INTIMACY POLICIES IN LONG-TERM CARE FACILITIES

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Sexual intimacy is an important topic in later life. This topic, however, has not been widely explored in long-term care facilities. This study surveyed long-term care administrators in nursing homes and assisted-living facilities throughout the state of Ohio to see if their facilities had policies regarding intimacy, what types of intimate behaviors are permitted, what different types of relationships are recognized, and how staff members handle intimate behaviors among residents. Over half of the administrators who participated in this study reported that their facilities had policies for intimate behaviors for residents. Specification of intimate behavior was shown to be lacking in the facilities that had policies in place, and the facilities that did not have policies in place still reported to allowing some intimate behaviors. The themes of consent, autonomy, privacy, and reviewing intimate relationships on a case-by-case basis were revealed as main components of the policies and attitudes toward intimate behaviors. Staff training was shown to be lacking throughout the facilities, and violations of policies varied by facility. Overall, the results show a need for clearly stated policies and staff training.
To my hero, my best friend, my dad:

Who is always with me, constantly motivating me to succeed in all that I do.

All of who I am, is all because of him.
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**Introduction**

Older adults as sexual beings are a reality that many individuals neglect to acknowledge. In long-term care facilities, this fact cannot continue to be ignored because despite their residency in facilities, their sexual needs are still of importance. Older adults in facilities may have different types of partnered relationships: married to another resident, married to a non-resident, single and wanting to initiate intimacy with a fellow resident, or married to a non-resident and wishing to engage in a new intimate relationship with a resident. The recognition of different types of relationships besides heterosexual ones has emerged in long-term care facilities in terms of lesbian/gay/bisexual/transgender (LGBT) relationships as well. Some long-term care facilities have policies in place in order to outline what is acceptable intimate behavior and what is not acceptable, and to understand how staff members are trained to react to intimate relationships. Staff perceptions and training is of interest as well; a staff member’s attitudes toward sexuality and their education on how to react in situations where one or more residents are engaged in intimate behavior is of importance to ensure that the resident(s) are safe and comfortable in their home. This study will explore if long-term care facilities have policies in place, what these policies specifically entail, and how staff plays a role in carrying out these policies.

**Sexuality in Later Life**

Sexuality in later life in terms of desire, activity, and function has been seen to be prominent amongst older adults (Kalra, Subramanyam, & Pinto, 2011). The idea that an individual is too old to enjoy sexual encounters is a misconception because the reality is that many older adults still have intact sexual desires and are concerned with being able to remain sexually active (Kalra et al., 2011). Studies have consistently revealed that older adults are still
active and interested in sexual activities (Walker et al., 1999) with 72% of older adult men and 46% of older women, between the ages of 57-72, reporting having sex in the past year (Karraker et. al., 2011).

Frequency of sexual activity amongst older adults often declines with age for most (Walker & Ephross, 1999), due to physical health, psychological well-being, and the availability of a sexual partner (Karraker, DeLamater, & Schwartz, 2011). On average, women outlive men, making finding a monogamous heterosexual partner for women fairly difficult, especially because a trend that has shown typically older men sexually partner with younger women (Karraker et al., 2011). Older adults who have specific illnesses, such as arthritis, may see a decline in sexual functioning, or certain medications, such as ones that are used to treat hypertension, may create impairment on sexual function (Karraker et al., 2011). Emotional well-being has a positive association with sexual activity and satisfaction; however, declines with mental health and cognitive functioning have been shown to have a negative effect on sexual expression (Karraker et al., 2011).

Another common reason that an older adult may have a decline in the frequency of their sexual activity is due to societal barriers. Older adults may have internalized negative attitude toward their sexuality because society has set forth an idea that sexual activity is considered youthful (Huffstetler, 2006), projecting the idea that older adults should not be sexually active. In more recent research, sexuality has been discussed as something that is a part of healthy aging and a lifelong practice (Sandberg, 2013). More specifically, research has discovered that oftentimes, sexuality and intimacy are explored even a little deeper, in the terms that it allows older adults to be more connected, increase closeness, and create a stronger emotional attachment to their partners (Sandberg, 2013). These deeper connections are due to the fact that
older adults do not have such strong “fiery urges” as they once did in adolescence, and intimacy in later life allows for a more romanticized approach to intimacy (Sandberg, 2013). Not only do these benefits arise, but also overall improvement in well-being can occur due to maintaining a sexual relationship (Watters & Boyd). This enhancement in well-being is due to the fact that sexual activity can bring love, intimacy, and closeness, three ideas that contrast what could occur without sexuality present, such as, social disengagement, depression, and diminishing self-worth (Watters et al., 2009). The idea that older adults are no longer sexual human beings due to their age is a fallacy, and facilities should not shy away from this reality (Watters et al., 2009).

Sexuality in Nursing Homes

Even though sexuality amongst older adults is relevant, the topic of sexuality in old age group is often ignored or considered to be unthinkable (Darnaud, Sirvain, Igier, & Taiton, 2013). However, professionals are aware that sexuality is a part of the lives of older adults, however, having a living situation that is compatible with older adults wishing to partake in sexual relations is fairly unorganized (Darnaud et al., 2013). Oftentimes, privacy in the nursing facilities is something that is not even provided for older adults to be intimate (Esterle, Munoz Sastre, & Mullet, 2011). Even if facilities do offer space for older adults to explore their sexuality, residents may still feel unable to be intimate due to the proximity of the room to other residents who may be able to overhear or witness sexual behavior (Rheaume & Mitty, 2008). The older adults in these facilities are aware of their need for sexual activity. Mroczek and colleagues (2013) studied the psychosexual needs of older adults in nursing facilities and found that residents recognized that there was a correlation between quality of life and sexual intercourse. Health status, education, age, gender, and marital status had no effect on whether a resident was
able to recognize this psychosexual need (Mroczek et al., 2013). Even in long-term care institutions, intimate relationships for older adults are necessary.

**Staff Perceptions**

Nursing home staff members tend to have difficulty and confusion when an intimate situation arises between residents, but more specifically, amongst residents with dementia (Di Napoli, Breland, & Allen, 2013). For residents with a cognitive impairment, staff may intervene by calling the resident’s family or calling a family meeting (Di Napoli et al., 2013). Also, staff may often not tolerate the affection that is displayed and often go as far as separating the individuals from each other, regardless if the resident has a cognitive impairment or not (Esterle et al., 2011).

Staff perceptions on resident sexuality are often influenced by the staff member’s individual comfort level with sexuality in general (Roach, 2004). Along with their own comfort level, staff members are also susceptible to the societal stereotypical and ideas about older adults not being sexual beings (Rheaume et al., 2008). Staff members may be more supportive if the residents are emitting caring and romantic type of behaviors, but overtly sexual behavior usually generates distaste and a need to protect the residents from this type of behavior (Rheaume et al., 2008). However, other research has found the nurses reported very negative attitudes when they discovered that residents were involved in intimate acts such as hugging, kissing, or holding hands (Gastmans, 2014), which are acts that would not generally be considered overtly sexual. While research has focused heavily on residents with dementia and how intimacy plays a role; however, research has not been specific to different types of relationships that can form in long-term care facilities among residents without any indication of a cognitive impairment.
Staff Training

The training aspect of staff around issues of sexuality has been investigated very little. Those who have researched this topic found that education on sexual expression in older adults and the role of the healthcare professional can have a fairly significant impact on staff’s acceptance of sexuality for residents in long-term care (Bauer, McAuliffe, Nay, & Chenco, 2013). Not only is education needed to improve acceptability, but also with incorporating an examination of staff member’s personal values and beliefs in regards to sexuality in general (Roach, 2004).

In the realm of residents with dementia and sexuality, the need for understanding how to care for these residents is necessary as well (Roach, 2004). Residents with dementia pose a potential threat to facilities in terms of sexuality. Facilities either risk not allowing residents to emotionally or physically express themselves or they risk potential liability if the resident has a degree of cognitive impairment (Lindsay, 2010; Heath, 2011). Ethical and legal issues are a main concern for older adults with dementia (Loue, 2005), which can result in the creation of policies and training programs being difficult to formulate. Even in facilities where sexual expression was seen as normal, and for residents with dementia, facilities did not offer policies that explicitly outlined sexuality, resulting in the staff handling any type of intimate issue informally and on an individual basis (Shuttleworth, Russell, Weerakoon, & Dune, 2010).

Overall, sexuality in later life, more specifically in long-term care facilities, is a topic that pertains to almost every older adult. Older adults are still sexual beings and have to be acknowledged as such while living in these facilities. Very little has been researched as to how different relationships in facilities are either approved or regulated. In addition, research has failed to examine whether facilities have an outlined policy related to intimacy at all. Research
that has been done on staff perceptions and training has been scarce as well; no two articles report the same exact information in this realm. This study will address several research questions: Do nursing homes and assisted-living facilities have explicit policies on sexuality within a facility? How are staff members made aware of formal/informal policies? How do administrators perceive how staff react and manage resident sexuality?

**Methodology**

**Procedures**

In order to address these research questions, this cross-sectional study was conducted using a list of long-term care administrators from a master list, which contained nursing home administrators from Northwest Ohio and a master list, which contained both nursing home and assisted-living facility administrators, from Leading Age Ohio. None of the administrators from Northwest Ohio were contacted from the Leading Age Ohio master list. Leading Age Ohio contained contact information for specifically non-profit nursing homes and assisted-living facilities. Participants were e-mailed a recruitment letter (Appendix A) informing them of their selection, the nature of the study, their voluntary participation, and the hyperlink to the questionnaire. The questionnaire (Appendix B) was developed via Qualtrics. Participation was acknowledgement of informed consent.

The anonymous survey contained a combination of close-ended and open-ended questions, with data being both quantitative and qualitative. To conceptualize the topic of intimacy, a checklist within the questionnaire was available in order to ensure that participants had a clear understanding of the main topic. The behaviors in the study that were used to define intimacy included hand holding, hugging, kissing, touching of sex organs, masturbation, oral sex, and vaginal/anal intercourse.
Participants

A total of 198 administrators were eligible with 88 potential participants coming from the Northwest Ohio master list and 110 potential participants coming from the Leading Age Ohio master list. The Northwest Ohio master list was contacted twice; the first time the e-mail was sent through the Qualtrics mailing option and the second time through a personal e-mail, to ensure that the e-mail was not being sent to their junk mailbox. Of the eligible participants, 12 long-term care administrators participated in the study, making the response rate 6%. The low participation rate may be due to the high turnover rate with administrators moving facilities, the contacts from the lists not being updated, and/or the e-mails being incorrect and unable to deliver.

Fifty-percent (6) of the participants identified their facility as a nursing home and 50% (6) of the participants identified that their facility included both nursing and assisted-living. Thirty-three percent of the facilities were identified to be in a rural area, 25% of the facilities were identified to be in an urban area, and 42% of the facilities were identified to be in a suburban area. The facilities were financial organized as 33% for-profit and 67% non-profit. Forty-two percent of the facilities were affiliated with a religious organization and 58% of the facilities were not religiously affiliated. The religious affiliations that were identified include United Methodist, United Church of Christ, American Baptist, and Values Based in Quaker Principles. Facility size ranged from 405 beds, which included both nursing and assisted living, to 60 beds, which was only a nursing home. One facility had 79 beds, five facilities had beds ranging from 90 to 110, and three facilities had beds ranging from 140 to 145. All of the participants were administrators within the state of Ohio.
Ethical Considerations

The Human Subjects Research Board (HSRB) at Bowling Green State University reviewed the study protocol. The HSRB indicated that their approval was not needed due to the nature of the study. However, all potential participants were given written information about the purpose of the study, how the data would be collected, and that their participation was voluntary and they could end their participation at any time. Informed consent was gained by beginning the questionnaire. Neither the questionnaire, nor Qualtrics gained any type of identifying information from the participants, making the respondents’ participation in the study completely anonymous. Participants were not compensated for their participation.

Analysis

Quantitative data were analyzed through Qualtrics, which formulated the statistical and numerical data that are presented in this study. Qualitative data were analyzed through a process of reading and re-reading the responses to the same question across every survey. Responses to open-ended questions were read several times, and then given one word to define what the statement was denoting. The consistent words that were given to each statement developed the formation of the themes presented in the data analysis.

Results

Quantitative Analysis

The results of the questionnaire identified that 58% (7) of the facilities have policies related to any degree of intimacy, versus the 42% (5) facilities that report that they do not. Along with the policy aspect, 75% of the facilities offer a private room that is available for residents to be intimate. With the questions pertaining to specific intimate behaviors, the majority of the
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Administrators not only checked all of the intimate behaviors on the list, but they also checked the option of “our policy(ies) do not specify,” making some percentages not equal 100%.

Residents who are married/partnered to someone not residing in the facility.

Fifty-eight percent of the administrators identified that hand holding, kissing, touching of sex organs, masturbation, oral sex, and vaginal/anal intercourse were permitted activities for their residents. Seventy-five percent of the participants, however, checked that their policies did not specify the type of intimate behavior permitted.

Of the facilities that had an intimacy policy in place, only one administrator claimed that they specify in their policies that all of the intimate acts listed be permitted. Three facilities identified that they allow all of the intimate behaviors, but their policies do not specify whether those behaviors are permitted. Also, three facilities marked that they have policies, but none of their policies specify what type of intimate behavior is allowed, and they did not select any of the intimate behaviors.

Of the facilities that had no intimacy policies in place, four facilities still checked that they permitted all of the intimate behaviors listed. Two of the administrators checked that they do not specify and did not check whether they permitted any of the intimate behaviors.

Two residents who are both married/partnered and are both residing in the facility.

Fifty percent of the participants identified that hand holding, kissing, touching of sex organs, masturbation, oral sex, and vaginal/anal intercourse were permitted activities for these residents. Seventy-five percent of the participants, however, checked that their policies did not specify the type of intimate behavior permitted.
Of the facilities that had an intimacy policy in place, three facilities reported that they specify in their policies that all of the intimate acts listed be permitted. Four facilities identified that they have a policy in place, however, their policies do not specify.

Of the facilities that had no intimacy policies in place, three facilities still checked that they permitted all of the intimate behaviors listed. Two of the administrators checked that they do not specify and did not check whether they still permitted any of the intimate behaviors.

Two residents who are single and wish to initiate an intimate relationship.

Forty-two percent of the participants identified that hand holding, kissing, touching of sex organs, masturbation, oral sex, and vaginal/anal intercourse were permitted activities for these residents. Seventy-five percent of the participants, however, checked that their policies did not specify the type of intimate behavior permitted.

Of the facilities that had an intimacy policy in place, only one facility reported that they specify in their policies that all of the intimate acts listed be permitted. One facility identified that they allow all of the intimate behaviors, but their policies do not specify whether those behaviors are permitted. Also, five facilities marked that they have policies, but none of their policies specify what type of intimate behavior is allowed, and they did not select any of the intimate behaviors.

Of the facilities that had no intimacy policies in place, two facilities still checked that they permitted all of the intimate behaviors listed. Two of the administrators checked that they do not specify and did not check whether they still permitted any of the intimate behaviors. Also, one facility checked that their facility permits all of the listed intimate acts except oral sexual activity.
Two residents where one or both are married to a non-resident.

Twenty-seven percent of the participants identified that hand holding, kissing, touching of sex organs, masturbation, oral sex, and vaginal/anal intercourse were permitted activities for these residents. Ninety-one percent of the participants, however, checked that their policies did not specify the type of intimate behavior permitted. Of the twelve respondents to the study, one did not respond to this particular question.

Of the facilities that had an intimacy policy in place, one facility identified that they allow all of the intimate behaviors, but their policies do not specify whether those behaviors are permitted. Also, five facilities marked that they have policies, but none of their policies specify what type of intimate behavior is allowed, and they did not select any of the intimate behaviors. Of the one respondent who chose to abstain from this question, their facility has a policy in place.

Of the facilities that had no intimacy policies in place, two facilities still checked that they permitted all of the intimate behaviors listed. Three of the administrators checked that they do not specify and did not check whether they still permitted any of the intimate behaviors.

Lesbian/gay/bisexual/transgender (LGBT) relationships.

Fifty-percent of the administrators identified that their facilities had policies related to LGBT relationships, and 50% identified that they do not have policies specific to these types of relationships. Forty-percent of respondents identified that they allow all of the intimate behaviors that are listed, and 80% of the participants said that their policies do not specify.

Of the facilities that did in fact include this group, two administrators marked that hand holding, kissing, touching of sex organs, masturbation, oral sex, and vaginal/anal intercourse were permitted activities for these residents.
Of the facilities that did have this group included in their policies, one facility identified that they allow all of the intimate behaviors, but their policies do not specify whether those behaviors are permitted. Three facilities marked that they have policies, but none of their policies specify what type of intimate behavior is allowed. One facility marked that they permit all of the behaviors, but that their policies do not actually specify. One of the non-respondents for this question selected that they have a policy in place for LGBT relationships.

The facilities that did not have this group included in their policies, four facilities still checked that they permitted all of the intimate behaviors listed. One of the non-respondents for this question selected that they do not have a policy in place for LGBT relationships.

**Staff training and family roles.**

The question on how prominent of a role family members play in a resident’s intimate relationships was presented. Administrators were asked to answer subjectively, and 58% of the participants do feel that family members play a role in whether policies are followed. In other words, there is a conflict between the policy and family desires. Forty-two percent of the administrators reported that family members do not play a role in a resident’s relationship. In other words, there is no conflict between the policy and family desires.

**Qualitative Analysis**

**Themes.**

The results of the open-ended questions revealed that there were four distinct themes present throughout the responses: consent, autonomy, privacy, and case-by-case basis. Each theme will be explored and quotes from the administrators are provided to support the themes. The type of the facility and the presence or absence of an intimacy policy are included along with the quote.
**Consent.**

The theme of consent surfaced as the most frequently mentioned and consistent amongst all of the different categories, regardless of marital status, sexuality, and cognitive status. The theme of privacy also overlapped with this category, with administrators emphasizing that consent is key as long as these actions are done in a private setting:

Married residents who are cognitively able to consent as well as any two consenting residents are free to engage in any form of affectation or sexual contact in a private setting. If the resident's do not share the same room, center will attempt to provide a room for their privacy (nursing home, policy in place).

Even for facilities that do not have policies specific to intimacy, the administrators still explained that being able to consent is key. One administrator noted, “We don't have any policies on intimate behaviors. In nursing, sexual activity is allowed in situations in which it is consensual, in which the resident is able to consent” (nursing home and assisted living, no policy).

The emphasis on an individual being cognitively competent to make decisions rang throughout the responses as well, describing the facilities attempt to ensure that individuals can do as the please if they are able to make the decision:

Our policy asks that one "lives life to the fullest", and that the rights of residents and employees must be respected. A crude synopsis is that whatever is consented to among alert, mentally competent individuals is acceptable behavior. No one is to be abused (nursing home and assisted-living facility, no policy).

If an older adult(s) who reside in the facility do not have the ability to give their consent, the facilities ensure that someone who is a responsible party for the individual gives their consent
before the facility allows intimate encounters: One administrator explained, “Two adults that live in our center if they are able to make their own choices or their guardian is in agreement with in the privacy of their own room maybe be together however they choose to be” (nursing home, policy in place).

*Autonomy.*

The theme of autonomy emerged throughout the responses in every category, with the emphasis from one facility specifically, that their policies fall within the accordance of basic resident rights, with their response in every category being. One administrator noted, “Part of the regulatory resident rights packet” (nursing home and assisted-living facility, policy).

Unless one of the individuals in the relationship is not in acceptance with the sexual acts that may be desired by their partner and/or fellow resident, facilities ensure that staff members allow their residents to make their own choices. One administrator said, “This would be of their choice as long as they can make their own decisions…facility staff would not intervene unless one party was not in agreement” (nursing home, policy).

If an older adult in the facility is married and embarks on a new intimate relationship with a new partner while they are residing in the facility, individual choices are still valued. One administrator explained, “This rarely occurs, but we permit this, but are sensitive to the non-resident marital partner” (nursing home and assisted-living facility, no policy).

Even for individuals that may wish to embark or are currently in an LGBT relationship, facilities respect their choices despite sexuality. One administrator noted, “This would be no different than other couples. Our person-centered policies support individual needs and considerations, including a sexual nature” (nursing home and assisted-living facility, policy).
Privacy.

The issue of privacy was a topic that was repeatedly present amongst the responses from the administrators. The idea of a person-centered approach to care was presented within the responses, which included the theme of privacy. One administrator mentioned, “We are a person-centered community. Individuals have sexual needs and residents have the privacy to maintain or initiate personal relationships to engage in any of the above activities. All resident rooms are single/private as well” (nursing home and assisted-living facility, policy).

The assurance that a resident’s health would not be at risk was of a concern of one facility, along with assurance that the acts are in private. One administrator said, “We permit sexual contact as long it is done in a private setting, and does not present a health risk to either participant” (nursing home and assisted-living facility, no policy).

Despite cognitive status, the idea of privacy being of key importance for the facility to allow intimate behavior was presented as well. One administrator explained, “If both are in agreement that they want relationships of this type they must do so in private. If one or both have a power of attorney or guardian then we ask permission if such a relationship is suspected” (nursing home, policy).

Case-by-case basis.

Although there was not much variety in responses with this theme, several administrators emphasized throughout their responses that often each situation has to be looked at and handled dependent on the individual. One administrator stated, “Our practices always take into consideration each person and the specific circumstances to be sure resident rights are being supported” (nursing home and assisted-living facility, policy).
The idea of sexual abuse was most prominent in this category, with administrators explaining that their policies only expand to the dimension of sexual abuse, and everything else has to be viewed individually. One administrator explained, “We have policies related to sexual abuse, however we do not have specific policies pertaining to non-abusive forms of intimacy. These cases are viewed on an individual basis and appropriate actions/education taken on a case-by-case basis” (nursing home, policy).

**Cognitive impairment.**

Though briefly discussed within the themes that arose from the questions regarding different intimacy circumstances, a separate, open-ended question was asked to respondents as to whether the policies that a facility may have in place apply to an individual residing in the facility with a cognitive impairment.

Throughout the responses to this particular question, the themes of consent and case-by-case basis are interlaced. Administrators described the difficulty in managing situations such as these:

This is a different issue and a very hard one to manage. If the resident is responsible for them and not causing harm to anyone including them, it is monitored and discouraged but sometimes it is hard to completely stop. If family is involved we try to follow the wishes of the family, but if a guardian/power of attorney is involved we try to abide by those wishes but it is a very difficult type of behavior to control/monitor (nursing home, policy).

The facilities role in protecting the resident from harm was continuously described in one way or another throughout the responses, indicating that they have to act in a way that protects the resident. One administrator explained, “If a resident is not able to cognitively consent to a
sexual relationship, center staff must take measures to ensure protection of the impaired resident” (nursing home, policy).

The prominence of family was the most evident in these responses as well, with a large majority of the administrators explaining that in situations where a resident has a cognitive impairment, the family is key to determining what actions need to take place. One administrator said, “They are different depending on the individual situations. Our job is to protect while upholding the resident's wishes and quality of life, many times family members are involved in these situations” (nursing home and assisted-living facility, policy).

The facility still has to consider the resident’s rights in situations like these, however, their consent is still of main importance, making the judgment on how to handle these situations pressing. One administrator noted, “Yes, it is different, for we have to balance the resident's rights with their ability to consent (to sexual activity)” (nursing home and assisted-living facility, no policy).

**Staff training and perceptions.**

The responses that were given in regards to how staff are trained to handle intimate behavior was somewhat scattered in how facilities ensure that staff are aware of how to handle intimate situations amongst residents. Only two of administrators explained that they have some type of specific training. One administrator stated, “We offer sexuality and intimacy training for our nurses as part of the CDP program” (nursing home, policy).

Other responses, on the other hand, did not indicate any specific type of training for staff members, but rather their education on resident rights; one administrator explained, “we inform of resident rights and educate” (nursing home and assisted-living facility, policy), while another stated, “the right of privacy is explained” (nursing home and assisted-living facility, no policy).
Also, the idea that staff react based on their personal attitudes and feelings was very honestly presented. One administrator admitted, “Staff react I guess based on their feelings with no regard for the adult person involved” (nursing home, policy).

Overall, the responses in this section indicate that there really is no consistent and formal training throughout facilities in order to ensure that staff is trained to formally handle intimacy situations with residents.

**Violations.**

When presented with the question regarding how facilities may handle a violation that is not in accordance with their policies, the responses were very mixed. Some responses emphasized that a resident’s rights is always upheld. One administrator said, “Expressions of intimacy are considered a resident right, so a violation of policy regarding sexual contact is considered an infringement of resident rights - a very serious matter” (nursing home and assisted-living facility, no policy).

Others discussed how there is no formal process as to how to handle certain violations. One administrator noted, “Individually based on the situation” (nursing home and assisted-living facility, policy).

The action of keeping two individuals apart was also a response that was given. One administrator stated, “Separated, monitored, and attempt to keep them apart” (nursing home, policy).

However, some responses addressed how violations can occur for not only residents, but by staff members as well:

Inappropriate sexual activities would be specifically addressed with suitable behavior approaches. Violations of policy might be a resident taking advantage of someone not
interested in any intimate activity. Or another violation might be that a staff member interferes with a resident's right to have intimate/sexual activities. Both would be addressed by appropriate personnel (nursing home and assisted living facility, policy).

The results from this section indicate that there is not set violation process and that each facility has their own method as to how to reprimand individuals, whether they are the residents or staff members.

**Discussion**

An expression of sexuality and intimacy in these long-term care facilities is an area that professionals recognize and permit to occur under certain conditions. Privacy has shown to be a large component in whether facilities allow their residents to be free in their intimate acts. Some facilities even offer a separate space for these individuals wishing to be intimate. Despite whether a resident was cognitively impaired or not, administrators acknowledged that sexual needs still exist, and staff members are to allow residents to fulfill these needs, depending on the degree of cognitive impairment and the context. Overall, these findings have been consistent with what has been discussed in previous literature; professionals are able to acknowledge that sexuality in later life is relevant (Darnaud et al., 2013) and these professionals were able to allow psychosexual needs to be met for these individuals (Mroczek et al., 2013). However, the privacy aspect showed some inconsistencies with research, as the respondents did not provide any indication that privacy for these residents was an issue (Esterle et al., 2011), nor did they indicate that residents had an issue when privacy was provided to these residents (Rheaume et al., 2008). The administrators who addressed the theme of privacy did not indicate that their residents have any issue having privacy for intimacy, but rather, they addressed that they permit behaviors as long as they are done in exclusivity. For further research, looking specifically at residents’
perceptions on privacy in facilities may be helpful to see what issues need to be addressed since administrators emphasize the importance of privacy.

Staff perceptions per administrators, in regards to residents with some degree of cognitive impairment, showed to be fairly complex. Staff members may have conflict in whether to let an individual partake in sexual behavior due to the fact that they may want to allow the resident to make autonomous decisions, however, a resident with a cognitive impairment may not be able to give consent. This situation leaves a large gray area in decision-making, because the staff members are there to ensure that the resident is protected from harm and they may need to intervene, or have family members intervene and consent or not, in situations such as these. The majority of administrators indicated that staff allow residents to make their own decisions regarding intimacy, however, one administrator confessed that he/she believe staff members may react in ways that they feel is right. The idea that staff members may have difficulty with intimacy amongst residents with a cognitive impairment is consistent with previous research (Di Napoli et al., 2013), along with the idea that family members may have to play a role in whether these intimate acts should be allowed to take place (Di Napoli et al., 2013). Some findings show consistencies with how staff members may react to intimate situations; the administrator who admitted that staff react based on their own feelings may be connected with their overall comfort level in regards to intimacy (Roach, 2004) or this may in fact be because they just do not tolerate it (Esterle et al., 2011). However, the majority of the study findings do not correlate with what research has found. The administrators believe that staff do not seem to have an issue with residents being intimate, no matter what the degree of intimacy is, despite what research has shown (Rheaume et al., 2008; Gastmans, 2014).
Staff training seems to be important, yet only two out of the twelve facilities provided training. Some said they emphasize privacy and residents’ rights, and some did not give any indication as to whether any type of training is in place at all. Most of the facilities have some type of intimacy policy in place; however, facilities that do have policies do not clearly define what is permitted intimate behavior. Those facilities that do not have a policy in place overall still allow residents to participate in intimate behavior, but this allowance is in an informal way. Oftentimes, situations are handled on a case-by-case basis, despite whether a resident has a cognitive impairment or not. These findings correlate with previous research in the aspect that more training and education is needed (Bauer et al., 2013). The facilities that did have a policy in place, but did not explicitly outline intimacy, supports previous findings as well (Shuttleworth et al. 2010). However, previous research has not discovered what facilities specifically allow, with or without policies. Also, the implementation of residents’ rights in nursing homes in 1987 was a topic that was discussed, which encouraged the notion that residents have the freedom to be independent to spend their time however they wish and be free to make decisions on their own. This legislation has lacked emphasis throughout previous findings as a source for creating or implementing training education or programs for staff.

Limitations

The biggest limitation to the research was the obtaining of e-mail addresses because there was no available list of long-term care administrators for the state of Ohio. The lists that were available had information that was either out-of-date or incorrect, which caused issues in being able to contact certain administrators. The method of e-mailing the questionnaire to the participants was also of concern as non-deliverable e-mails, change in facility management, and nonresponse were all results of this method of data collection. The small sample size leads to
difficulty in determining relationships in the data. Another limitation is that all responses were self-reported, which may have affected the validity of the answers. A minor setback with the study was that one of the questions pertaining to staff perceptions and family interactions had to be omitted due to the fact that the question was not clear and the options given were not mutually exclusive.

**Implications**

The lack of definition, clarity, and consistency throughout both the facilities with or without a policy points out an important need for policies to be created and a clear outline of what exactly is and is not allowed, especially for the facilities that deal with certain intimate situations by the theme of case-by-case basis. This individual aspect may allow for discrepancies between two very similar situations being handled in two completely different types of ways. Without clear definitions in policies, inconsistencies in regards to how each intimate situation is handled may occur with residents, despite whether a facility has policies in place or not.

Staff training and perceptions are areas that need to be addressed throughout long-term care facilities. The lack of consistent training throughout facilities leaves too much room for interpretation as to how staff should handle intimate behaviors amongst residents. Also, without detailed policies about what is and what is not allowed, there is not any type of documentation to hold staff members accountable to their actions. If a staff member reacts to a resident’s intimate behavior in a way that they deem is best, there is no set documentation to use as a source to solidify that their reactions are a violation. In order to improve training, a program could be implemented and directed by an outside consultant or another resource at a staff member’s orientation. The program should contain some type of evaluation that makes the staff member evaluate their own personal values and beliefs and where these ideals fall in line with their views.
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of intimacy. The program should also contain education about sexuality in later life, such as the positive impacts a sexual relationship can have on quality of life.

For future research, a mailed out questionnaire or a phone questionnaire may be better in order to yield more responses. Also, interviewing in person may yield better information. A different selection of participants, such as the social worker or the director of nursing in facilities may give a different perspective on intimacy in long-term care facilities and the questions that were asked for the study.

Conclusion

The majority of the facilities that were involved in this study do in fact have sexual intimacy policies in place; however, the majority of these facilities do not specify in their policies what types of intimate behaviors are allowed. The majority of the facilities that do not have a policy in place still allow intimate behavior. These administrators responded that their facilities do not actually have anything in place that is specific to intimacy, but they still allow all of the intimate behaviors that were listed in the questionnaire to occur. Seventy-five percent of the facilities in the study offer a private room for residents to be intimate, a room that is separate from their regular room that they stay in. Relationship status of the resident does not change what types of intimate behaviors are allowed. There were four different relationships listed throughout the study, each with a list of the intimate behaviors to be selected from. Despite the different relationships, all of the intimate behaviors that were listed are allowed for residents. The majority of the administrators did not specify what was permitted intimate behavior for LGBT relationships. Even for the facilities that do include LGBT relationships in their policies, the administrators still selected the option that the intimate behaviors that are allowed are not specified for this population. The majority of the facilities identified that family members play a
role in whether intimate relationships or behaviors are allowed. The administrators acknowledged that a resident’s intimate relationship can be affected by what a family member may feel is best.

There were four themes identified after analyzing the open-ended responses: consent, autonomy, privacy, and case-by-case basis. The administrators acknowledged that residents should be able to have intimate relationships as long as every resident involved in the relationship are able to give their consent. The administrators also recognized the right of the residents to be able to be autonomous and make decisions based on their own personal freedom. The issue of privacy was very consistent throughout the responses that mentioned it, with all of the administrators outlining that intimacy is allowed as long as it is done somewhere that is private. The theme of case-by-case basis yielded two different types of responses; either the facility only has cases related to sexual abuse, therefore, everything else is looked at individually, or the facility overall looks at every intimate relationship on an individual basis. Residents with cognitive impairments proved to be situations that are difficult to manage. The administrators acknowledged the residents right to be able to make autonomous decision, however, they also pointed out that staff members are there to shield the resident from harm, and residents with a cognitive impairment may not be able to give their full consent. Therefore, family members are often called upon in situations where staff may fear that the resident cannot give their consent, and the family members are then left to make the decisions. One administrator admitted that they feel that staff does not always act in the best interest of the resident, but often they react in ways that the staff member feels is right. This idea may be due to the staff member’s own personal beliefs about sexuality or due to lack of training. The ways in which
violations are handled vary, as one facility may try to keep the residents apart, whereas another administrator acknowledged that violations could be with the resident or with the staff member.

Hopefully from this study, long-term care facilities will be able to understand the importance of having a clearly defined policy in place, and either revise their policies or initiate a creation of a policy. Also, this study brings to light the need for an improvement of staff training, which needs to become a priority throughout each facility. Without these policies and trained staff in facilities, a resident may be denied their basic rights as a resident, and not be able to experience a full intimate relationship.
References


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Appendix A. Recruitment Letter

Hello, my name is Maria D’Avello and I am a graduate student in the college of Health and Human Services at Bowling Green State University. I am currently working on a Master of Science in Interdisciplinary Gerontology and my thesis advisor for this study is Dr. Wendy Watson (wwatson@bgsu.edu). I am researching different policies that are currently in place in various long-term care facilities throughout Ohio regarding intimate relationships. To receive this information, I am contacting the administrators of these long-term care facilities in Ohio.

I am contacting you because your facility has been selected to participate in this study. The study will involve a brief survey that will last about 15 minutes of your time. Your participation in this study is completely voluntary and you can choose to not participate or opt out at any time. The study is completely anonymous; neither yourself as the administrator nor your facility will be able to be identified after the survey has been submitted.

By clicking on the link to the survey below, you are giving your informed consent.

https://bgsu.az1.qualtrics.com/SE/?SID=SV_08GH1JMW4fuSShf
Appendix B. Questionnaire

For what type of facility do you administer?
- Nursing Home
- Assisted Living
- My facility includes both

How would you describe the location of your facility?
- Rural
- Urban
- Suburban

How is your facility organized/financed?
- Profit
- Non-profit

Is your facility a part of any type of religious organization?
- Yes
- No

If you answered yes to the above question, please state what religious organization/denomination with which the facility is affiliated below.

What is the size of your facility (number of beds)?

Does your facility have any policies related to any degree of intimacy? (this can include hand holding, hugging, kissing, touching of sex organs, oral/vaginal/anal sexual intercourse)
- Yes
- No

Please check all that are permitted activities for residents who are married/partnered to someone not residing in the facility and are wishing to engage in intimate behaviors
- Hand holding
- Hugging
- Kissing
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- Touching of sex organs
- Masturbation
- Oral sex
- Oral sex
- Vaginal/anal intercourse
- None of these
- Our policy(ies) do not specify

Please explain

Please check all that are permitted activities for two residents who are both married/partnered each other and are both residing in the facility

- Hand holding
- Hugging
- Kissing
- Touching of sex organs
- Masturbation
- Oral sex
- Vaginal/anal intercourse
- None of these
- Our policy(ies) do not specify

Please explain

Please check all that are permitted activities for two residents who are single and wish to initiate an intimate relationship

- Hand holding
- Hugging
- Kissing
- Touching of sex organs
- Masturbation
- Oral sex
- Vaginal/anal intercourse
- None of these
- Our policy(ies) do not specify

Please explain

Please check all that are permitted activities for two residents where one or both are married to a non-resident and wish to initiate an intimate relationship

- Hand holding
- Hugging
- Kissing
- Touching of sex organs
- Masturbation
- Oral sex
- Vaginal/anal intercourse
- None of these
- Our policy(ies) do not specify

Please explain
Hand holding
Hugging
Kissing
Touching of sex organs
Masturbation
Oral sex
Vaginal/anal intercourse
None of these
Our policy(ies) do not specify

Please explain:

Do the policies in your facility include lesbian/gay/bisexual/transgender (LGBT) relationships?
Yes
No
There is a separate policy(ies)

Please check all that are permitted activities for LGBT relationships:
Hand holding
Hugging
Kissing
Touching of sex organs
Masturbation
Oral sex
Vaginal/anal intercourse
None of these
Our policy(ies) do not specify

Please explain:

If a resident has some degree of a cognitive impairment, do these policies still apply to them or are they different? Please explain.

In your opinion, do family members play a role in whether this policy(ies) are followed? In other words, do their wishes usually impact whether some type of intimate relationship is controlled in your facility?
Yes
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☐ No

In your opinion, do staff react to a resident’s intimate relationship based on the policy or on what they, the staff, or the family member believe is right?

☐ Yes
☐ No

Please explain how the staff is trained to handle if a couple is partaking in intimate behavior?


Does your facility offer a private room for residents who wish to be intimate?

☐ Yes
☐ No

How are violations of policy(ies) handled?

