Title

Nurses' experiences and reactions towards intimacy and sexuality expressions by nursing home residents: A qualitative study

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Abstract

Objectives: To better understand how nurses experience and react to intimate and sexual expressions of nursing home residents.

Background: Although many nursing home residents continue to desire intimacy and sexual expression, they commonly perceive negative attitudes of nursing staff towards them as a major barrier to their sexual wellbeing. To eliminate this barrier, it is crucial to gain a more in-depth understanding of nurses' personal experiences and reactions towards intimacy and sexuality in aged care.

Design: Our study used a qualitative design, rooted in grounded theory.

Methods: Semi-structured interviews with 15 nurses between 34 and 59 years of age were conducted. Participating nurses were recruited from seven different nursing homes in Flanders, Belgium. We used the Qualitative Analysis Guide of Leuven (QUAGOL) for data analysis. We followed the COREQ guidelines to ensure rigour in our study.

Results: Nurses experienced and dealt with intimate and sexual expressions of residents in an individual way, which was focused on setting and respecting their own sexual boundaries and those of residents and family members. Depending on their comfort level with residents' expressions, nurses responded in three ways: active facilitation, tolerance, and termination. Nurses' responses depended on contextual factors, including their personal experiences with sexuality, the nature of their relationship with the

residents involved, the presence of dementia, and the organisational culture of the facility.

Conclusions: Nurses face a wide range of experiences and emotions when confronted with residents' expressions of sexuality and intimacy. A supportive approach is needed to guide nurses in dealing with these highly sensitive situations. This approach can be promoted at the institutional level through continuous educational programmes.

Relevance to clinical practice: This study advocates a contextual and interpretative ethical approach to sexuality in older adults, taking as starting point nurses' own vulnerability and that of residents and relatives.

Key words

Attitudes; Ethics; Nursing homes; Organizational culture; Qualitative research; Sexuality

WHAT DOES THIS PAPER CONTRIBUTE TO THE WIDER GLOBAL CLINICAL COMMUNITY

- This paper offers in-depth understanding of nurses' experiences with and reactions to residents' sexual expressions in nursing homes, as well as the contextual factors affecting them.
- This paper shows that nursing staff experiences and reactions depend on their individual comfort level with residents' expressions and to what degree nursing homes respond to older adults' sexuality.
- This paper advocates a contextual and interpretative ethical approach toward sexuality in older adults, taking as a starting point nurses' own vulnerability and that of residents and family members.

1. Introduction

Sexuality and intimacy are increasingly being recognised as essential components of the wellbeing and quality of life during old age. Large-scale population studies show that up to 30% of older adults over the age of 70 remain sexually active (Hyde et al, 2010; Herbenick et al., 2010). Accordingly, a working definition developed on behalf of the World Health Organization states that sexuality is a central feature throughout the entire lifespan:

“Sexuality is a central aspect of being human throughout life and encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction. Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviours, practices, roles and relationships. While sexuality can include all of these dimensions, not all of them are always experienced or expressed. Sexuality is influenced by the interaction of biological, psychological, social, economic, political, cultural, ethical, legal, historical, religious and spiritual factors” (World Health Organization, 2017, p. 3).

Intimacy specifically refers to involvement in a close and enduring personal relationship (Simpson, Horne, Brown, Wilson, Dickinson & Torkington, 2017a), which might be expressed physically, emotionally, as well as intellectually.

Admission to a nursing home does not necessarily reduce the importance that older people place on their sexual wellbeing. A survey of 85 nursing home residents, for instance, found that 51% have sexual desires (Mroczek, Kurpas & Gronowska, 2013). A systematic review concluded that older adults express these desires in various ways, ranging from different forms of physical and verbal affection (e.g., holding hands, hugging, caressing, kissing, giving compliments) to more erotic expressions (e.g.,

intercourse, watching pornography, and masturbation) (Mahieu & Gastmans, 2015). Nevertheless, the nursing home environment could present several potential barriers to older adults engaging in intimate and sexual activities, such as a lack of privacy, absence of an intimate partner, presence of health problems and dementia, as well as fear of gossip and negative perceptions of fellow residents, staff, and family members (Mahieu & Gastmans, 2015; Bauer, Haesler & Fetherstonhaugh, 2016; Palacios-Ceña et al., 2016; Aguilar, 2017; Cook, Schouten, Henrickson & McDonald, 2017; Roelofs, Luijckx & Embregts, 2017, Simpson et al., 2017a; Simpson, Brown Wilson, Brown, Dickinson & Horne, 2017b).

Nurses have a key responsibility in promoting residents' sexual health and wellbeing because of their intensive day-to-day involvement in the holistic care of nursing home residents. This responsibility may involve actively listening to sexual concerns and problems, correcting potential misunderstandings about sexuality in older adults, promoting residents' self-esteem, and encouraging them to discuss their concerns with partners, family, and friends (Peate, 2004). Nevertheless, nursing home residents and their partners often have difficulties communicating issues of intimacy and sexuality with nursing staff, as they perceive them to be indifferent or disrespectful towards the topic (Bauer et al., 2016; Roelofs et al., 2017). Such negative attitudes might reflect persisting socio-cultural stereotypes of older adults as asexual beings, who have lost their interest and physical capacity for sexual activity (Peate, 2004; Roach, 2004; Bauer et al., 2016; Simpson et al., 2017a; Simpson et al., 2017b; Aguilar, 2017). Expressions of intimacy and sexuality may thus be perceived by staff to be behavioural 'problems' rather than fundamental expressions of identity and connection. Such attitudes may threaten the quality of care delivered by nurses.

Moreover, dealing with sexuality in older adults can be considered as “*fragile moral work*”, as it relates to residents’ “*vulnerabilities associated with the most intimate aspects of their lives, including how they express themselves sexually*” (Victor & Guidry-Grimes, 2018). As found by Mahieu and Gastmans (2012), the four principles of biomedical ethics (i.e. respect for autonomy, beneficence, non-maleficence, and justice) are largely proposed in the literature as an ethical framework to deal with sexual expressions of institutionalized older adults. However, it is questioned whether this framework is effective when it comes to people with cognitive impairments such as people with dementia. Therefore, there may be the need for a different normative framework to support nurses’ decisions and actions in dealing with expressions of intimacy and sexuality in people with dementia.

In order to better support residents’ intimate and sexual needs, it is important that nurses become aware of their own feelings and stereotypes with respect to sexuality in older adults. It is crucial, then, to better understand how they experience, deal with, and react to expressions of intimacy and sexuality. A systematic review targeting nursing staff attitudes found an overall rather positive appreciation of sexuality in older adults. However, the majority of the included studies (14/18) had a quantitative research design. We should keep in mind that quantitative self-reports are susceptible to social desirability (Mahieu, Van Elssen & Gastmans, 2011). Moreover, they insufficiently take into account the influence of context on nurses’ experiences and reactions. When considering the scarce qualitative evidence available, an alternative picture emerges. Specifically, nursing staff attitudes depend on two things: (1) a nurse’s individual comfort level towards a resident’s sexual expressions, and (2) the institution’s degree of responsiveness to older adults’ need for intimacy and sexuality (Roach, 2004). The latter attitude was reflected by the organization’s values and policies. Qualitative studies found also that the type of sexual behaviour had an important impact. Nurses typically felt

supportive of behaviours that expressed mutual love and caring; however, they were embarrassed or disgusted by erotic expressions (such as sexual intercourse or masturbation). Therefore, staff commonly discouraged or even tried to put an end to the latter type of behaviours. The purported reasons for this policy were to protect the nurses' own quality of life and the dignity of residents and family members (Ehrenfeld, Bronner, Tabak, Alpert & Bergman, 1999; Tzeng, Lin, Shyr & Wen, 2009). With respect to behaviours like cuddling and kissing, nurses commonly made humorous responses to conceal their real feelings or to conceal their ridicule of the residents' intimate needs and to avoid having to engage in a serious conversation (Bauer, 1999).

Given these mixed findings, more qualitative studies are needed to gain an in-depth understanding of nurses' experiences with and reactions to sexual expressions in aged care settings, as well as to identify the contextual factors affecting them. Such nuanced understanding might help nursing home managers to identify and overcome potential barriers to sexuality in older adults, with the aim of improving the sexual wellbeing and quality of life of institutionalized older adults. This contextualized insight into nurses' experiences and reactions will also be important to inform an ethical framework that can support nurses dealing with residents' intimate and sexual expressions. Addressing these issues will be increasingly important when considering that more people are, and will increasingly be, living longer in better health. Thus, this study aimed to further explore nurses' experiences and reactions to intimate and sexual expressions of nursing home residents.

2. Methods

2.1. Study design

We used a qualitative research design, as we aimed to gain a detailed and in-depth understanding of nurses' subjective experiences and reactions. First, we obtained their personal histories and case stories. As we were interested in uncovering the complex processes underlying these experiences, we used a grounded theory approach (Corbin & Strauss, 2008). This approach involves simultaneous cycles of data collection and analysis, the use of theoretical sampling, and constant comparison of new data with previously obtained data in the study. We followed the COREQ guidelines to ensure rigour in our study (Tong, Sainsbury & Craig, 2007).

2.2. *Recruitment and participants*

We gave a written study invitation to caregivers and directors from 85 different nursing homes in Flanders. These individuals had attended a seminar on 'intimacy and sexuality in aged care', which was organised by the last author and delivered on September 18, 2014. We employed this recruitment strategy to ensure that staff of the included nursing homes were sufficiently sensitive to ethical issues regarding the intimacy and sexuality of residents and were willing to reflect upon this topic. Of the 14 nursing homes interested in participating, 7 were selected. We aimed to obtain a sample that was balanced geographically, as previous quantitative research revealed significant differences in knowledge and attitudes between nurses working in different provinces across Flanders (Mahieu et al., 2016). The seven participating organisations had between 80 and 140 beds. Three of them had a written policy document dealing with residents' intimate and sexual behaviour.

Within each participating nursing home, a contact person was appointed to facilitate communication between the researchers and the nurses. This person distributed an information folder to all colleagues who had a registered nurse degree, were Dutch-

speaking, and were willing to discuss their experiences during an interview. The nurses confirmed their participation by filling out and returning an informed consent form, along with a completed short structured questionnaire. The questionnaire collected demographic characteristics of the nurses and the frequency and types of intimate or sexual behaviour of residents they had encountered. In addition, the nurses were invited to include one or more recent personal experiences or cases involving intimate or sexual behaviour by older residents in their care.

Questionnaires and informed consent forms from 38 nurses were returned to the research team. After analysis of the questionnaires and cases, we purposively selected an initial sample of nine nurses to be interviewed. We included participants with a variety of demographic and professional characteristics (e.g., gender, education level, working experience), and who reported having various personal experiences with intimacy and sexuality of residents (in terms of frequency as well as types of behaviours). After analysing these nine interviews, we replaced purposive sampling with theoretical sampling based on the emerging findings. This process led to the inclusion of six additional participants, allowing us to further refine the emerging concepts identified in the first round of interviews until saturation was reached (i.e. when all dimensions were thoroughly explored in detail and no new meaningful data emerged from the subsequent interviews). The interviewer phoned all participants to make an appointment for the interview, which gave them the opportunity to ask additional questions.

Our final study sample included 13 female and two male nurses between 34 and 59 years of age ([Table 1](#)). They had 1-27 years of working experience in nursing home care, most often in full-time employment (n=13). Nearly half of the participants had an

undergraduate nursing degree (n=7), while the other half had a Bachelor's (n=7) or Master's degree (n=1).

All participants had at least some experience with situations involving intimate and sexual behaviours by older residents (Table 1). Nevertheless, the frequency of encountering such situations ranged from 'seldom' (n=2) to 'weekly' (n=3). These behaviours predominantly involved sexual remarks (n=12) or sexual advances (n=11) towards caregivers, cuddling with their own partner (n=9) or fellow residents (n=9), and intimate relations between residents (n=8).

TABLE 1: Overview of participant characteristics (N=15), frequency of encounters (N=13) and experiences (N=14) with situations involving intimate/sexual behaviour of residents.

2.3. *Data collection*

Interviews were conducted between April 2015 and February 2016 by two of the authors, who are female. One of them had several years of professional experience as a nursing home nurse and participated here as part of her Master's thesis in nursing science. The other interviewer was a postdoctoral researcher in bioethics. Depending on where participant nurses felt most comfortable discussing this 'delicate' subject, the interviews were held either in a private room at the nursing home (n=11) or at their home (n=4). The interviews were conducted in Dutch and lasted, on average, 67 minutes (range, 33-135 minutes). With the participants' permission, they were digitally recorded and afterwards the recording was transcribed verbatim.

The interviews followed a semi-structured interview guide that was based on a previously published systematic review (Mahieu et al., 2011), and further refined by discussions among the research team. We conducted a pilot interview with one nurse, which was held in February 2015. At the start of the actual interviews, nurses were asked to describe and reflect upon the case they listed previously in the questionnaire or other personal experiences from their nursing home work. Afterwards, the interviewer further probed respondents' viewpoints by asking open-ended questions pertaining to the context in which they encountered the intimate or sexual behaviour (e.g., place, time, persons involved); nurses' feelings and thoughts about the encounter; and their concrete actions in response to the situation. In addition, participants were asked to reflect about their organisation's culture with respect to intimacy and sexuality, such as specific rules and procedures in the nursing home, the possibility of discussing experiences with colleagues and superiors, and the perceived impact of institutional policy documents on nurses' personal reactions. The interviewer took field notes describing their observations with regard to the context wherein the interview took place.

2.4. *Ethical considerations*

The study was approved by the ethics committee of the Faculty of Medicine of ANONYMOUS. The participating nursing homes were allowed to submit the research protocol to their local research ethics committee on request; however, no participating organisation required additional study approval.

All nurses were provided with written information about the study purpose and nature, and their rights as study participants, such as being allowed to stop the interview at any time, or to refuse to answer a particular question for any reason. Written informed consent was obtained when collecting demographic data and repeated orally at the beginning of the interview. All participants agreed to have their interview digitally recorded. In order to protect participants' privacy, access to the recordings and interview transcripts was restricted to the research team. In addition, all identifiable information about the participating nurses and nursing homes was treated confidentially and anonymised within the manuscript.

2.5. *Data analysis*

We used the Qualitative Analysis Guide of Leuven (Dierckx de Casterlé, Gastmans, Bryon & Denier, 2012), an iterative guidance tool for qualitative data analysis. It consists of a preparatory coding process and an actual coding process. In the preparatory stage we compiled a list of meaningful, empirically based themes that emerged from a holistic understanding of the essence of each interview, instead of breaking down the data through purely inductive, line-by-line coding process. Thus, all members of the interdisciplinary research team first familiarised themselves with the interviews by carefully reading and discussing the content of the transcripts and field notes. On the basis of these discussions, two researchers (LM and CV) independently

prepared a narrative summary report for each interview. Next, this report was translated into a conceptual interview scheme, in which the concrete narrative descriptions were clustered on a more abstract conceptual level. In order to optimise the quality of these conceptual interview schemes, all authors re-read the interviews with the identified themes in mind, and potential discrepancies were discussed during regular team meetings. As a final preparatory step, the concepts were further refined and developed by identifying similarities, differences, and connections among different themes within and across interview schemes. This resulted in an overall list of approximately thirty core themes.

During the actual coding process, two authors independently (KT and LM) coded the interviews in detail using the previously identified themes. The software QSR International's NVivo 9 (2010) was used for the coding process. After linking all relevant text fragments to the appropriate codes, we then determined the meaning, dimensions, and characteristics of each theme by closely examining all its associated quotations. This analysis enabled us to describe all concepts and integrate them into an overall conceptual framework, which answered the research question ([Figure 1](#)). The validity of this framework was repetitively verified against the conceptual interview schemes, as well as through frequent team discussions about data saturation. Finally, our findings were translated into a narrative storyline and illustrated with relevant participant quotations that were translated from Dutch to English by the first author.

FIGURE 1: Conceptual framework

3. Results

The participant nurses experienced and dealt with sexual expressions in an individual way. Nurses draw on their personal values and life experiences to make decisions, rather than making decisions in a more reflective way. There were three types of reactions, depending on how comfortable the nurses were with these expressions: active facilitation, tolerance, or termination of the behaviour. Nurses' reactions also depended on various contextual influences, including their personal experiences with intimacy and sexuality, their involvement with residents with dementia, the quality of the nurse-resident relationship, as well as the institutional culture with respect to sexuality in older adults ([Figure 1](#)).

3.1. *Dealing with residents' sexuality and intimacy in terms of limit-setting*

The study participants predominantly described their encounters with intimacy and sexuality as experiences of limit-setting. Specifically, the nurses were primarily concerned with recognising and protecting a self-determined boundary, setting a demarcation along a continuum from personally comfortable to uncomfortable experiences. Once this boundary had been crossed, intimate and sexual expressions were no longer deemed acceptable, necessitating interventions to stop the residents' behaviour.

‘All the intimacy and the personal zones, no one can come near there except myself or my partner. That is the limit for me. So, a kiss on the cheek can for me; a stroke on my hand or arm can also for me...what he has done is just stroking my face and my cheek...I have a hard time with that. I think that is too much.’

Comfortable experiences were associated with a positive appreciation of intimacy and sexuality, which was regarded as natural and self-evident needs of older people. Nurses deemed these kinds of manifestations as being valuable for the residents, as they were signs of mutual care, friendship, and trust that were intended to improve their emotional and social wellbeing. By contrast, uncomfortable experiences were perceived negatively, because the nurse's self-determined boundary was crossed and because they had significant potential to inflict harm. Behaviours causing nurses to be uncomfortable could be expressed in several ways. For example, where intimate behaviour between residents and caregivers was concerned, this might involve violation of the nurse's physical integrity. For most nurses, this was the case when residents would touch a nurse's intimate body parts, such as breasts or genitals. The nurses also felt uneasy with situations that threatened their own safety and emotional wellbeing. For several nurses, for instance, public masturbation was viewed as a threatening act that raised fear of being physically assaulted by the resident.

Nurses deemed residents to cross the line when their behaviour endangered the wellbeing or care of other residents, potentially leading to direct or indirect harm. Direct harm included insult or molestation of vulnerable residents who could not defend themselves. Indirect harm might occur when residents felt uneasy about the sexual activities of others; for instance, when couples engaged in sexual activities in communal spaces. Several participants also emphasised the importance of respecting the limits of family members. Indeed, some nurses recognised that a resident's overt sexual expressions are often a shocking experience for children and grandchildren, who do not always understand that these expressions and the desires behind them might be driven by the resident's age-related neuropathology.

Participant: 'He seldom joined the group, so the residents were not so bothered by the masturbation behaviour of this man. But I found the situation difficult to address to the family.'

Interviewer: 'How so?'

Participant: 'The family came to me several times to talk about it. Yeah, they come to visit as child or grandchild, and the father or grandfather sits there masturbating. To be confronted as a child or grandchild with this must be terrible, I think. I tried as much as possible to explain, such as 'it's because of his illness'. I've also asked them, 'how would you like us to respond?'

This example clearly shows that nurses struggle to know what is the right course of action.

Nurses' awareness of setting limits was expressed as well in the narratives they had provided beforehand in their short structured questionnaire. Of the 20 narratives collected, 19 involved situations that nurses considered as 'crossing the line'. These out-of-bound encounters included public masturbation, requests for sexual services by nursing staff, as well as inappropriate sexual remarks to or touching of caregivers or fellow residents.

Nevertheless, many nurses said setting limits was difficult, because they were often uncertain about how to react to situations involving intimacy and sexuality.

'Since a while ago, he wants to give me a kiss when I come in. He wants to give me a kiss on the cheek. And I remember well the first time that he wanted to do that. I honestly didn't know how to react. I thought to myself: 'Should I allow this or not? Where will this end? Where should I draw a line?''

Uncertainty was related to three factors. First, setting boundaries was generally described as a spontaneous act. Specifically, the nurses described their response as a personal ‘gut feeling’ that helps them to understand the meaning of the behaviour and whether it has a good or bad intention. Nurses’ responses were not based on ethical concepts or decision-making frameworks. Consequently, many nurses had difficulties explaining the precise reasons why a particular behaviour was deemed acceptable or not. Second, what constituted a boundary was different from one nurse to another, as every nurse relied on her own ‘internal compass’ of right and wrong. This in turn was influenced by her demographic, professional background, personality, and life experiences. Third, nurses’ responses to intimacy and sexuality were determined case-by-case and situation-by-situation, depending on the nature of the behaviour and the context in which it occurred. Therefore, several nurses considered it to be difficult to universally implement one ‘gold-standard’ approach, as one solution does not fit every situation. Several nurses, therefore, remarked that organisational viewpoints and policies on dealing with intimacy and sexuality have only limited utility, and some nurses were not even aware of whether their organisation had a written policy.

3.2. Reactions to intimacy and sexuality

Along the comfortable-to-uncomfortable continuum of experiences, nurses displayed three types of reactions: active facilitation, tolerance, and termination.

3.2.1. Active facilitation

Active facilitation means that nurses actively helped older residents fulfil their desires and needs for intimacy and sexuality. Intimate gestures and conversations between nurses and residents were mentioned as one possibility of satisfying these needs. For instance, one nurse said that cuddles or kisses on the cheek might be

comforting for residents with dementia who have difficulties communicating verbally. Another participant explained how making up sexually oriented jokes was a mutual source of enjoyment for her and one of the residents. However, the nurses were only willing to engage in such behaviours when they felt completely reassured that the residents involved experienced these as expressions of care, appreciation, or friendship, without having any mutual sexual connotation.

‘If you know his past, he was a really social person, who always had social contact. He’s always been a lovely person, a pleasant person...you can still say that about him. Then I think to myself, “he does nothing wrong”, his intention isn’t bad. He does that out of friendship, like “I like you” or “I’d like to go with you”.’

In addition, several nurses mentioned the need for more structural interventions to define what intimate and sexual behaviour is appropriate in nursing homes. For example, some participants mentioned offering resident partners the possibility of sharing a bed, spending the evening in each other’s company, or being involved in each other’s intimate care, such as bathing. One nursing home also offered such support to a single resident, by monthly accompanying him to a brothel for sexual assistance.

3.2.2. Tolerance

Tolerant reactions meant that nurses’ allowed, or did not actively object to, the residents’ intimate and sexual activities. In other words, intimacy and sexuality were considered to be a purely private matter, from which nurses tried to refrain from intervening as much as possible. According to several participants, respect for privacy was best promoted by tacitly authorising intimate and sexual activities, provided that they took place in the residents’ own private room. Indeed, nurses argued that older

adults' room should be considered as their proper home, in which they are allowed to live according to their own desires and values. In addition, restricting sexual activity to the residents' private room lowered the chance that nurses would unexpectedly encounter residents having sexual intercourse, which was largely considered to be very embarrassing.

‘We don’t oppose it. They spend the whole day together in his room. There’s a sofa, and they regularly lie in bed chatting or cuddling. The night staff also has found them together in bed, but that’s allowed.’

Tolerance was made explicit most frequently by ignoring or avoiding situations that might involve intimacy or sexuality. Specifically, such situations were ignored when nurses pretended not to notice residents' desires or changed their focus of attention. For instance, one nurse recalled how starting small talk about the weather diverted her attention from a male resident's erection during bathing. Avoiding strategies involved creating a physical distance away from intimate or sexual behaviour, which could be expressed in several ways depending on the situation. For instance, most participants regularly would knock on residents' door before entering to announce their presence, and some advocated the use of 'do not disturb' signs on the residents' doors. One nurse even mentioned slipping medication under the door out of fear that she might encounter the resident during sexual intercourse. Avoidance was often used as well in response to residents' masturbating during intimate care. In those situations, as a rule, nurses interrupted their caregiving task and left the room, providing the resident with sufficient privacy to satisfy his needs.

3.2.3. Ending, or terminating, offensive behaviour

The third and final type of reaction was putting an end to, or terminating, the intimate and sexual behaviours that were perceived as offensive or disruptive to nursing staff or other residents. In most cases related by the participating nurses, staff felt sexually harassed by cognitively competent residents. However, in some cases residents with some degree of cognitive impairment engaged in behaviours that staff interpreted as offensive. Terminating offensive behaviour was a common response, especially when this behaviour involved unwanted sexual remarks or physical advances towards nursing staff. If participants felt that their physical integrity was threatened, for instance, by inappropriate touching of breasts or genitals, they withdrew from the intimate encounter immediately. As a rule, the nurses immediately intervened by expressing disapproval. These expressions commonly were verbal rebukes that directly and firmly articulated nurses' rejection of the offensive conduct and their plea to residents to immediately stop the offensive behaviour. In addition, several nurses displayed non-verbal signals of rejection, such as withdrawing intimate body parts when the older person attempts to make physical contact. In some situations, however, the nurses preferred more subtle expressions to demonstrate their displeasure, which often involved using humorous remarks. Indeed, some nurses specified that humour might be an effective strategy to avoid hurting the feelings of residents to whom they feel emotionally attached.

‘I actually dare to say that quite directly. Because I have a good bond with him I can say a lot. But I also say it in a friendly and courteous manner. I say “*Pfft*, I don’t think I can.” And also, “my partner wouldn’t be happy with this” or “my partner has to know this.”’

If these immediately stated words appeared to be ineffective, or if the inappropriate behaviour entailed considerable discomfort for other residents, the nurses

resorted to more explicit interventions that were intended to dampen residents' sexual arousal. These interventions included isolating the resident from public spaces and activities in the nursing home until he became calm again, which according to some nurses might imply using physical restraints. Residents' sexual desire was also suppressed pharmacologically, which the nurses deemed to be particularly effective when residents simultaneously exhibited aggressive behaviour along with the inappropriate sexual behaviour.

Interviewer: 'Someone who's masturbating. How do you deal with that?'

Participant: 'Well, physical restraint measures, using one-piece pyjamas so he can't masturbate anymore. It is bothersome for co-residents and the personnel if the behaviour is public. If so, we intervene immediately with pharmacological interventions or physical restraint measures like requiring the resident to wear one-piece clothing during the day.'

It did not appear that staff had any strategies to explore the possible meaning and reasons to public masturbation before imposing chemical or physical restraints.

3.3. *Factors influencing nurses' experiences and reactions*

Nurses' responses depended on contextual factors, including their personal experiences with sexuality, the nature of their relationship with the residents involved, the presence of dementia, and the organisational culture of the facility.

3.3.1. *Nurses' personal experiences with sexuality*

First, nurses' personal experiences with intimacy and sexuality had a major impact on how they perceived and dealt with sexuality in residential care. For example,

this topic raised feelings of unease or shame in several participants, whose own families had always maintained a culture of silence with respect to sexuality.

‘Peoples’ position [towards sexuality in older adults] also partly depends on their upbringing. At my place, for instance, it was never discussed. It was a private matter, which was none of our business.’

By contrast, some other nurses explained how overt expressions of intimacy within their private life (e.g., kissing as a customary way of greeting relatives) helped them to become more responsive to the intimate needs of older residents.

3.3.2. Closeness of the nurse-resident relationship

Nurses’ perceptions of intimate and sexual expressions depended as well on the closeness of their relationship with the residents involved. Specifically, the nurses felt more comfortable dealing with expressions from residents with whom they shared feelings of mutual appreciation and sympathy. These feelings were commonly the result of a long process, during which nurses became increasingly familiar with the residents’ personal and social background. This knowledge helped nurses to better understand the reasons and intentions underlying the intimate or sexual expressions. Several nurses emphasised that their willingness to engage in intimate contacts with a resident depended to a large degree on a combination of the latter’s personality, present life situation, and life history. For instance, one nurse felt confident that cuddling was a way of comforting a lonely widower who had also lost his children in death. Another nurse recalled how she overcame her initial reluctance to kiss a resident, when she discovered that this behaviour was consistent with his personality and past social lifestyle. For this resident, regular kissing had always been a sign of friendship and involved no sexually charged motive.

Interviewer: ‘How can you tell if he is doing it [asking for a kiss] out of friendship?’

Participant: ‘Because I have known him for a long time. At first, I was hesitant. But now I have known him for several years. [...] And I have become acquainted with him and his historical background. I think that makes a huge impact. We know the people inside and out. That also determines whether you allow a kiss or cuddle.’

By contrast, when nurses experienced the nurse-resident relationship as distant or threatening, they commonly viewed the resident’s intimate or sexual expressions as offensive. For some nurses, such feelings of danger sometimes occurred when providing intimate care (e.g., bathing) to younger residents, out of fear being physically assaulted.

Interviewer: ‘Does the age of the resident matter?’

Participant: ‘Yeah, definitely. Before we had an 81-year-old man. Sometimes he also gets an erection during morning care, but I didn’t find that so difficult. Age plays a role. The man that we have now is 55 (with Wernicke-Korsakov syndrome). I usually wash old, not young people. I don’t want a resident of 55 to get an erection because of me. Ohhh no.’

Interviewer: ‘Why is that, do you think?’

Participant: ‘This has to do with safety, I think. I think that I have to protect myself in case he would want to go a little further. That scares me. I feel safer with an 81-year-old than with a 55-year-old resident.’

3.3.3. *Dementia*

All nurses also emphasised the heightened ethical complexity of dealing with the intimate and sexual needs of residents with dementia. Nurses considered these residents to be at higher risk for sexual abuse by others, because of their progressive cognitive decline and impaired verbal and nonverbal (e.g., apathy) communication abilities. These functional limitations made it difficult for nurses to determine whether engaging in sexual activity truly reflected a resident's wish.

However, nurses considered sexual disinhibition and aggression, which could characterise the dementia process (e.g., public masturbation, sexual insults, physical harassments), also to be threats to the physical and social wellbeing of other residents and nursing staff. One nurse explained that such disturbing behaviours were counterproductive to the inherent intimate nature of dementia care, which she perceived as a barrier to her personal involvement in the caring process.

‘I work with people with dementia and [...] you are standing very close to the people when providing care. And that's much more difficult when someone is immediately squeezing your butt. And that's very burdensome because the care ought to be provided in an intimate way. And that troubles me, because he doesn't know the limit and that makes it harder. That aspect repulses me. You actually want to keep [your] distance, because he doesn't know or realise...’

In addition, the nurses considered it to be very difficult to discourage and stop such disturbing behaviours, since verbal rebukes or humorous disapproving remarks were generally deemed ineffective for nursing home residents. Therefore, some nurses considered it appropriate to resort to more intrusive strategies, such as the use of sedative medication.

3.3.4. Institutional culture

The institutional culture towards intimacy and sexuality was a final factor influencing nurses' experiences and reactions. Institutions with a so-called closed culture contributed to an individualistic and problem-based approach towards the topic. These institutions commonly lacked a clear policy on issues of intimacy and sexuality of residents. They were also characterised by a lack of communication avenues with superiors, colleagues, and family members, except for cases involving problematic or disturbing behaviours. In these institutions, a retrospective approach was used, meaning that they only discussed cases that went wrong in the past. There was no open communication about how to prevent problems in the future. Only when these problematic experiences had been considered and debated during team debriefings or multidisciplinary meetings were formal agreements made (top-down) to address the resident's problems. Although some participants did not perceive a need to discuss non-problematic aspects of sexuality, this lack of social support provoked feelings of uncertainty or fear in others.

Participant: 'Once the behaviour becomes violent or crosses a line, it is immediately discussed. But not for all other behaviours. It is hushed up. Everything is fine until a certain level is breached. And afterwards, one intervenes immediately.'

Interviewer: 'Can you do something about it?'

Participant: 'I could discuss it with the head nurse, but I don't. As I said, out of shame of what other colleagues might think of me.'

The fact that the nurse did not talk with the head nurse out of shame about her experiences with residents' sexual expressions is an indication of the closed culture regarding sexuality in the nursing home.

4. Discussion

4.1. *Strengths and limitations*

The qualitative design of this study allowed us to obtain an in-depth understanding of nursing staff experiences and reactions with regard to sexual expressions in nursing homes. The QUAGOL (Dierckx de Casterlé et al., 2012) guided us in describing nurses' experiences in their richness as well as the contextual factors affecting them. Its case-oriented approach, forward-backward dynamics using a constant comparative method and team approach enabled us to achieve coherence in the meaning and interpretation of the core categories and their mutual connection (Dierckx de Casterlé et al., 2012). The credibility of the findings has also been enhanced through researcher triangulation, i.e., the interviews and the analysis were carried out by two different researchers (interviews: LM and CV; analysis: LM and KT), data triangulation, i.e., space triangulation (including participants from seven nursing homes in view of a balanced geographical spread) and person triangulation (purposely recruiting participants with various personal experiences with intimacy and sexuality of residents), and method triangulation, i.e., we collected data by quantitative and qualitative methods. An additional strength is the interdisciplinary feature of the research group that conducted the study, composed of ethicists and nurses with academic and 'real-world' practice backgrounds. Finally, the quality of the interviews and of the data analysis contributed to saturation of the key concepts of our conceptual framework.

As we interviewed nurses in our study, almost all the data concerned sexual expressions directed towards nursing staff. More data about how staff responds to residents' desire to touch other residents and engage with them in intimate or sexual ways would have resulted in a more comprehensive understanding of nurses' experiences

and reactions to intimate and sexual expressions of nursing home residents. The participants' concerns for the wellbeing of other residents and their family when it comes to intimate and sexual expressions support the need for further research in this area.

The most important limitation of this study concerns the sampling of participants. Although we used a purposive and theoretical sampling and achieved variability on dimensions of interest (e.g. age, education, work experience, and encounters with intimate/sexual behavior of residents), we probably did not include all relevant perspectives and backgrounds that could have enriched or challenged the emerging conceptualization. Because participation of nursing homes and nurses was voluntary, we might have missed the viewpoints of nurses who did not want or dare to share their experiences about and reactions to the sensitive research topic. The underrepresentation of males could have biased the results toward a female perspective. This lack of variability may have limited the credibility and theoretical generalizability of the findings. The rich and thorough description of the context and findings, however, supported the transferability of the results.

4.2. *Discussion of substantial findings*

With regard to residents' manifestations of sexuality, nurses in our study described a variety of situations that provoked both positive and negative experiences. However, all but one of the collected cases included negative experiences, ranging from discomfort to perception of danger for the nurses or other residents. Such experiences often result in rejection (e.g., gossip, verbal rebukes) and/or intervention (e.g., isolation, pharmacological management). Staff's negative experiences towards residents' manifestations of sexuality and its correlation with negative reactions have been reported in numerous studies (Ehrenfeld et al., 1999; Roach, 2004; Hayward, Robertson &

Knight, 2013; Villar, Serrat, Celdran & Faba, 2016; Nielsen et al., 2017; Simpson et al., 2017a; Simpson et al., 2017b; Villar, Celdran, Serrat, Faba & Martinez, 2018). In this regard, the study of Villar et al. (2016) seems to report contradictory results. While the majority of nurses in their study reported having positive attitudes towards resident masturbation, the expected reactions from colleagues are mostly negative. Therefore, on average, negative reactions outnumbered the positive ones. According to the authors, this indicates that, although less overt than in the past, masturbation still provokes discomfort, embarrassment, and rejection among nursing staff.

The fact that several nurses mentioned pharmacological management and physical restraint (e.g., isolation) as a reaction to residents' expressions of sexuality is an alarming result. Searching for explanations for this finding from our study, we found that some nurses tend to routinize care. Without formal policies and education, some nurses intervene with highly restrictive measures as pharmacological restraint rather than exploring milder interventions. Evidence shows that pharmacological treatments can successfully be used to address disinhibited or inappropriate sexual manifestation in patients with dementia (Ozkan, Wilkins, Muralee & Tampi, 2008; Tucker, 2010; Joller et al., 2013). However, pharmaceuticals can also provoke negative side effects (Ozkan et al., 2008; Tucker, 2010; Joller et al., 2013). Moreover, sometimes inappropriate manifestations have a non-sexual origin, and they can be more easily addressed with non-pharmacological approaches. For example, a resident who presents himself naked in public may simply have forgotten to dress (Joller et al., 2013). Therefore, non-pharmacological strategies (e.g. providing relevant information that will help the resident to reduce potential harms, encouraging the resident to take appropriate precautions, bringing the resident to a private room) should always be prioritised (Ozkan et al., 2008; Tucker, 2010; Joller et al., 2013), and pharmacological and physical

restraint should be limited to only crisis situations when inappropriate sexual behaviours constitute a risk for the staff or the other residents (Everett, 2008; Bauer, Fetherstonhaugh, Tarzia, Nay & Beattie, 2014). To this regard Everett (2008) offers a valuable tool to understand when the interference with patients' wishes and behaviours is permissible. Based on Everett's framework interference is only permissible when it is *"effective, it does not create a greater harm than it prevents, it is the mildest possible, it is not discriminatory, and thought justifiable by those upon whom it is imposed"* (Everett, 2008, appendix 2, p. 96). In order to further minimise the use of restraints, further reflection is needed on the development and implementation of measures to prevent physical and pharmacological interventions.

We also mention the danger of pathologizing normal sexual behavior in older adults whose sexual behaviour might have become ambiguous because of dementia. By solely stressing the 'inappropriateness' of inappropriate sexual behaviour too much power might be vested with social compliance. Perceptions of what constitutes appropriate behaviour vary from person to person. Hence, as Mahieu et al. pointed out, disinhibited or inappropriate sexual behaviour *"is not to be confused with forms of sexual intimacy that are in essence consistent with the normal intrapersonal behaviour that might be observed in persons who do not have dementia but are misplaced in social context."* (Mahieu, Anckaert & Gastmans, 2017, p. 56)

In line with the existing literature, our study confirms that nurses' reactions depended on the interplay of different factors, such as nurses' own comfort level with sexuality in general (Hayward et al., 2013; Vandrevalla, Chrysanthaki & Ogundipe, 2017), and the personal history they had with the resident (Hayward et al., 2013; Cook et al., 2017). Another relevant factor was the type of sexual behaviour expressed by the resident, as classified by Ehrenfeld et al. (1999). Nurses in our study had positive

reactions towards behaviours that can be categorised as expressions of love and caring (e.g., intimate conversation or gestures), and had negative reactions towards behaviours that can be categorised as erotic expressions (e.g., masturbation). In general, the evidence suggests that expressions of mutual affection were likely to be accepted and even encouraged by the caring staff, whereas expressions of eroticism provoked rejection and intervention (Bauer, 1999; Ehrenfeld et al., 1999; Tzeng et al., 2009). Finally, nurses' responses to residents' sexual desires and needs were influenced by the institutions' organisational ethos and by the presence or lack of specific institutional policies (Roach, 2004; Tzeng et al., 2009; Aguilar, 2017; Cook et al., 2017; Nielsen et al., 2017; Villar et al., 2018). This is clear in the study of Aguilar (2017), in which nurses reported that restrictive policies required them to restrict residents' sexual needs, regardless of their own positive attitudes they may have had towards sexuality in older adults.

There is a consensus among the participants in our study, as well as in the literature, that dementia raises specific challenges in dealing with intimate and sexual needs (Roach, 2004; Hayward et al., 2013; Kontos, Grigorovich, Kontos & Miller, 2016; Nielsen et al., 2017; Vandrevalla et al., 2017; Villar et al., 2018). As explained by the participants, residents with dementia have an increased vulnerability that exposes them to a higher risk of sexual abuse. However, dementia is also often associated with sexual disinhibition and aggression. Therefore, the distinction between sexual harassment and intentional behaviour is often blurred, making it difficult for nurses to determine the appropriate reaction. The tension between the need to safeguard and the desire to enable older residents is also mentioned in Hayward et al. (2013), Cook et al. (2017), Nielsen et al. (2017), and Simpson et al. (2017a). As a result, the majority of nurses adopt an individualised approach. For example, in the study of Villar et al. (2018) on partnered

sexual expressions, it was found that nurses tended to intervene in order to prevent abuse only when one partner is affected by dementia. To the other extreme, nurses deal with relationships between two patients with dementia in a more nuanced and positive way. However, a tool supporting nurses in their decisions and reactions with regard to sexual expressions of residents with dementia may improve the quality of care provided to those residents. An example of such a tool can be found in the appendix of Everett (2008). The article also offers a valuable case study showing how the theoretical tool can be applied to practical situations.

5. Relevance for clinical practice: a shift in the ethical interpretation of sexuality in older adults

As highlighted by Mahieu and Gastmans (2012), the moral reasoning related to sexuality and intimacy in institutionalised older adults is predominantly based on the four principles of biomedical ethics, i.e., respect for autonomy, beneficence, nonmaleficence, and justice (Beauchamp & Childress, 2013). This four-principle approach is often simply called principlism. When dealing with residents' sexual manifestations, respect for autonomy — and the corresponding concept of informed consent — is generally assumed to determine whether or not to intervene. Autonomy can be defined as the capacity for self-determination, a right for which a patient is entitled to act according to his or her own values and choices. Obviously, this definition is problematic if applied to people with severe dementia, whose cognitive impairments might hinder them in giving a true cognitive-based informed consent for sexual engagement. Nevertheless, sexuality and intimacy can be a way for people with dementia

to express themselves, to maintain connection with their partners and, as such, it can also contribute to their wellbeing (Mahieu et al., 2017).

Furthermore, principlism was conceived as a universalistic approach to biomedical ethics, meaning that little attention is paid to the particular context in which decisions have to be made. This is again problematic in the case of institutionalised older adults, in which the context and the specific features of each case are absolutely important. For example, our study showed that having a close relationship with a patient cultivated throughout the years and knowing their personal history allows nurses to understand whether their request for kissing is a manifestation of sexuality or of friendship. Based on this knowledge, nurses decide whether to grant the request. Indeed, our study demonstrated that nurses tend to apply a case-by-case approach in dealing with residents' expressions of sexuality. Rather than adhering to general ethical principles, the nurses in our study advocated a particularistic and contextual ethical approach to sexuality in older adults. From our analyses, context encompasses different dimensions, all of which have to be properly addressed. These are the individual context (e.g., nurses' and residents' personal histories), the relational context (e.g., closeness of nurses and residents, family dynamics of residents), and the institutional context (e.g., the institutional ethos with regard to sexuality and intimacy) (Hayward et al., 2013; Cook et al., 2017).

Based on our study results and on the relevant literature, we think that the concepts of vulnerability, care, and dignity (Gastmans, 2013; Mahieu, Anckaert & Gastmans, 2014) might inspire an ethical approach on sexuality and intimacy in institutionalised aged care. First, expressions of sexuality in older adults may generate a profound feeling of vulnerability in all the parties involved. For example, nursing homes are often characterised by lack of privacy (i.e., common unlockable rooms, “no-knock”

policies, lack of private areas), which exposes institutionalised older adults engaged in sexual or intimate behaviours to the gaze of others (Villar et al., 2016; Palacios-Ceña et al., 2016; Simpson et al., 2017b). This increases the vulnerability not only of residents but also of nurses, who are often unprepared to deal with these situations and feel powerless, and co-residents, who may be offended by the fellow residents' sexual manifestations (Tzeng et al., 2009; Nielsen et al., 2017; Villar et al., 2018). Finally, families often struggle to understand and accept their relative's sexual behaviour (Cook et al., 2017). Vulnerability may threaten the dignity of all the people involved, and it has to be properly acknowledged and addressed.

Second, care conceived of, and practiced, as an interpretative dialogue is the response to the above-mentioned vulnerability. Care is the process in which all the people involved engage to find the best solution within a specific context. For example, we observed that tension exists between safeguarding and enabling when dealing with residents with dementia (Hayward et al., 2013; Cook et al., 2017; Nielsen et al., 2017; Simpson et al., 2017a). Such tension results from the acknowledgment that, although residents with dementia are more vulnerable to abuse, sexuality and intimacy may also be beneficial for them. For these residents, sexuality and intimacy can be a way to express themselves and to maintain a connection with their partners (Mahieu et al., 2017). Getting answers to several questions may help nurses to analyse the situation and identify the best solution for the patient: Does the resident in question willingly engage in sexual activity? What risks does the displayed sexual behaviour entail? Are these risks unreasonable? How does one deal with the family? (i.e., do they have right to be informed? Should nurses intervene under request of the family?) (Everett, 2008; Mahieu et al., 2017). Clearly, an interpretative dialogue is needed to properly answer these questions and, thus, it should be implemented in everyday care.

Finally, as an intrinsic dimension of the human being, dignity is assumed to be the ethical criterion of care (Gastmans, 2013). This means that care should always respect and promote the dignity of all the parties involved. For example, as previously mentioned, lack of privacy threatens residents, nurses, and relatives' dignity. Different measures can be assumed to address the problem, such as knocking before entering a room and creating more private areas (Tzeng et al., 2009; Mahieu et al., 2011). Family can also be better informed of how dementia can alter people's sexual behaviour (Mahieu et al., 2011). Dignity has to be promoted also at the institutional level. Evidence shows that knowledge and attitudes towards intimacy and sexuality in older adults are positively correlated (Aguilar, 2017; Bauer et al., 2016; Mahieu et al., 2016). Therefore, institutions should offer continuous training and education for nurses. Moreover, as noted by Roach (2004), positive attitudes and facilitation towards sexuality and intimacy in nursing homes can be supported by context-sensitive policies. However, scarce evidence about the prevalence of policies regarding sexual expression in nursing homes reveals that these policies are rarely implemented (Celdran, Villar, Serrat, Faba & Martinez, 2018). Hence, there is room for improvement in developing written policies for dealing with sexuality and intimacy in aged care. This would enable nurses to deal effectively with residents' manifestation of sexuality and reduce their own vulnerability in these interactions. Conversely, this would also reduce residents' vulnerability by addressing their needs in a sensitive and effective manner and thus by promoting dignity-enhancing care.

6. Conclusions

Nurses' reactions to older nursing home residents' expressions of sexuality and intimacy can be positive (i.e. active facilitation), neutral (i.e. tolerance), or negative (i.e. termination), depending on personal, relational, and institutional contexts. Situations of

sexual expressions made both nurses and residents feel vulnerable, the former unprepared to deal with them, and the latter, denied. Nurses need guidance in dealing with residents' expressions of intimacy. Continuous educational programs for nurses and creating opportunities for open communication among colleagues, residents, and family members will promote dignity-enhancing care, both from the perspective of the residents and from the nurses' perspective.

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Table 1 Overview of participant characteristics (N=15), frequency of encounters (N=13), and experiences (N=14) with situations involving intimate/sexual behaviour of residents.

Characteristic (N=15)	N (%)
Gender	
Male	2 (13)
Female	13 (87)
Age	
51 - 60	1 (6)
41 - 50	9 (61)
31 - 40	5 (33)
Employment status	
Full-time (> 80%)	13 (87)
Part-time	2 (13)
Working experience in nursing home (years)	
26 - 35	2 (13)
16 - 25	2 (13)
6 - 15	7 (47)
0 - 5	4 (27)
Level of education	

Undergraduate nursing degree	7 (47)
Bachelor in Nursing	7 (47)
Master in Nursing Science	1 (6)
Frequency of encounters with intimate/sexual behaviour of residents (N=13)	
	N (%)
Weekly	3 (23)
Biweekly	2 (15)
Monthly	1 (9)
Occasionally	5 (38)
Seldom	2 (15)
Never	0 (0)
Experience with situations involving intimate/sexual behaviour of residents* (N=14)	
	N (%)
Making sexual remarks	
towards caregivers	12 (86)
towards other residents	3 (21)
towards family members	0 (0)
towards visitors	0 (0)
Making sexual advances	
towards caregivers	11 (79)
towards other residents	7 (50)
towards family members	0 (0)
Cuddling / kissing	

Cuddling with own partner	9 (64)
Cuddling with other residents	9 (64)
Kissing with own partner	7 (50)
Kissing with other residents	6 (43)
Masturbation	5 (36)
Intimate relations between residents	8 (57)
Other (cuddling/kissing with caregivers; inappropriate sexually deviant behaviour)	3 (21)
* Multiple items possible: total >100%	

Figure 1: Conceptual framework