Nurse Manager Perceptions regarding Sexual Intimacy Rights of Aged Care Residents: An exploratory Queensland study

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Abstract

Basic human rights to sexual intimacy and freedom of sexual expression for aged care residents can be denied or under-valued, due partly to stigma associated with older people and sexuality. The objectives of this study were to report Nurse Manager perceptions regarding residents' rights, policies and factors that facilitated or constrained sexual intimacy. A qualitative pilot study using semi-structured interviews was developed, Senior Nurse Managers in Central Queensland) were interviewed, and a thematic analysis undertaken. Results indicated that most facilities had unwritten policies regarding residents' rights to sexual intimacy. Residents demonstrated desire for sexual intimacy in various ways. Privacy considerations, duty of care, residents' cognitive functioning, residents' families and staff attitudes and education facilitated or constrained residents' sexual expression. Conclusions were drawn that residential facilities were complex sites for the expression and management of sexual intimacy; specific factors could facilitate or constrain residents' rights.

Key words: Aged care residents; Sexual intimacy; Nurse managers; policy.

Introduction

The right to sexual intimacy is fundamental for all adults in society including those who are elderly or of advanced age (Bauer, McAuliffe and Nay 2007; Gott 2005; Sherman 1998; Matthias, Lubben, Atchison and Schweitzer 1997; Wiley & Bortz 1996). Ageing *per se* does not necessarily diminish the desire for sexual intimacy and many older people can still yearn for the comfort of sexual or physical contact, whether it be as little as a hug or touch of the hand or as much as full sexual intercourse (Sherman 1998). For the older person however the importance of sexual contact can be readily forgotten or neglected as older people in Western society are typically undervalued and may be stigmatised in this regard (Nay, McAuliffe and Bauer 2007; Reed 2007).

For older people living in aged care facilities, such rights can become potentially more jeopardised as health professionals and service providers can be instrumental in facilitating, or constraining, expressions of sexuality within this environment (McAuliffe, Bauer and Nay 2007). Institutional aged care facilities can be highly complex sites which simultaneously embody clinical and organisational issues. These imperatives include addressing rights, needs and diverse preferences of a wide range of residents. The recognition of residents' needs regarding sexual intimacy for example may become secondary within an organisational

context which is underpinned by a biomedical framework and a strongly regulated industry based on the *Aged Care Act 1997.* For some elderly people therefore, entering an institutional aged care facility could mean that they confront the end of, or significant restrictions in, opportunities for sexual contact or intimacy with others. Few studies have been conducted within the Australian context to date regarding how management and staff in nursing homes perceive and facilitate the sexual intimacy rights of their residents (Minichiello, Plummer and Loxton 2000; Miles & Parker 1999).

This paper reports findings from a small qualitative research project that was undertaken by the first author in 2006 as a component of an Honours degree in social work and as a result of her special interest in the area of human rights and older people. The researcher's intention was to engage in collaborative and reflexive research and to raise awareness and promote discussion regarding sexuality rights and issues within residential aged care facilities. In so doing, it was hoped that older people, families, residential facility nursing staff, policy makers and professionals would benefit from the findings.

Sexual intimacy and the older person

Notwithstanding the fact that ageing is a normal part of life, it is often viewed in Western society with distaste. Many older people are discriminated against on the basis of age alone, a phenomenon referred to as ageism (Bessant & Watts 2002). Discrimination can be based on misconceptions about old peoples' characteristics and capabilities (McMurray 1999). Weeks (2002) argues that the concept of ageing is often associated with negative stereotypes based on prejudice and ignorance; such a portrayal potentially affects the perceptions of older people themselves as well as health care professionals in the gerontological field (McAuliffe et al, 2007; Sherman 1998). This stereotyping is supported by multi-media portrayals of sexuality as being directly associated with being young, beautiful and healthy (Sherman 1998; Minichiello et al 2000).

Negative perceptions, stereotyping and discrimination regarding the older person are therefore also directly linked with sexuality issues (Nay et al, 2007). Over the centuries, human sexuality has been primarily conceptualised as having its basis in 'fixed' human physiology which is associated with sexual 'urges' and the need for penetrative sex. Sexual intimacy is far more than an 'urge' for penetrative sex however and can encompass a wide range of feelings and behaviours (McAuliffe et al, 2007). According to Moss and Schwebel (cited in Kuhn 2002), intimacy can take many forms including commitment, affective intimacy, cognitive intimacy and physical intimacy.

Similarly Sherman (1998) argues:

> Sex and sensuality encompass a kaleidoscope of feelings and activities; from the deepest longings for mutual affection to the simple enjoyment of the company of a loved one. Sexuality also covers a gamut of behaviours – touching, kissing, caressing and cuddling, genital intercourse with mutual orgasm and feelings of closeness and of being wanted and valued as a human being. (p.3)

Finally Miles and Parker (1999) argue that sexual intimacy is integral to all human existence and is a deeply rewarding experience that encompasses concepts such as companionship, passionate love and satisfying sexual intercourse.

For aged people as for all others therefore, sexuality remains fundamental to the human condition and to human expression. Ageing alone does not diminish the yearning for sexual intimacy nor does the diagnosis of a dementing disease (Kuhn 2003). Matthias et al. (1997) argue that sexual expression can help protect people against feelings of separation, fear and coldness, particularly in times of change.

For residents of aged care facilities therefore, although sexual expression and intimacy can be potentially significant in their lives, such expressions within a primarily medical context could be overlooked (McAuliffe et al, 2007) or even interpreted as 'problem behaviours' that require medical interventions like sedation (Dersch, Harris, Kimball, Marshall and Negretti 2005). Robinson (2003) argues however that only a small percentage of nursing home residents have inappropriate sexual behaviours that are associated with dementia.

Sexual intimacy and residents of aged care facilities

Little research in Australia and elsewhere has been undertaken to date involving sexual intimacy and residents of aged care facilities (Reed 2007). According to Archibald (2002), research evidence indicates a general discomfort by the public towards old age sexuality which can also be reflected amongst nursing home staff if confronted with residents' sexual behaviours. McAuliffe et al (2007) argue that the attitudes of health practitioners potentially constitute significant barriers to the sexual expression of older people in aged care facilities.

Similarly Roach (2004) claimed that the attitudes and comfort levels of nursing home staff and management regarding sexuality in general, and sexual activity of old people in particular, could be instrumental in facilitating, or opposing, sexual expression in nursing homes. Roach called this 'Guarded Behaviour' theory. Roach (2004) also found that nursing homes tended to be either 'reactive' or 'proactive' regarding how staff perceived and accommodated the expressed sexual needs of residents; depending on which stance was adopted, staff could 'guard' their discomfort about their own and residents' perceptions of sex. Generally, reactive organisations tended to be supported from top management, with staff discomfort regarding residents' sexually intimate behaviours guarded by ignoring or actively repressing such behaviours. By contrast, proactive nursing homes with associated organisational cultures offered protection, advice and support to all concerned within nursing homes regarding the sexual expressions of residents. This was achieved through staff support and education, consultation with residents' families and allowing residents to freely express their sexuality and their needs for intimacy. Roach (2004) argues however that many nursing home residents are not supported to form or maintain sexual contact or intimacy on a daily basis.

This reflects a denial of basic human rights however and reinforces social attitudes that devalue older people. McAuliffe et al (2007) argue strongly that this is an important policy

issue for aged care facilities and urge policy development, guidelines and staff training. McAuliffe et al (2007) propose a range of possible strategies for aged care facilities and the health professionals working within them that would facilitate the sexual expression of those residents for whom this issue is significant.

The study

This study was a small qualitative study conducted with nurse managers of five Central Queensland aged care facilities. It aimed to explore manager perceptions about relevant policy within their facilities and about factors they believed could facilitate or inhibit residents' rights to form or maintain sexually intimate relationships. The project was approved by the ethics committee of Central Queensland University (CQU) and was conducted according to standards for ethical research as determined by the National Health and Medical Council (NHMRC).

Method

Five Senior Nurse Managers at selected Central Queensland facilities were invited to participate in the research. Data were collected via semi-structured interviews and audio-recorded with participants' permission: later being transcribed for analysis. Interviews lasted between 20 and 60 minutes. This approach allowed participants to report their views in their own terms and provided the researcher with flexibility to explore issues as fully as possible within the parameters and time frames of the study.

In keeping with the conventions of qualitative data analysis (Marlow 2001), interview data were collated, organised and coded for meaning as well as commonalities and differences in thematic content. Coding was cross checked through comparison with that undertaken independently by the first author's research supervisor. Thematic analysis was undertaken manually given the small number of interviews conducted. Emerging themes were then considered in light of key literature and previously gained knowledge (Marlow 2001).

Findings and discussion

Defining sexual intimacy

The importance of defining sexual intimacy was a key theme that emerged from the interview data. Most participants readily identified that sexual intimacy was more than sexual penetration and included physical contact like hand holding and hugging, as well as non-physical contact such as talking and sharing emotions.
One participant reported observing particular behaviours between residents within her facility that she would regard as constituting sexual intimacy:

> *... basically I notice when I'm doing my rounds, that a couple may be holding hands or just being together.*

Similarly a second interviewee reflected upon the meaning of sexual intimacy within the context of the aged care facility:

> *... well I guess part of it is just...just showing some emotion together and holding hands, hugs and that sort of thing.*

A third participant presented a more holistic approach in her thinking about sexual intimacy:

> *Many people when they see sexuality ... think it's got to be physical, penetrating, whatever else. Sexuality…it's spiritual, it's physical, it's emotional, all that is bound in a person's sexuality…*

The last definition, which was provided by the manager of the only facility that had a formal written policy relating to sexual intimacy, reflects Moss and Schwebel's view (cited in Kuhn 2002) that sexual intimacy encompasses a range of emotional, physical and spiritual factors. Of the four remaining participants, one talked about sexual intimacy against a background of the facility's privacy policy while the remaining two participants presented their views against backgrounds of informal, non-written policy regarding sexual issues in their facilities. The latter were less clear in their definitions of sexual intimacy.

One participant only reported having a written policy within their organisation regarding residents' sexual intimacy rights. In general terms, developing and implementing formal policies within organisations can be complex and time-consuming (Hancock 1999). When such policies relate to a potentially challenging area such as older people's rights to sexual expression within a residential care context, proactively developing and implementing policy can be made even more difficult (McAuliffe et al. 2007; Roach 2004).

Facilitating or inhibiting residents' sexual intimacy

Findings suggested that the aged care facility context was a complex one in terms of managing sexually intimate relationships. Interviewees reported a range of factors within the organisational context that could facilitate or inhibit the sexual intimacy rights of residents. These included consideration of privacy principles, duty of care, residents' cognitive functioning, residents' families and staff attitudes and education.

Privacy principles

Several participants considered privacy principles to constitute an important framework within which to consider sexual intimacy issues. One Nurse Manager for example stated:

> *We make sure that everyone's privacy and dignity is maintained and as a couple that is acknowledged and recognized as well…*

while another noted:

> *basically we just follow the privacy principles, providing there is no … we can see that there is no sort of abuse…*

A third participant reported:

> *…it[all] comes down to policy … one thing we can comfortably say in aged care …is that there is a very strong legislative basis for our operation…The current Aged Care Act under which we operate is quite prescriptive in rights of residents. …*

Regard for upholding privacy principles therefore informed facility approaches to sexual intimacy policy, whether it was formal or informal. Roach (2004) and McAuliffe et al (2007) both strongly argue that the attitudes of organisations, health professionals and service providers are paramount in determining whether sexual intimacy rights are facilitated or not. While consideration of privacy provides a useful framework of reference for consideration of residents' rights to sexual expression in some ways, the concept of privacy is subjective however and can be open to wide variations in the interpretation of what is an acceptable level of privacy for people wishing to exercise their sexual intimacy rights (Hughes 2004). Within the broader policy context, there are currently no specific references to sexual intimacy rights within the *Aged Care Act (1997)* or the associated accreditation standards for aged care facilities in Australia (Department of Health and Ageing 2001).

Duty of care factors

Duty of care is inextricably tied to the day-to-day operation of nursing homes and often informs policy as well as practice (Gibson 1998). Several participants clearly linked the duty of care principle to their consideration of residents' rights to sexual intimacy while simultaneously acknowledging potential challenges such as protecting residents from any harm:

One participant noted for example:

> *We have a duty of care to ensure that the resident who is in our care comes to no harm …*

while another perspective reflected having to prioritise protection from harm as a primary principle:

> *…if there was nobody being intimidated or harmed in anyway, or if nobody was at risk, there would be no objection……*

While the potential for residents being harmed is important when considering duty of care, such a focus has the potential to limit residents' ability to maintain or establish sexually intimate relationships. As Gibson (1998) argues, there is a 'potential conflict between residents' rights and the duty of care'. Clinton and Scheiwe (1998) also acknowledge the complexity for clinical managers who may need to address the legal implications associated with day-to-day operations within an organisation. This was clearly expressed by one participant who indicated *We have an obligation to protect people so we exercise that.*

Cognitive and family factors

Closely linked with duty of care responsibilities were concerns about the cognitive capacity of residents and the potentially difficult issue of family reactions to a parent or spouse forming sexually intimate relationships within the aged care home. Several participants described their concerns about these two issues and gave accounts of difficult situations that they had dealt with in this regard; for example:

> *We have a lady who calls everybody dad, which is what she used to call him* (her husband) *and still does, but any male that's around she calls dad and tends to follow them and is happy to sit and hold their hands.*

Concerns were also expressed about how children might view a parent developing an intimate relationship, with some participants believing that spouses or children should be informed and their feelings considered before residents could be 'allowed' to form or maintain a relationship. One participant expressed this in the following way:

> *…if for example, there is an opportunity for people to develop a friendship … into a level of intimacy then one of the things we would probably be doing is to have discussions with the families, especially if there is a query or concern about the level of cognition…*

While participants perceived the need to consult with family about a spouse or parent developing a sexually intimate relationship, most also reported that, after consultation, families were generally accepting of such situations. McAuliffe et al (2007) have proposed that aged care facilities involve family members in education about the normality of sexual expression in older people and its importance for general health and wellbeing.

When cognitive capacity was not an issue, all participants expressed acceptance of residents' rights to form intimate relationships; for example one interviewee noted:

> *…it comes down to the capacity of that person. If they have got full capacity it's not really an issue…*

While cognitive capacity is clearly an important and complex issue within the aged care context, there can also be a danger of upholding stereotypical attitudes about older people based on implicit assumptions about the lack of capacity of old people to make decisions and control their own lives (McMurray 1999). Even where participants believed residents had such capacity however, there was still a sense of responsibility and concern regarding the potential reactions, or even over-reactions, of residents' family members. Kuhn (2002) highlights the potential for disputes to arise between staff, family members and residents about what is deemed best for residents and for concerns from nursing home administrators about possible litigation. For reasons such as this, Sherman (1998) has argued that the consideration of sexuality can depend more on the organisation's values and policy than the wishes and needs of the resident. Nevertheless, consultation with families did appear to be a relevant factor in trying to ensure that elderly residents had the right to form sexually intimate relationships.

Staff and education factors

Previous research [Kuhn 2002; Archibald 2002; Roach 2004) regarding attitudes of nursing home staff have indicated that staff can struggle with the concept of elderly people wanting and enjoying sexual intimacy. Staff attitudes have the potential to affect professional practice as well as policy development and its implementation. Within this study, several participants expressed awareness of the importance of staff attitudes about residents' rights to sexual expression and considered that education and training could alleviate stereotypical or judgemental attitudes. These participants strongly supported the value of education for staff and families about sexuality issues. Also noted by a participant:

> *In the beginning before policy was bought in they* [staff] *were finding difficulty in accepting intimacy of any sort within residential care. Some staff were excellent but others, and I say probably 40-50% were finding difficulties in …I'd say managing it, in just accepting it, recognizing …that there was a need there.*

Kuhn (2002) argued 'Staff members must be aware of their own values and biases in addressing residents' expressions of intimacy and sexuality'. Similarly, Roach (2004) maintained that staff responses to residents' sexual behaviour were influenced by their own level of comfort with sexuality issues. McAuliffe et al (2007) described the importance of adequate staff education regarding sexuality and older people, including the need for staff to explore their own beliefs, values and potential biases in regard to these issues in order to understand how these can become barriers to providing holistic quality health care to residents.

Although the value of education was espoused by participants, their accounts also suggested that training and education appeared to be undertaken on a 'needs' basis rather than as part of a fully planned and proactive program (the exception to this was the organisation with formal written policy). In other words, unless an incident had occurred or had come to the nurse manager's attention, no specific training had been provided regarding sexuality issues or the rights of residents to sexual intimacy. Such practices which are largely reactive rather than proactive have the potential to deny or limit residents in their rights to lead sexually fulfilling lives.

This study was small in scale primarily due to the scope and associated time frames related to the honours degree with which it was associated. Nonetheless, the project can be described as an exploratory pilot study, the results of which merit reporting in our opinion in order to raise awareness about issues relating to sexual intimacy and older people, particularly those residing in care facilities. Generalisations from the study cannot be made. However the aim of the research was to explore the issue of sexual intimacy rights within aged care facilities from selected Nurse Managers' perspectives and to identify the factors that they regarded as facilitating or inhibiting residents' rights. Documenting the perceptions of residents of aged care facilities themselves about these issues would contribute greatly to further understanding.

Conclusions

This study has documented the perceptions of a small number of Nurse Managers of Central Queensland aged care facilities regarding the rights of aged care residents to sexual intimacy and expression. Nurse Managers' consideration of their duty of care responsibilities, the cognitive capacity of residents, the reactions of family members and staff attitudes were all regarded as potentially instrumental factors in facilitating or constraining older people's sexual expression. Nurse Managers also believed that education for staff and families about sexual intimacy and older people was important as were accreditation standards and policy and principles relating to privacy and dignity principles. Older people's rights to sexual expression and intimacy within aged care facilities can be regarded as potentially complex and challenging as there may be inherent competing imperatives. Further research is indicated including documenting the perspectives of older people themselves about these issues as well as members of the general community. Engaging in debate and further research will raise awareness, inform and facilitate best practice and policy development and contribute to ensuring that residents of aged care facilities are valued holistically and their human rights upheld.

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