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Need or right: Sexual expression and intimacy in aged care

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ABSTRACT

This paper explores how the residential aged care sector could engage with residents' sexual expression and intimacy. It is informed by a study of 19 aged care staff members and 23 community members, and initially designed on the principles of Appreciative Inquiry methodology. The data were collected through focus groups and interviews and analyzed using discourse analysis. We found that staff members mainly conceptualize sexual expression as a *need* to be met, while community members (current and prospective residents) understand it as a *right* to be exercised. We conclude that the way in which sexual expression is conceptualized has critical implications for the sector's engagement with this topic. A 'needs' discourse informs policies, procedures and practices that enable staff to meet residents' needs, while a 'rights' discourse shapes policies, practices and physical designs that improve residents' privacy and autonomy, shifting the balance of power towards them. The former approach fits with a nursing home medical model of care, and the latter with a social model of service provision and consumption.

Introduction

There is now no question that people's sexual desire and activity can continue well into later life. This knowledge was established as far back as the Kinsey's studies in the 1940s and 50s (Kinsey, Pomeroy, & Martin, 1949; Kinsey, Pomeroy, Martin, & Gebhard, 1953), and in subsequent studies (Gott, 2005; Hite, 1976; Masters & Johnson, 1966; Minichiello, Plummer, & Loxton, 2004). Studies also show equal levels of sexual desire between older people who reside in and out of aged care, although this interest is rarely acted upon in the facility (Hubbard, Downs, & Testerm, 2003). Yet the aged care sector has largely ignored or pathologized residents' sexual expression (Gilmer, Meyer, Davidson, & Koziol-McLain, 2010), and only recently has shown interest in this knowledge. The primary question explored in this paper is *how* the residential aged care sector could engage with the sexuality of older people. This question becomes all more salient with the impending entrée into the aged care sector of the baby boomers, who as part of the 'so-called' sexual revolution and other social movements in the 1960s and 70s, including the women's and gay liberation movements, have championed more liberal attitudes towards sex, sexuality and sexual relations than previous generations (Jönson & Jönsson, 2015).

This paper draws upon findings from a research project that sought staff and community member views about how the residential aged care sector *currently* responds to residents' sexual expression, and how it might respond *in the future*. As one manager of an aged care facility claimed, in relation to the subject and its future, 'we have to get this right'.

This research builds upon a previous project conducted by one of the authors that explored the current sexual experiences of baby boomers, and found a strong trend within this cohort of men and women towards feeling more confident and comfortable with expressing their sexuality as they age (Rowntree, 2014). The baby boomers in the first study expressed concerns about the capacity of aged care services, particularly residential, to recognize their expectations about sexual expression (Rowntree, 2014). These fears about erosion in sexual autonomy appear well-founded given that previous studies have found that sexual expression in aged care facilities remains invisible and problematic (Frankowski & Clark, 2009), negative attitudes exist by staff towards residents' sexual expression (Bouman, Arcelus, & Benbow, 2007; Gilmer et al., 2010), education is still required to improve staff attitudes and beliefs

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(Bauer, McAuliffe, Nay, & Chenco, 2012; Shuttleworth, Russell, Weerakoon, & Dune, 2010; Walker & Harrington, 2002), including training in sexual diversity and hetero-normativity (Tolley & Ranzijn, 2006) and other institutional barriers exist, such as lack of privacy (Gilmer et al., 2010), and lack of information and policies (Bauer, Nay, & McAuliffe, 2009).

Privacy, protection and power dynamics in aged care

An emerging multidisciplinary body of knowledge within the nursing, social work, legal, sociological and anthropological literatures also acknowledges the challenges and dilemmas of the aged care sector's dual remit towards providing residents with privacy on the one hand, and protection on the other. For example, a study of two Swedish nursing homes found the sector's ambivalent mission as a place of care and a place of residence compromised residents' autonomy (Wikström & Emilsson, 2014). A study of three assisted living settings in the US found that matters of sexual expression were further confounded by ambiguity about who the rightful client and primary decision-maker is, and at what point a resident's cognitive decline impinges on their capacity to make competent decisions (Frankowski & Clark, 2009). In another study of seven US assisted living settings that investigated whether the criteria for quality of life in aged care differed between the perspectives of residents, relatives and staff members, the quandary of who controls 'the lock and key' featured in all stakeholders' narratives (Morgan, 2009). According to Morgan, 'the room lock' is emblematic of the unresolved balance in residential aged care between protection and safety on the one hand, and privacy and autonomy on the other. The former responsibility is indicative of a medical model, and the latter, a social model of care.

Reingold and Burros (2004) identified two additional dynamics within nursing homes that seriously undermine residents' sexual expression. The first is the existence of conservative values stemming from their religious affiliations. The second is the administration's fear of liability leading them to defer decision-making to relatives. The findings of this study indicate that these norms are so powerful that residents will, if cognitively competent, acquiesce to them and cease sexual activity even when they are still interested. Relatives were also found to over-ride residents' choices in a US study of the perspectives of ombudsmen who had intervened in disputes over sexual expression, despite the aged care facilities espousing philosophies about promoting resident autonomy and independence (Cornelison & Doll, 2013). This finding led Cornelison and Doll to conclude that facilities should honor rather than compromise the values they advocate, by ensuring residents have access to a rights advocate, staff have access to training, and structural designs are improved to enhance physical privacy.

An Australian phenomenological study found that while staff members were well aware of the low level of privacy for residents in aged care, they were not uncomfortable about it, justifying their position in terms of fulfilling their care-giving responsibilities (Bauer, 1999). Lack of privacy in aged care, though, is not only related to lack of space and time. The study also identified that privacy is compromised through lack of confidentiality, with detailed personal information often being freely shared amongst staff, even when it has nothing to do with their care. The position by staff that this control is valid supports another study by Petriwskyj, Gibson, and Webby (2015) that explored the negotiation of power in staff/client engagement within an Australian aged care service. The researchers found that a difference in the way staff and clients viewed this control of power. The use of such control within an ethic of care was seen as unproblematic by staff. Clients on the other hand held mixed views, with some accepting and even expecting staff power over decision-making, and others resentful of this control. This latter view is more strongly reflected in yet another Australian phenomenological study that explored the meanings older people who receive high levels of community care attach to their experiences, particularly regarding the impact on their autonomy, independence and personal fulfillment (Doyle, 2014). Doyle (2014) found that participants were dissatisfied with the erosion of their power, describing situations in which caregivers were inclined to ignore or over-ride their wishes (Doyle, 2014).

This body of knowledge about privacy, protection and power dynamics in aged care is particularly salient when it comes to discussing the findings of our study. Given the paucity of this nascent literature, we have included studies that refer to both residential and community settings, and include terms such as nursing homes, residential aged care facilities and assisted living. While our study refers to residential aged care, the results may well be useful in other aged care settings and the aged care sector in general.

The sample

The University of South Australia Human Research Ethics Committee approved this study that gathered staff and community member views about how the residential aged care sector has responded to or could facilitate sexual expression and intimacy. In this study community members include both current and prospective aged care residents. We refer to these latter community members as 'prospective residents' given that they are contemplating their futures in residential aged care. Firstly, research participants were recruited through an advertisement placed in *The Advertiser*—the main newspaper in South Australia. Community members responded to the newspaper advertisements by contacting one of the researchers to express an interest in participating in the study. The interviews were conducted by both researchers in venues nominated by the participants such as their homes, and the focus groups were held at a room in the university. Emails were also sent to all residential aged care settings across Adelaide, South Australia. However, it was not until a respondent to the newspaper advertisement, who had previously worked in the aged care sector, facilitated our contact with the manager of a large residential facility with multiple locations, that we were able to recruit staff members. A flyer was circulated to all staff members inviting them to an interview with one of the researchers in a room organized by managers at two separate locations. Interested staff members were provided an Information Sheet and their written consent was obtained before being interviewed.

The total sample comprised 42 participants—19 staff members (18 women and one man) and 23 community members (15 women and eight men). Our intention had been to hold separate focus groups with staff and community members