poe et al., 1994;

Mroczek et al., 2013), or has not focused on direct consultation with older adults (Elias & Ryan, 2011). Therefore, the present study is significant in that it values the voice of LTC residents and captures nuanced, first-person perspectives to counter myths and stereotypes regarding sex and aging. For example, study findings lend support to the idea that age alone is not as consequential as other factors in individuals' experience of intimacy and sexuality, and that change is not always synonymous with decline in older age.

Not only is the study significant in terms of its design, but also in terms of its findings. Results demonstrate the importance of moving beyond standardized definitions of sexuality and intimacy, instead emphasizing the importance of understanding and conceptualizing these terms from the perspectives of residents. Furthermore, while much of the existing literature focuses exclusively on the barriers that LTC facilities present to residents' experiences of intimacy, the present study identifies both barriers and facilitators. This presents an opportunity to build upon existing strengths, rather than solely presenting criticisms of the current system. This dual focus represents a key starting point for creating culture change within the facility. Finally, study findings highlight the interplay between individual- and system-level factors. Examining and deconstructing this relationship is of great importance and relevance for the field of health promotion, providing support for the notion that health promotion is about more than fostering individual-level change.



## **Recommendations for Future Research**

Future research on the topic of intimacy and sexuality in LTC should build upon the strengths identified above. Namely, researchers should strive for continued emphasis on qualitative studies that seek to recognize the variability and fluidity in older LTC residents' perspectives on intimacy/sexuality. Capturing these first-person perspectives in different settings will allow for an even more nuanced understanding of sexuality and intimacy in LTC. Moreover, these studies could establish features that are unique to each facility, as well as useful points of comparison between different facilities and study participants. Additionally, future studies should build upon the life review approach as a precursor to interviews on sensitive topics with older LTC residents. The methodological knowledge base would also benefit from more research exploring the utility of a life review approach for research in LTC settings and with older adults more generally. This research could seek to establish the merits and drawbacks of employing life review as a research methodology, rather than its usual application as part of care practices.

The present study has also pinpointed two gaps in knowledge that remain unaddressed by study findings. First, there is a need for more research that focuses on intentional recruitment of residents with dementia and other forms of cognitive impairment. The absence of research on the sexual and intimate needs of residents with dementia was previously identified by Parker (2006), who indicated that these residents were commonly excluded from studies. The present study made a concerted effort to address this gap by defining participation criteria more broadly and developing a procedure for a third-party delegate to be involved in informed consent. However, given that no participants recruited for the study required the use of this procedure, it can be

assumed that the participants in the present sample had relatively high cognitive functioning. With this in mind, future researchers may wish to design studies that focus exclusively on sexuality and intimacy among those with dementia, or to actively recruit participants with varying levels of cognitive functioning in order to represent these important perspectives.

Second, given the findings regarding the significance of change in residents' experiences of intimacy and sexuality, there is an apparent need for research methodologies that capture this change more effectively. While the life review approach represents a step in the right direction—as it allows residents to contextualize their current experiences within their past—future research may benefit from more longitudinal studies to capture change at various points throughout the life course.

Finally, discussion of present study findings has uncovered a series of interesting directions and questions for future research. For instance, future research may seek to disentangle the effects of age stereotypes within older adults' experiences of sexuality and aging. It would be interesting to examine to what extent declines in sexual desire and expression are determined by physiological change, and to what extent they occur as a result of negative expectations and internalized stereotypes about sex and aging. Future studies may also focus on facility infrastructure from the perspective of both residents and care providers. These studies could seek to establish the types of infrastructure that would be best-suited to maintaining an effective balance between resident safety/care, and resident privacy/intimacy. Future researchers should also explore the utility of a strengths-based approach such as appreciative inquiry for promoting organizational culture change. While the present study incorporated pieces of this approach by inquiring

about facilitators as well as barriers, an exclusive focus on facility strengths rather than deficits may provide useful insight on how to promote effective change within the facility. Finally, future researchers may be interested in exploring residents' concepts of home as they relate to intimacy and sexuality. Although residents' sense of home in LTC facilities is a complex topic in and of itself, study findings show that it may also have particular relevance to residents' experiences of intimacy and sexuality. Results from these studies could have important implications for research and practice on intimacy and sexuality in LTC settings.

Ultimately, the current study findings suggest that: a) recognizing and supporting diversity and positive change between and within individuals, while b) minimizing barriers and maximizing facilitators, can promote system-level change in LTC facilities that would have individual-level, health-promoting impacts. Findings emphasize that if older LTC residents wish to engage in continued intimate and sexual expression, that opportunities should be available to them—in the words of study participants, “all the power to them.” Upon further reflection on the study's methods, it also becomes apparent that this phrase has another meaning. Namely, to fully understand and advocate for the sexual and intimate needs of LTC residents, there is a need to position residents' voices at the centre of the discussion; thereby, giving “all the power to them.”

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**APPENDIX A**  
**Recruitment Material**



**[Facility Name] Residents:**  
*let's talk about intimacy*



Are you a [facility name] resident age 50 or older? Would you like to share some of your life stories and talk about intimacy and sexuality?

If so, you might be interested in participating in a research project with Mariah Malone, a Master's student from Dalhousie University.

For more information, talk to [liaison name and job title at facility], or contact Mariah Malone at (506) 869-0923.



# [Facility Name] Residents: *let's talk about intimacy*

## *What is the project all about?*

We are interested in exploring older residents' thoughts about and experiences with intimacy and sexuality, especially in the long-term care setting. We are curious about how residents describe their intimate needs, how they are/are not being met, and how their current experience is shaped by their personal histories.

## *Who can take part?*

We are looking to talk to a total of 6-10 [facility name] residents who are: a) 50 years or older, b) able to provide consent/assent to participating in the study, and c) able and willing to participate in 3-4 interview sessions with the researcher.

## *What does your participation involve?*

Residents who agree to participate will meet with the researcher 3-4 times. Each of these sessions can be expected to take 45 minutes to 1 hour. The first 2 or 3 meetings will be life review sessions where you and the researcher will get to know one another and you will have the opportunity to share life stories and photos. After these sessions, we will meet again for an interview on the topic of intimacy and sexuality.

## *What's in it for you?*

By participating in this study, you may receive a sense of satisfaction for contributing to knowledge about this important topic. You will also receive a life story album made up of some of the stories and photos you shared during the life review sessions. Finally, you will be offered an honorarium of \$15 per session as a thank you for your time and insight.



APPENDIX B  
Guiding Questions for Life Review Sessions

# Interview Guide:

## *life review session #1*

### *Introductions and General Life Stories*

Where did you grow up?

- ▶ What did you like about growing up there?

Can you tell me about the most memorable times from your childhood?

- ▶ Can you think of a couple of stories that stick out to you right away?

Where did you go to school?

- ▶ What were your school days like?

What has been your most memorable work or volunteer experience?

- ▶ What made it so memorable?

Can you describe some of your favourite hobbies or pastimes?

- ▶ Do you remember when you first started this hobby?
- ▶ What made you interested? How did you learn it?

Did you travel much?

- ▶ *If so*, can you tell me about your favourite travel experience?
- ▶ *If not*, where was your favourite place to spend your time?

How would you describe your personality?

- ▶ Are you an introvert? An extrovert?
- ▶ How would your family/friends describe you?

Can you tell me about your family?

- ▶ Can you tell me about your closest family members?
- ▶ *If participant mentions marriage*: How did you meet your spouse? How many years have you been married for?
- ▶ *If participant mentions children*: What are your children like?

# Interview Guide:

## *life review session #2*

### *Stories of Companionship, Relationships, and Intimacy*

Can you tell me a bit about the person/people in this photo?

- ▶ *If photos are provided.*
- ▶ Do you remember when the photo was taken?
- ▶ What was happening that day?

Who would you describe as your closest friend?

- ▶ What is he/she like? Why do the two of you get along so well?

Do you remember your first date?

- ▶ What was it like?

How about your first kiss?

- ▶ What was it like?

Can you tell me about some of the happiest moments from your relationship(s)?

- ▶ What do/did you like to do together?
- ▶ What's the key to a successful relationship?

Do you remember the 'sexual revolution' back in the 1960s to 1980s?

- ▶ *If yes:* Tell me about it. Was it something you were a part of, or just observed? What did you think about it all?
- ▶ *If no:* There was a movement in many parts of Canada and the United States called the sexual revolution. This brought on changes in people's attitudes and behaviours about sexuality (such as sex before marriage, contraception, and more open discussion about sex and sexuality). Do you remember any of these changes? How did you feel about it then? How do you feel about it now?



APPENDIX C  
Semi-Structured Interview Guide

# Interview Guide:

## *let's talk about intimacy*

### *Demographic Questions*

- In what year were you born?
- What gender do you identify with?
- Do you currently have a partner?
- How long have you been a resident in this facility?

### *General Knowledge & Perceptions*

- What does intimacy mean to you?
  - ▶ How would you describe intimacy?
- What does sexuality mean to you?
  - ▶ In your own words, how would you define sexuality?

*(\*Note: responses to the above questions will determine the researcher's word choice for the remainder of the interview, to use terms that resonate with each participant's experience.)*

How would you describe the opportunities for intimacy/sexuality/  
companionship between residents in this facility?

- ▶ Would you be able to tell me a bit about the types of intimate/sexual behaviours people typically engage in here?

Generally, do you think this environment encourages intimacy/sexuality  
among residents?

- ▶ If so, why do you think this? If not, why do you think this?

## *Personal Experiences & Opinions*

How has the value you place on intimacy changed over time?

- ▶ In other words, do you experience intimacy in the same way now as you did when you were younger?
- ▶ Do you experience intimacy in the same way now as you did before you entered long-term care?

To what extent does a person's age determine his/her ability to stay sexually active?

- ▶ Have you noticed that your own age has influenced your sexual needs, desires, or behaviours?
- ▶ If not age, what other factors might impact a person's ability to stay sexually active?
- ▶ *If health hasn't already been addressed:* How would you describe your level of health currently? Do you feel that your health impacts your sexuality?

Would you say that feeling attractive is important to your sexuality?

- ▶ Why or why not?
- ▶ What practices or actions help you to feel attractive?

Do you feel that your intimate needs are being met in this facility?

- ▶ Why or why not?

## *Barriers, Facilitators, and Recommendations*

Do you think [facility name]'s practices could be adapted in any way to ensure residents' intimate/sexual expression is able to occur in this environment?

- ▶ In other words, how could the facility help to meet residents' intimate/sexual needs?

Can you describe some examples of barriers to residents' intimate needs or desires in this facility?

- ▶ Can you give me an example of a time someone at [facility name] experienced these barriers?



## *Barriers, Facilitators, & Recommendations (cont'd)*

Can you think of some of the ways that the long-term care facility helps residents to feel more comfortable being intimate?

- ▶ Do you have any specific examples of these supports?

When people first came to this home, what sort of information is given about their right to engage in intimate or private activities?

- ▶ Do you remember being given any information?

How would you describe the level of privacy in this facility?

Are you aware of any resources that are available to residents who want to engage in intimate activities?

- ▶ *If yes:* Can you think of any examples of these resources?

How do you think a staff member would behave if they were to walk in on a resident engaging in an intimate activity?

How comfortable do you think a resident here would be when discussing their intimate needs with a member of the [facility name] staff?

How do family members influence residents' intimate or sexual behaviours within the facility?

- ▶ Examples?

## *Questions About Research Experience*

Can you describe your experience participating in this research project?

- ▶ Are you happy you decided to participate? Why or why not?

How did you feel about the life review sessions when we talked about some of your life stories and compiled the life story album?

Did these sessions make you feel more trusting of me, (the researcher)?

- ▶ *If yes,* could you tell me more about this trust-building?
- ▶ *If not,* what could have been done differently?

### *Questions About Research Experience (cont'd)*

Did these sessions make you feel more comfortable with the research topic (intimacy/sexuality)?

- ▶ If yes, why do you think the sessions had this effect?
- ▶ If not, what could have been done differently?

Do you think other long-term care residents would enjoy taking part in similar life review sessions?

- ▶ Why or why not?
- ▶ To what extent would life review sessions like this be useful all on their own?
- ▶ To what extent would they be useful as precursors to research studies on other topics?

*Thank you for your participation!*

**APPENDIX D**  
**Resource List**

**[Facility Name] Resident Resources:**  
*continuing the conversation*



After your participation in the study has finished, if you are feeling distressed or you want to follow up on any physical/mental/sexual health concerns, please remember that the following resources are available to you as a [facility name] resident:

- ▶ The registered nurse on your unit
- ▶ The social worker for your unit
- ▶ Your physician

For more information or assistance with your concerns, you may wish to contact [liaison name and job title at facility].

- ▶ Phone: [liaison phone number]

**APPENDIX E**  
**Receipt of Honorarium**

**RECEIPT OF HONORARIUM**

Interview # \_\_\_\_\_

- I hereby confirm that I have received a sum of \$15 from Mariah Malone as an honorarium payment for participating in the research project entitled: *A Multi-Level Analysis of Later-Life Intimacy and Sexuality Among Older Long-Term Care Residents*.
- I have received this honorarium in cash.
- I understand this honorarium is taxable income and it is my responsibility to claim it on my income tax as Dalhousie University will not be issuing a T4A for this payment.

Participant signature: \_\_\_\_\_ Date: \_\_\_\_\_

Interviewer signature: \_\_\_\_\_ Date: \_\_\_\_\_



**RECEIPT OF HONORARIUM**

Interview # \_\_\_\_\_

- I hereby confirm that I have received a sum of \$15 per session (\$\_\_\_\_ total) from Mariah Malone as an honorarium payment for participating in the research project entitled: *A Multi-Level Analysis of Later-Life Intimacy and Sexuality Among Older Long-Term Care Residents.*
  
- This honorarium has been/will be deposited into my trust account.
  
- I understand this honorarium is taxable income and it is my responsibility to claim it on my income tax as Dalhousie University will not be issuing a T4A for this payment.

Participant signature: \_\_\_\_\_ Date: \_\_\_\_\_

Interviewer signature: \_\_\_\_\_ Date: \_\_\_\_\_

**APPENDIX F**  
**Informed Consent Forms & Signature Pages**



**INFORMED CONSENT FORM**  
**[RESIDENTS]**

**Project Title:** A Multi-Level Analysis of Later-Life Intimacy and Sexuality Among Older Long-Term Care Residents

**Lead Researcher:** Ms. Mariah Malone, MA Health Promotion Candidate, School of Health and Human Performance, Faculty of Health Professions, Dalhousie University.

*Contact information:* Email: [mariah.malone@dal.ca](mailto:mariah.malone@dal.ca) Telephone: [\(506\) 869-0923](tel:5068690923)

**Research Supervisor:** Dr. Brad Meisner, Assistant Professor of Health Promotion, School of Health and Human Performance, Faculty of Health Professions, Dalhousie University.

*Contact information:* Email: [brad.meisner@dal.ca](mailto:brad.meisner@dal.ca) Telephone: [\(902\) 494-1158](tel:9024941158)

**Invitation:** You are invited to take part in a research study being led by researchers at Dalhousie University. Taking part in this research project is up to you—it is entirely your choice. Even if you decide to take part, you may leave the study at any time for any reason. The information below tells you about what is involved in the research, what you will be asked to do and about any benefit, risk, inconvenience, or discomfort you might experience. Please ask as many questions as you like. If you have any questions later, please contact the lead researcher.

**Purpose and outline of the research study:** This research looks at intimacy among older adults in long-term care. Specifically, the goal of this research is to explore the experiences of managers, staff, and older residents as they relate to residents' sexuality. Researchers are interested in how the facility supports and/or challenges residents' sexual expression, and how the facility's current policies and practices match up with individual residents' needs and desires. By exploring this topic, the researcher hopes to find out more about how older adult sexuality is understood and experienced in the long-term care setting and provide recommendations to improve policies and practices in the future.

**Who can take part in the research study?** You may participate in this study if you are currently a resident at [facility name], age 50 or older. Everyone who takes part in the study must be able to speak and understand English, and have the ability to participate in a 45-60 minute, one-on-one interview with the researcher.

**How many people are taking part in the study?** There will be approximately 6-10 residents taking part in this study.

**What you will be asked to do:** To help us to explore long-term care residents' experiences of intimacy, we will ask you to take part in two study phases. The first phase is called a life review approach. It will involve two to three casual sessions with the researcher where we will work together to compile a life story album. You will be invited to share stories and photos with the researcher about important life experiences, especially those that relate to intimacy and companionship. Each session is expected to take between 45-60 minutes, and will happen on different days over the course of several weeks. The second phase will be a 45-60 minute interview with the researcher. The interview will require you to engage in conversation with the researcher, to explore your experiences with and views on intimacy in the [facility name] setting. All meetings will be scheduled at a time that is convenient for you. They will take place in a private, neutral meeting room onsite at [facility name]. The study is expected to take a total of 3-4 hours, depending on the number of life review sessions and the length of discussion with the researcher.

**Possible benefits, risks, and discomforts:** One possible benefit that you may receive if you take part in this study is a sense of contribution to a study that is relevant to you. By participating in this study, you will also be helping us to gain more knowledge about the experiences of residents related to their sexual and intimate needs, and how these are supported or challenged in the long-term care setting. These insights can be used to create suggestions for long-term care settings to support the health and wellbeing of older adult residents. This knowledge might not benefit you directly, but we might learn things that will benefit others. Also, as a result of participation in this study you will receive a life story album, put together with the help of the researcher, which will display many stories and photos from your personal history.

The risks involved with this study are minimal. Given that this study will involve you talking about past life stories and personal experiences with intimacy, there is a chance that you may feel discomfort or emotional. It is possible that some questions will make you feel embarrassed or upset. Also, given that the interview will take place at [facility name], other employees or residents may become aware that you have chosen to participate in the study. However, every effort will be made to minimize these risks. The researcher will schedule meetings at a time and location within the facility that will not draw attention to your participation. Even if others become aware that you are taking part, you should rest assured that your level of care will not be affected by your decision to participate in the study. Also, at any time, you can choose not to answer a question should you feel uncomfortable and at any time, you may choose to take a break or remove yourself from the study. As an added safeguard, you will be provided with a list of health-related resources that are available within [facility name] in the event that participation in the study prompts you to seek help with mental, physical, or sexual health concerns. Finally, we assure you that the information you provide to us will be held in the strictest confidence.

**Compensation:** As a gesture of our thanks for your time and contribution to this research project, you will be given a \$15 honorarium for every session you participate in, amounting to a total of \$45-\$60. The total honorarium will be deposited in your [facility name] trust account upon completion of your interviews. If a trust account is not available, it will be given to you in cash after each interview session. You will be asked to sign a receipt to confirm that you have received the honorarium.

**How your information will be protected:** Information that you give us will be kept private. Only the research team will have access to this information. We will describe and share our findings in a final report that will be submitted for publication and presented to members of the [facility name] community. However, we will be very careful to only talk about group results so that no one will be identified. Given the nature of this study, including personal accounts of your experiences, direct quotations may be used in the final report. However, your name and any other identifying information will not be attached to this quotation, protecting your privacy. This means that you will not be identified in any way in our reports. The people who work with your information have a responsibility to keep all research information private. In the event that abuse or neglect of a child or an adult is revealed, the researchers are required by law to inform legal authorities. Also, we will use a pseudonym (not your name) in our records so that the information we have about you contains no names. All your identifying information will be kept in a separate file, in a secure place. All electronic records will be kept secure in a password-protected file on the researcher's personal computer or on a Dalhousie University secure server.

**If you decide to stop participating:** You are free to leave this study at any time. If you decide to stop participating at any point during the study, you can also decide whether you want any of the information that you have contributed up to that point to be removed or if you will allow us to use that information. You can also decide for up to one week following your interview if you want us to remove your data. After that time, we will not be able to remove it because it will already be de-identified and possibly analyzed. After you have agreed to participate in the study, if you choose to stop participating, you will still receive the honorarium as a thank you for your time.

**How to obtain results:** We can give you a short description of group results when the study is finished; however, no individual results will be provided. You can get these results by contacting the researcher on this consent form. You may also wish to attend the presentation to the [facility name] community, and we can give you more information about this talk when a time and location have been set. Results will be available as soon as the study is completed but for no longer than a year.

**Questions:** We are happy to talk with you about any questions or concerns you may have about your participation in this research study. Please contact Ms. Mariah Malone at (506) 869-0923 or [mariah.malone@dal.ca](mailto:mariah.malone@dal.ca) or Dr. Brad Meisner at (902) 494-1158 or [brad.meisner@dal.ca](mailto:brad.meisner@dal.ca) at any time with questions, comments, or concerns about the research study. We will also tell you if any new information comes up that could affect

your decision to participate. If you have any ethical concerns about your participation in this research, you may also contact the Director, Research Ethics, Dalhousie University at (902) 494-1462, or email: [ethics@dal.ca](mailto:ethics@dal.ca).



**INFORMED CONSENT SIGNATURE PAGE  
[RESIDENTS]**

Interview # \_\_\_\_\_

**Project Title:** A Multi-Level Analysis of Later-Life Intimacy and Sexuality Among Older Long-Term Care Residents

**Lead Researcher:** Ms. Mariah Malone, MA Health Promotion Candidate, School of Health and Human Performance, Faculty of Health Professions, Dalhousie University.

*Contact information:* Email: [mariah.malone@dal.ca](mailto:mariah.malone@dal.ca) Telephone: [\(506\) 869-0923](tel:506-869-0923)

**Research Supervisor:** Dr. Brad Meisner, Assistant Professor of Health Promotion, School of Health and Human Performance, Faculty of Health Professions, Dalhousie University.

*Contact information:* Email: [brad.meisner@dal.ca](mailto:brad.meisner@dal.ca) Telephone: [\(902\) 494-1158](tel:902-494-1158)

**I have read the explanation about this study. I have been given the opportunity to discuss it and my questions have been answered. I agree to take part in this study. I realize that my participation is voluntary and that I am free to leave the study at any time. I agree that the researcher may audio-record the life review sessions and interview with me. I agree that the researcher may use a direct quotation from the verbal dialogue. I understand that my name and other identifying information will not be attached to the quotation. If the researcher suspects any abuse/neglect over the course of my participation, I understand that it is the researcher's obligation to report it to the appropriate authorities:**

Participant Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Researcher Signature: \_\_\_\_\_ Date: \_\_\_\_\_



**INFORMED CONSENT FORM**  
**[RESIDENT ASSENT + THIRD-PARTY DELEGATE]**

**Project Title:** A Multi-Level Analysis of Later-Life Sexuality and Well-Being among Older People in Long-Term Care Facilities

**Lead Researcher:** Ms. Mariah Malone, MA Health Promotion Candidate, School of Health and Human Performance, Faculty of Health Professions, Dalhousie University.

*Contact information:* Email: [mariah.malone@dal.ca](mailto:mariah.malone@dal.ca) Telephone: [\(506\) 869-0923](tel:5068690923)

**Research Supervisor:** Dr. Brad Meisner, Assistant Professor of Health Promotion, School of Health and Human Performance, Faculty of Health Professions, Dalhousie University.

*Contact information:* Email: [brad.meisner@dal.ca](mailto:brad.meisner@dal.ca) Telephone: [\(902\) 494-1158](tel:9024941158)

**Invitation:** The resident is invited to take part in a research study being study being led by researchers at Dalhousie University. Taking part in this research project is completely voluntary—it is entirely the resident’s choice. Even if s/he decides to take part, the resident may leave the study at any time for any reason. The information below tells you about what is involved in the research, what the resident will be asked to do and about any benefit, risk, inconvenience, or discomfort the resident might experience. Please ask as many questions as you like. If you have any questions later, please contact the lead researcher.

**Purpose and outline of the research study:** This research looks at intimacy among older adults in long-term care. Specifically, the goal of this research is to explore the experiences of managers, staff, and older residents as they relate to residents’ sexuality. Researchers are interested in how the facility supports and/or challenges residents’ sexual expression, and how the facility’s current policies and practices match up with individual residents’ needs and desires. By exploring this topic, the researcher hopes to (a) find out more about how older adult sexuality is understood and experienced in the long-term care setting and (b) provide recommendations to improve policies and practices in the future.

**Who can take part in the research study?** Individuals may participate in this study if they a resident at [facility name], age 50 or older. Everyone who takes part in the study must be able to speak and understand English, and have the ability to participate in a 45-60 minute, one-on-one interview with the researcher.

**How many people are taking part in the study?** There will be approximately 6-10 people taking part in this study.

**What the resident will be asked to do:** To help us to explore the lived experiences of sexuality among residents of long-term care, we will ask the resident to take part in two phases of data collection. The first phase is called a life review approach. It will involve two to three informal sessions with the researcher where the researcher and the resident work together to compile a life story album. The resident will be invited to share stories and photos with the researcher about important life experiences, especially those that relate to intimacy and companionship. Each session is expected to take between 45-60 minutes, and will happen on different days over the course of several weeks. The second phase will be a 45-60 minute interview with the researcher. The interview will require the resident to engage in conversation with the researcher, to explore his or her experiences with and views on sexuality in the [facility name] setting. All meetings will be scheduled at a time that is convenient for the resident, and the third-party delegate, if both individuals agree that the third-party should be present throughout the entire data collection process. Meetings will take place in a private, neutral meeting room onsite at [facility name]. The study is expected to take a total of 3-4 hours, depending on the number of life review sessions and the length of discussion with the researcher.

**Possible benefits, risks, and discomforts:** One possible benefit that the resident may experience as a participant in this study is a sense of contribution to a study that is personally relevant. By participating in this study, the resident will also be helping us to gain more knowledge about the experiences of residents in relation to their sexual and intimate needs, and how these are supported or challenged in the long-term care setting. This information can be used to make recommendations for long-term care settings that support the health and wellbeing of their residents. This knowledge might not benefit the resident directly, but we might learn things that will benefit others. Also, as a result of participation in this study the resident will receive a life story album, put together with the help of the researcher, which will display many stories and photos from your personal history.

The risks involved with this study are minimal. Given that this study will involve the resident talking about past life stories and personal experiences with intimacy, there is a chance that s/he may feel discomfort or emotional. It is possible that some questions will make the resident feel embarrassed or upset. Additionally, given that the interview will take place at [facility name], other employees or residents may become aware that the resident has chosen to participate in the study. However, every effort will be made to minimize these risks. The researcher will schedule meetings at a time and location within the facility that will not draw attention to the resident's participation. Even if others become aware of participation, the resident should rest assured that his or her level of care will not be affected by the decision to participate in the study. Also, at any time, the resident can choose not to answer a question should s/he feel uncomfortable and at any time, s/he may choose to take a break or withdraw from the study. As an added safeguard, the resident will be provided with a list of health-related resources that are available within [facility name] in the event that participation in the study prompts the resident to seek help with mental, physical, or sexual health concerns. Finally, we assure



you that the information the resident provides to us will be held in the strictest confidence.

**Compensation:** As a gesture of our thanks for the resident's time and contribution to this research project, s/he will be given a \$15 honorarium for every session s/he participates in, amounting to a total of \$45-\$60. The total honorarium will be deposited in the resident's [facility name] trust account upon completion of your interviews. If a trust account is not available, it will be given to the resident in cash after each interview session. The resident will be asked to sign a receipt to confirm that s/he has received the honorarium.

**How the resident's information will be protected:** Information that the resident gives us will be kept private. Only the research team will have access to this information. We will describe and share our findings in a final report that will be submitted for publication and presented to members of the [facility name] community. However, we will be very careful to only talk about group results so that no one will be identified. Given the nature of this study, including personal accounts of residents' experiences, direct quotations may be used in the final report. However, the resident's name and any other identifying information will not be attached to this quotation, protecting his or her privacy. This means that the resident will not be identified in any way in our reports. The people who work with the resident's information have a responsibility to keep all research information private. In the event that abuse or neglect of a child or an adult is revealed, the researchers are required by law to inform legal authorities. Also, we will use a participant number (not the resident's name) in our records so that the information we have about him or her contains no names. All identifying information will be kept in a separate file, in a secure place. All electronic records will be kept secure in a password-protected file on the researcher's personal computer or on a Dalhousie University secure server.

**If the resident decides to stop participating:** The resident is free to leave this study at any time. If s/he decides to stop participating at any point during the study, the resident can also decide whether s/he wants any of the information that has been contributed up to that point to be removed or if we will be allowed to use that information. The resident can also decide for up to one week following his/her interview if s/he wants us to remove his/her data. After that time, we will not be able to remove it because it will already be de-identified and possibly analyzed. After the resident has agreed to participate in the study, if s/he chooses to stop participating, the resident will still receive the honorarium as a token of appreciation for his/her time.

**How to obtain results:** The resident can be given a short description of group results when the study is finished; however, no individual results will be provided. These results can be obtained by contacting the researcher on this consent form. The resident may also wish to attend the presentation offered to the [facility name] community, and we will provide more information about this talk when a time and location have been set. Results will be available as soon as the study is completed but for no longer than a year.

**Questions:** We are happy to talk with the third-party delegate and/or the resident about any questions or concerns regarding the resident's participation in this research study. Please contact Ms. Mariah Malone at **(506) 869-0923** or **[mariah.malone@dal.ca](mailto:mariah.malone@dal.ca)** or Dr. Brad Meisner at **(902) 494-1158** or **[brad.meisner@dal.ca](mailto:brad.meisner@dal.ca)** at any time with questions, comments, or concerns about the research study. We will inform both the third-party delegate and the resident if any new information comes up that could affect the resident's decision to participate. If there are any ethical concerns about the resident's participation in this research, please contact the Director, Research Ethics, Dalhousie University at **(902) 494-1462**, or email: **[ethics@dal.ca](mailto:ethics@dal.ca)**.



**INFORMED CONSENT SIGNATURE PAGE  
[RESIDENT ASSENT]**

**Project Title:** A Multi-Level Analysis of Later-Life Sexuality and Well-Being among Older People in Long-Term Care Facilities

**Lead Researcher:** Ms. Mariah Malone, MA Health Promotion Candidate, School of Health and Human Performance, Faculty of Health Professions, Dalhousie University.

*Contact information:* Email: [mariah.malone@dal.ca](mailto:mariah.malone@dal.ca) Telephone: [\(506\) 869-0923](tel:5068690923)

**Research Supervisor:** Dr. Brad Meisner, Assistant Professor of Health Promotion, School of Health and Human Performance, Faculty of Health Professions, Dalhousie University.

*Contact information:* Email: [brad.meisner@dal.ca](mailto:brad.meisner@dal.ca) Telephone: [\(902\) 494-1158](tel:9024941158)

**As the resident, I have read the explanation about this study. I have been given the opportunity to discuss it and my questions have been answered. I agree to take part in this study. I realize that my participation is voluntary and that I am free to leave the study at any time. I agree that the researcher may audio-record the life review sessions and interview with me. I assent to participation in this study. I agree that the researcher may use a direct quotation from the verbal dialogue. I understand that my name and occupation will not be attached to the quotation. If the researcher suspects any abuse/neglect over the course of my participation, I understand that it is the researcher's obligation to report it to the appropriate authorities:**

Participant Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Researcher Signature: \_\_\_\_\_ Date: \_\_\_\_\_



**INFORMED CONSENT SIGNATURE PAGE  
[THIRD-PARTY DELEGATE]**

**Project Title:** A Multi-Level Analysis of Later-Life Sexuality and Well-Being among Older People in Long-Term Care Facilities

**Lead Researcher:** Ms. Mariah Malone, MA Health Promotion Candidate, School of Health and Human Performance, Faculty of Health Professions, Dalhousie University.

*Contact information:* Email: [mariah.malone@dal.ca](mailto:mariah.malone@dal.ca) Telephone: [\(506\) 869-0923](tel:5068690923)

**Research Supervisor:** Dr. Brad Meisner, Assistant Professor of Health Promotion, School of Health and Human Performance, Faculty of Health Professions, Dalhousie University.

*Contact information:* Email: [brad.meisner@dal.ca](mailto:brad.meisner@dal.ca) Telephone: [\(902\) 494-1158](tel:9024941158)

**As the third-party delegate who is responsible for decision-making regarding the above resident's health and well-being, I have read the explanation about this study. I have been given the opportunity to discuss it and my questions have been answered. I give my informed consent for the resident to take part in this study. I realize that the resident's participation is voluntary and that he/she is free to leave the study at any time. I agree that the researcher may audio-record the life review sessions and interview with the resident. I consent to the resident's participation in this study. I agree that the researcher may use a direct quotation from the verbal dialogue. I understand that the resident's name and other identifying information will not be attached to the quotation. If the researcher suspects any abuse/neglect over the course of my participation, I understand that it is the researcher's obligation to report it to the appropriate authorities:**

Third-party Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Researcher Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**APPENDIX G**  
**Ethics Approval**



**Health Sciences Research Ethics Board**  
**Letter of Approval**

October 27, 2015

Dr Brad Meisner  
Health Professions\Health & Human Performance

Dear Brad,

**REB #:** 2015-3607

**Project Title:** Bringing Sexy Back: A Multi-Level Analysis of Later-Life Sexuality and Well-Being Among Older People in Long-Term Care Facilities

**Effective Date:** October 27, 2015

**Expiry Date:** October 27, 2016

The Health Sciences Research Ethics Board has reviewed your application for research involving humans and found the proposed research to be in accordance with the Tri-Council Policy Statement on *Ethical Conduct for Research Involving Humans*. This approval will be in effect for 12 months as indicated above. This approval is subject to the conditions listed below which constitute your on-going responsibilities with respect to the ethical conduct of this research.

Sincerely,

Dr. Brenda Beagan, Chair

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Post REB Approval: On-going Responsibilities of Researchers

After receiving ethical approval for the conduct of research involving humans, there are several ongoing responsibilities that researchers must meet to remain in compliance with University and Tri-Council policies.

1. Additional Research Ethics approval

Prior to conducting any research, researchers must ensure that all required research ethics approvals are secured (in addition to this one). This includes, but is not limited to,

securing appropriate research ethics approvals from: other institutions with whom the PI is affiliated; the research institutions of research team members; the institution at which participants may be recruited or from which data may be collected; organizations or groups (e.g. school boards, Aboriginal communities, correctional services, long-term care facilities, service agencies and community groups) and from any other responsible review body or bodies at the research site.

## 2. Reporting adverse events

Any significant adverse events experienced by research participants must be reported **in writing** to Research Ethics **within 24 hours** of their occurrence. Examples of what might be considered “significant” include: an emotional breakdown of a participant during an interview, a negative physical reaction by a participant (e.g. fainting, nausea, unexpected pain, allergic reaction), report by a participant of some sort of negative repercussion from their participation (e.g. reaction of spouse or employer) or complaint by a participant with respect to their participation. The above list is indicative but not all-inclusive. The written report must include details of the adverse event and actions taken by the researcher in response to the incident.

3. Seeking approval for protocol / consent form changes Prior to implementing any changes to your research plan, whether to the study design, methods, consent form or study instruments, researchers must submit a description of proposed changes to the REB for review and approval. This is done by completing an Amendment Request (available on the Research Ethics website). Please note that no reviews are conducted in August.

## 4. Submitting annual reports

Ethics approvals are valid for up to 12 months. Prior to the end of the project’s approval deadline, the researcher must complete an Annual Report (available on the website) and return it to Research Ethics for review and approval before the approval end date in order to prevent a lapse of ethics approval for the research. Researchers should note that no research involving humans may be conducted in the absence of a valid ethical approval and that allowing REB approval to lapse is a violation of University policy, inconsistent with the TCPS (article 6.14) and may result in suspension of research and research funding, as required by the funding agency.

## 5. Submitting final reports

When the researcher is confident that no further data collection or participant contact will be required, a Final Report (available on the website) must be submitted to Research Ethics. After review and approval of the Final Report, the Research Ethics file will be closed.

6. Retaining records in a secure manner Researchers must ensure that both during and after the research project, data is securely retained and/or disposed of in such a manner as to comply with confidentiality provisions specified in the protocol and consent forms. This may involve destruction of the data, or continued arrangements for secure storage. Casual storage of old data is not acceptable.

It is the Principal Investigator's responsibility to keep a copy of the REB approval letters. This can be important to demonstrate that research was undertaken with Board approval, which can be a requirement to publish (and is required by the Faculty of Graduate Studies if you are using this research for your thesis).

Please note that the University will securely store your REB project file for 5 years after the study closure date at which point the file records may be permanently destroyed.

7. Current contact information and university affiliation The Principal Investigator must inform the Research Ethics office of any changes to contact information for the PI (and supervisor, if appropriate), especially the electronic mail address, for the duration of the REB approval. The PI must inform Research Ethics if there is a termination or interruption of his or her affiliation with Dalhousie University.

8. Legal Counsel The Principal Investigator agrees to comply with all legislative and regulatory requirements that apply to the project. The Principal Investigator agrees to notify the University Legal Counsel office in the event that he or she receives a notice of non-compliance, complaint or other proceeding relating to such requirements.

9. Supervision of students Faculty must ensure that students conducting research under their supervision are aware of their responsibilities as described above, and have adequate support to conduct their research in a safe and ethical manner.