

5-8-2015

Attitudes toward Aging Sexual Expression in Nursing Homes: An Exploration of the Older Adult Resident Phenomenon

Angela Marie Schubert

University of Missouri-St. Louis, amr7b2@mail.umsl.edu

Follow this and additional works at: <https://irl.umsl.edu/dissertation>



Part of the [Education Commons](#)

Recommended Citation

Schubert, Angela Marie, "Attitudes toward Aging Sexual Expression in Nursing Homes: An Exploration of the Older Adult Resident Phenomenon" (2015). *Dissertations*. 191.

<https://irl.umsl.edu/dissertation/191>

This Dissertation is brought to you for free and open access by the UMSL Graduate Works at IRL @ UMSL. It has been accepted for inclusion in Dissertations by an authorized administrator of IRL @ UMSL. For more information, please contact marvinh@umsl.edu.

Attitudes toward Aging Sexual Expression in Nursing Homes:

An Exploration of the Older Adult Resident Phenomenon

by

Angela M. Schubert

M.Ed., Counseling

B.A., Psychology

A Dissertation Submitted to The Graduate School at the
University of Missouri—St. Louis in partial fulfillment of the requirements

for the degree Doctor of Philosophy in Education

with an emphasis in Counseling

May, 2015

Advisory Committee

Mark Pope, Ed.D.

Chairperson

Susan Kashubeck-West, Ph.D.

Virginia Navarro, Ph.D.

Michael Rankins, Ph.D.

Committee Members

Copyright Angela Marie Schubert, 2015

UNIVERSITY OF MISSOURI—ST. LOUIS
GRADUATE SCHOOL

May, 2015

We hereby recommend that the dissertation by:

ANGELA M. SCHUBERT

Entitled:

ATTITUDES TOWARD AGING SEXUAL EXPRESSION IN NURSING HOMES: AN
EXPLORATION OF THE OLDER ADULT RESIDENT PHENOMENON

Be accepted in partial fulfillment of the requirements for the degree of:

Doctor of Philosophy in Education

Dr. Mark Pope
Chairperson

Dr. Susan Kashubeck-West
Committee Member

Dr. Virginia Navarro
Committee Member

Dr. Michael Rankins
Committee Member

ABSTRACT

Previous research on older adults in nursing home facilities has focused on medical care, safe and dignifying living conditions, quality of life variables, and assessment of senility and sexual disinhibition, or inappropriate sexual behavior, almost all of which was conducted using quantitative methods. The aim of this study was to give voice to ten older adults (six men and four women) who had been living in a nursing home and the four staff (one social worker and three registered nurses) who cared for them. This study aimed to explore sexual expression as it was perceived, experienced, and practiced by those older adults. Participants were asked to give their accounts during semi-structured interviews. The succeeding transcripts were analyzed using interpretative phenomenological analysis and seven emergent themes were identified, including (1) demographic differences, (2) gender differences related to marriage and sexual interest, (3) self as a sexual being, (4) updating the sexual script, (5) affordances to sexual expression, (6) barriers to sexual expression, and (7) actual and perceived relationships with nursing staff and others. Nursing staff were also interviewed to elaborate on the sexual expression in nursing homes. Overall, the findings illustrated older adult sexual expression to be a complex human condition that can be influenced by the nursing home environment, self-ascribed ageist views toward sexual expression, and/or identification as a sexual being. These findings are compared to previous research and future directions are suggested.

Keywords: older adult sexuality, nursing home resident, aging sexual expression, widows, widowers, staff attitudes

ACKNOWLEDGMENTS

Dr. Mark Pope, thank you for your unwavering support, mentorship, and kindness. As my chair and mentor, your eloquent and timely advice provided me with the confidence I needed to move forward throughout this process. At times, your words instilled a healthy sense of fear which only inspired me to have courage and move forward. I will always appreciate your patience and I look forward to your continued guidance in the future.

Dr. Susan Kashubeck-West, thank you for your support and encouragement. Your conviction to research and social justice is both inspirational and humbling. Thank you for challenging me to explore the data more deeply. It truly made for a more in-depth and authentic representation of the participants. I can always count on you for your honesty and wisdom.

Dr. Virginia Navarro, thank you for your dedication to academic rigor and your commitment to qualitative work. Thank you for guiding me through the research portion of my dissertation and for your patience and critique.

Dr. Michael Rankins, thank you so much for agreeing to participate on my committee. I value the lens from which you viewed my research. I look forward to future conversations.

I would also like to thank the doctorate students both past and present, all of whom played a vital role in my success and sanity. Dr. Mariamee Gonzalez, Dr. Dixie Meyer, Dr. Laura Partridge-Rauscher, Dr. Erika Cameron, Dr. David Hart, Dr. Brandon Whittington, Dr. Deirdre Walker, Dr. Jessica Taylor, Dr. Stacy Henning, Dr. Amaris Tippey, Dr. Al Sarno, and Dr. Hsin-hsin Huang. Each of you are incredible human

beings. Thank you for paying it forward and offering me the opportunity to complete this aspect of my life's journey.

I would also like to thank the University of Missouri – Saint Louis for their generous contributions.

Joan, merci mille fois mon esprit de parenté.

Finally, a SHOUT OUT to Starbucks Store #2417! Thank you for your refreshing drinks and inclusive environment. My home away from home.

DEDICATIONS

To my husband, Cory and my two incredible children, Marley and Kennedy:

For the past ten years, the entire time I have known you, you have dedicated your life to me and our family. You allowed me the opportunity to pursue my academic dream. Times were trying but you remained steadfast. When in the car, you never asked me to stop playing Howard Rosenthal's NCE preparatory cd's. During comps, you didn't complain when I would recite material over and over again. Here we are at the end of this chapter in our lives and it dawned on me that we have never known each other outside of academia. I look forward to our future. Wasaba, boo. I dedicate this work to you three.

To my parents, Jennifer and Gary, my in-laws, Michal and Dick, and my siblings, Nick, Meghan, Shannon, and Ariel:

I further dedicate this dissertation to each of you. Mom, thank you for all of your support and "pick me up" speeches. You believed in me even when I didn't believe in myself. You tried so very hard to say the right words and ask the right questions. Your cheerful check-in's inspired me to carry on. Dad, thank you for being your very Austrian stoic self and for the grumbled "I love you's." I love you both. Michal and Dick, thank you for opening your hearts and your home to me. Your stable love and support is awe inspiring. To my siblings, you guys are geeks and I heart you. I am so very proud of each and every one of you. Thank you for letting me use your names in my dissertation.

To my CMU Crew, Dr. Connie Johnmeyer and (soon-to-be Dr.) Theresa Keown:

You are such an amazing crew! I appreciate your kind words and timely sassiness. I wouldn't be where I am right now if it were not for you two waiting at the finish line. I look forward to more conversations and battling the 2-HDs in our future.

TABLE OF CONTENTS

ABSTRACT	iii
ACKNOWLEDGMENTS	iv
DEDICATIONS	vi
LIST OF TABLES	x
LIST OF FIGURES	xii
CHAPTER 1: INTRODUCTION	1
History of Older Adult Care and Policy Evolution.....	3
Legal Issues and Sexual Expression in Nursing Homes.....	7
Perceptions of Quality of Life among Older Adult Residents	8
Aging Sexuality and Quality of Life.....	9
Perceptions and Barriers of Aging Sexual Expression and Cultural Norms	12
Statement of Purpose	14
Research Questions.....	15
Definition of Terms.....	15
Significance of Study.....	17
Locating Myself in the Story	18
Summary	20
CHAPTER 2: REVIEW OF RELATED RESEARCH LITERATURE.....	22
Quality of Life in Nursing Homes	23
Tenderness and Human Connection	26
Sexual Expression and the Older Adult Population.....	28
Critique of Lindau et al. Study.....	47
Attitudes of Aging Sexual Expression in Nursing Homes.....	50
Senility and Sexuality in Nursing Homes.....	53

Summary	54
CHAPTER 3: METHODOLOGY	57
Research Questions	57
Research Design.....	58
Participants and Sampling.....	63
Setting	65
Plan of Action	67
Data Collection	72
Data Analysis	74
Managing and Recording Data	78
Trustworthiness in Qualitative Research	79
Ethical Considerations	81
Summary	82
CHAPTER 4: INTERPRETATIVE FINDINGS	83
Resident Participant Profiles.....	84
Constant Comparative Method Results	92
Superordinate Themes	96
Theme 1: Demographic Differences Associated with Sexual Interest.....	97
Theme 2: Gender Differences Associated with Marriage and Sexual Interest....	111
Theme 3: Self as a Sexual Being.....	119
Theme 4: Updating the Sexual Script.....	1255
Theme 5: Affordance to Sexual Expression	1345
Theme 6: Barriers to Sexual Expression.....	139
Theme 7: Actual and Perceived Relationships with Nursing Staff and Others	1466

Summary of Member Checks	155
Reflexivity and Interpretative Summary.....	1566
Summary of Research Findings	1599
CHAPTER 5: NURSING STAFF PERSPECTIVES	160
Staff Participant Profiles	1611
Staff Superordinate Themes.....	1622
Interpretative Summary	1833
Summary of Research Findings	1833
CHAPTER 6: DISCUSSION.....	1855
Summary of the Study	185
Implications for Nursing Homes.....	2133
Limitations of this Study.....	2166
Recommendations for Future Research	2188
REFERENCES	2211
APPENDICES	2455
Appendix A: Call for Facilities.....	2455
Appendix B: Call for Resident Participants.....	2477
Appendix C: Call for Staff Participants	2499
Appendix D: Informed Consent - Residents.....	253
Appendix E: Demographic Questionnaire—Resident	2533
Appendix F: Informed Consent - Staff	2555
Appendix G: Cover Letter for Member Check	2577
Appendix H: Interview Questions	2588
Appendix I: Master table of Superordinate and Subordinate Themes	260

LIST OF TABLES

Table	Page
1. Resident Participant Criteria Data	63
2. Plan of Action	68
3. Data Sources.....	72
4. Data Analysis Process.....	755
5. Demographic Data and Current Living Situation	855
6. Relationship Status and Interest in Intimate Relationships.....	86
7. Superordinate Theme 1 and Related Subordinate Themes.....	98
8. Superordinate Theme 2 and Related Subordinate Themes	125
9. Superordinate Theme 3 and Related Subordinate Themes	135
10. Superordinate Theme 4 and Related Subordinate Themes	140
11. Superordinate Theme 5 and Related Subordinate Themes	147
12. Superordinate Theme 6 and Related Subordinate Themes	140
13. Superordinate Theme 7 and Related Subordinate Themes.....	147
14. Nursing Home Site Information.....	161
15. Nursing Staff Master Table of Superordinate Themes	163

LIST OF FIGURES

Figure	Page
1. ATLAS-ti example of constant comparative method using supercode “Interest in Masturbation”	95
2. Network graph utilizing ATLAS-ti.	96

Chapter 1

Introduction

By nature, humans are sexual, relational beings and are subject to instinctive sexual desire. Across the lifespan, many elements influence how one perceives himself or herself as a sexual being. Biological, psychological, and physiological transformations occur, which include sexual desire. The sexual response patterns of humans indicate a natural proclivity towards sex, desire, and intimacy. Healthy sexual expression is influenced by intrapersonal, interpersonal, cultural, and psychological factors (Doll, 2014). Although many modern cultures embrace youthful love, desire, and sexual expression. With such a focus, little regard for older adult sexuality exists. According to Buehler (2014), sexual activity over the lifespan undergoes a transformative process, influenced by culture, biology, and experiences.

The sexual script of an older person inevitably differs from that of a younger person – what a healthy person may be capable of doing with their body at a young age may not necessarily be the case when they are older. Not surprisingly, heterosexually-oriented individuals across the lifespan tend to believe that vaginal intercourse is the primary way to engage in sexual activities (Baumeister, Catanese, & Vohs, 2001). As the body ages and penile-vaginal intercourse may no longer be possible, older adults may learn to broaden their sexual script to include “nonpenetrative behaviors such as manual and oral sex, cuddling, kissing, and *frottage* (rubbing genitals against someone to produce orgasm)” (Buehler, 2014, p. 217) as the primary ways to engage in sexual activities. Although the script may change, older adults also have sex and engage in sexual expression in other ways.

Sex and aging may be considered a taboo subject in the United States; however, aging sexual expression continues to exist. In fact, the rate of sexually transmitted infections has increased among the older adult population in the United States. The Centers for Disease Control and Prevention (CDC, 2013) reported that cases of syphilis and chlamydia among those 55 and older increased 43% compared to the 2009 study. Nearly one in four persons living with human immunodeficiency virus (HIV) or acquired immunodeficiency syndrome (AIDS) in the United States is 50 or older (CDC, 2013). Although older adults may have acquired HIV or AIDS at a younger age, a late diagnosis might be the result of society looking at older adults as non-sexual beings. Health care providers may not consider testing older adults for HIV and the symptoms connected to the virus may be misperceived by the older adult as normal aging (CDC, 2013).

Although research on the topic of aging sexuality is present in current literature, albeit limited, literature on aging sexual expression among older adults in nursing homes is practically nonexistent. Other changes occur to people as they age, and if a person is in need of medical care or is no longer able to live independently, a decision might be made to move in with family or to move to a nursing home. What happens to an older person's natural desire to be sexual once he or she moves into a nursing home? Very little research on the topic of healthy aging sexual expression has focused on individuals residing in nursing homes. This would suggest a need to examine how sexual interest changes and how sex is defined by older adult nursing home residents who experience these changes. It is important to first review the evolution of the nursing home with special attention to the progress it has made to become more person-centered.

History of Older Adult Care and Policy Evolution

We can never insure one hundred percent of the population against one hundred percent of the hazards and vicissitudes of life, but we have tried to frame a law which will give some measure of protection to the average citizen and to his family against the loss of a job and against poverty-ridden old age. – President Franklin Roosevelt, upon signing the Social Security Act, 1935 U.S. (Social Security Administration, 2009a)

Since its inception, the United States has dealt with issues involving older adults and facilitated care (Katz, 1986). When specifically addressing the care of older adults prior to the creation of nursing homes, older adults who could not reside with family or friends were limited to psychiatric institutions and almshouses (Katz, 1986). Almshouses, typically provided to low-income or homeless people by charities, acted as a social remedy to shelter the homeless, sick, mentally ill, dangerous, poor, and old away from the public eye (Katz, 1986). The abysmal living conditions of the almshouses challenged the government to seek out new means of providing security and protection for older adults (Katz, 1986).

As the Great Depression developed throughout the United States, politicians were forced to address the specific economic issues of the ever-rising homeless and elderly population who resided in the almshouses. In 1935, President Franklin D. Roosevelt signed the Social Security Act ([SSA] U.S. Social Security Administration, 2009a), which provided federal security benefits to American citizens who were retired workers aged 65 and older. The benefits included a minimum pension benefit package covering disability and retirement (U.S. Social Security Administration, 2009a) to federal railroad employees. The age of 65 was based on a pragmatic calculation of the average age of

retirees in the Railroad Retirement System, in addition to actuarial studies conducted on payroll taxation (U.S. Social Security Administration, 2009b).

In order to improve the quality of life of the older adult population, only those who moved out of the almshouses were allowed to receive social security benefits. The funds were expected to offer older adults an opportunity to pay for quality care and to move out of the almshouses. As a result of the SSA, the federal government established new facilities to support the medical needs of the pensioners and older adults (U.S. Social Security Administration, 2002).

The quality of care, however, of older adults who moved into the nursing care facilities continued to be an issue even after the passage of the SSA. In the 1950s, noncompliance and lack of adherence to code requirements in the nursing care facilities spawned the Amendment to the Social Security Act; this amendment required state compliance in mandating licensing requirements for nursing care facilities (Katz, 1986).

As a result of the noncompliance, the U.S. federal government established intermediate care facilities in the 1960s (Katz, 1986). Again, the intermediate care facilities proved to be an inadequate solution for overall quality of care and support mainly because of untrained staff and poorly structured medical support (Katz, 1986). In 1971, Public Law 92-603 or the Older Americans Act, was passed. This law required government-funded insurance programs to reimburse nursing home programs (U.S. Social Security Administration, 2009b). This effort also turned out to be problematic when nursing homes were exposed for not maintaining healthy environmental conditions and for participating in fraudulent billing practices (Werner, 2011).

In 1987, reports of substandard care, consistent violation of individual rights, and failure to comply with healthcare codes resulted in the enactment of the 1987 Resident Bill of Rights as part of the Omnibus Budget Reconciliation Act of 1987 ([OBRA] Resident Rights, 2002). This act allowed privacy rights and immediate privileges to be bestowed upon nursing home residents and their families (Resident Rights, 2002). Some of the most important changes made as a result of the OBRA emphasized a resident's quality of life as well as the quality of care. Resident expectations included encouragement to execute daily activities (e.g., walk, bathe, eat, and other activities of daily living), participate in treatment planning and to select a physician, to safely maintain or bank personal funds with the nursing home, and access to personal medical records, and to get access to privacy in an individual room (Resident Rights, 2002).

The Resident Bill of Rights, moreover, was established to provide the resident population with an Ombudsman Advocacy Board. The role of the Ombudsman was to provide services to assist the residents in protecting their own health, safety, welfare, and rights (Werner, 2001). The Resident Bill of Rights emphasized the civil liberties of the residents to be “free from mental abuse; free from unauthorized chemical and physical restraints; to be treated with recognition of personal dignity, individuality, and privacy; and to hold private visits with spouses” (Resident Rights, 2002, p.1).

Since the creation of the SSA by President Roosevelt in 1935, the establishment of the Older Americans Act of 1965, and finally the OBRA 1987 by President Reagan, the U.S. government has attempted to provide solutions to protect and care for the older adult population. According to the 2010 Census (Werner, 2011), there are presently 40.3 million Americans ages 65 and older, representing 13% of the total population. Of the

40.3 million, 2 million citizens aged 65 and older resided in a skilled living facility or nursing home (approximately 20,000 nursing homes and facilities) in 2010 (Werner, 2011). As the nursing home industry continues to increase in the United States, quality of care continues to undergo evaluation to address the needs of this ever-growing older adult resident population.

On the other side of the nursing home reform coin, older adult residents have also faced great adversity in overcoming maltreatment and neglect. Only through the struggle of these residents were changes made to nursing home policies and reforms. The needs of older adult residents have always varied on the biopsychosocial spectrum; however, historically and, in more recent times, most attention has focused on the medical care and maintenance of the aging body. The needs of older adult residents are far more complex than just their biological and medical needs (Hajjar & Kamel, 2004). To encapsulate quality of life standards would suggest a more holistic approach to include not only meeting the biological and medical needs, but also to include attention to other important basic human needs such as touch, human connection, and intimacy (Hajjar & Kamel, 2004; Knaplund, 2008).

An informal Google search using the term *nursing home purpose statements* resulted in several individual nursing home websites that proclaimed a “holistic approach to care.” For example, a website of a nursing home named FBC Care Homes proclaimed its purpose was to ensure the values of “privacy, dignity, independence, choice, rights, and fulfillment” (Cherry Holt Care Home, 2007, p. 3). The website offered a general statement for each value, yet there was not anything specific about intimate expression. The Resident Bill of Rights was adopted by many states; however, several nursing

facilities remain to this day without a specific policy on the privacy rights for intimate expression (Knaplund, 2008).

Legal Issues and Sexual Expression in Nursing Homes

In *Lawrence v. Texas* (2003), the Supreme Court overturned a Texas anti-sodomy law as unconstitutional. The definition of sodomy includes any sexual act that does not lead to procreation. According to Breland (2014), this decision ultimately ruled in favor of broadening the scope of sexual expression beyond that of a traditional heterosexual marriage as an aspect to the right of privacy, even in institutional settings such as nursing homes. Although privileges may be bestowed and, as previously mentioned, dignity and autonomy are often supported by nursing home staff, it is critical to understand the intention and balance of sexual expression as experienced and practiced by the nursing home residents.

Nursing homes were established as a medical support system for people in need. Although the model of the nursing home has transformed from a hospital-like setting to a more person-centered setting, medical issues are still of primary importance and “there are many concrete concerns about geriatric patients that could justify curtailment of sexual activity; particularly the often-fragile cognitive state of older adults who suffer from dementia or other mental diseases” (Breland, 2014, p. 180). The Resident Bill of Rights (1987) declared that older adult residents deserve quality care from the nursing homes in which they reside—a right to privacy, a right to be treated with respect and dignity, and a right to have private visitors (Knaplund, 2008). Although privacy is mentioned, there is nothing clearly stated on the topic of sexual expression. According to Lindsay (2010), even the U.S. Constitution

has been interpreted so that states may not pass laws unduly interfering with or restricting private sexual conduct, a prohibition that extends to nursing homes. Yet, nothing expressly requires a state to affirmatively pass a law granting the right to private sexual activity for nursing home residents. Therefore, a facility has no affirmative obligation to make sex possible; it has no obligation to enable sex or assist residents who may otherwise need help. (p. 319)

The unclear status of state and federal protections and rights leave residents vulnerable to the interpretation by facilities of these statutes. This is not to suggest that all facilities are guided by administrator morality on sexual expression; however, individual settings may use the ambiguous language as justification to deny sex for all residents, regardless of consent, privacy, or respect for human dignity (Lindsay, 2010).

Perceptions of Quality of Life among Older Adult Residents

The Resident Bill of Rights (1987) declared that older adult residents deserve quality care from the nursing homes in which they reside—a right to privacy, a right to be treated with respect and dignity, and a right to have private visitors (Knaplund, 2008). Quality of care, however, does not necessarily equate to quality of life; rather, it may be considered an element of the *quality of life* concept. The definition of *quality of life* is difficult to specify as each person may have his or her own unique definition of the concept (Bowers et al., 2009). Research findings suggest, however, that perception of *quality of life* may be directly connected to the quality of medical care received and fundamental human needs such as touch, integrity, autonomy, human connection, and intimacy (Hajjar & Kamel, 2004; Knaplund, 2008).

There are a range of human needs found in nursing homes. As previously mentioned, the most notably reported are attention to medical needs and illness (Hajjar &

Kamel, 2004; Knaplund, 2008). Older adults who are no longer able to care for themselves and who do not have caregivers at home are left with the decision to be cared for by professional nursing staff within institutional settings. Nursing homes were created to maintain life and focus mainly on the problems and diseases of their residents (Hargrave, 1999). Beyond the apparent need for medical attention, older adult residents also identify several other human privations such as, intimacy, human connection, and interpersonal relationships.

Quality of care requires privacy, dignity, respect, quality food services, medical professionals, and more (Bowers et al., 2009). The transition into a nursing home can be quite an arduous task. Bowers et al. (2009) suggested that older adult residents encounter a rather surreal experience when entering the nursing home system and face unique challenges as they adjust and assimilate to the new, and possibly permanent, living environment—primarily because their perceptions of rights and independence may be in conflict with the new rules and procedures of the facility. Those who perceive adequate privacy, however, report considerably higher life satisfaction in nursing homes (Aday, Kehoe, & Farney, 2006; Loue, 2005; Street, Burge, Quadagno, & Barrett 2007). Self-reported positive internal social relationships (relationships within the nursing homes) were also considered critical components to perceived well-being among older adult residents (Aday et al., 2006; DeWever, 1977; Loue, 2005, McGilton & Boscart, 2007; Street et al., 2007).

Aging Sexuality and Quality of Life

Beyond positive internal social relationships, touch is seen as one of the greatest indicators of human thriving, especially among babies and the elderly (Montagu, 1986). In the research literature, the concept of touch is seen as absolutely necessary for a

quality of life (Gleeson & Timmons, 2004). Montagu (1986) examined in depth the concept of touch from gestation and beyond and how skin-to-skin connection affects mental health, physiological immunity, thriving, and overall quality of life, and asserted, aging often brings limitations due to health problems or disability, but this does not have to bring an end to the quality of life, for while the premises inhabited may break down the spirit will flourish—if it is encouraged to. (p. 393)

Hajjar and Kamel (2004) reported desire and intimacy gradually progress in meaningfulness as a person begins to age, regardless of physiological changes. Although sexual problems are frequent as a result of physiological aging, the presence of sexual behaviors and interest in sex and sexual expression remain active among older adults (Lindau et al., 2007; Pope & Schulz, 1990).

Freedom of sex and sexual expression are also seen as indicators of psychological well-being among older adult residents. Hajjar and Kamel (2004) explained that, because sexuality is so critically interconnected with an individual's sense of self, the denial or refusal to express sexuality may lead to negative self-image, lack of self-esteem, deterioration in social relationships, and/or depression in nursing home residents. Everett (2008) described four ethical contentions supporting sexual expression in nursing homes.

First, people should be allowed to do that which is not prohibited by law; second, it is discriminatory to deny private, appropriate places to engage in sexual activity; third, people should be allowed to engage in behaviors that improve well-being; and fourth, institutions should provide access and resources if sexual life contributes to quality of life. (Everett, 2008, p. 89)

Everett (2008) warned that, although these ethical guidelines should be granted, the overall well-being of all individual residents must be taken into consideration when dealing with sexual expression, and all involved must be consenting parties to the sexual activities.

Intimacy, on the other hand, is a concept that goes beyond that of physical sexual expression. The definition of intimacy is unique to each individual and continues to vary on the sexual spectrum as humans get older. Perhaps this phenomenon is due in part to cultural definitions of aging sexuality or it may be a specific result of the aging body and how older adults view themselves as intimate beings. Regardless of age, studies have shown intimate touching to be highly correlated with positive perception of well-being (Gott & Hinchliff, 2003a; Montagu, 1986). Gott and Hinchliff's (2003) study on older adult resident's sexuality suggested intimate touching (e.g., a hug, a kiss, or an sensual caress) to be a significant factor in perceived well-being among older adult resident participants, regardless of age and especially when penetrative sex was no longer possible. Trafford (2009) suggested that, although age brings forth physical illness, fragility, and wrinkles, age also brings higher attunement to emotions and relationships. Doll (2003) suggested older adult residents may display intimacy "through affection, romance, enjoyment of each other's company, taking care of one's physical appearance, having the need to feel attractive and still wanting to be seen as a woman or a man" (p. 7).

Although there are studies that have explored aging sexuality in nursing homes, most research has been conducted on the presence of cognitive impairment (Hajjar & Kamel, 2004). Hajjar and Kamel (2004) reported cognitive impairment to be the primary

barrier to sexual expression among residents, as most staff is apprehensive of nonconsensual sexual activity or inappropriate sexual behavior. Healthy sexuality is viewed in the periphery of nursing home policy and practice, yet it is necessary to address both the benefits and limitations of sexual expression within the confines of a nursing home setting.

Perceptions and Barriers of Aging Sexual Expression and Cultural Norms

Much research and literature has also discussed aging sexual expression as viewed by staff; however, there is a dearth of data regarding the perceptions of sexual expression by residents. Quantitative research has shown a steady interest in sexuality and sexual expression among older adults (Brown, 1989; Knaplund, 2008; Pope & Schulz, 1990; Willert & Semans, 2000). This is perhaps due to the anonymity of most quantitative surveys and assessments. Qualitative studies often request one-on-one interviews and/or group discussion on a given topic. Sexuality was and remains today a taboo topic in the United States, specifically on aging sexual interest and behavior (DeLameter & Moorman, 2007; Hillman, 2000; Willert & Semans, 2000). The participants may, therefore, find it difficult to express themselves freely on the topic, especially for those who reside in institutional settings such as nursing homes or assisted living facilities. For the purpose of this study, questions were asked strategically and sensitively. This researcher was also trained by Brick, author of *Older, Wiser, Sexually Smarter* (2009) and a pioneer and advocate for sex education in nursing homes. Brick emphasized respect and humor as the main keys to conducting conversations around sexuality with older adults.

Additional barriers to open sexual expression might involve the perception and attitude of the nursing home and staff, the perception of the older adult in response to the

community, his or her own internalized ageism, or the older adult resident's lack of sexual functioning knowledge. "Many older people consider sexual intimacy to be only or most appropriate in marriage; thus death and divorce leave many older Americans without a sexual partner" (DeLamater & Moorman, 2007, p. 5). Although older adult men were more interested and reported to actively engage in sexual behavior, older adult women were less likely to engage in sexual activity (Lindau et al., 2007). These findings were also found in the studies of DeLamater and Moorman (2007) and Kontula and Haavio-Manilla (2009).

For individuals who desire to be intimate with another, or with themselves, the nursing home setting may pose a major barrier. The setup of a standard nursing home room is often open and occupied by multiple residents, making it quite difficult for any resident to distance himself or herself from each other (Hajjar & Kamel, 2004). Moreover, nursing homes often segregate men and women and even refuse accommodations for spouses. For those couples who are allowed to be in the same room, the bed arrangement typically does not allow a bed for two, but rather, two single beds usually placed on opposite sides of the room. Consequently, couples and spouses may in turn feel pressured to behave a proscribed way or deny mutual intimacy.

Barriers of knowledge and biased attitudes of staff and residents also pose a problem for open sexual expression. Both residents and staff who engaged in an educational training of older adult sexual functioning reported an increase in sexual interest and confidence among older adult residents and an increase in comfort level among nursing staff (Bouman & Arcelus, 2001; Bouman, Arcelus, & Benbow, 2007; Willert & Semans, 2000). To increase comfort of staff and residents on the topic of aging

sexuality and freedom of resident sexual expression, it is important to educate residents and staff on aging sexual expression (Reingold, 1997). “We encourage our residents to express their sexuality in a responsible, ethical and moral fashion, while acknowledging the need for our staff to be trained” (Reingold, 1997, p. 53).

Most research on the presence of older adult sexual desire and functionality is based on quantitative studies (DeLamater & Moorman, 2007; Hillman, 2000; Kontula & Haavio-Manilla, 2009; Lindau et al., 2007; Pope & Schulz, 1990; Willert & Semans, 2000). There is, therefore, a lack of qualitative research that focuses on older adult residents’ perception of themselves as sexual beings and how those beliefs correspond with cultural norms. Interviews—one-on-one conversations with older adult residents—have the potential to provide an enormous amount of rich data on the topic of aging sexual expression in nursing homes.

Statement of Purpose

This study aimed to explore how nursing home older adult residents in the United States experience their lives as sexual beings and as a culture. This exploratory study used a phenomenological research design drawing on interpretative phenomenological tenets to (a) explore the level of self-reported interest in sexual expression among elderly residents; (b) generate awareness of sexual activity or sexual interest among elderly residents, as perceived by nursing home staff and resident peers; and (c) understand the roles and relationship between nursing home staff and the residents around issues of sexual expressiveness. Phenomenological research design allows the researcher to explore the essence of subjective truth as expressed by older adult residents and the staff who work for them.

Research Questions

1. How and under what circumstances do the older adult residents and staff feel comfortable with resident sexual expression in nursing home settings?
2. What barriers and affordances to sexual expression are experienced by older adult residents in nursing home facilities?
3. What differences and similarities in expressed attitudes exist between and within residents and staff on the topic of older adult resident sexual expression?
4. How do older adult residents and attending staff perceive opportunity and constraints in expressing a sexual self within the cultural context of a residential facility?

Definition of Terms

The following concepts and terms are used repeatedly throughout this dissertation, although some terms are used in various ways within the general literature.

They are as follows:

Assisted living facility. Apartment-style housing that allows for a larger degree of freedom than a traditional nursing home facility and is designed to provide assistance with basic daily living needs, such as laundry, preparing meals, medication encouragement, and so on. Staff is always available if needed.

Certified nursing assistant (CNA). A person who has completed a 3- to 4-month health-care training program and assists the registered nurses (RNs) and licensed practical nurses (LPNs) with direct patient care.

Intimacy. An ongoing, reciprocal process of compassion and connection (Masters, Johnson, & Kolodny, 1994), not to be confused with the concept *love*. As Masters et al. (1994) suggested, love does not have to be shared. In fact, the authors suggest that a prolonged relationship often involves an increase in intimacy as a result of a decline in love intensity (Masters et al., 1994).

Licensed practical nurse (LPN). A person who has completed a 1- to 2-year nursing program.

Negative sexual fantasies. Sexual or erotic cognitions reported as “unacceptable, unpleasant, and ego-dystonic” (Renaud & Byers, 2010, p. 27).

Older adult residents. Older adults, aged 65 and older, who reside in a nursing home setting.

Older adult sexual education. Education on older adult sexual expression, statistics, the human sexual response cycle, myths and assumptions on aging sexuality, and high-risk behaviors.

Positive sexual fantasies. Sexual or erotic cognitions reported as “acceptable, pleasant, and ego-syntonic” (Renaud & Byers, 2010, p. 27).

Privacy rights. Specific to the study at hand, the freedom to close doors and to engage in self-sexual/sensual activities or with another person without interruption or negative consequence.

Registered nurse (RN). A person who has received either an associate’s or bachelor’s degree in nursing and health care.

Sexual disinhibition. Inappropriate sexual behavior is another term for sexual disinhibition. Examples of sexual disinhibition include “lewd or suggestive language,

implied sexual acts (eg., requesting unnecessary genital care, viewing pornography in public), and overt sexual acts (eg., touching, grabbing, or disrobing of self or others, public masturbation)” (Joller et al., 2013, p. 255). Sexual disinhibition is common in individuals with dementia (Joller et al., 2013).

Sexual expression. “Words, gestures or movements (including reaching, pursuing, or touching) which appear motivated by the desire for sexual gratification” (Reingold, 1997). Sexual expression can include touching, holding hands, massaging, or other forms of demonstrating affection. Sexual expression may take the form of a physical or emotional act, or both. Throughout the lifespan, even a simple touch or stroke may be considered important, and sometimes preferred sources of physical intimacy among the older population (Leiblum & Segraves, 1989).

Sexuality. For the purpose of this study, sexuality is defined by the level of interest in sexual activity and expressiveness.

Skilled nursing facility. The traditional type of nursing facility which provides 24-hour medical services to residents in addition to assistance with basic daily living needs.

Touch. Tactile connection whether towards self, or another. “Without tactile communication—what the body feels and says nonverbally—the experience of sex can only be at most incomplete” (Montagu, 1986, p. 167).

Significance of Study

Previous studies illuminated areas of interest around the education and specific attitudes of nursing home staff (Bouman & Arcelus, 2001; Bouman et al., 2007; Hillman, 2000; Knaplund, 2008), yet there is a paucity of qualitative data surrounding the stories and experiences of those involved in the nursing home experience. Qualitative research can be exploratory in areas of inquiry where little previous research has been done

(Merriam, 2002). This is especially useful when the researcher does not know the important variables to examine (Creswell, 2003). The qualitative phenomenological method serves to illuminate the existence of a phenomenon without any form of external assumption (Nakhtnikian, 1964). In order to expand on the exceptional experiences of the growing aging population, a phenomenological qualitative research design was selected. It is also of importance to assess how older adult residents are affected by the attitudes and extent of education by professional caregivers in relation to their comfort with being sexually expressive (Bouman & Arcelus, 2001).

Locating Myself in the Story

As a qualitative study, it is important that I provide some background on why this specific subject is important to me and position myself in the research. I first was introduced to the nursing home setting when I was 15 years old. I always wanted to be in a position where I could help others, so naturally, I looked to the nursing homes for any opportunity. When I walked in, several residents sat silently in their wheelchairs next to what appeared to be their rooms. I was 15, but I had the impression that something felt wrong. Nurses walked right past the residents as they held out their hand. They appeared to be looking for someone, perhaps even yearning for physical connection—human touch. I left that nursing home desiring to one day hold their hands.

When I was in college, I went to the local hospital to interview for a hospitality position, only to leave with a scholarship for the Certified Nursing Assistant (CNA) program at the local community college. Although my intentions were not to work in a nursing home, my world came full circle and I worked as a CNA at a nursing home to pay for college. There, I met so many older men and women, couples and singles, who expressed desire and flirted. There was a man there who was known as a “dirty old man”

for reaching out and touching the legs of nurses. What no one cared to find out was why. He was in a wheelchair, aphasic, and desired human connection. His specific nursing home did not have the appropriate protocol or policy to address the man in a positive and affirming way. Another time, I accidentally interrupted a female resident masturbating. I apologized and walked out quietly. Shortly after, a nurse went in and reprimanded her. There was a woman who was aphasic but went to her weekly bingo games at the local community center. Before every game, she made sure her fiery red lipstick was perfect and sprayed herself with perfume. Acceptance and approval appeared to depend on which charge nurse was working at the time. Some were approving and encouraging while others documented sexual behaviors as incidents and proceeded to explore disciplinary action.

In my masters of counseling program, a colleague and I conducted video interviews of one couple and three single older adult women on the topic of aging expression. The findings of those interviews suggested what had already been reported. Sexual expression had evolved for those individuals. Sexual intercourse decreased over time but the desire to be affectionate and close increased. And finally, in my doctoral program, I interviewed an expert in the field, Brick, founder of Sexuality and Aging Consortium at Widener University. From this interview, I was assured by Brick that my study, no matter how small a sample size, would aid in the effort to bring freedom of sexual expression and sex education into nursing homes. She exclaimed the topic of aging sexuality was so taboo that she was concerned I would not be able to gain access into nursing homes to discuss sexuality with the inhabiting residents; however, if I did gain access, then I would be one of the very few who have done so. To consider how

many older adults currently reside in the nursing home, it seems important for the narratives of residents and their sexual stories be heard.

Summary

Since their inception, nursing homes have gone through several transformations to meet the needs of their ever growing resident population. For many nursing homes, policy and care procedures have focused on medical needs and quality environmental standards. Sexual expression, however, is a quality of life indicator that has not been well researched or considered in nursing homes in general. Sexual expression is influenced by intrapersonal, interpersonal, cultural, and psychological factors (Doll, 2014) and remains to be an important component to life throughout the lifespan for many people.

Similar to the issues that first created the nursing home in 1939, individuals who take refuge in a nursing home often do so out of concern of becoming a burden to family or because there is no one in the family able to care for them (Beeber, 2011). The “choice” to move into a nursing home is often seen by older adults as the last choice for fear of nursing staff neglect, loss of independence, and normalcy of private home life including intimate engagement (Beeber, 2011). As a result of this study, challenges most often seen by the older adult population may result in the reframing of the definition of elderly and restructuring of policy on the topic of privacy rights and sexual expression among older adult residents in nursing homes. These individuals might also be the pioneers who steer this society in a new direction of thought towards older adult life and love.

Chapter 2 explores the literature of the major concepts related to aging sexual expression, including physiological effects of the aging sexual body, psychological

effects of the aging sexual mind, aging sexual expression, attitudes towards sexual expression, and a description of the resident phenomenon.

Chapter 2

Review of Related Research Literature

This systematic review focuses on how older adults in the United States experience and express their sexual lives as individuals and community members within the cultural context of a nursing home. This review of the literature on the topic of aging sexual expression and nursing home settings (a) explores the level of self-reported interest in sexual expression among elderly residents; (b) looks at awareness of sexual activity or sexual interest among elderly residents, as perceived by nursing home staff and resident peers; and (c) reports on the roles and relationship between nursing home staff and the residents around issues of sexual expressiveness.

This chapter provides a summary and review of the major concepts related to aging sexual expression, including quality of life variables, physiological effects of the aging sexual body, the psychological effects of the aging sexual mind, fantasy and aging, aging sexual expression, attitudes towards sexual expression, and a brief description of the resident phenomenon. The complex factors that shape human sexual behavior including physiological changes, desire, intimacy, sexual expression, and sexual behavior are covered in this section to convey the varying degrees of desire and interest in conjunction with identified barriers such as age, loss of partner, poor health, illness, and internalized ageism, which may interfere with individual sexual expression.

As previously discussed in Chapter 1, Omnibus Budget Reconciliation Act (OBRA) 1987 (Resident Rights, 2002) was an innovative achievement for the nursing home population in the United States. The OBRA 1987 law established the critical groundwork for most of the legal rights and protections for nursing home residents in the

United States and continues to challenge nursing care reform (Mollot, 2006). Although OBRA 1987 pertains only to federally funded nursing homes, because the majority of facilities are certified to receive government reimbursement, the law has served as an industry-wide standard (Mollot, 2006). Prior to OBRA 1987, residents faced living life in nursing homes with abysmal care and living conditions (Katz, 1986). Upholding OBRA 1987 standards, however, remains a national challenge for most nursing homes.

This dilemma is only further complicated by the steady growth of the older adult population in need of residential care. According to the 2010 U.S. Census Bureau (as cited in Werner, 2011), 1.3 million people (3.1% of the total 65-and-older population) ages 65 and older resided in skilled nursing facilities. The skilled nursing facilities themselves are inhabited by approximately 1.8 million of the total U.S. population. These findings suggest that 86.2% of the total skilled nursing facility population is made up of people ages 65 and older, making this age group the fastest growing population in the skilled nursing home setting (Werner, 2011). Moreover, women in this population account for approximately 2.5 times more than men in the skilled nursing home setting (U.S. Census Bureau, 2012). The ever-growing older adult population only increases the need for exemplary standard of care in skilled nursing facilities.

Quality of Life in Nursing Homes

There is a great deal of literature on *quality of life* measures in nursing homes and yet, little research has addressed sexual contact or intimacy as indicators of exemplary standard care. Most research in the field of skilled nursing facilities and *quality of life* indicators have focused on living condition standards and medical care (Burack, Weiner, Reinhardt, & Annunziato, 2012; Hajjar & Kamel, 2004; Kane et al., 2003). The complex nature of human needs would suggest, however, a more comprehensive examination

would include attention to the psychosocial well-being of residents, including important basic human needs such as emotional connection, sexuality, and intimacy (Doll, 2012; Hajjar & Kamel, 2004; Knaplund, 2008).

The lack of research on the topic of sexuality as a *quality of life* indicator for nursing home residents can be seen by the limited number of academic and research publications that have been produced on the topic. No more than seven total publications were identified in a PsychINFO search using *sexuality*, nursing homes, and *quality of life indicator* as keywords. The number of citations is even less (only three total publications) when the term *sexuality* is replaced with *intimacy*, and again, even less with a total result response of one citation when replacing the word *sexuality* with *touch*. From the seven total publications (three peer-reviewed journal publications, two book publications, and two book chapter publications) only two were peer-reviewed studies, which reflects a 30-year-gap in the literature (Mroczek, Kurpas, Gronowska, & Karakiewicz, 2013; Ragno, 1996; Wasow & Loeb, 1979). These small numbers become even more perplexing when the Boolean search for *quality of life* and *nursing homes* found over 1,000 citations in the same PsychINFO search.

Miles and Parker (1999) also identified few academic and research publications in their own literature review regarding intimacy and nursing home facilities. They argued for the nursing home facilities to take on healthcare functions in the “form of the background rather than the foreground of the experience of daily life” (p. 41). Wasow and Loeb’s (1979) study was the first and only identified qualitative study. Wasow and Loeb interviewed 27 male residents and 26 female residents on the topic of attitudes towards sexual expression among residents in nursing homes. Although sexual thoughts

and feelings were reflected by the participants ($N = 66$), there were no reports of sexual engagement—chiefly due to lack of opportunity (Wasow & Loeb, 1979). Moreover, all participants believed sexual activity in nursing homes to be an appropriate activity. The results of this study appear to align with that of the Mroczek et al. study (2013).

Mroczek et al. (2013) conducted quantitative interviews to examine how nursing home residents in Poland ($N = 85$) identified individual psychosexual needs as indicators of *quality of life* by nursing home residents, aged 58–92 years ($M = 74.2$, $SD = 11.2$). Although differences may exist when comparing Polish culture and American culture, it was important to explore the study of Mroczek et al. (2013) from a humanistic perspective. Psychosexual needs and quality of sexual intercourse were considered the most important indicators of *quality of life*, even compared to other *quality of life* indicators such as health problems, education, age, gender, and marital status (Mroczek et al., 2013). The 5-point Likert-type scale was used to determine the importance of psychosexual needs, from the least (1) to the most important (5). Psychosexual needs were identified as conversation ($M = 5$, $SD = 0.7$), tenderness ($M = 4.56$, $SD = 0.7$), emotional closeness (e.g., empathy, understanding; $M = 3.68$, $SD = 0.954$), and physical closeness ($M = 2.07$, $SD = 1.203$). Interestingly enough, more than half ($n = 43$) of the respondents reported feeling sexual tension.

This sense of sexual tension was reported to be specifically connected to the lack of opportunity or access to physical intimacy, or connection, to others. All the men and half of the women regarded the need for “tenderness” as important; however, due to its quantitative framework, the data do not illuminate what “tenderness” and “touch” exactly meant to those individual participants. It was unclear from this study whether

“tenderness” was defined as emotional or physical, relational or practical as may be seen by staff to resident. This current study aimed to explore how the individual older adult resident experiences life as a sexual, intimate human being, more specifically studying constructs such as tenderness.

Tenderness and Human Connection

From the time of birth, humans yearn for connection. As human beings, we thrive as a result of human connection (Montagu, 1986). Much research on tactile stimulation directly after birth indicates a positive correlation between skin-to-skin contact and positive physiological and psychological development. Continued physical touch increases body temperature of babies (Mori, Khanna, Pledge, & Nakayama, 2010), shapes brain responses to stress (Champagne, 2008), stabilizes heart rhythm pattern (Esposito et al., 2013), and decreases crying sessions and increases alertness (Erlandsson, Dsilna, Fagerberg, & Christensson, 2007). Most importantly, tactile stimulation from the time of birth is documented in the literature as the essential bridge to the psychological bonding of one human to another human—a human’s first relationship (Ainsworth, 1985; Klaus & Kennel, 1982; Montagu, 1986; O’Brien & Lynch, 2011).

In fact, a study conducted by Grewen, Anderson, Girdler, and Light (2003) found touch, in the form of hugging, to be especially therapeutic for individuals on a physiological level as well as a psychological level. Grewen et al. ($N = 185$) assessed for an association between cardiovascular activity of cohabitating and married individuals, a social stressor, and positive physical contact. The experimental group ($n = 100$) and the control group ($n = 85$) were given a public speaking task to be individually presented in front of two researchers. Prior to the speaking task, each couple in the experimental group was asked to engage in warm contact (e.g., touch in some positive way and discuss

something positive about their relationship) for approximately four minutes, then watch a 5-minute segment of a romantic movie, and were then asked to hug for 20 seconds. The participants in the control group were asked to relax for 10 minutes by themselves and then stand alone for 20 seconds before moving on to the speaking task.

Throughout the study, cardiopulmonary readings of the participants were documented among both control and experimental groups. From the readings, Grewen et al. (2003) identified a positive effect on both heart rate and blood pressure responses to a stressful event as a result of a brief positive interaction (e.g., hugging). The blood pressure and heart rate of the male and female participants in the experimental group decreased by half as compared to the control group who relaxed alone (Grewen et al., 2003). The findings of the Grewen et al. study (2003) were supported by previous studies (Bland, Krogh, Winkelstein, & Trevisan, 1991; Seeman, 2000). From the Grewen et al. study (2003) along with similar studies, social contact was supported as a direct link to healthy living and overall happiness with life, especially when undergoing stressors.

Positive social and physical interactions across the lifespan increase oxytocin levels (Esposito et al., 2013), decrease blood pressure and heart rate (Esposito et al., 2013), and are connected with a healthy life. Contrarily, negative or absent physical and social contact increases blood pressure, heart rate, and other health risks. Humans continue to desire positive intimate connection and physical contact throughout their lives (Montagu, 1986). From that first relationship of parent and child and throughout the human lifespan, touch and intimate connection remain pervasive components to overall fulfillment and life satisfaction. Positive touch, especially among the older adult population, increases a psychological sense of safety, comfort and self-confidence, and

decreases anxiety (Routasalo & Isola, 1996). Tactile connection may increase with importance as a person grows older (Montagu, 1986) and, as people age, individuals tend to become more in tune with their emotions and their need for relationships strengthens (Hillman, 2000).

Sexual Expression and the Older Adult Population

As defined in Chapter 1, sexual expression can include touching, holding hands, massaging, or other forms of demonstrating affection. Sexual expression may take the form of a physical or an emotional act or both (Leiblum & Segraves, 1989). Throughout the lifespan, even a simple touch or stroke may be considered important and sometimes preferred sources of physical intimacy among the older population (Leiblum & Segraves, 1989).

Several quantitative studies on sexual behavior and sexual expression were found in the research literature; however, only two identified comprehensive population-based studies of sexuality including older adults (DeLamater & Moorman, 2007; Lindau et al., 2007) were found. Lindau et al. (2007) conducted one of the largest national studies in the United States. Lindau et al. (2007) utilized the National Social Life, Health, and Aging Project to examine associations among sexual expression, sexual behavior, sexual problems, and physical and emotional health, illness, medication use, sensory function, and social connectedness among the older adult population. Participants ($N = 3,005$) ranged from 57 to 85 years of age (male $n = 1,455$ and female $n = 1,550$). This study consisted of (a) a self-administered questionnaire completed during the in-home interviews; (b) a leave-behind questionnaire to be completed by respondents after the interviews; (c) a complete marital and cohabitating survey; and (d) blood, salivary, and vaginal mucosal specimens collected at the time of the in-home interview.

The researchers utilized 95% confidence intervals (95% CI) to explain results of logistic regression analysis to assess odds of sexual activity, engagement in sexual behaviors, and specific sexual problems among three selected age groups (57–64 years, 65–74 years, and 75–85 years) and self-rated health (“excellent,” “very good,” “good,” “fair,” or “poor”) of two genders (male and female). Findings of the study indicated sexual interest does indeed continue throughout the lifespan of an individual; however, variables such as death of a spouse or poor health may pose significant barriers to continued interest or engagement in sexual expression (Lindau et al., 2007). Gender differences were also present, specifically individuals who identified themselves as caregivers were less interested in sexual intimacy (Lindau et al., 2007).

The second identified comprehensive quantitative study was conducted by DeLamater and Moorman (2007). The researchers utilized secondary data from the American Association of Retired Persons (AARP) Modern Maturity Sexuality Survey (1999) to examine the biological and psychosocial variables associated with sexual behavior in adults. The surveys were disseminated to 1,709 individuals who agreed to participate in the study. The eligible participants ($N = 1,384$) ranged from 45 to 94 years of age (male $n = 639$ and female $n = 745$). Five dependent variables including kissing or hugging, sexual touching or caressing, oral sex, sexual intercourse, and masturbation were assessed along with several independent variables involving age, illness, participant sex restrictions, attitudes towards sexuality, desire, satisfaction, and partner restrictions.

The authors utilized ordered logistic regressions to assess frequency of the five sexual behaviors when compared to age and biological/psychosocial factors. Four of the variables were identified as partnered behaviors; therefore, participant responses for the

regression analyses were restricted to data of those who identified as having a sexual partner. Findings of the study indicated sexual satisfaction and sexual attitudes are strongly related to the frequency of partnered sexual interactions (DeLamater & Moorman, 2007), specifically sexual intercourse. Moreover, the data suggested desire is influenced by frequency of masturbation among both male and female participants (DeLamater & Moorman, 2007). The authors also found age to be negatively associated with the frequency of all five behaviors.

Several results came from the DeLamater and Moorman (2007) study and the Lindau et al. (2007) study that are discussed throughout this literature review. Findings of the study indicated sexual interest does indeed continue throughout the lifespan of an individual's life; however, biological and physiological changes were identified as critical variables in level of interest and frequency.

Biological/Physiological

The biological makeup of sexual response was most notably documented by researchers Masters and Johnson (1966), pioneers of human sexual response cycle research, and Kaplan (1977), who modified Masters and Johnson's model to better address female sexual dysfunctions.

Masters and Johnson (1966) identified a four-phase pattern of the sexual response cycle for both men and women. Those phases included *excitement*, *plateau*, *orgasm*, and *resolution*. The *excitement phase* for both sexes included nipple erection; vasocongestion, or engorgement, of the penis, the clitoris, the vaginal wall, and the labia minora; a sex flush appears (red blotchiness appears on the cheeks and chest); heart rate and blood pressure increase; vaginal lubrication begins; the testicles swell and tighten; and myotonia or, muscle tension occurs (Masters, Johnson, & Kolodny, 1994). Duration of

the *excitement phase* may last up to an hour or as little as a few minutes (Masters, Johnson, & Kolodny, 1994). The *plateau phase* includes a sexual tension that continues to increase as a physical reaction towards orgasm, as well as a continued increase in blood pressure and heart rate, and the development of the orgasmic platform, where vasocongestion of the labia majora and purple darkening of the vaginal wall occurs in women (Masters, Johnson, & Kolodny, 1994). The *plateau phase*, as identified by Masters and Johnson (1966), only lasts minutes at most.

The *orgasm phase* pertains to the climax phase of a sexual encounter. This phase generally includes muscle spasms, sudden forceful release of sexual tension, the muscles of the vagina and uterus contract, and release of seminal fluid from the Cowper's gland in men (Masters, Johnson, & Kolodny, 1994). Women may go back to the plateau phase if they do not orgasm. The orgasm phase is the shortest of all phases, typically lasting a few seconds for men and slightly longer for women (Masters & Johnson, 1966). The *resolution phase* concludes the cycle as heart beat and blood pressure return to normal levels, the penis becomes flaccid, swelling of anatomy parts decreases back to normal, and sex flush subsides. Masters and Johnson (1966) also included what they called a *refractory period*, which was a "delayed response to ejaculate during the man's resolution phase" (Masters, Johnson, & Kolodny, 1994, p. 30).

As a result of hormonal lessening or complete depletion, the phases, moreover, look different as a result of aging (Masters & Johnson, 1966). According to Masters and Johnson (1966), the *excitement phase* includes a decrease in breast enlargement as well as the labia minora; the labia majora may not become engorged at all; the vaginal wall progressively thins, and as a result, capacity diminishes; a decrease in lubrication and

maintenance of lubrication occurs; a delay and maintenance of an erection; engorgement of scrotum decreases; and elevation of testicles lessens compared to earlier years. During the *plateau phase*, the clitoris begins to retract, diminishing clitoral stimulation and excitement in women; a full erection occurs just before climax as opposed to earlier in the phase in men (Masters & Johnson, 1966). The *orgasm phase* includes physiological changes such as a decrease in tension, a decrease in contractions, lessened frequency of rectal contractions, shortened vaginal contractions in women, and a decrease in seminal fluid in men (Masters & Johnson, 1966). The labia minora, penis, and nipples transition quickly back to relaxed state during the resolution phase, and men may take longer to transition from resolution to the refractory phase (Masters & Johnson, 1966). As a natural consequence of healthy aging, the body physiologically continues to respond to sexual stimuli; however, there is a significant delay in the reaction time and response pattern (Masters, Johnson, & Kolodny, 1994).

The sexual being, according to Kaplan (1977), will naturally and reflexively respond to sexual stimuli; however, the human mind plays a much greater role in the sexual response cycle than do the body's sexual reflexes (Kaplan, 1977). Sexual reflexes in men and women "comprise of complex integrated systems that are influenced by hormonal levels and sensory signals that are regulated by the central and peripheral nervous systems" (Marson, 2009, p. 3682). As a response to the Masters and Johnson studies, Kaplan (1977) argued for the inclusion of a *desire stage*, which would precede all other stages. Kaplan (1977) reported the *desire stage* to begin as a result of a hormonal balance and increase of testosterone, serotonin, dopamine, and catecholamines, which are triggered as a result of the mind's perception and attitudes toward the sexual activity.

Kaplan (1977), moreover, argued for the removal of the *resolution phase*, as she believed it was the absence of a sexual response and, therefore, need not be part of the cycle.

Kaplan later modified Masters and Johnson's (1966) phases to a three-stage linear model.

Kaplan's model included the *desire stage*, *the excitement stage*, and the *orgasm stage*.

The *excitement stage* is similar to both the *excitement* and *plateau phases* of Masters and Johnson (1966), as Kaplan argued that no distinguishing differences existed between Masters and Johnson's *excitement* and *plateau phases*. The *orgasm stage* was also the same as Masters and Johnson's *orgasm phase*.

Both Kaplan (1977) and Masters and Johnson (1966) have since been criticized for being both too biologically and medically focused, especially when considering the female sexual response cycle (Basson, 2001; Whipple, 2002). Both Basson (2001) and Whipple (2002) argued the medical sexual response cycle model assumes orgasm to be the ideal and "natural" outcome of a sexual activity. Based on the medical model, an inability to achieve or have difficulty achieving orgasm are considered pathological; however, the *Diagnostic and Statistical Manual of Mental Disorders* ([*DSM-V*] American Psychiatric Association, 2013) presents a clearer range of healthy sexual expression, that includes non-orgasmic sexual experiences. When considering the sexual expression of an older person, the prognosis for sexual problems and sexual health are evaluated more comprehensively, rather than just biologically.

As the body ages, the physiological response to sexual engagement changes. Rather than chronological age itself, the general health of the human body is one of the primary indicators of sexual health. "Biological factors have an indisputable effect on sexual activity among the elderly, but they do not directly determine it" (Kontula &

Haavio-Mannila, 2009, p. 46). For men, research has shown a decline of sperm production (Croft, 1982), decreased testosterone (Croft, 1982), diminished force of ejaculation (Croft, 1982; Gentili & Mulligan, 1998; Lindau et al., 2007), increased size of the prostate gland (Croft, 1982), slower development of excitement and erections (Croft, 1982), maintenance of erections for longer periods prior to ejaculation (Croft, 1982; Hayes & Dennerstein, 2005; Lindau et al., 2007; Willert & Semans, 2000), less frequent ejaculation (Croft, 1982; Hayes & Dennerstein, 2005), and lengthened refractory period (Croft, 1982). The most common physiological problems reported by older adult men include erectile and ejaculatory difficulties (Lindau et al., 2007). Decreases in testosterone in both men and women occur in older age (Gentili & Mulligan, 1998; Hayes & Dennerstein, 2005; Lindau et al., 2007).

Older women most commonly report a noticeable decrease in vaginal lubrication (Lindau et al., 2007). Other physiological changes in older women include decreased amounts of estrogen and progesterone (Croft, 1982; DeLamater & Karraker, 2009; Gentili & Mulligan, 1998), shrinking of the external genitalia (Croft, 1982; Hayes & Dennerstein, 2005), loss of pubic hair (Croft, 1982), decrease in duration of orgasm (Willert & Semans, 2000), inability to achieve orgasm (Willert & Semans, 2000), vaginal dryness and maintenance of lubrication (Lindau et al., 2007; Willert & Semans, 2000), and loss of elasticity and thinness of vaginal wall (Croft, 1982; Lindau et al., 2007; Willert & Semans, 2000).

The biological makeup of the sexual human being undergoes complex changes throughout the lifespan. As a result, researchers cannot agree on a specific theory of the physiological response of both men and women towards sexual engagement. Whether

correlational or causal, the sexual response patterns of humans indicates a natural proclivity towards sex. As previously noted, the sexual body goes through many physiological changes. This would suggest a need to examine how sexual interest changes and how sex is defined by older adults who experience these changes. According to King (2014), “sexual dysfunctions are now understood to have requisite biological underpinnings that are influenced by intrapersonal, interpersonal, cultural, and psychological factors” (p. 12). Older adults are no exception when considering healthy sexual expression.

Sexual Activity

Sexual activity is often defined as sexual intercourse, but a broader definition is more applicable to most individuals. Although sexual activity declines with age, men and women, even during their 80s and 90s, report being actively engaged in a variety of sexual activities, including vaginal intercourse, oral sex, and masturbation (Lindau et al., 2007). Findings of the Lindau et al. study (2007) suggest that although the presence and frequency of sexual activity declined with age (73% among the 57–64 years age group, 53% among participants in the 65–74 years age group, and 26% among participants who were part of the 75–85 years age group), sexual activity and interest in sexual engagement was still present among all age groups. In the oldest age group, 54% of sexually active participants reported engaging in sexual activities at least two to three times per month, 23% reported having sex once a week or more, and 31% reported engaging in oral sex. Masturbation practices were also still present among both genders; however, frequency decreased with age, and men were more likely than women to masturbate in the oldest age group (Lindau et al., 2007). Lindau et al. (2007) also found

that, of the 53% of individuals who were 65–74 years of age, women were less likely to engage in sexual activity (Lindau et al., 2007).

Desire and Lack of Interest

The term *desire* is defined in a variety of ways. According to DeLamater and Sill (2005), theorists most commonly define the term within two constructs: biologically, humans are inherently sexual beings driven by instinctual motivating forces, and desire exists within the larger relational context between individuals. Felluga (2011) reported that Freud supported the first construct of desire, as he believed humans to be instinctually pleasure-seeking beings, whether it was conscious or unconscious, and therefore, heavily influenced thoughts and behaviors of sexual expression. Masters and Johnson (1966) worked from the second construct and reported that desire is a direct result of arousal (e.g., thoughts, fantasies, and interest to engage in activity). Kaplan (1977) later debated Masters and Johnson's theory of desire by stating that desire is part of an interpersonal and romantic attraction that is directed toward fulfillment of sexual needs. Kaplan furthermore supported the idea that desire should be seen as a distinct stage in the sexual response cycle, rather than a result of the arousal phase, as supported by Masters and Johnson.

Although Kaplan (1977) addressed desire as a distinct stage of the sexual response cycle in women as opposed to a primal instinct suggested by Masters and Johnson (1966), the concept of desire was founded in the same medical model as Masters and Johnson. Critics of both Kaplan and Masters and Johnson argue desire and sexual interest derive from a combination of complex biopsychosocial variables. Whipple (2002) argued the medical models imply equivalent sexual response patterns among men and women, negating how most women generally incorporate socio-sexual and non-

biological experiences when engaging in sexual activity. Non-biological experiences include personal interest, personality, satisfaction, self-esteem, confidence, compatibility, and other relational associations. Basson (2001) supported Whipple's claim of a biopsychosocially based concept of desire with her claim that many women are interested in sexual engagement simply as a result of their partner's sexual interest. This notion would argue against the medical model of libidinal instinct to self-pleasure.

According to Hillman (2000), research on later life sexual expression supported the second construct of desire in that it is related to personal motivation, needs, and satisfaction of elderly individuals. In later stages of life, Hillman reported that desire may actually be positively associated with biopsychosocial constructs, such as

fostering of emotional intimacy; experiencing and enjoying physical pleasure; satisfying continuing biological urges; asserting independence and experimenting new things; feeling youthful; challenging societal myths; reestablishing societal myths; heighten bodily awareness; and engender comfort and familiarity with the changing body. (Hillman, 2000, p. 18)

Although the body undergoes several changes over the course of time, the literature still suggests sexual desire remains to be an important aspect of life for the older adult

(DeLamater & Sill, 2005; Hajjar & Kamel, 2004; Hillman, 2000; Masters et al., 1994).

According to Pope, Wierzalis, Barret, and Rankins (2007),

Sexual activity may increase or decrease as men age. Although sexual performance may subside, the range of erotic fantasy can extend and enliven such performance. For many older gay men, the availability of sex continues to be a source of pleasure. (Pope et al., 2007, p. 74)

These findings were supported by other studies on the topic of desire and interest in the older adult population. Pope and Schulz (1990) disseminated a questionnaire to same-sex individuals to assess level of sexual activity and interest of midlife and older gay adults. The authors found 5% of the same-sex participants (60 and older) reported engaging in sexual activity more than once per week. Thirty-eight percent of the participants (age 60 and older) reported having sex at least once per week. Moreover, Pope and Schulz found an overall decrease in sexual interest with age; however, 45% of participants 60 years of age and older reported having strong sexual desire and interest.

DeLamater and Moorman (2005) also supported the findings of Lindau et al. (2007). DeLamater and Moorman administered the Modern Maturity Sexuality Survey to assess desire among older adults ($N = 1,384$). From the study, the results suggested high blood pressure, perceived age, and presence of partner were significantly correlated with desire. Specifically, those with high blood pressure were less interested in desire. The level of desire and interest steadily increased among the older participants but was considered not as important until ages 75 and older for the majority of both female and male participants (DeLamater & Moorman, 2005). Partner status was also positively correlated with desire. Seventy-eight percent of the female participants without partners responded with a low level of sexual desire and 83% of the female participants with a partner reported high level of sexual desire (DeLamater & Moorman, 2005). Contrary to the partnered female participants, 84% of the male participants with partners reported low levels of sexual desire.

Sexual Fantasy

Masters and Johnson (1966) considered sexual fantasies to be part of the desire phase of the human sexual response cycle. More specifically, sexual cognitions were

identified as content fantasies leading up to the sexual act (Masters & Johnson, 1966). Recent research, however, suggested that a dichotomy of sexual fantasy or erotic fantasy exists and are characterized as either positive or negative sexual cognitions (Renaud & Byers, 2010). Renaud and Byers (2010) conducted a study to assess similarities and differences between positive and negative sexual cognitions among college students ($N = 292$). From the study, the authors identified content of the fantasy to be insufficient in discerning differences between positively experienced sexual cognitions and negatively experienced sexual cognitions (Renaud & Byers, 2010). As a result, the authors identified “positive sexual cognitions as cognitions that were acceptable, pleasant, and ego-syntonic and negative sexual cognitions as cognitions that were unacceptable, unpleasant, and ego-dystonic” (Renaud & Byers, 2010, p. 27).

Health, Illness, and Death

Sexual interest and sexual activity can be therapeutic and increase overall health for elderly individuals, possibly even decrease chances of heart attacks (Hillman, 2000; Kontula & Haavio-Mannila, 2009; Willert & Semans, 2000). Health was considered a main predictor of sexual engagement and interest (Lindau et al., 2007). Findings of the Lindau et al. (2007) study suggested a strong correlation with continued interest or disinterest in sexual activity and self-reported physical health, regardless of age. Participants were asked to select a response from a standard 5-point Likert-type scale, which included “excellent,” “very good,” “good,” “fair,” and “poor.” Participants who self-reported their health as excellent, very good, or good reported feeling desirous and inclined to sexual activity. Individuals in good health were more likely to engage in sexual activity across all age groups. Among men, masturbation was also positively perceived for those who reported feeling both physically and psychologically healthy

(Lindau et al., 2007; McKinlay, 1999). On the other hand, poor health was positively associated with a decrease in masturbatory practices among women (Lindau et al., 2007).

Those who rated their health as being fair or poor had a higher prevalence of sexual issues, including interest in sex, decreased experience of pleasure, erectile difficulties, delayed onset and/or continued presence of self-created lubrication, and pain (Lindau et al., 2007). Specific health issues such as diabetes and arthritis were more positively associated with sexual disinterest among women compared to women without diabetes or arthritis (Lindau et al., 2007). Illness was also found as a possible contributor to decreased interest in sexual activity in the Wiley and Bortz (1996) study. The longitudinal study (span over ten years) found 92% of participants ($N = 118$) desired to have sex once a week; however, less than half reported weekly sexual activity. The authors supported the claim that, regardless of age, illness was seen as the primary contributor to disinterest in sexuality (Wiley & Bortz, 1996).

Poor health of the individual was also considered a main contributor of sexual disinterest, specifically among men (Lindau et al., 2007). Lindau et al. (2007) reported that 61.4% of the male participants confirmed poor physical health to be a main contributor of disinterest in sexual activity. These findings were further supported by Gott and Hinchliff's (2003a) study on attitudes toward sexuality among older adults. Gott and Hinchliff conducted a mixed methods approach to examine attitudes toward sexuality among individuals 50 to 92 years of age ($N = 44$). The researchers utilized grounded theory interviews to compare to the results of the administered World Health Organization Quality of Life Importance Scale.

The researchers found all participants to be relatively interested in sex ($N = 44$), although they varied in response to the level of importance (Gott & Hinchliff, 2003a). Those who rated sex as highly important considered it to be an essential part of their relationship ($n = 15$). Lack of partner (divorce, death of spouse, or inability to see oneself in a future relationship) and health status (partner or self) were identified as barriers for those who reported little value in sex ($n = 12$). Illness may also determine the level of activity and interest in desire or physical intimacy. Some participants in the study who reported illnesses explained the act of penetrative sexual activity was considered impossible, and, therefore, the definition of physical intimacy transformed from penetrative sex to cuddling and intimate touch (Gott & Hinchliff, 2003a). Both were reprioritized as key components to healthy intimacy in the relationships. Although identified by a small number of participants, some reported sex to increase in importance and pleasure as they aged ($n = 5$; Gott & Hinchliff, 2003a).

Variables such as health of self and health of a partner were also considered important barriers to continued interest or engagement in sexual expression in the Lindau et al. (2007) study. Sixty-four percent ($n = 95$) of women in the 75–85 years age group compared to 63.4% ($n = 105$) of women in the 65–74 years age group who were involved in relationships identified the male partner's physical health as the main reason for sexual inactivity (Lindau et al., 2007). Partner health was further supported by the Drummond et al. (2013) study, which looked at the impact of caregiving on older women's ($N = 6$) sexuality and sexual expression.

The Drummond et al. (2013) study found the caregiving role to be too all-consuming, leaving little to no room, emotionally or mentally, for the caregiver. All

female participants reported a shift in identity, from intimate partner to caregiver, which consequently forced an “outsider” perception of self and of their partner. As a means of coping, female participants considered sexual expression to be irrelevant and reported pushing all sexual interest aside. Those who encouraged sexual intimacy were met with futile attempts of physical intimacy with their male partner (either because the caregiver could not see past the male partner’s new role as receiver of care or because the male partner refused or denied their sexual invitation; Drummond et al., 2013). Many of the female participants, however, reported identifying ways to balance their caregiving role and sexual needs, including self-intimate play, redefining sexual expression that met the intimate needs of both the caregiver and partner, or through the development of other forms of meaningful relationships with others in order to create a sense of intimacy and connection (Drummond et al., 2013).

Across the lifespan, illness and death are seen as barriers, both psychologically and physiologically. People of any age who experience sexual difficulties may experience negative psychological side-effects, including anxiety, depression, and lowered self-esteem (Wise, Rabins, & Gahnsley, 1984). For those in later stages of life, however, experiences of illness or pain may almost certainly push sexual needs, desires, and expression aside to the background (Gentili & Mulligan, 1998; Lindau et al., 2007; Willert & Semans, 2000). As previously mentioned, physical illness can be seen as a major barrier to those who desire physical intimacy with self or with another person (Gott & Hinchliff, 2003a). Illness and “uncertainty of their sexual functioning and the psychological impact of their misunderstood sexual capacities can become obstacles to sexual satisfaction” (Levine, 1998, p. 98).

Psychosocial Effects

In modern societies where youth and beauty are emphasized, older adults are more inclined to receive negative messages toward sexual expression than their younger counterparts (DeLamater & Sill, 2005; Hajjar & Kamel, 2004, Kaas, 1981; Laflin, 1996; Lindau et al., 2007). “Society’s admonition to older people to ‘act their age’ is, in fact, a demand that they stop listening to their bodies’ needs to be touched, stroked, cuddled, and caressed. It is unbecoming to feel sexual, appropriate to feel ill” (Laflin, 1996, p. 46). Consequently, sexuality—when denied—is seen as having a negative impact on self-image, social relationships, and mental well-being (Hajjar & Kamel, 2004). Historically, socially conservative older adults are more highly critical of their sexual selves and hold a higher degree of sexual guilt (Hudson, Murphy, & Nurius, 1983; Laflin, 1996). Those with more socially conservative attitudes are inclined to internalize negative societal messages (DeLamater & Sill, 2005) and, as a result, deny their sexual needs. Specifically, internalization of ageism coupled with the physiological changes of aging may result in what Kaas (1981) defined as symptoms of *geriatric sexuality breakdown syndrome*.

According to Kaas (1981), there are specific psychological and social characteristics that may render older adults more prone than others to *geriatric sexuality breakdown syndrome*. Kaas described two steps: susceptibility and dependence. The first step refers to those older adults who are inherently vulnerable and are more likely to perceive their sexual selves through a negative lens. This precondition of vulnerability is naturally exacerbated by weakened ego strength and response to the physiological changes that occur in the sexual response cycle (Kaas, 1981). The susceptibility of *geriatric sexuality breakdown syndrome* also includes how a person responds to the assumed attitudes and behaviors of society towards aging (Kaas, 1981). This step is only

strengthened by the natural response of the aging body to sexual expression. Considering desirability and social standards, chronic illness may be especially distressing to a person's confidence and sense of sexual well-being (Laflin, 1996).

The second step is described as a lack of independence and connection with the community (Kaas, 1981). As social beings, people are inclined to look to partners and older peers and adults for knowledge and social guidance. As these people die, sharing of knowledge is limited and a person who is vulnerable may become more susceptible to complying with current societal cues and mores towards aging sexual expression. For example, if a society proclaims that sexuality is primarily for the youth or for procreation purposes, older adults with diminished ego strength and lack of positive role models may intrapersonally communicate negative messages towards their own sexual desires and interests; furthermore, they may even begin to see themselves as sexually deviant or asexual. Society, therefore, plays a critical role in *geriatric sexuality breakdown syndrome*. In societies where messages of beauty, health, and sex are ascribed to the youth culture, often older adults are challenged with their own sense of beauty and sexuality.

Due to social stigma and internalized ageism (whether perceived or experienced), older adults have difficulty addressing sexual concerns with others interpersonally. In the Lindau et al. (2007) study, only 38% ($n = 927$) of the male participants and 22% ($n = 1,058$) of the female participants (65 years of age and older) reported discussing sexual issues with their physician. To make it more problematic, the same participants reported they had not spoken of sexual issues to a physician since they were 55 years old. Symptoms of *geriatric sexuality breakdown syndrome* and internalized ageism may be alleviated and potentially cease to exist as a result of changing societal perception of

elderly sexuality and/or of educating the older individual on positive coping strategies when dealing with negative societal cues (Kaas, 1981).

Interest in sex does not necessarily diminish with admission to a care home but engagement in sexual behavior has shown to decrease in frequency (Elias & Ryan, 2010; Mulligan & Palguta, 1991). Older adults may resign themselves to celibacy if they deem it unnecessary or if proscribed moral values conflict with internal desire to achieve sexual gratification (Muzacz & Akinsulure-Smith, 2013). Wasow and Loeb (1979) conducted a qualitative interview ($N = 66$) on the topic of attitudes towards sexual expression among residents in nursing homes. Although sexual thoughts and feelings were reflected by the participants, there were no reports of sexual engagement—primarily due to lack of opportunity. Moreover, all participants believed sexual activity in nursing homes to be an appropriate activity and identified caressing and touching as the more typical methods of intimate and physical connection (Wasow & Loeb, 1979). Mulligan and Palguta (1991) also found couples who reside in nursing homes are highly susceptible to feeling frustrated and emotionally and physically deprived as a result of lack of privacy and/or negative staff and family attitudes towards sexual expression.

When considering the influence of family and caregivers, there is a great potential for residents to be influenced by their caregivers as well as staff. According to Montagu (1986), humans are essentially social beings who require connection to others across the lifespan, especially during the older stages of life. Depending on the attitudes of caregivers, residents may be restricted from having partners, restricted from engaging in sexual activities, and denied privacy (Bentrott & Margrett, 2011; Hajjar & Kamel, 2004; Lindau et al., 2007; Pope, 1997). Residents may feel torn as a result because of their

social need to stay connected to their family and primary caregivers; therefore, these individuals may refrain from freely expressing themselves. For example, adult children, who have power of attorney over their mother who resides in a nursing home, may request privacy to be denied to their mother for sexual engagements with another resident. “Grown children of divorced and widowed older Americans often discourage their parents from behaving as sexual beings” (Laflin, 1996, p. 46).

Familial and caregiving support are historically more complex for residents who identify as a non-heterosexual. Although each person may struggle throughout his or her life with community and connection, there is a greater chance that LGBT individuals have gone through multiple challenges finding support and establishing a community. As a result, LGBT residents may be less inclined to take any unnecessary risks when it directly involves potentially losing a caregiver or other forms of help (Laflin, 1996). Once in a nursing home, LGBT residents may refrain from exposing their sexual orientation (Pope, 1997).

Gay men can be abandoned by family and friends, scorned by society, and unsure about whether they wish to belong in gay society. Therefore, the importance of intimacy through sexual activity becomes a validating experience, especially when the individual feels rejected on many other social dimensions. (Pope et al., 2007, p. 72)

Although gay male residents and members of the LGBT community may find it challenging to maintain a relationship while residing in a nursing home, according to Bentrott and Margrett (2011), the environmental support system of the resident must

work on every level in order for the residents to feel secure enough to express themselves sexually. Little data are currently present on the topic.

Critique of Lindau et al. Study

Although the Lindau et al. (2007) study is credited in many published articles and is considered one of the most comprehensive studies of aging sexuality, it is important to address the limitations. The reported purpose of the Lindau et al. study was to obtain estimates of the prevalence of sexual activity, behaviors, and problems in the older adult population; however, the study limited behaviors to only three types of sexual interaction (vaginal intercourse, oral sex, and masturbation). Moreover, the researchers did not clearly define the aforementioned behaviors. Vaginal intercourse, for example, is considered throughout the sexual literature as heterosexual intercourse, where the penis penetrates the vagina. Without clearly defining vaginal intercourse in the study, participant responses may have been limited to agree or disagree to heterosexual involvement, without consideration of same-sex sexual orientation, or proclivity to engage in same-sex play. In fact, the study reported self-disclosure of three men and five women who were involved in a same-sex relationship at the time, or in 12 months preceding the time the study was conducted (Lindau et al., 2007, p. 764).

The researchers did not report other forms of sexual activity such as anal intercourse, mutual masturbation, foreplay (kissing, hugging, fondling, petting, sensual massages, and so on), or the use of sexual objects (e.g., dildos, vibrators, penis rings, anal plugs, and so on), which may have been commonly practiced by the participants. Finally, traditional forms of intercourse and oral sex may be difficult for older individuals, especially when considering health issues such as arthritis. Again, when considering the purpose of the study, it is possible that the researchers were not able to accurately

describe the existence of sexual activity or behavior among the older adult population. Other limitations of the Lindau et al. study (2007) included the following: the ethnic groups were not appropriately identified, as some participants who identified as both Black, or African American, and Hispanic were considered African American; participants were not asked to specifically identify sexual orientation as part of the questionnaire; and data from the three men and five women who reported their relationship status to be with someone of the same sex appeared to not be represented in the findings. Although the limitations of Lindau et al. may seem great, the findings of the study offer the most comprehensive report of aging sexual expression in the last 60 years.

Attitudes of Aging Sexual Expression in Nursing Homes

Knaplund (2008) conducted a study examining current legal documents and nursing home policies on privacy rights of nursing home residents. From the study, Knaplund found a similar outcome to “sexually inappropriate behavior” demonstrated by the nursing home residents. Knaplund (2008) reported “seniors in nursing homes are lectured and ridiculed, even transferred involuntarily, for having a sexual relationship” (p. 248). “The doctor (and nurse) has been taught to be interested not in health but in disease” (Montagu, 1986, p. 123). Doll (2012) suggested sex between nursing home residents is often viewed “as a behavior problem rather than an indication of an unmet need” (p. 23). To make matters more complex, Laflin (1996) reported that nursing homes rarely collect a sexual history in the intake assessment or as part of the activities of daily living.

Anecdotal reports from several sources have reported a variety of disciplinary actions forced on individual residents for engaging in sexual activity of some nature. Married and single residents who attempted sexual intimacy have been historically

penalized by loss of privacy, formally reported for sexual misbehavior, confined to geriatric chairs, have had clothes placed backwards, have been placed in zipperless jumpsuits, relocated in the home, separated from others, and even evicted from the nursing homes (Knaplund, 2008; Miles & Parker, 1999).

Miles and Parker (1999) found staff to be directly linked to the overall health and sexual well-being of residents, depending primarily on their own attitudes toward aging sexuality. From their study, the authors identified five assumptions that would increase the prevalence of staff intervention towards sexual expression among residents:

First, private and apparently consensual sexuality between residents is more likely to be secretly coercive than are sexually intimate relationships outside of a facility. Second, sexuality between residents is more likely to be harmful than sexually intimate relationships outside of a facility. Third, staff have a professional duty to try to lower the risk of harm in sexually intimate relationships to a level that does not exist for people who are not nursing home residents.

Fourth, staff are able to evaluate consensual intimacy adequately to address the three preceding assumptions. Fifth, staff have a duty to represent the absent authority of proxy decision makers—mainly family—in supervising or limiting any sexually intimate relationship (Miles & Parker, 1999, p. 39).

Miles and Parker (1999) reported that the level of intervention depends on engagement in one of these five identified assumptions. As a result, ageism and medicalization of the nursing home facility appear to hold great influence on the level of permissiveness of sexual expression among nursing home residents. Miller and Parker hypothesized that, if older adult residents are not allowed the freedom to openly express

themselves in a physically intimate way, the “failure to accommodate sexually intimate relationships in nursing homes would lower quality of life, aggression, confusion, feelings of confinement, of being deserted, of powerlessness, greater difficulty making decisions, and greater use of psychiatric care and medical sedatives” (p. 40).

Aging Sexuality Knowledge and Attitudes Scale (ASKAS)

A great deal of research has focused on the attitudes, knowledge, and practices of nursing staff and residents. Previous literature indicated that, historically, the most commonly utilized instrument to study knowledge and attitudes about aging sexuality was the Aging Sexual Knowledge and Attitudes Scale (ASKAS) by White (1981). This quantitative instrument was used to exclusively focus on “issues of the aged, on the contexts of the aged persons, and on the sexual changes unique to the aged” (White, 1981, p. 493). The purpose of the ASKAS was to study the effects of education and training as measured by pre- and post- tests given to staff who worked with the aged, the residents, and their family members. The scale consists of 61 items including 35 true/false questions that measure *Sexual Knowledge* and 26 scaling questions based on a seven-point Likert-type scale to measure *Sexual Attitude*. “*Sexual activity in aged persons is often dangerous to their health*” is an item found in the *Sexual Knowledge* section. In the *Sexual Attitude* scale, the item “*Aged people have little interest in sexuality (Aged = 65 and older)*” is one of the 26 scaling items presented in the ASKAS. Participants are asked to rate the items on a Likert-type scale between 1 = disagree to 7 = agree.

Research results indicated that health care professionals fail to provide comprehensive care as a result of ageist views (Nay, 1992). Untrained caregivers tend to rely on their own religious, ethnic, and other personal beliefs to decide what is right for

residents (Bauer, McAuliffe, Nay & Chenco, 2012; Rosenweig, 2012). Goldstein-Lohman and Aitken (1995) identified similar findings in their study of occupational therapy students. Participants received an ASKAS pre-test to determine knowledge and attitudes toward aging sexuality. They were then provided a parallel instruction of an educational intervention, which consisted of informing them about the physiological changes of the aging sexual body, dispelling common myths about sexuality, and training the occupational therapist's role with sexual counseling. Three weeks post-intervention, an ASKAS post-test to assess level of effectiveness of the intervention was administered to participants. The study found significant improvement in knowledge ($p < .0001$) and understanding ($p < .001$), as well as understanding of occupational therapy students as a result of implementing an educational intervention on the topic of aging sexual expression (Goldstein-Lohman & Aitken, 1995).

Bouman et al. (2007) collected 234 ASKAS questionnaires from LPNs, RNs, CNAs, and program managers from both nursing homes ($n = 7$) and residential homes ($n = 9$) in the United Kingdom. The results of the study identified age ($p < 0.01$) and experience ($p < 0.01$) to be significant indicators of permissive or restrictive attitudes towards aging sexual expression among nursing staff. The researchers found young staff who had less than five years of nursing experience ($n = 90$) were more restrictive and held negative attitudes towards aging sexual expression. These findings are supported by previous research showing more permissive attitudes of aging sexual expression among those who were both older and had more experience (Hillman & Stricker, 1996; Walker & Harrington, 2002).

Hinrichs and Vacha-Haase (2010) utilized the ASKAS to assess attitudes toward same-sex couples and intimacy among nursing home staff ($N = 218$) in long-term care facilities. The authors utilized a self-response format, which consisted of a 7-point Likert-type scale with 1 = *negative* to 7 = *positive*. The questions assessed personal attitudes and reactions of nursing home staff (e.g., how surprised would you be about what you observed? [Vignette of male-male intimacy]). Findings of the study found staff to be significantly more surprised by observing two men intimately engaged ($M = 5.01$, $SD = 1.86$) than by two women ($M = 4.26$, $SD = 1.94$, $p < .01$) or a heterosexual couple ($M = 3.36$, $SD = 1.88$, $p < .05$). Moreover, the staff rated intimate engagement of heterosexual couples to be significantly more acceptable than same-sex male couples ($M = 4.01$, $SD = 2.03$, $p < .01$) or same-sex female couples ($M = 4.22$, $SD = 1.94$, $p < .01$; Hinrichs & Vacha-Haase, 2010). From the study of Hinrichs and Vacha-Haase, an educational intervention did not appear to make a difference in overall staff attitude and ratings of same-sex intimacy. It could be therefore surmised that regardless of education, values informed by early religious trends also effect attitudes toward same-sex intimacy.

Knowledge and Attitudes toward Elderly Sexuality (KATES)

Walker, Osgood, Richardson, and Ephross (1998) created and administered the KATES to assess knowledge, attitudes, and practices of staff and residents. From their study, the authors found 73% of staff ($n = 92$) were more likely to place higher importance ($\chi^2 = 22.14$, $p = .00006$) on sexuality compared to 50% of the older adult residents ($n = 34$). Moreover, the older adult participants were less tolerant and more socially conservative with sexual discussion than staff participants. Forty-seven percent ($n = 9$) of the older adult participants compared to 26% ($n = 8$) of staff participants agreed that the institution should contact family members in the case that a resident became

involved in an intimate relationship. On the other hand, 43% ($n = 6$) of older adult resident participants compared to 10% ($n = 3$) of staff participants agreed that staff should assist residents to obtain erotic material, if requested (Walker et al., 1998). The authors reported 60% of elderly resident participants and 55% staff participants both agreed that same-sex intimacy was morally wrong; however, they did not provide the number of responses of each group on this particular question.

These results in particular, compared to more recent studies utilizing the KATES, ASKAS, and similar quantitative instruments, found positive changes in overall attitudes of both staff and residents, except that of attitudes toward same-sex couples and intimacy (Hinrichs & Vacha-Haase, 2010; Walker et al., 1998). Cahill, South, and Spade (2000) estimated more than 2 million gay and lesbian older adults currently live in the United States. By the year 2030 there will be from 4 to 6 million lesbian and gay older adults. These numbers reflect a real and potentially dangerous dilemma for same-sex individuals who need to reside in a nursing facility as many may feel threatened to disclose their sexual orientation for fear of discrimination or eviction. “Partnership and sexual intimacy play a vital role in making aging transitions less isolating and burdensome to help gay men through this aspect of their developmental journey” (Pope et al., 2007, p. 72).

Senility and Sexuality in Nursing Homes

Nursing homes are required to protect each resident from themselves and from others, especially in cases where nonconsensual sexual behavior is presented. As part of the foundation of the nursing home, it would make sense that much research has been done on the topic of sexual expression among individual residents who present with deteriorating neurocognitive functioning. “Dementias are the most common type of neurodegenerative disorder. Behavioral disturbances are seen in more than 80% percent of

patients suffering from these disorders” (Black, Muralee, & Temp, 2013, p. 158).

Although not every resident at a nursing home has some form of dementia, this neurodegenerative disorder with an 80% behavioral disturbance rate poses a potentially great threat to individuals residing in nursing home facilities. Due to the consensual nature of sexual activity, it is understood why there is a proliferation of literature on the topic of consensual sexual expression and dementia (Archibald, 2002; Elias & Ryan, 2011; Mahieu & Gastmans, 2012) and also why this study investigated only individuals who were at a healthy cognitively functioning level to participate in the study (Black et al., 2013).

Summary

I was a little scared—but I decided that I was just going to do this! What could happen?! I will have you know that your 81-year-old mother had an orgasm in like 2 minutes! It was so fast! And I soaked the bed! I had forgotten what that felt like! I had forgotten the feeling. It was so good! I guess I didn't lose it from not using it! – Shameless Woman (Madsen, 2010)

During the last 60 years, detailed research data, political reports, and anecdotal data have shown repeatedly that healthy sexuality is not only present throughout the later stages of life, but also it is enjoyed and appreciated by people well into the last decades of their life. The majority of the research on the topic of aging sexual expression, however, is specific to older adults who do not reside in residential facilities. Although many older adults live out their lives at home, there is a growing community of older adults in need of residential care. The number of such residents will continue to increase as people in the United States continue to live longer and potentially healthier lives.

The view that nursing home facilities have on influence the *quality of life* experiences of nursing home residents is a consistent focus throughout the literature on older adults who reside in nursing home facilities. Although there has been research specific to the sexual experiences of nursing home residents, most of the research has primarily concentrated on quantitative attitudinal studies of staff and some residents on resident sexual expression and sexual behaviors of residents with cognitive deterioration. Over the past few decades, there has been a proliferation of research related to sexual expression of nursing home residents who present with degenerative cognitive diseases. Most of that research examines consensual sexual behavior and to what degree should mental capacities deteriorate before sexual encounters are considered nonconsensual and psychologically damaging. People decide to live in nursing homes for a plethora of reasons and not every resident who lives in a nursing home has some form of cognitive deterioration.

From the literature review it can be seen that research on sexual intimacy has had problematic methodological issues. Researchers rarely discussed how interviewers were trained to obtain responses on this sensitive topic. Most research focused on the frequency of sexual behavior, unless it was considered aggressive, rather than on the experience of the individual person and his or her own perception of meaning making on the topic of sexual intimacy and expression. Also, very few studies asked for demographic information that was gender-inclusive or asked about sexual orientation. Finally, few studies operationally defined their research variables (for example, Lauman et al. 2007; Mroczek et al., 2009).

Both qualitative and quantitative researchers on the topic of aging sexuality expressed the need for further research on the residents' and their interpretation of sexuality and sexual expression. Elias and Ryan (2013) reported "of equal importance is the need to undertake more rigorous qualitative studies with a particular focus on care home residents' perspective of their sexual health and well-being" (p. 1673). DeLamater and Sill (2005), moreover, supported the need for qualitative research as a complement to the quantitative studies, specifically to learn the differences and similarities in thoughts surrounding desire between identified men and women.

There are very few studies that captured the residents' individual experience within the nursing home as it pertains to sexual expression and positive sexuality. Given the research on sexual expression among older adults who do not reside in nursing home facilities, how nursing home residents access opportunities to express themselves sexually and intimately merits consideration. Chapter 3 covers the methodological procedures of the research design.

Chapter 3

Methodology

The purpose of this phenomenological qualitative study was to explore the unique attitudes, values, and experiences of older adult residents and staff around the issue of physical and relational intimacy and sexual expression in a nursing home residential setting. This chapter presents the research design and method used to explore if, how, and under what circumstances, these older adult residents and staff felt comfortable with self-sexual expression in the nursing home setting. This study hoped to document the “essence” (Moustakas, 1994) of being an older adult desiring connection and intimacy within a nursing home environment, especially exploring the “inner experiences unprobed in everyday life” (Merriam, 2002, p. 7) of these older adult residents. Finally, the beliefs and actions of some of the staff who worked for the residents were also explored.

This exploratory study used a phenomenological research design and drew from the tenets of interpretative phenomenological analysis in order to: (a) explore the level of self-reported interest in sexual expression among elderly residents; (b) generate awareness of sexual activity or sexual interest among elderly residents, as perceived by nursing home staff and resident peers; and (c) understand the roles and relationship between nursing home staff and the residents around issues of sexual expressiveness. Interpretative phenomenological analysis is a systematic investigation that is both hermeneutic and idiographic. This type of analysis was used to explore the unique stories of the individuals involved in this study.

Research Questions

1. How and under what circumstances do the older adult residents and staff feel comfortable with resident sexual expression in nursing home settings?

2. What barriers and affordances to sexual expression are experienced by older adult residents in nursing home facilities?
3. What differences and similarities in expressed attitudes exist between and within residents and staff on the topic of older adult resident sexual expression?
4. How do older adult residents and attending staff perceive opportunity and constraints in expressing a sexual self within the cultural context of a residential facility?

Research Design

Nay and Garratt (2009) argued that older adult residents' voices on the topic of sexual expression in nursing homes had not been comprehensively addressed in the research literature. Even within the frequent quantitative studies, research on aging sexuality has evolved little since the late 1970s, when White (1981) created the *Aging Sexual Knowledge and Attitudes Scale* (ASKAS). Despite compelling quantitative evidence of sexual interest and capability among older adults, individual voices of the older adult population remain unheard (Bauer, 1999; Nay & Garratt, 2009). This may be partly due to the sensitivity in United States culture around older adults and sexual activity (Nay & Garrett, 2009).

Qualitative research is largely “inductive, seeking out an understanding of the social world from the point of view of the participants in the study” (Ryan, Coughlin, & Cronin, 2007, p. 740). Previous qualitative research on the topic of aging sexual expression has been primarily limited to the staff and their attitudes toward resident sexual expression (Roach, 2004). Instead of quantifying data from a mass subject pool,

qualitative data seeks to explore, in depth, the essence and shared experiences of the individual participants. The rich, inductive data do not come from the number of participants, but from the complexity of individual experiences (Ambert, Adler, Adler, & Detzner, 1995). As Ambert et al. (1995) explained,

Qualitative research is not necessarily guided by “traditional” perspectives, nor is it necessarily propelled by literature-driven questions and hypotheses, although it can accommodate hypothesis testing. The primary commitment is to the empirical world, to convey its workings in its phenomenological integrity (Ambert et al., 1995, p. 880).

Phenomenological research aims to discover the essence of the phenomenon under examination.

Phenomenology

Phenomenology, or the science of pure phenomena (Groenewald, 2004) is based on the subjective reality of the human consciousness, where the external reality is processed and translated through the eyes of the individual. Phenomenological research, moreover, is exploratory by nature in that it seeks to understand the individual from a holistic perspective and “the reflective study of the essence of consciousness as experienced from the first-person point of view” (Nakhtnikian, 1964, p. 47). In the same vein, interpretative phenomenological analysis also seeks to explore the subjective layers of consciousness found within the phenomenon.

Interpretative Phenomenological Analysis

Interpretative phenomenological analysis is both hermeneutic and idiographic. Founded on the principles of interpretation, interpretative phenomenological analysis is considered a double hermeneutic because the researcher attempts to understand the

subjective reality of the participant(s) in the study (Smith, Flowers, & Larkin, 2009). Through a systematic investigation of the participants' stories, the IPA researcher is concerned with both depth of analysis and a focus on the specific nuances discussed by the phenomenon (Smith et al., 2009), or idiographic narratives.

Linking Phenomenology and Gestalt Worldviews

I specifically chose the phenomenological research path because it coincides with my background in Gestalt counseling. Like Gestalt counseling, qualitative research similarly is founded on the premise that a phenomenon is “more than the sum of its parts” (Ryan et al., 2007, p. 738). I postulate the same principle exists for people. Human beings, like qualitative research itself, are ever evolving; there is never a time where one person's lived experience remains static, nor do his or her stories. As a clinician, I am more comfortable listening, reflecting, and interpreting the subjective experiences of my clients' stories, although ethically I cannot confer any of my own presuppositions in place of their stories.

Qualitative research parallels in some respects the counseling approach to practice in that the counselor/researcher takes into account the stories of the clients with an intentional curiosity towards meaning making. Of course, research interviews are also fundamentally different from therapeutic encounters. Ultimately, the goals are different. Qualitative data are likely to evolve as participants tell their stories and share their experiences (Creswell, 1998). As they do so, awareness of the phenomenon are generated dialogically (Hancock, 2002). The focus, therefore, is not the result or quantification of variable outcomes, but rather the process of coming to name and understand the experience as definitive themes emerge.

Phenomenological Interviews

Phenomenological interviewing allows participants to provide an in-depth description of their lives and, in turn, “webs of meaning” of the cultural constructions of how the participants’ lives are constructed by the interviewer (Geertz, 1973). In order to truly bear witness and accurately describe the experiences of the individual participants, phenomenological research was the most culturally sensitive design to conduct this particular research because it aims to focus on a complex and sensitive phenomenon (Bauer, Nay, & McAuliffe, 2008; Creswell, 1998).

Non-Directive Interviewing Approach

To truly engage in a phenomenological interview, the researcher must take a non-directive approach where the participant works within his or her own range of comfort and subjective understanding (Merton & Kendall, 1946). A non-directive approach to interviewing was especially useful considering the researcher did not know which important variables existed in the phenomenon (Creswell, 2003). Seidman (2013) suggested limiting questioning to one or two broad topics to start the interview. Seidman also emphasized the importance of life stories because they connect deeply with perceptions.

Merton and Kendal (1946), early on, recognized the power of this non-directive approach, which allowed the researcher to encourage participants to disclose responses that were aligned with their own context of understanding rather than forcing responses into a framework predicated by the researcher. The non-directive approach is also supported by the exploratory and phenomenological stance of bracketing assumptions and judgments. Due to the nuances of the specific phenomenon of aging sexual expression in the research literature, the researcher cannot predetermine a comprehensive

list of questions to ask and, moreover, “not all participants would equally find meaning in the language or symbolic associations used by the interviewer” (Berg & Lune, 2012, p. 111).

This study, therefore, adapted Seidman’s (2013) interviewing process to interview the resident participants. The researcher met and interviewed the resident participants two different times, approximately three days apart. The first interview focused on the life story of the participant and lasted from 15 to 30 minutes. The second interview focused more on the sexual experiences and presents interests of intimacy and sexual expression. The length of the second interview lasted 45 to 60 minutes.

Focus Group Interviews

The focus group interview is a unique and opportunistic form of data gathering because it is specifically designed to explore the subjective responses of persons exposed to a situation previously analyzed by the investigator (Merton & Kendal, 1946) and has the ability to provide valuable insight into the interpretation of a social or behavioral event in a general context (Frey & Fontana, 1991). In order to gain a more comprehensive and triangulated perspective of the phenomenon, the researcher attempted to organize one focus group from each of the two facilities. Participants were notified that participants’ statements were confidential in the study results. They were asked to share their past experiences with residents in a narrative form, thus calibrating their perceived realities.

The focus group was used to probe stories of resident sexual conduct/ (mis)conduct, policies, beliefs, observations, and practices around sexuality. Data were collected on both what the participants said and how they interacted (Sim, 1997). The researcher presented the focus group opportunity to the staff at each site; only one of the

nursing homes produced a focus group. Some of the staff from the other nursing home reported the research topic was “uncomfortable” and “odd.” From that facility, one RN volunteered to answer questions during a smoke break. This individual staff interview lasted seven minutes while the focus group at the other home lasted approximately 18 minutes.

Participants and Sampling

Participants in the study were recruited from nursing home residents and staff professionals. Staff participants included one social worker and three RNs.

In order to acquire the appropriate number of participants for a qualitative research study, Seidman (2013) identified two criteria: sufficiency and saturation. The numbers must reflect a perspective where others might connect to the experiences of the participants in the study, and the research must continue until nothing new may be learned (Seidman, 2013). Creswell (1998) proclaimed that a minimum of eight participants would adequately illuminate focus topic findings, whereas, Boyd (2001) suggested a greater range from two to ten participants.

Smith and Osborn (2008) argued that phenomenological data analysis is so rigorous that it can only be conducted appropriately when collecting data from a small sample size, especially when approaching this type of research for the first time (Smith, 2008). For the sake of this study, the researcher selected a number of resident participants to achieve saturation. Saturation was achieved after six residents; however, the researcher decided to interview a total of ten residents in hopes of increasing chances of diversity among the sample and increasing the number of female residents in the sample.

Criteria for residents included an age range from 65 years and older. The approved residents had to score a 27 or above on the Mini-Mental State Exam (MMSE).

The MMSE is a brief 11-question measure used to screen cognitive impairment (Kurlowicz & Wallace, 1999). Participants who scored below a 27 were considered below normal cognitive functioning (Kurlowicz & Wallace, 1999). If residents scored below a 27, the interview was discontinued and the resident thanked for his or her time (Kurlowicz & Wallace, 1999). The MMSE administration took approximately 10 minutes to complete for each resident participant (Kurlowicz & Wallace, 1999). All genders and ethnicities were encouraged to participate in the study. Qualifying data of the approved resident participants are presented in Table 1.

Table 1. Resident Participant Criteria Data

Resident participants (<i>N</i> = 10)	Age range (years)	Years in nursing home	MMSE score
Women = 4	84–92	2.5–9	29–30
Men = 6	76–94	2.5–9	27–30

Focus Group Participants

The ideal size of a focus group is typically from six to eight participants; however, it depends on the topic of the focus group (Krueger & Casey, 2000). Difficulties with focus groups consisting of four or fewer participants potentially limits a lower number of total experiences, as compared to a larger group which may turn out to be too difficult to control (Boyd, 2001; Krueger & Casey, 2000). Schroeder and Neil (1992) supported the use of focus groups, particularly when studying issues in nursing related to care. For the purpose of this study focusing on insights and experiences with residents, a smaller group size was deemed to be most beneficial. Recruitment aimed at four to six staff participants per focus group in each of the two facilities involved; however, only one focus group was successfully recruited.

Staff members with a minimum of five years in practice were offered the opportunity to participate. The number of years in practice helped to homogenize the pool of participant experience and ensure sufficient experience in the setting to know the culture well. Bouman et al. (2007) identified experience as an indicator of more positive and permissive attitudes toward resident sexual expression. In their study, young staff with less than five years of experience were more likely to present with negative and restrictive attitudes towards sexual expression than staff with more experience (Bouman et al., 2007). The staff in this study consisted of one social worker and three registered nurses. Staff age range was 25 to 56 years. The staff participants reported a range of five to forty years of experience in the nursing home.

Sampling

Administrators from each facility received a letter (see Appendix A) requesting permission to recruit participants. The administrator of Nursing Home A approved for the study to be presented at the facility. The administrator of Nursing Home B authorized the social worker to approve the study. At each nursing home, the study was presented and residents were handed brochures (see Appendix B) during the residents' meal time and during the monthly resident/facility meeting. The residents were also notified that the study was completely voluntary and that individuals may cease to participate at any time.

Attached to the brochure was a perforated sheet simply asking for the first name and initial of last name, room number, gender, and two boxes—YES and NO. All residents who were present were encouraged to select either YES or NO, while reminding them there was no penalty for not participating in this process. The sheets were collected from each attendee. Confidentiality of the self-nomination was assured throughout this process.

Originally, the recruitment plan was to conduct a simple random sampling strategy; however, this strategy could not occur because too few residents volunteered at the time of the presentation. A “Plan B” strategy was then used in recruiting subjects which included a combination of convenience sampling and self-nomination.

Each staff member also received a brochure explaining the purpose of the study, the expectations of the staff participants, focus group definition, identification of potential staff participant roles, and the time needed to participate in the study (see Appendix C). Contact information of the researcher was printed on the back of the brochure, so that those staff members who were interested in participating in the study could contact the researcher. The same simple random sampling strategy was originally attempted; however, the strategy was modified to self-nomination and convenience sampling as a result of initial non-interest.

Setting

The invitation to participate in this study was sent to nursing homes in rural areas of the Midwest. The nursing home facilities must have been established for ten years or longer and be state licensed to ensure quality of site and longevity of practices. Facilities in the designated area were contacted and permission was requested to conduct the study at their facility. It was difficult to find nursing homes willing to participate in this study. After 11 rejections, two nursing homes agreed to participate in the study. Both met the criteria (e.g., state certified and established ten years or longer); however, both were in a rural setting. Both nursing homes reported to have a policy on resident sexual aggression and Nursing Home B reported to have a specific policy on sexual expression. Both nursing homes were unwilling to provide a copy of the policy manual for the institution. Staff reported that they were not allowed to share the policy manual with non-employees.

Resident participants were interviewed separately at a location in the nursing home that was most convenient to them. A private setting away from both staff and other residents, was suggested. The suggested private setting was important in case the resident felt confined to his or her settings. One resident participant had a deaf roommate and decided to be interviewed while the roommate was in the room. Also, one couple decided to be interviewed together.

Although the study was presented to staff during staffing meetings and individually, staff were reluctant to participate. One staff participant was recruited from Nursing Home A and the participant selected the staff smoking area to answer questions. No one else was present during the individual interview. At Nursing Home B, the focus group of staff participants met in the social worker's office. The room was set up as a roundtable for interactive discussion. Prior to the interview and focus group, all participants were again presented with the Call for Participants form and consent form. Staff were encouraged to ask questions about the study to ensure full understanding.

Plan of Action

The process of this study followed a developmental format of qualitative data collection (see Table 2). The development of the study was a "heuristic process through which one discovered the nature and meaning of experience and developed methods and procedures for further investigation and analysis" (Moustakas, 1994, p. 17). Through constant comparative analysis, each step of the data collection process built upon previous data as patterns emerged (Merriam, 2002). This process deepened understandings of the nursing home experience as lived by the residents. The knowledge and experience gained by each participant and nursing home extended the knowledge of the next setting. Seidman (2013) explained, "the governing principle in designing

interviewing projects might well be to strive for a rational process that is both repeatable and documentable” (p. 25); therefore, triangulated data are needed to confirm patterns across contexts (Merriam, 2002).

Table 2. Plan of Action

Process steps	Action taken
1	IRB was approved and then an invitation to facilities to participate in study was disseminated.
2	Research study opportunity was presented at each facility.
3	Scheduled interviews and focus group interviews.
4	Interviewed resident participants. <ul style="list-style-type: none"> * Administered MMSE to resident volunteers (to qualify) * Administered demographic questionnaire (1st interview) * Conducted interviews with eligible participants (2nd interview) Transcribed and analyzed interviews.
5	Conducted focus group and staff interview. Transcribed and analyzed interviews.
6	Conducted constant comparative method across transcripts
7	Analyzed field and observational notes and reflective journal.

Step 1

Once university institutional review board approval was secured, letters were sent to state-licensed nursing homes in the United States. The researcher personally handed letters to state-licensed nursing home administrators. The letter introduced the study and extended an invitation to participate. Two nursing homes were selected from those who met the criteria and responded affirmatively. One nursing home with a reported policy on sexual expression was selected and one without a policy on sexual expression was selected. An appointment with the administrator at each nursing home was made. They were provided a formal letter with the description of the study and a clear outline of what

study participation would involve (see Appendix A). The administrator from Nursing Home A approved the study and the social worker, who was designated by the administrator, approved the study on behalf of Nursing Home B.

Step 2

Once a facility administrator permitted the researcher to conduct the study, the study was presented to the nursing home staff and residents together. Later, the researcher attempted to present the material again during staff meetings and with individual staff members. At that time, they were provided a brochure highlighting the purpose of the study, the expectations of the participants, the time needed, and the disclosure of audio recording as a means to collect data (see Appendix B and Appendix C).

Audio recordings of the interview in qualitative studies is an important means of data capture for analysis purposes. Without a recording, “important details could be missed and inevitably the actual writing down of notes during an interview could interfere with the overall flow and establishment of rapport” (Smith & Osborn, 2008, p. 64).

Step 3

Residents and staff self-nominated or nominated others. Initial meetings were scheduled with interested residents. At this time, staff were also contacted to identify an appropriate time to meet as a group. At Nursing Home A, the study was presented individually to a staff member who then approved to participate and interviewed at that time. Scheduling difficulties occurred with Nursing Home B; however, a date and time were found to interview three staff participants.

Step 4

The informed consent (see Appendix D) explained the purpose of the study, the interview, the potential risks, and the requirement to be recorded. The informed consent also explained how transcription was conducted by a professional and by the researcher due to dissertation time constraints. Once informed consent was given, interested participants were administered the MMSE. Of 15 individuals who took the MMSE, ten scored above a 27. These participants were selected to participate in the study. The other five individuals who scored below a 27 were thanked for their time and the interview ended.

The resident participants were then asked to respond verbally to a demographic questionnaire (see Appendix E). A demographic questionnaire in this phenomenological study was used to collect important inclusion data such as age and gender and also helped to illuminate the essence of the resident experience through questions such as sexual orientation, current partner status, current roommate status, and so on.

In order to fully capture the consciousness of the individual participant and his or her cultural setting, thick description was used to describe fully the participants of the study without compromising confidentiality (Ponterotto, 2006). Thick description involves the documentation of specifying descriptive and proscriptive details, conceptual structures, and meanings of the phenomenon (Geertz, 1973). As a modification of the Seidman (2013) three-interview protocol, this process required only two interviews with each individual participant, approximately three days apart. Some general questions about life history were part of the initial interviews and then the interviewer narrowed the focus on sexual expressiveness in the current context in the second interview. Audio recordings of resident participant interviews were transcribed within 48 hours of the interview. The

transcription was then analyzed using ATLAS-ti software, drawing on analysis traditions of ground theory. For a comparison, data were also manually analyzed.

Step 5

Interviews were recorded and conducted with staff participants after the informed consent was signed (see Appendix F). Interviews were then transcribed and analyzed using ATLAS-ti software. For a comparison, data were also manually analyzed.

Step 6

After each transcript was analyzed, the coded data were again analyzed using the constant comparative method process.

Step 7

Field and observational notes and reflective journal was analyzed.

This step-by-step process was repeated for a second nursing home with the constant comparative analysis of the data retrieved from first nursing home informing the type of questions used in the second nursing home. Although it is not a goal of qualitative research to conduct a study that has findings that are generalizable, a phenomenological stance asserts the importance of seeking out universal understanding of the essence of the phenomenon (Moustakas, 1994). In other words, the small sample size in qualitative work cannot be assumed to be representative of a larger population, but if issues, concerns, or narrative stories across participants have some common themes or ideas expressed, it is likely considered that residents in similar nursing care contexts might well express similar thoughts and experiences.

Data Collection

In qualitative studies, the researcher heavily relies upon the depth of the interviews and his or her own personal observations of the individuals and interview setting. For the purpose of this study, several data sources were used (see Table 3).

Table 3. Data Sources

Data Sources
1. Demographic Questionnaire
2. Audio Recordings <ul style="list-style-type: none"> 2.1 1 Focus Group and 1 Individual Staff Interview 2.2 ten Individual Resident Interviews
3. Field Notes and Reflective Journaling

Demographic Questionnaire

A brief basic questionnaire was administered to collect demographic data (e.g., age, race, gender, ethnicity, marital status, family history, and so on), former and current nursing home history, and support networks of family/friends (see Appendix E). To ensure that this information was protected and confidential, demographic data sheets were assigned a coded title that corresponded to a password-protected file on the researcher's computer. No identifying information linking particular participant histories to findings were used; only descriptive summary information of participant demographic data were used. Pope and Schulz (1990) supported the notion that some older individuals may become less inclined to disclose their sexual orientation. Resident participants were offered the opportunity to complete the demographic questionnaire by themselves; however, each resident responded verbally.

Audio Recordings

Qualitative research seeks to record and transcribe data as a means to ensure all parts of the participant experiences are heard and coded during analysis. For the purpose of this study, verbatim analysis is the most critical component to the study; therefore, the audio recording occurred from the beginning of the interview until the end (Sim, 1997; Smith, 2008). Audio recording was necessary for the purpose of this research study, and was a condition of participation as the recruitment literature and consent form indicated.

Field Notes and Reflective Journaling

Field notes are a critical component to qualitative research because they document the context of a study. According to Krueger (1994), it is important for the researcher to personally record highlighted thoughts and feelings through handwritten notes recorded during the interview. Moreover, note taking during the interview is a helpful way of capturing the nonverbal behaviors and interactions among the researcher and participants, and may serve as a protection from potential mechanical errors, such as audio recording malfunctions (Sim, 1997).

Field notes were recorded during the interview process and when the research was presented to the facilities. Field notes consisted of information regarding the orientation to the nursing home layout which included how the facility was set up, and the documentation of the smells and sounds in the environment. This information was used to inform the data collected throughout this study (Moustakas, 1994; Schwandt, 2001). Moustakas (1994) explained that “the self of the researcher is present throughout the process and, while understanding the phenomenon with increasing depth, the researcher also experiences growing self-awareness and self-knowledge” (p. 17) Analysis of self-growth is presented in Chapter Six. Phenomenological research aims to comprehensively

understand the conscious voice of the participants through the thick description afforded by the reflective response of the qualitative researcher. Therefore, to

thickly describe social action is actually to begin to interpret it by recording the circumstances, meanings, intentions, strategies, motivations, and so on that characterize a particular episode. It is this interpretive characteristic of description rather than detail per se that makes it thick. (Schwandt, 2001, p. 255)

Policy Artifacts

For this study, it was important to examine the policies currently in place regarding sexual expression; however, neither facility provided a copy. Data sources included the demographic questionnaire; audio recordings of one focus group, one individual staff interview, and ten individual resident interviews; field notes; and reflective journaling.

Data Analysis

Data were collected and analyzed throughout the research process. Although qualitative research is considered an inductive process, the critical analysis of data take on a more deductive approach in phenomenology and similarly in interpretative phenomenological analysis. The analysis of phenomenology is similar to that of grounded theory in that the process of analysis is inductive; however, eventually the data evolve into a deductive process as clusters of meanings or superordinate themes are found.

The phenomenological approach does not attempt to create a theory from the data, as is done in grounded theory (Creswell, 2003; Moustakas, 1994). The phenomenological reduction of data analysis in interpretative phenomenological analysis requires the researcher to interact with the data through a three-step process according to Smith and

Osborn (2008): bracketing, horizontalization, and clusters of meanings or superordinate themes (see Table 4).

Table 4. Data Analysis Process

Analysis stage	Analysis step/process
Bracketing	1. Bracketing of preconceived notions.
Horizontalization	2. Read and reread transcriptions. 3. Initial noting of individual and focus group transcriptions. 4. Develop emerging themes of individual participant interviews.
Cluster of meanings/ superordinate themes	5. Look for patterns across participant interviews. 6. Identify emerging themes across participants. 7. Identify idiographic narrative accounts that are unique.

Bracketing

Bracketing is a reductive process in which the researcher turns to the self and brackets all preconceived notions outside of the research focus, allowing the entire process to focus on the phenomenon under study (Moustakas, 1994). Bracketing allows for the researcher to “rely on intuition and to suspend all judgments, as humanly possible, about what is considered reality to the participants” (Moustakas, 1994, p. 34).

Traditionally all qualitative research requires the researcher to identify pre-existing beliefs and understandings prior to undertaking the study (Boyd, 2001; Heidegger, 1996; Moustakas, 1994; Munhall, 1994). Only through identification of and reflection on pre-existing beliefs or bracketing can the researcher examine the phenomenon with openness (Moustakas, 1994, Munhall, 1994; Smith & Osborn, 2008).

Pre-existing beliefs on the phenomenon of aging sexuality in nursing homes were documented using the bracketing strategy. Such beliefs included that: (a) human

constructs of experience and understanding are based on how the experience is perceived through the individual human lens, and yet such constructions of reality are susceptible to shifting, depending on the social understanding of the same experience (e.g., no longer feeling free to be sexually expressive because sex is for the young); (b) residents in institutions still want to be engaged in intimate relationships, both physical and emotional, but residents may not seek out guidance on desire, love, or sexual interest for fear of receiving a negative response by staff or peers; (c) residents who have lost their significant other may feel they cannot engage in a relationship with another person for fear of disrespecting their deceased significant other; (d) residents do not necessarily know of the risks of sexual behaviors (e.g., engaging in unprotected sex because they no longer can get pregnant); (e) nursing home staff attitudes on elderly sexual expression vary depending on education and level of acceptance; and (f) it may be difficult for participants to speak about sex with someone, especially someone who is much younger than themselves.

Bracketing is not just a noting of personal biases. As Fischer (2009) explained, bracketing is not simply an initial account of personal biases that might influence the researcher's view of the phenomenon. In an attempt to prevent imposing meanings on the data, bracketing is an ongoing process where the researcher identifies and records personal assumptions and interests on the phenomenon (Fischer, 2009). Personal biases and assumptions surfaced for the researcher throughout the interviews in this study.

Overall, I wanted to interview more women because I presumed they would be actively interested in physical intimacy and sexual desire. When this did not occur, I attempted to find more women to interview. It was not surprising that low desire was

reported by all four women, but I recognized my hope to hear something else. This realization allowed the researcher to look deeper into the individual experiences of these women and how such experiences effected their sexual expression. Bracketing was an important component to the interpretative analysis of this study. The researcher found herself exploring the material more deeply as personal biases appeared and were confronted.

Horizontalization

Horizontalization is the process of laying out the data and seeking the essence of the phenomenon of each nuance as it is consciously approached. Similar to a counseling approach, clinicians are encouraged to self-reflect and identify any potential biases throughout the course of their clinical career (bracketing) in order to truly facilitate therapeutic growth of the client. Horizontalizing is looking at the data from a *tabula rasa* stance. Specifically, working from intuition, each nuance or statement made during the interview is held with equal value and importance. Eventually, as the sessions continue with the client, the more important and salient issues come to the surface, leaving the superficial pieces aside (horizons). The data in the horizontalization process evolves from a once-equal stance to a critical “grappling” with the data to identify the horizons or meanings and principles of the phenomenon (Moustakas, 1994).

Cluster of Meanings or Superordinate Themes

These horizons were then organized into clusters of meanings, which then become superordinate themes. As attempts were made to make sense of the data, connections between meanings were found and superordinate themes emerged. This process could only be conducted by means of “drawing on one’s interpretative resources to make sense of what the person is saying, but at the same time one is constantly checking one’s own

sense-making against what the person actually said” (Smith & Osborn, 2008, p. 72).

Open-ended emerging data were collected “with the primary intent of developing themes from the data” (Creswell, 2003, p. 18).

This phenomenological analysis was a heuristic process in which the researcher must return to the self and expand the consciousness beyond the researcher’s own subjective reality in order to immerse the self into the world of the experience, thus creating a space for awareness and understanding and illuminating the themes of the consciousness within the phenomenon (Moustakas, 1994). “The phenomenological reductions make it possible for the mind to discover its own nature; originally lost in the world, the mind can find itself again by means of these reductions” (Kockelman, 1967, p. 222). These findings emerged from the research questions posed in this study.

Managing and Recording Data

Data were audio-recorded, transcribed, and analyzed using ATLAS-ti. Field notes and researcher reflections were documented throughout the interviews and saved in ATLAS-ti. Memos were recorded during the interpretation process and saved in ATLAS-ti. The transcriptions were saved in ATLAS-ti as one whole hermeneutic unit for analysis and constant comparative method. All electronic material was password-protected and all hard copy material was coded.

After initial review of data from both the focus group interviews and the individual resident interviews, ATLAS-ti software was utilized to conduct open and initial coding, with the goal of developing meaningful themes and clusters. ATLAS-ti allowed the researcher to easily define codes within the transcriptions, logically organize data, and triangulate data from different transcriptions, memos, and field notes.

During the analysis, the raw data went through a great transformation—from simple words to initial codes, horizons, and themes. Once the transcription was complete, it was important not to overcode or undercode, but to analytically critique each utterance and unit of meaning. Researcher beliefs and perceptions were considered to reduce bias of meaning. I tried to not assume that my perception of a given word, for example, *love*, meant the same to the participant as it does to me. Finally, constant comparative analysis was conducted after each interview and focus group by comparing data through the ATLAS-ti software.

Trustworthiness in Qualitative Research

Trustworthiness of data was achieved through three strategies: dependability, confirmability, and credibility (Lincoln & Guba, 1985) Blash (2010) summarized the concepts of dependability and confirmability as follows:

Confirmability refers to the degree to which the results could be confirmed or corroborated by others. Dependability emphasizes the need for the researcher to account for the ever-changing context within which research occurs. The researcher is responsible for describing the changes that occur in the setting and how those changes affected the way the researcher approached the study (Blash, 2010, pp. 85–86).

Dependability was assessed through the researcher's report of any changes that might have affected the way the researcher approached the study and, moreover, the way the participant engaged in the study. Confirmability, "the degree to which the results could be confirmed or corroborated by others" (Blash, 2010, pp. 85).

Credibility was assessed through engagement, persistent observations, triangulation, and member checking. Engagement is the process by which the researcher

remains in the study collecting data until saturation occurs (Merriam, 2002). Through the process of persistent and reflective observations, the researcher created the space for interpretation with an open mind. The researcher, by persistent observation, also used this opportunity to critically reflect on how conscious perception of the phenomenon may influence the data. To engage in this observation, self-perceptions and biases were identified and distinguished to garner a more accurate picture of the phenomenon (Merriam, 2002).

Trust and validity were enhanced through member checking information (Merriam, 2002). Member checking in this study was conducted by asking the participants to review a transcript interview for accuracy (see Appendix G). Participant or member checking assisted in confirming information produced through the interviews with each individual. Lincoln and Guba (1985) argued that member checking is the “most critical technique for establishing credibility” (p. 314). Participants had the opportunity to participate in member checking via e-mail or by phone. Due to the sensitive nature of the material, the member check also allowed participants to identify any passages that they felt were too personal. Every effort was made to respect any request for an exclusion of certain passages from the data; however, no one requested such exclusions. Results of the member checks are included later in this chapter.

Triangulation was achieved by means of self-reflexivity and examining the data derived from both resident and staff participants, field notes, and reflections. This process identified key biases of the researcher by means of bracketing researcher background and experience with the topic. Self-reflexivity was another measure to attempt triangulation. It was the process of “explaining key biases and how one would deal with them” to

establish “an important aspect of maintaining fairness within the research process” (Yeh & Inman, 2007, p. 387). A constant comparative analysis was also conducted with the use of ATLAS-ti software.

Saturation of data regarding qualitative research was delineated in Chapter 3. The interviewer/researcher decided to interview the maximum number of participants, a total of ten interviews, although saturation in the form of repetition of interview responses of participants occurred after only six interviews. Thus, data collection was completed with a total of ten interviews.

Ethical Considerations

Due to the complex nature and sensitivity of the identified population, ethical considerations were examined closely. It was ultimately the responsibility of the researcher to ensure confidentiality and protection of the facility and all who participated in the study. Facility names were not known to anyone but the researcher. Staff participants received a brochure as a group of people at a presentation and were provided with the researcher’s contact information. The back page of the resident brochures were collected from every resident to ensure individual confidentiality of participation interest. Neither the facility, staff, nor the residents were provided information on any participant.

Additionally, it was important to consider how each participant felt about these data and how they might be interpreted. All participants were free to refrain from answering a question or cease continued participation at any time during the process. Upon request, a full report of this study will not be made accessible until one year from the date the study was concluded.

It was also important to address the potential issues surrounding visual or hearing impaired individuals. Modifications were made to assist in the research process. Mainly, the researcher was asked to speak louder and slower during some of the resident interviews. Ethical concerns were reviewed with great care, as well as the limitations of the study.

The overall goal was not to change individual values of the participants, but to create an awareness of the connection between quality of life, sexual interest, and lived experiences of residents in a nursing home community.

Summary of Research Methods

As previously mentioned, studies of sexual expression among nursing home residents have been limited to the deductive process of quantitative research. The topic of aging sexuality is considered a social taboo in the United States. Major research contributions of nursing homes are limited to two domains of the nursing home: the physiological effects of aging on the sexual human being (Lindau et al., 2007) and the concern for inappropriate sexual behavior and cognitive impairment in nursing homes (Archibald, 2002; Holmes, Reingold, & Teresi, 1997; Tabak & Shemesh-Kigli, 2006).

Qualitative data on the topic are limited to staff member perceptions, attitudes, and beliefs in elderly sexual expression. Because little research in the field examined the actual voices of the resident population, this study explored and illuminated the essence of the older adult resident community phenomenon through one-on-one interactive interviews and staff-based focus group formats. Consequently, a phenomenological approach was the most suitable method to examine the essence and conscious reality of the resident and his or her sexual sense of self. Chapter 4 discusses data findings and interpretations of the resident participants.

Chapter 4

Interpretive Findings

This phenomenological study presents interpretation of the lived experiences of older adults who reside in nursing homes. Phenomenology provides an opportunity for individuals to share their stories from their perspective in order to illuminate the reality of a particular group of people (Bogdan & Biklen, 1993). The purpose of this phenomenological qualitative study was to explore the unique attitudes, values, and experiences of older adult residents and staff around the issue of physical and relational intimacy and sexual expression in a nursing home residential setting.

This chapter presents the key findings obtained from ten in-depth interviews beginning with a brief description of the interviewees. The results of the study inform an understanding of the “essence” (Moustakas, 1994) of being an older adult, especially exploring the “inner experiences un-probed in everyday life” (Merriam, 2002, p. 7) of these older adult residents. Finally, this analysis includes, in Chapter 5, a careful phenomenologically deductive exploration, from a focus group and individual interview with staff, of the beliefs and actions of the staff who work with the residents. I conclude with a summary of suggested policy and practice for nursing homes and nursing home staff in Chapter 6. Additionally, this study adds a unique perspective to the literature, that of older adult residents’ voices and staff voices pertaining to residents’ needs and experiences of sexuality.

Data were collected in the form of two sequential interviews (15 to 30 minute initial interview and a 45 to 60 minute follow-up semi-structured interview) with ten resident participants and a 10 to 20 minute semi-structured interview with staff

participants at the residential facilities. Following the idiographic approach to analysis, each interview was coded separately and themes were developed before coding the next transcript. Themes from each transcript were then analyzed together by clustering meanings (themes) into superordinate themes. The researcher utilized the ATLAS-ti auto-coding function to create initial coding, sometimes called free contextual analysis. The researcher then identified clusters of meaning or superordinate themes from the themes created. In order to ensure data coding quality, the researcher also printed the code list and cut each of them apart. Each initial code (approximately 350 codes) was then manually organized into a set of codes which evolved into themes.

The ATLAS-ti auto-coding process identified 12 themes, while the manual coding process elicited 30 themes. Although the manual coding process elicited more themes, once the researcher reviewed the themes again for clusters, the outcome was comparable to that of the ATLAS-ti results. Finally, as part of the iterative process, the superordinate concepts were then reviewed back to the original quotes to ensure each quote accurately reflected the themes.

The focus of this chapter is to present the results of the data based on semi-formal, in-depth participant interviews. This included delineation of each research question, followed by themes, patterns, and supporting quotes for each interview. A discussion of results follows as Chapter 6 (Discussion).

Resident Participant Profiles

This study included ten nursing home residents, four women and six men, who were either currently married, widowed, or divorced. Participants' confidentiality is maintained throughout this document by referring to them by their code names:

“George,” “Alma,” “Harry,” “Sally,” “Ginny,” “Buddy,” “Chuck,” “Jackson,” “Bonnie,”

and “Clyde.” Each participant successfully scored a 27 or above on the MMSE. Couples had been married 68–69 years. Widows (women with a deceased spouse) and widowers (men with a deceased spouse) had been married 7–50 years. Participants were from a Midwestern town and resided in a rural nursing home. Six out of ten participants were former military professionals. Nine out of ten identified as primarily or exclusively heterosexual. All ten identified as Caucasian, but one reported that she was half Cherokee (full nationality/ethnicity unknown due to adoption status). Following is a brief description of each participant’s age, identified, gender, sexual orientation, and living situation (see Table 5).

Table 5. Demographic Data and Current Living Situation

Resident participant	Age range	Identified gender	Identified sexual orientation	Living situation (private/roommate)
George	85–89	Male	Straight	Private
Alma	80–84	Female	Straight	Private
Harry	90–94	Male	Partly bisexual	Private with spouse
Sally	90–94	Female	Straight	Private with spouse
Ginny	90–94	Female	Straight	Roommate
Buddy	75–79	Male	Straight	Private
Chuck	90–95	Male	Straight	Roommate
Jackson	85–89	Male	Straight	Roommate
Bonnie	90–94	Female	Straight	Private with spouse
Clyde	90–94	Male	Straight	Private with spouse

In this study, information was sought to identify possible relationships between and within gender and relationship status. From this exploration, marriage duration, marital satisfaction, and interest in future relationships for those who were either

widowed or divorced were identified in connection with how each individual perceived sexual interest and desire (see Table 6).

Table 6. Relationship Status and Interest in Intimate Relationships

Resident participant	Relationship status	Marriage duration (current status)	Interest in future intimate relationship (widows/ widowers only)?
George	Widower 2x	1st wife, 50 years 2nd wife, 7 years	No
Alma	Widow	27 years	No
Harry	Married	68 years	N/A
Sally	Married	68 years	N/A
Ginny	Widow	61 years	No
Buddy	Divorced 3x	Duration unknown	No
Chuck	Widower 2x	1st wife, 14 years 2nd wife, 11 years	Yes
Jackson	Widow/married	1st wife, 39 years 2nd wife, 23 years	N/A
Bonnie	Married	69 years	N/A
Clyde	Married	69 years	N/A

What follows is a summarized profile of each participant. It was important to explore their life story prior to moving into the nursing home because their experiences inevitably shape their viewpoint on sexuality and intimacy.

George

George was an 88-year-old former Army Air Corps sergeant who later retired and worked at a shoe factory for 40 years until the plant closed down. He was a Caucasian man who identified as a heterosexual. George has a high school education. He was married to his first wife for 50 years until she died. He later married his second wife and they were married for seven years before she died. Before his second wife passed, she

moved into a nursing home due to physical limitations that prevented her from living in their home. George moved shortly to be reunited with his wife. His children from his first marriage lived in other states. He has lived in a private room in the nursing home for four years. George readily agreed to participate in the study and answered questions with ease and laughter and without much contemplation or pause. The most prominent theme for George was concern and anxiety connected to his inability to obtain an erection. George's concern was fueled by his strong desire to be with a woman sexually. George explained in his interview, "I like females as well as I ever did, but I can't do anything with them sexually" (George, Line 116). George's second theme was connected to a lack of opportunity to interact socially with younger women. George believed he would never be able to meet or be attracted to someone at the nursing home and considered himself more or less "trapped" in the nursing home.

Alma

In 1992, Alma, now 84 years old, lost her only husband of 27 years. She was a Caucasian woman who identified as heterosexual. She was a retired factory worker. She considered her two stepdaughters as her own children. She has lived in the nursing home for two years after her medical condition worsened. Alma takes great comfort in knowing she is loved by her children and six grandchildren. Alma has her own private room. Although she volunteered to participate in the study, she was resistant to respond to questions deemed too "personal." She approached every question with caution and responded with short answers. The researcher continued to check in with Alma and her level of comfort to secure her response—only for her to respond that she desired to continue the interview; however, she was not going to answer specific questions about

sex. Alma's most notable theme was her disinterest in romance and involving herself in an intimate relationship with another man.

Harry

Harry, age 94, was a Caucasian man who self-identified as "partially bisexual." He later explained how he was physically and emotionally attracted to some men but that he had never acted on his desire. He has a college education and was a former pastor of 50 years. He enjoys education, music, and the church. He resides with his wife, Sally, at the nursing home. They came to live in a nursing home after Harry fell and was hospitalized. Sally, too, has medical conditions that prevented her from living by herself at their old home. Prior to coming to the nursing home, they shared one bed and took great pleasure in gardening, cooking, and dancing. Now, they sleep in separate beds and have a connected room, which they use as a living room. Harry readily answered the questions with ease and a smile on his face. He reported enjoying the questions and talking about intimacy and love with the researcher. He took long pauses, but only as if he was reflecting back to a time when he and his wife were more independent and enjoying life.

Harry displayed a great deal of passion and a wide range of emotions during the interview. When asked about his perception of his own attractiveness, Harry closed his eyes and recalled how much he had adored his body and how hurtful it was to watch his body decay due to Parkinson's disease. Harry's chief themes were his desire to be connected with his wife and his frustration with the limited opportunity to be alone with his wife without interruption. Harry reported engaging in a morning and evening love ritual with his wife every day since they moved to the nursing home two years ago. He

also reported that staff was very supportive of their needs, but that it was the only time they had with each other.

Sally

Sally was a 90-year-old Caucasian woman who identified as heterosexual. Sally has a college education and was a piano teacher up until the time she retired. She has three children with Harry and they have been married 68 years. She describes her love for music and appreciation for the nursing staff. She and Harry have lived in the nursing home for two years after physical ailments prevented them from living on their own. Sally reported that she was reluctant to leave her home, but it was not wheelchair-accessible. Sally was reserved with her answers and took time to respond to each question. She spoke rather matter-of-fact and seemed slightly nervous until about half way through the interview. Sally's prominent theme was her enjoyment of her husband and how they have had to be more creative with their demonstrations of love as they grew older. Sally explained, "we've mentioned many times recently that it would be nice to be in bed together, but with my problem and with his, we have to admit that it is not practical" (Sally, Lines 373–375). She then described how they engaged in a morning and evening love ritual, which she enjoyed and appreciated.

Ginny

Ginny is a retired nurse's aide who actually resided at the nursing home where she formally worked. She was a 92-year-old Caucasian woman who only knew she was part Cherokee, as she was adopted and lived in orphanages during her childhood years. She identified as heterosexual. She was married to her one and only husband of 61 years before he died. Shortly thereafter, she decided to move into a nursing home so as to not burden her children. She has resided in the nursing home for approximately three years.

Ginny shares a room with a woman she did not know prior to her move. Ginny happily volunteered to participate in the study and smiled and laughed throughout the interview. She had difficulty hearing the questions, and therefore, clarifying statements were made throughout the interview. Ginny appeared to enjoy telling the researcher how she used to be mean as a younger person and that she could “fight pretty good” (Ginny, Line 143) growing up. She shared this because it was vastly different than how she presently perceived herself. Ginny’s major theme was her lack of interest in sexual intercourse throughout her life. She reported, “Sex never did bother me” (Ginny, Lines 256–257).

Buddy

Buddy, married three times and twice to the same woman, was a 76-year-old Caucasian man. He identified as “straight as a fishing rod before a fish hits it” (Buddy, Line 122). Buddy was a former Navy sailor who spent his last working years volunteering on retired war ships and providing tours to civilians. He took great pride in telling stories about the famous people he met on those tours. He moved to the nursing home nine years ago due to diminishing health and recently moved to a private room. It took him over two years to receive a private room. Buddy was the first to volunteer to participate in the study after the researcher presentation ended. He prided himself on being disciplined and enjoyed telling stories of his life during the interview. It was difficult to hear him at times because his oxygen machine was very loud, but we were able to successfully continue the interview. Buddy’s main theme was his perception of women and the two women he married and how that impacted his understanding of love, trust, and intimacy. He reported, “I feel like I’ve lived my life the way it is and I’m better off without them” (Buddy, Line 395).

Chuck

A former Navy sailor, Chuck retired and worked the elevator at a hotel until he retired. He has some college experience. He moved to the nursing home 2 years prior to this interview when he was no longer able to walk without falling at home. He was a 90-year-old Caucasian man who identified as heterosexual. He was married to his first wife for 14 years until she died due to Alzheimer's. His second wife was an old high school friend and they were later reunited. They were married for 11 years and, approximately a year before this interview, she decided to move out of state to be cared for by her children. While there, she fell and was hospitalized. She died one month prior to the interview. Chuck did not see her when she died, nor was he able to attend the funeral. Chuck described his grief with how his relationship with his wife ended:

She went to Texas and I was here by myself. So I didn't have much opportunity. I don't—maybe we could have tried more often. I don't know. Maybe I could have gone down there or she could have come up here. I don't know. It didn't work out that way. Number one was I needed help when I walked and that was one reason I couldn't go places because I didn't have anybody to go with me. (Chuck, Lines 793–797)

Chuck actually sought out the researcher in hopes to participate in the study. He wheeled towards the researcher and addressed her, “Hey, you looking for me? Are you the lady who wants to talk to us geezers about sex?” The researcher then set up a time to meet with Chuck and he was more than happy to answer all of the questions. Chuck shared a room with another male roommate. Chuck was attentive and sat very close to the researcher during the interview.

One of his most important themes was an urgency to discuss his feelings surrounding his erectile dysfunction. Chuck reported that he desired intimacy and sex just as much as he did in the past and that he wanted to be involved in a sexual relationship, but that most of the women he encountered were married or divorced (these women were all identified as the nursing staff). Chuck reported that it had been approximately one year since he last had sexual intercourse with his late wife.

Jackson

Jackson, an 88-year-old retired veteran, took residency in the nursing home after he and his second wife felt that it was time for more assistance. Jackson identified as a heterosexual man. He was married to his first wife for 39 years until she died. He later married his second wife and they have been together for 23 years. He lived with another male roommate. When he first came to the nursing home, he explained his frustration with his initial room where people who were lower functioning resided, “I didn’t think I was going to be able to stand it down there even for a couple of weeks, although they told me they would move me up here” (Jackson, Lines 596–597).

His wife was not allowed to stay at the same facility as Jackson because she did not have veteran status. She resided in an assisted living facility one hour away from Jackson. They met twice a week at his nursing home and spoke to each other every day and night. He reported that he “missed her dearly.” Jackson was very forthcoming with his responses and appreciated the intellectual conversation. Jackson prided himself on his “mental capacities,” although “physically I am a wreck” (Jackson, Line 163). When Jackson was asked about his feelings towards his current marriage, he sighed and smiled. In fact, he smiled the entire time he responded. He exclaimed that she was “1 in 100

billion, I'll tell you that right now . . . so many people have said they would like to be just like us when they get older" (Jackson, Lines 164–167).

Jackson's primary theme involved his concern with the barriers that prevent him from being with his wife physically. Jackson reported that approximately eight years ago, an untreated urinary infection left him unable to urinate and, therefore, having to use a suprapubic catheter. Prior to this event, Jackson explained that he and his wife had an amazing sex life. Something related to this theme that was very important to Jackson was his desire to die at the same time as his wife. Jackson explained, "I would give anything right now if I could click my fingers and my wife and I could both pass away at the same time" (Jackson, Lines 695–696). Although he had no desire to die, he could not imagine a life without his wife. Again, he described his deep feelings for his wife's closeness, "I'd give anything if my wife could be right on the other side of that" (Jackson, Lines 913–914), as he pointed to the hanging fabric that acted as a divider for he and his roommate's space.

Bonnie and Clyde

Veterans, Bonnie and Clyde, both 91 years old, Caucasian, and heterosexual, met each other in World War II. She was a nurse and he was a soldier; they fell quickly in love and have been married for 69 years. Prior to the nursing home, Bonnie assisted Clyde with his disc jockey business. Together, they deejayed at weddings and veterans' events. Bonnie decided to move into the nursing home because her husband wanted her to be there. Clyde explained,

Well, she wanted to come because of me and I wanted her to come because of her. If I hadn't of—I might have not been in the situation or come to this veterans' home. I might have went to a private home, but then the expenses would have

been too high and we couldn't have afforded both of us. You've got to use your head. (Clyde, Lines 406–409)

Bonnie felt compelled to justify their decision to move to the veterans' home, "we were both eligible. We were both service people. We spent our time in the service so we deserved to use—we paid the taxes" (Bonnie, Lines 411–412). They have children who reside in different states.

Bonnie and Clyde decided to interview together. Clyde had a difficult time hearing the researcher, and so Bonnie repeated several of the questions in conjunction with the researcher. Both Clyde and Bonnie were helpful in their responses and comical. Clyde made several jokes throughout the interview. He kidded Bonnie for not having "boobs" and Bonnie heckled Clyde for his tattoo of the name "Alice" (a former girlfriend) on his arm.

Clyde's major themes that emerged were his perception of privacy without interruption, his view that although desire for intercourse has waned, he very much was still in love with his wife. Bonnie's primary theme was her continued love and desire for her husband. Bonnie explained, "It's a passion and a kind of—what kind of a love do you call it—there's a love there that to me doesn't have to depend on sex" (Bonnie, Lines 489–490). It was encouraged for them to interview separately, however, they both preferred to be together during the interview.

These narratives offer insight into the worldview of each participant. For the purpose of this study, the details of the stories were then deductively scrutinized to identify emerging themes.

Constant Comparative Method Results

The constant comparative method in the analysis of qualitative data assists to

“systematize the analysis process and to increase the traceability and verification of the analyses” (Boeije, 2002, p. 391). In this study, a constant comparative method was conducted with the ATLAS-ti software. Quotations were coded and were later reviewed and analyzed with the constant comparative method to identify emerging themes. The superordinate themes were identified as follows: attraction and desire, reactions to nurse affections, attraction of self, interest in masturbation, privacy and opportunity, and reactions to erectile difficulties. An example of the constant comparative method used to illuminate data on the topic of interest in masturbation can be seen in Figure 1. As stated at the top of Figure 1, 12 quotations were linked to interest in masturbation. The hermeneutic unit was identified as resident participants, which was established at the time the document was uploaded in ATLAS-ti. Participant P1 (George) and his specific quote are presented at the bottom of the example.

Report: 12 quotation(s) for 1 code

HU: RESIDENT PARTICIPANTS

File: [C:\Users\Staff\Desktop\ATLAS-TI ANALYSIS\RESIDENT PARTICIPANTS.hpr7]

Edited by: Super

Date/Time: 2014-12-21 17:47:41

Mode: quotation list names and references

Quotation-Filter: All

Interest in Masturbation

P 1: GEORGE 1.doc - 1:191 [I could do that, but I don't...i.] (2018:2018) (Super)

Codes: [Interest in Masturbation]

No memos

I could do that, but I don't...it don't seem like it appeals to me much.

Figure 1. ATLAS-ti example of constant comparative method using supercode “interest in masturbation.”

Creating a network (in semantic view) is another useful tool to help identify the links between the quotations, initial coding, and patterns. An example of a network can be seen in Figure 2 using the data related to reactions to erectile difficulties:

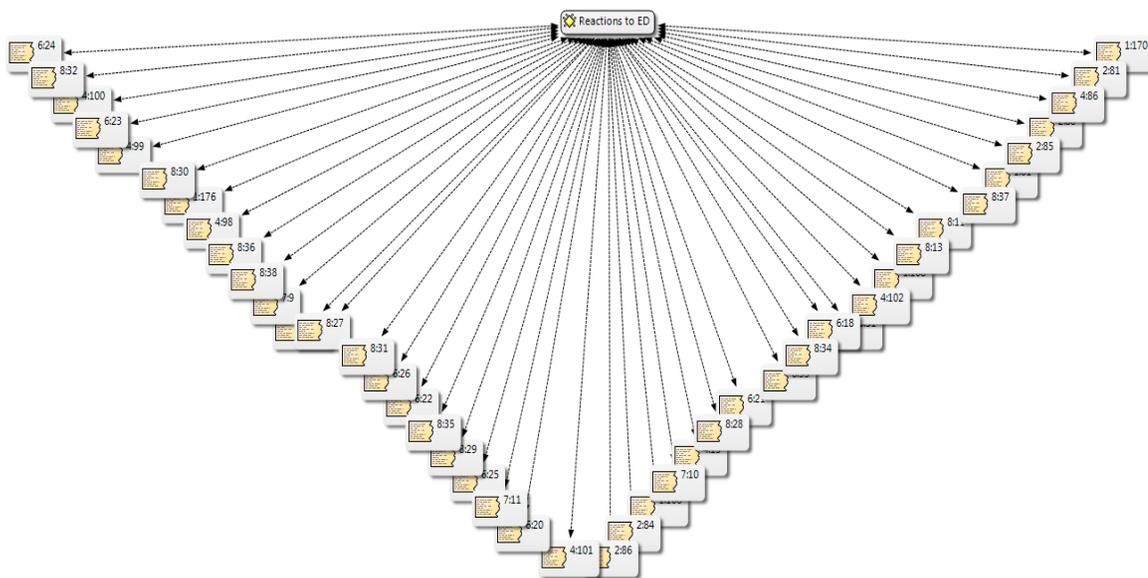


Figure 2. Network graph utilizing ATLAS-ti. Each box denotes a specific quote connected to erectile difficulties.

From this constant comparative method, the researcher was able to identify emerging clusters of meaning, or major themes from the ten interviews. The following section provide not only a summary of research findings of each identified cluster of meaning, but also idiographic details of individual participant experiences worthy of mentioning.

Superordinate Themes

Participants were prompted with general questions on the subject of sexual expression in order to prevent leading the conversation or overly guiding the responses. Although the narratives contained several similar themes, the stories were also unique and emerged from the individual life experiences involving relationships and their

understanding of self as a sexual being. Several superordinate themes emerged from the data. These themes were not reported by all participants, but occurred frequently during narratives; moreover, idiographic themes were also described throughout the text.

Seven superordinate themes were found that expand and enrich our understanding of the lived experience of older adult residents in nursing homes. The first theme takes a look at the emerging patterns found within the demographic data. The second theme explores gender differences related to interpersonal experiences with marriage. The third theme was a gap between participants' actual and perceived sexual beliefs about themselves. The fourth theme was stress and creativity developed as a result of their current beliefs regarding their sexual script, the result of which was spillover into their intimate and personal domain. The fifth and sixth themes emerging pointed to a variety of affordances and barriers the residents experienced in the nursing home. The seventh theme involved a seemingly benign perspective toward perceived relationships with nursing staff compared to a more complex image of intimate opportunity with staff (see Appendix I for Master Table of Superordinate and Subordinate Themes).

Theme 1: Demographic Differences Associated with Sexual Interest

This theme explored gender role differences and the presence of generational attitudes among resident participants toward sexual interest. Some of the participants were steadfast in their opinion about sexual intercourse, discussion of intimacy, and attitude toward sexual expression. In modern culture, gender roles tend to proscribe sexual freedom to males and sexual constraint to females (Baumeister, 2001). American social values have been primarily based upon a heteronormative value-laden infrastructure where female sexuality and sexual activity are acceptable only in the

context of marriage while male sexual activity is often considered socially acceptable prior to marriage (Baumeister, 2001) and even outside of marriage. The attitudes of these participants toward sexual interest were partially formed by subthemes related to gender ascription, age, education and career (see Table 7 for Theme 1 Superordinate Theme and Relate Subordinate Themes).

Table 7. Superordinate Theme 1 and Related Subordinate Themes.

Themes	Sample quotes from interviews
1. Demographic Differences Associated with Sexual Interest	
1.1 Etiology of ascribed gender role and sex education	“The birds and the bees.”
1.2 Education and career experiences	“The Army Air Corps and I know I picked up a girlfriend in Massachusetts and we had sex.”
1.3 Age and desire	“91 years old. How much sex you think you’d want to?”

1.1 Etiology of Ascribed Gender Role and Sex Education

Participants interviewed were asked how they first learned about sex and how those teachings and other sexual experiences influenced their attitude as a sexual being. Varied responses were provided by each participant. Two were taught sex education by family members. Alma jokingly described a story her mother told her about sex:

My mom told me a story once that they told her that babies came from underneath the bridge and she says there were times she went over a bridge and she looked to find those babies and I thought that was so funny (Alma, Lines 131-133).

Alma clarified that her parents never spoke of sex beyond the rule that sex is private and to never have premarital sex. She later identified her brother who informed her about basic sexuality information. She did want to make clear that it was not until the day of her

marriage, at age 34 years old, that she learned about sex the formal way “it just sort of happened” (Alma, Line 150). These details bear confirmation of Alma’s beliefs on sexuality. Alma chose to not elaborate on anything sexual except that she carried a negative judgment for those who engaged in premarital sex and those who had children out of wedlock.

George first learned about sex from his older cousins.

I had a lot of misinformation about it before I really learned about it. I expect it was in the grade school. I had some cousins down there and they were authorities, they thought, on sex. (laughing) I found out that they didn’t really know too much about it. (laughing) (George, Lines 300-302).

When asked if he had ever received formal sex education as part of school curriculum or by a parent, George said “no.” George further reported that he had learned about sex in high school from a “sexy teacher” in an informal setting. “Not really a class on it but they had a teacher that was pretty sexy (laughed). A young lady” (George, Lines 326-327). He clarified,

GEORGE: We was in a little class in school and they liked to get on sex and it really didn’t matter what the outline said, we’d talk about it.

ANGELA: Okay.

GEORGE: Her [the teacher] husband was in the Army and she missed him. When we had a get together down at a park, a fairly close friend paired off with her down there that night (George, Lines 336-342).

Learning about Sex

He later described his first sexual experience where he met a girl and had sex with her during his time away at boot camp while in the Army Reserves. The excerpt above shows how George learned from the misinformation made by his cousins, the informal conversation in the classroom setting, the observer role he played in the park as he watched his teacher leave with a classmate to have sexual intercourse, and the casual sexual encounter with a girl in a different state. These encounters are critical to understanding the ways in which George understood sexual engagement and relationships. Throughout my conversation with George, he maintained a sexually liberal attitude toward sexual engagement and the sexual pursuit of a woman.

Three participants were taught sexual education in school. Sally was taught human sexuality in high school. “Oh, I suppose I learned in physical education and health class in high school. They separated the boys and girls and we had to watch films” (Sally, Lines 63-64). She later reported that she learned to not have sex because she did not want to become pregnant. Harry, too, learned about sex in school; however, he educated himself with the help of a librarian after waking up from a nocturnal emission. Harry laughed, “When I began to have wet dreams my parents didn’t tell me. I went to the library and asked the librarian to get some books to help me understand what happened” (Harry, Lines 67-69). As reflected on that experience, Harry described a pleasurable and exciting exploration into the world of human sexuality.

Although Bonnie did not learn much from her friends, she reported learning nothing from her mother. “My mother never told me anything about sex or menstruation. I kind of had to learn all of that by myself. I learned the truth about sex in the nursing

program” (Bonnie, Lines 67-69). Again later in the interview, Bonnie repeated that she had never learned anything from her mother regarding sexuality. This suggests that Bonnie almost felt a sense of loss over her missed opportunity to learn about sexuality and her menstrual cycle from her mother.

From these three short excerpts, it is interesting to see what each person took from their sexual education. As a young teen, Sally had learned that sex results in pregnancy and Harry was not only assisted by the librarian to find resources, but he also had a library with books that informed him of his first wet dream and other components of sexuality.

Clyde reported that he had learned about sex with his wife in the back seat of a car.

Well, there’s a saying. ‘A stiff dick has no conscience.’ I learned in the back of a car with my wife, I guess. I didn’t have a father. My father left when I was young. And mother didn’t talk about it. I guess my sister had to explain everything to me. She had an illegitimate child. That really made my mother mad but we took care of the baby. (Clyde, Lines 163-166).

The saying, “A stiff ‘prick’ has no conscience” is actually a quote from the 1967 novel, *The Arrangement*, by Elia Kazan. The story is about a former WWII veteran now executive who has an interesting marriage arrangement involving infidelity. It is important to address that he mentions the quote several times throughout his interview. When asked what he meant, Clyde explained that he liked sex when he was able to have an erection. Additionally, from this excerpt and the excerpt from Bonnie regarding sexuality education, it is apparent that both Clyde and Bonnie felt that their parents were

supposed to be the ones to teach them about sexuality and puberty. Both individuals described a purposeful avoidance in the home regarding sexuality; similarly, Ginny described how her mother never spoke to her about sex.

Although she would not disclose details, Ginny reported that she learned about sex “the hard way” in her early teens. Additionally, without any guidance by her mother or the school system, Ginny vowed to educate her children on sexuality, pregnancy, and sexually transmitted diseases.

I had to learn the hard way. My mother would never tell me anything and I said if I ever had a daughter... My daughter said the other day, she said ‘You told us before we pooped we pooped’. But if I would be embarrassing, but I would rather tell my daughters and my sons and be a little embarrassed because it came from mom or dad then let it be embarrassing than somebody else tell them the wrong thing. That’s the way I look at it (Ginny, Lines 288-292).

There are several important issues to note within this extract. Ginny’s initial response about sex education was that she had learned “the hard way” was quite unclear but something that she did not want to elaborate on. She further reported that she received no guidance from her mother on the subject and reflected on the importance of addressing sexuality in a matter-of-fact way with her children. This communicates the desire for her as a mother to protect them through education on sexuality in hopes of preventing them from being misguided, as she may have been in the past. She understood the potential embarrassment of having a conversation about sexuality with a parent but that was not considered a priority for Ginny – sexual knowledge was the priority. Given her generation, it seems quite unorthodox for mothers to have such candid conversations

about sexuality with their children. This suggests that Ginny chose knowledge over the possible social mores of her time.

Jackson laughed and reminisced about the time his uncles took him to Mexico City for a “sex ed. lesson.” At age 17, Jackson’s first sexual experience was with a prostitute in a foreign country, a place where he did not know the language nor the woman whom he shared his virginity.

I went down and the bell captain there where we were staying took me out and I’ve got a hunch looking back at it, my uncles told him to ‘go out and get him laid.’ So I did it with some prostitute down in Mexico City. It’s surprising now that I didn’t get every disease known to man, but I didn’t so that was the beginning of my sex. (Jackson, Lines 209-213).

The extract above illustrates the simultaneous engagement with relational dynamics of family members on one hand and high-risk, casual sexual engagement on the other. Clearly for Jackson the lack of family dynamics shaped the sexual activity. He describes his willingness to engage in sexual intercourse as part of going along with his uncles. As hindsight, he reflected on how risky this sexual encounter was and how it could have resulted in him contracting a disease.

Chuck explained how he had not formally learned about sexuality in school but it was in high school where learned about sexuality through various sexual encounters with female classmates. “Not particularly. I just – I’m like everybody else. I was going with girls and wound up introducing myself to sex” (Chuck, 182-183). Buddy, quickly described how he had also learned about sex through a sexual experience with a girl two

grades above him, “I had a girl teach me back when I was about 16, I guess” (Buddy, Line 181).

Out of all ten participants, only one person reported obtaining input from a parent regarding sexuality and even she claimed that it was misinformation. Out of six men, only one received educational information on the topic of sexuality. The rest learned from sexual experiences with female peers. The social mores of their generation affirmed teenage sexual expression for boys as a time for ‘boys to be boys’ and for girls to never engage in premarital sex or present themselves in a provocative way. It is important to note that Sally, Harry, Clyde, and Alma each first experienced intercourse with their spouses. As these individuals grew up, some learned more as a result of their education and career experiences, which will be discussed in the next section.

1.2 Education and Experiences Associated with Sexual Attitudes

The participants matriculated to the nursing home from diverse lived experiences. As part of the study, it was important to explore whether a participant perceived sexual expression for others from a positive or negative stance. Questions and conversations surrounded individual perception of how others in the nursing home expressed themselves sexually or intimately and what the residents thought about those narratives. From these interviews, affirming values toward sexual expression appeared to be associated with higher level education and an interest or passion in the arts and humanities. Participants reported either a positive or negative attitude toward others in the nursing home in relation to sexual expression, intimacy, and relationships.

Harry, a pastor with a post-graduate background and a passion for music and art, exclaimed, “They’ve got to touch each other!” (Harry, Line 922). From these short

excerpts, it is suggested how passionate Harry is about love and tactile, human connection. From this stance, it is surmised that Harry believed in the importance of meaningful connections with other people, especially those in the nursing home. There almost seems to be a profound symbolic language which people can draw upon. Harry, who had his life partner living with him, goes on to emphasize the difference between a touch with a stranger and a meaningful connection with a loved one. “They need to feel loved. To touch someone and to be touched. Not a stranger but they need to feel connected to someone they love” (Harry, Line 926–927).

With some college education and a passion for intellectual conversations and music, Jackson also expressed a positive attitude toward a romance in the nursing home:

I think it’s so nice—one of the men—it’s a storybook romance. She just came in here. She was a nurse—this was back in World War II, he was injured, he came into the hospital and they got together. She was of course, a lieutenant and they weren’t supposed to be doing anything and I guess had to hide their feelings and so forth. She came in here last month or so but he hadn’t been in there too long himself, but they were able to be together, which is so nice (Jackson, Lines 907–914).

He then reflected on his own romance and lamented, “I’d give anything if my wife could be right on the other side of that [pointing to the other side of the room]” (Jackson, Lines 913–914). Jackson’s positive and affirming stance towards other’s need for connection, highlighted his own desire to be with his wife who resides in an assisted living facility 30 miles away.

Bonnie, a veteran nurse, shared a story of a man and a woman—the woman was someone who did not need to be in the nursing home, but moved there to be with her disabled husband. The husband, as Bonnie explained, was someone who could no longer talk and who was not consciously aware of things around him. She explained, “She sold her home and moved here—I think that’s what I call true devotion in a marriage” (Bonnie, Lines 353–354). Reflecting on the experience of that couple, one could address how Bonnie herself came to the nursing home. As her husband explained, “Well, she wanted to come because of me and I wanted her to come because of her” (Clyde, Lines 406-407).

These two extracts describe the ways in which couples demonstrate compassion and loyalty within a relationship where one person is able to live on his or her own and the other one is in need of medical care. Ideas around making a gift of the self and indeed being aware of the self as not just a person but a spouse illustrate the magnitude of the feelings and commitment involved.

Interestingly, those with a high school education or below described a less favorable attitude toward resident sexual expression. Buddy and Alma, who graduated high school, and Ginny, who graduated 8th grade, shared a similar judgmental response toward others’ interest in intimacy. Alma explained how some residents have reported loneliness as a reason why they established a relationship in the nursing home, “they always say, ‘Well, we are both lonely,’ and that’s all that is to it. That’s fine with me” (Alma, Lines 588–589). Although the judgment is inferred, the tone in which Alma responded suggested a less than positive stance toward others’ desires. George, a high school graduate and writer, was the only one who outwardly reported both feeling jealous

and appreciative for others who are able to engage in sexual expression. George mockingly described a male resident and a female resident who frequently visited each other in the night. Although he expressed a positive attitude toward the midnight rendezvous, he also suggested that he was “jealous.”

Although it is not appropriate at this time to suggest education to be the cause of positive or negative feelings toward sexual interest, it can be suggested that a relationship exists between education and positive attitudes toward sexual expression. These narratives are also supported by the research literature that is presented in both Chapter 2 and Chapter 6.

1.3 Age and Desire

During the later stages of life, aging begins to affect the body and the mind in unique and incredible ways. Although there is evidence to suggest that living a healthy life (e.g., healthy diet, exercise, possible medication compliance, sleep, and relationships) extends overall quality of life and the actual chronological age of life (Davies, 2011), it can also be said that no human is exempt from the effects of aging.

As they reflected on their level of sexual desire as a younger person, many described a waning interest in overall desire due to age. Most, however, claimed desire was still present. Sally explained, “I’m satisfied. Well, I knew as I grew older, it would fade away somewhat, and it has. But the love is still there” (Sally, Line 746–747). This short excerpt from Sally not only reflects on Sally’s recognition of her sexual mortality but also illuminates the transition from a more active sexual engagement to a deeper, more intimate connection with her spouse.

Harry, with a big smile on his face, described Sally as the love of his life and clarified, “Until we were about 80, we were fulfilling our sexual desires occasionally. Then it got less and less” (Harry, Lines 145–146). Harry later clarified that although his ability to engage in intercourse had stopped, he remained desirous of his wife. The extract above illustrates the simultaneous acceptance of the effects of aging on Harry’s body and the deepening of his relationship with his wife. Surprising to him, he also reported that he had fallen in love (or perhaps lust) with another woman at the age of 93. “I was surprised at my age that I could still feel that way about a woman” (Harry, Line 325).

Emotionally and physically loyal to his wife, he believed it was of critical importance to share these feelings with his wife and request permission to share those feelings with the woman. Harry explained how excited he was to feel that way again. This extract draws our attention to the time frame of relationship development. It was only after 60+ years of marriage that this new found issue became a central feature of this couple’s relationship. It also speaks to the depth and trust within the relationship of both Harry and his wife – so trusting that individuality was both embraced and honored.

Bonnie and Clyde spoke of their ability to engage in sexual activities with slight tension due to their age. They both described a presence of desire for one another, but explained that age has made it difficult. Clyde explained, “We don’t have no sexual desires anymore. Well, we have them, but it’s all in thought. That’s all. 91 years old. How much sex you think you’d want to?” (Clyde, Lines 214-215). The tension again is addressed with Clyde’s words, “How much sex you think you’d want to?” The quote suggested something greater and more important; a tension of sarcasm and anger toward his aging body and his youthful memories.

Bonnie also experienced this tension but qualified her sexual loss with the presence of mutual love. Bonnie further clarified, “A married couple who don’t like sex. That’s not true. We like it but we can’t do it. We love each other” (Bonnie, Lines 264–265). From these quotes, again this concept draws our focus on the time frame of relationship development. Bonnie and Clyde too have been together for 60+ years. They raised children and watched them leave the nest. They celebrated the years after the children left and they are now in a place where at least one of them is no longer able to engage in sexual intercourse. The resolve for sexual intimacy is challenged by depth of devotion and loyalty for one another.

Bonnie, moreover, was the only female participant who reported a noticeable decrease in her level of sexual desire after she went through menopause: “Menopause. When I stopped, I didn’t have the desire as much as I had. Once I passed menopause, I think the desire definitely decreased” (Bonnie, Line 429). This view of age-related disinterest in sexual desire is principally seen to apply after menopause (Nobre & Pinto-Gouveia, 2006). Of course, Bonnie also included that she considered her chronological age to be the primary determinant of her sexual disinterest, as did Sally. Koch et al. (2005) found that, among midlife women, it was age and not menopausal status that was related to perceived sexual desire.

Focusing on the individual interests of the widows and widowers, each made at least one comment directed towards their age and their inability to engage in sexual activity or entertain desirous thoughts. “Well I have friends. I have lady friends but would I get intimate with them, no. No. I think I’m a little bit too old” (Buddy, Lines 399-400).

Buddy's short statement suggests that he no longer sees himself as capable of being exclusively intimate with another person. When questioned about her desire to be intimate with another person, Ginny described her disinterest to be in an intimate relationship: "No, if a Hollywood movie star, I might be, but plain old me? No way." (Ginny, Line 108).

Ginny hits on something that has yet to be heard from these narratives. In this short narrative, Ginny describes how celebrity status might increase a person's likelihood to be sexual and/or interested in intimacy. Minimizing herself as a sexual being under the preface that "plain old me" is not special enough secures her belief system around her own sexuality. To explore further into her dismissive thought patterns around sexuality, when masturbation was addressed as a possible option, Ginny retorted, "I don't know nothing about it. I'm too old to learn about it" (Ginny, Lines 427-428). Of course, the idea of masturbation could have been considered too taboo for Ginny to discuss openly.

On the other end of the interest spectrum for the widower group, both George and Chuck repeatedly reported how they desired to be with someone intimately and were often attracted to other women; however, both agreed that because of their age, women they desired were not interested in being with them. "My big problem is those that I meet now who I would like to get intimate with won't consider me because I am too old" (Chuck, Lines 316-318).

In summary, this theme has highlighted how each person identified age as a reason for their diminished desire, whether it be personally experienced due to illness, or as a result of how age was perceived by others, such as in the case of George and Chuck. Perceived age also affected how one understood him or herself as a sexual being, as in

the case of Ginny and Buddy who simply stated they were “too old.” Differences in sexual interest were not only connected to age but also connected to gender, specifically with regard to relationships.

For those residents who were involved in invested relationships, age was seen as a bittersweet rite of passage for both the individual and the relationship. Where once sexual engagement was a primary interest for the couple, now had evolved into a relationship that was more meaningful and loving. In fact, love was a term used to describe the quality of the relationship with distinguished pride by each individual in the relationship. The rich description of mutual love could also be seen as a modified version of sexual engagement. The tender kisses and the warm embrace exchanged between each of the couples were representations of sexual engagement.

Theme 2: Gender Differences Associated with Marriage and Sexual Interest

All participants were either married or had been married in the past. Two widows and three widowers participated in this study and Buddy was the only divorcee. Only five participants were still married and, of these five participants, four resided with their opposite sex spouse. For many, their state of marriage influenced how they felt about sex, intimacy, and interest. Some described their marriages as extremely positive and they were provided with the love and security they needed to be sexual. Three reported the quality of marital experiences had negatively impacted their level of sexual desire and overall belief system regarding sex and relationships. Marital beliefs associated with sexual interest differed from person to person and are explored in this section (see Table 8 for Superordinate Theme 2 and Related Subordinate Themes).

Table 8. Superordinate Theme 2 and Related Subordinate Themes.

Themes	Sample quotes from interviews
2. Gender Differences Associated with Marriage and Sexual Interest	
2.1 Marriage as a life-long commitment	“I trained one.”
2.2 Marriage versus isolation	“Ain’t no such thing as a date before marriage.”
2.3 Marriage and intimacy evolved	“We found new ways.”

2.1 Marriage as a Life-long Commitment

For Alma and Ginny, their relationship with their husbands greatly influenced their sexual desire. Both Ginny and Alma believed their marriages to be a life-long commitment. Marriage was sacred and forever. When her husband died, Alma no longer desired to be with a man. As a caregiver of the household, she viewed her role in the relationship as a trainer. Alma clarified, “I always say this and it’s kind of a smart-alecky way of saying it, I trained one and I don’t want to train another one. That’s the way I felt” (Alma, Lines 629–630).

Marriage for both Alma and Ginny (who had also never married again) ended with the death of their spouse, along with a desire to be with anyone else intimately. Ginny described her one and only marriage as “rocky,” but that she had made a choice to be with him until the day he died. Ginny explained how sex had provided her with children and how that was the only benefit of intercourse. “I like my children. I love them. But as far as—like you said a lot of people like sex—I didn’t see what was so hot about it” (Ginny, Lines 404–405). The two women looked to family and friendship for love.

This speaks again to the values and standards of both Alma and Ginny’s upbringing. As a widow, both Alma and Ginny did not desire a new relationship. To the women, a new relationship meant much more than a loving connection or sex – it meant

marriage, work, sacrifice, and quite possibly a lack of appreciation. As a result of their values, they also did not believe in premarital sex, and therefore, intercourse was no longer considered part of their journey. Women, moreover, tend to be content with the independence after the death of a spouse (McCabe & Goldhammer, 2011). The perspectives of these two women fall in line with the literature on marriage from the perspective of the heterosexual female spouse (see Chapter 6) (Lamanna, Reidman, & Stewart, 2015). Different perspectives of marriage articulated by three of the men.

2.2 Marriage versus Isolation

As earlier stated, every resident in this study was married at least once. Gender differences existed among those who attempted to marry for a second time after the death of a spouse. Ginny and Alma both described their marriage similarly and were left feeling a new relationship was not worthwhile. Contrarily, both George and Chuck married twice and remained married to both of their wives until the time of their death. When addressing the age at which each person learned about sex and how they learned of intimacy and relationships, it says something when the two female widows say they desired no new relationship as it only means work and sacrifice and the two men widowers only wanted to be cared for by another woman both romantically and in an almost maternal way.

Marriage or dating in this sense almost takes a path of conquest; a conquest for fear of being alone, isolated, or rejected by another woman. The nursing home experience for the widowers was seen as both isolating and lonely. The only women they perceived to be available (e.g., nurses) rejected them. During George's video, Chuck for example was ready to find another woman only one month after the death of his second wife. This

speaks to earlier gender role ascription. Men were expected to secure a wife and provide for the family. Chuck desired someone who could care for him as well. It seems that Chuck had adapted to death “I’ve been through it twice. So I’ve got so now I’m accustomed to it” (Chuck, Line 381) From this excerpt, Chuck addressed the finality of life without reservation. Death is not something typically accepted and yet Chuck has experienced the death of two wives. As he spoke of his wife, however, the emotions surrounding her death became visible. This excerpt combined with reported desire to be with someone suggests Chuck’s fear of being alone.

Although Chuck and George both desired a relationship with another woman after their marriages ended with the death of their spouses, marriage appeared to be too difficult of an experience for Buddy. As a result of two failed marriages, Buddy chose isolation. Buddy described how his past marriages influenced his understanding of self as a sexual being. After his second divorce, Buddy, however, tried again for love for the third time:

I met up with her and she seemed all right then. I guess I was in need of somebody then, so we wound up getting married. Lo and behold, I was walking out of the furnace and into the fire. Her family was nuttier than a fruitcake. Anyway, I just didn’t have the desire to be intimate with any other woman (Buddy, Lines 546–550).

Buddy described his past three marriages as the main reason why he did not desire to be in an intimate relationship:

I had one girl who had been trying to get her hooks into me but I said, ‘No way.’ She’s a member of my first wife’s family and I found out something about her and

I wasn't too happy. I said, 'We can be friends but ain't no such thing as a date before marriage.' (Buddy, Lines 249–251)

He later clarified "I haven't been around any woman for—I mean intimate—for many, many years and it hasn't bothered me a bit" (Buddy, Lines 350–351). Again, to look at how men and women in Buddy's generation were raised, it makes sense that marriage would be of utmost importance for women. Premarital sexual encounters were considered inappropriate for most women of Buddy's generation. To even suggest a date without the possibility of marriage; was inconceivable for many women his age. As a result, Buddy in a sense considered dating as a bait for women to get men to marry them as he bitterly suggested that a woman had "been trying to get her hooks" (Buddy, Line 350) into him.

Gender differences were seen throughout the narratives with regard to intimacy and relationships. Differently experienced, however, were those relationships that existed at the time of this study. Participants were able to identify specifically how their relationships had evolved over the decades.

2.3 Marriage and Intimacy Evolved

As the participants were asked questions whether intimacy was present in their current relationship, all participants responded affirmatively. Questions and conversations explored their understanding of intimacy and how intimacy had evolved over time. Harry responded with a sense of acceptance regarding the level of exhaustion he experienced while engaging in sexual intercourse with his wife:

One time I said, "Sally, I don't think we're getting out of it what we used to. Why don't we try doing without it?" And she said "Alright, I'm willing." We found it okay. We found other ways of fulfilling that need (Harry, Lines 147–159).

Eventually the future of their relationship as a sexual couple depended upon their open communication regarding their physical limitations. When Harry asked to no longer engage in sexual intercourse, both he and his wife identified ways to meet their intimate needs. He described later how much the intimacy had transformed with his wife:

Snuggling up more often, talking about important things, intimate things, talking about our family, expressing our love, I mean orally and all. We still touch each other some areas that are sensitive. Just holding. We got as much satisfaction out of that. We found that the changeover was not difficult at all (Harry, Lines 154–158).

Although individually interviewed, Sally responded in the same way as Harry. There are several important elements to note within the excerpt above and the one not mentioned by Sally. Both Harry and Sally decided to be creative in their pursuit to meet their sexual needs. This sense of relationship development being associated with newfound ways to enjoy each other physically seemed to enhance and strengthen their marital foundation. Such sexual acts were associated with expression of love, trust, and commitment. As a result, this token of creative devotion made it easier to modify their sexual script when age and illness challenged their traditional sexuality.

The second participating couple, Bonnie and Clyde, both used humor to describe the evolution of their intimacy. Clyde explained,

It was one of our anniversaries and of course she slept in one bed and I slept in the other bed, so I went in her bedroom. I undressed and she undressed and we sat on the side of the bed and started praying (Clyde, Lines 294–296).

They both laughed and explained how desire and intimacy had evolved as they aged: “We used to sneak around and do it at my folks’ house when we were first married” (Bonnie, Lines 327–328). Bonnie reported a decrease in desire over time and Clyde agreed with Bonnie and her lack of desire; however, he claimed it was because “my wife does not have a good set of boobs” (Clyde, Line 444). Bonnie laughed and agreed. She then comically announced, “What nature has forgotten we fill with cotton” (Bonnie, Line 453).

From this interchange of discourse, the couple exposes both their love and somewhat insensitive banter. These exchanges are presented to highlight the rich dynamics found in this relationship. Couples often excel at recognizing their partners qualities and shortcomings .After 60+ years of marriage, they appear to not only speak frankly about each other, but do so in a humorous and playful way.

The couple later exclaimed that intercourse was consistently enjoyed until Clyde’s erectile dysfunction: “Well we are 91. I’m 91 and you know I still touch, feel, [and] kiss” (Bonnie, Line 442), described Bonnie. She further explained specifically how she demonstrated her affection for Clyde:

Just spur of the moment. If I feel like kissing him I kiss him. Sometimes when he goes off to play cards I kiss him because he’s leaving me. Sometimes when I thought I was going on a trip and he wasn’t. I kissed him this morning because I was going up to the rec room and so I was just going to leave him and so I kissed him (Bonnie, Lines 201–204).

Although Jackson no longer resided with his wife, he explained how their love and intimacy had only strengthened over time and distance:

It must have slowed down some as time went by, but we still were able to do it and enjoy doing it. Maybe not as frequently as we did starting out, but it was still very enjoyable and pretty frequent (Jackson, Lines 467–469).

Prior to erectile dysfunction, Jackson explained their continued engagement in sexual intercourse. He then described his present means of expressing his love, “We do kiss hello and goodbye and spend private time together, playing cards” (Jackson, Lines 538–539).

According to Jackson, their love and affection for one another supersedes physical touch. Jackson reported a longing for his wife—who lived in a different nursing home—and described how he felt about her, “Yeah, I guess it’s [desire is] unnecessary because we know we have our feelings toward each other—at a distance, I guess you’d say” (Jackson, Lines 544–545).

In summation, this theme has emphasized how within romantic relationships the meaning of sexual engagement can be differently experienced and defined based on gender, and how relationships can change across the lifespan of relationship. For those who still desired and had no partner, their sexual script appeared fixed in the past. Both Chuck and George described frequent sexual activity with their late wives. When their partners died, the only perceived option was to meet another person. When they began to have erectile difficulties, they, however, perceived no future option with a woman. Each couple expressed time and age as contributing factors for their waning desire and, as a result, attempted to creatively modify their sexual script to match their current understanding of self as a sexual being. The reported evolution of each couple, including the report of Ginny who described her relationship with her husband as a “rocky”

journey, but one that developed in appreciation towards the end, are reflective of a developmental perspective of aging relationships.

Theme 3: Self as a Sexual Being

Whether one portrayed himself or herself as a sexual being or not, and how such portrayal was actualized was described in this theme. Participants were asked to describe their sexual background and experiences that led them to their present understanding of self as a sexual being and attraction of others (see Table 9 for Superordinate Theme 3 and subordinate themes).

Table 9. Superordinate Theme 3 and Subordinate Themes.

Themes	Sample quotes from interviews
3. Self as a Sexual Being	
3.1 Self-attraction	“I think I am attractive.”
3.2 Gender differences associated with interpersonal attraction	“Men are more sexual than men.”

3.1 Self-Attraction

Participants were asked to reflect on their perception of attractiveness toward self and toward others in relation to their sexual identity. A disparity of responses resulted. Harry reported a lifetime of self-attraction, self-attraction being how one perceives his or her own level of attractiveness. Harry implied how he saw his own beauty but was saddened by how his body had changed as a result of Parkinson’s disease:

I think I am attractive. I always thought I was a good looking man. I keep myself clean. I was proud of my body when it was strong but I am losing weight and I cannot control losing my muscles. I loved my body. The Bible said love yourself and I did. I found out I had Parkinson’s a year and a half ago. It helped me [his

body] to be confident, open, nonjudgmental, not a prude. It helped me be a better husband and father (Harry, Lines 73–78).

The physical and experiential impact of Parkinson's was clearly profound. From this excerpt Harry simultaneously expressed his insightful appreciation for his body and his strength as it helped to establish his identity as a human being, while also mournfully disclosing the impact Parkinson's has had on his body.

Although Harry remained positive, the other nine participants reported displeasure in their current appearance and identity as a sexual being. George explained that it was difficult to feel attractive with current incontinence difficulties:

I always wear a button down shirt and slacks but I ruined so many pants, and I had a bunch of them. I absolutely ruined them. They told me they [adult diapers] could handle anything. And when I was going through a bad time, and pretty often that happens, I start wearing them things for a few days and I get rid of them when I need to (George, Lines 1322–1325).

This specific recall of incontinence experienced by George reflects the events which led him to no longer identify as attractive with confidence. When asked how the incontinence had affected his self-attraction, George quickly replied, "No, I just forgot about it" (George, Line 518). This short quote is powerful. His reported cognition that incontinence had changed his understanding of personal attractiveness, suggests that forgetting about self-attraction was the only conceivable choice.

Quite differently experienced, Ginny linked her self-attraction to her voice. She explained,

Not really [do I feel sexy]. I used to sing a lot. I sang at church, at PTA meetings, at school. I used to be a good singer. I'm not very good now. That's what hurts me, I can't sing now at all (Ginny, Lines 130–132).

From this quote, Ginny did not initially report her physique as a key feature of her beauty, but she did identify her voice as the central component to her self-attraction. Singing is not simply looked upon like physical beauty; it permeates the minds and hearts of those listening. Ginny had lost her ability to attract others and connect with others in a melodious way. This was also the first time she had described something painful, suggesting the powerful impact of losing her voice and what it meant to her to no longer sing.

Ginny adds to this way of thinking by describing how she felt within her body. “When I was younger I'd like to look like that, but you can't always look skinny and slender and boobs just right and the butt—I hate big butts” (Ginny, Lines 546–548). Ginny later clarified, “Right now I hate it. I like being slender. I like to be a little more slender. I'm getting there but I do hope to enjoy it” (Ginny, Lines 592–593). There is a great deal of resentment and frustration presented in this excerpt. By hating “big butts” Ginny exposes hatred for her body.

Alma and Sally shared similar thoughts on self-attraction. Both described how they never felt sexy or attractive, yet both described a desire to be appear “nice.” Alma explained,

I don't know really that I do feel sexy. I try to look nice. I don't always succeed in that. But when one of the aides comes by and says, “You look very nice,” it makes

me feel good. If I can get over there to my drawer, I put on my lipstick (Alma, Lines 203–205).

Self-attraction was perceived in such unique ways for each of the participants. Physical appearance was not the only way in which participants described self-attraction. A tube of lipstick for Alma, a voice for Ginny, and intellect for Jackson and Harry are just a few examples from the participants in this study. It was also noted that again, many believed the concept of sexiness was no longer part of their present day appearance. When the researcher modified her terminology directly after asking about “sexiness” to “beautiful” to “attractive,” participants were more apt to support other variations of beauty. Regardless of gender, appearing well-groomed was expressed as the central focus for appearance appreciation to exist. When clothes were clean and matched, many participants described feeling positive about their looks. Regarding attraction to others, some participants, however, greatly varied in their response.

3. 2 Gender Differences Associated with Interpersonal Attraction

Like other beings from the animal kingdom, humans are typically inclined to view others as sexually attractive, although attraction varies from person to person. This section explores the dichotomy of interest in intimacy and interpersonal attraction, as reported by the participants. As will be later discussed, the women in this study considered the opposite sex to be handsome, but reported no interpersonal attraction. Contrarily, few of the men reported frequently being attracted to others and desiring intimate relationships. One person described fluctuations in who he finds attractive.

Harry was very open and reflective throughout the interviewing process. During the first interview, he identified as heterosexual but when asked about his level of

attraction during the second interview, Harry wanted to amend his original identification with an emphasis on his love for his wife:

Harry: I'm partly bisexual (Harry, Line 490).

Angela: Okay.

Harry: The only person I've ever had relations, [with] sexual relations [with], has been my wife. There is something about a handsome boy that touches me, too (Harry, Lines 494–495).

He then went on to say,

I don't know whether it was sexual or not, I think it's partly. Partly. Umm, there was one special boy in Higginsville . . . he was in our confirmation class and had been very active. He was a delight. Everybody liked him. He was fun. Just to see his movements were humorous. Everybody liked David and I had that feeling toward him, but that is as far as it ever went (Harry, Lines 505–509).

When asked to describe the feeling he spoke of, Harry smiled and said, "Beauty. Beauty. To me, they're the most beautiful things. The most beautiful things God ever created" (Harry, Lines 513–514). Again to look at the generational climate of Harry's upbringing, same-sex sexuality was not only never discussed but it was considered sexually deviant, or abnormal and something to be feared. It may even be surmised that I was the first person to ever ask him to identify his sexual orientation. Harry had the courage, however, to describe himself as a man who was attracted to both men and women.

Basson, (2000) suggested a pattern for both women and men, where at times, a woman's sexual desire may be more directly linked to situational factors such as feelings

of closeness to her partner rather than occurring spontaneously in the form of sexual thoughts or fantasies as it does in most men. For the two widows in this study, in the absence of a partner, both Ginny and Alma reported a lack of sexual desire and attraction for other men.

The two women both reported that some men might look handsome but both made it very clear – the comment meant nothing sexual. Alma cautiously clarified her disinterest in men: “I have no desire for any kind of—how am I going to say this—anything to do with men in a sexual way. I just have no desire for it” (Alma, Lines 278–279). In this excerpt it becomes clear how adamant Alma was regarding her contempt towards being perceived as a desiring person. It, moreover, revealed her guarded stance toward being alone. From Alma’s account, it could be suggested that being sexual meant to give up or lose something special to a man. From this perspective, after decades of marriage, she no longer desired to give any more of herself to anyone, especially a man.

In summary, this theme has highlighted attractiveness as a construct individually defined and experientially formed. It was important to explore how participants conceptualized themselves as a sexual being across the lifespan. A majority of participants described a decrease in level of attraction toward others and self-attraction. Relationships, past and present, were reported to have had a significant influence on how participants, both men and women, viewed intimacy, desire, and interpersonal attraction. Those men who were without spouses described a level of loneliness and frustration with the lack of opportunity to meet women who they viewed as attractive. That sense of frustration, loneliness, and opportunity for intimacy is included in what the researcher describes as the sexual script.

Theme 4: Updating the Sexual Script

Many of the interview questions and conversations sought to understand the complexity of sexual expression in older adults. The findings described the inevitable truth about aging sexual expression – medical complications due to age affect sexual expression, or the sexual script of the person. A sexual script is often tied to how one perceives himself or herself as a sexual being, which may include personal philosophy and ascription to sex, gender, expression, sexual health, and identity. Both male and female participants reported a transition that occurred at the time they or their partner experienced erectile difficulties (see Table 10 for Superordinate Theme 4 and Related Subordinate Themes).

Table 10. Theme 4 Superordinate Theme and Related Subordinate Themes.

Themes	Sample quotes from interviews
4. Updating the sexual script	
4.1 Personal reaction to sexual difficulties	“It’s just gone.”
4.2 Desire and mental imprisonment	“It’s on my mind, but that’s as far as it goes, I think.”
4.3 Confusion and conflict with masturbation	“I could do that, but I don’t . . . it don’t seem like it appeals to me much. . . . It don’t replace a woman.”

4.1 Personal Reaction to Sexual and Medical Difficulties

Medical conditions were experienced by almost every participant in this study. Eight out of ten participants used wheelchairs. Although couples had the choice to select one large bed, everyone opted for single beds due to varying medical complications. Every male participant experienced erectile dysfunction (ED). Prior to ED, five out of six

male participants reported continuous engagement in sexual activity well into their 80s. One male participant started to have erectile dysfunction in his 70s. The questions and conversations were intended to elaborate on what it meant to have sexual and/or medical difficulties and how their condition changed their perception of intimacy and sexual relations.

Residents at nursing homes are sometimes able to request a bed capable of holding two people. Although Sally reported her waning desire, she also clarified that she still desired to be close to her husband in one bed; however, it appeared impossible due to medical difficulties. Sally explained, “We’ve mentioned many times recently that it would be nice to be in bed together, but with my problem and with his, we have to admit that it is not practical” (Sally, Lines 373–375). For Harry and Sally, both decided to move to the nursing home because of medical difficulties. What they had not expected was how hard it would be to go from one bed to two beds—to be disconnected in a time they perceived was designated for intimacy. Sally explained, “We didn’t think of the bed at the time” (Sally, Line 163), and she later clarified, “We have had problems to get over, not much but—the only big thing is that we don’t sleep together” (Sally, Lines 252–253).

When asked how she experienced the separation of beds, she explained, “I just decided to accept it” (Sally, Line 716). Harry, however, reported that he did not want to sleep separate: “We’ve always, I’m always wanting to get a single bed, but Sally says with my leg syndrome, it got pretty bad” (Harry, Lines 813–814). Both reported ailments that prevented them from sleeping in the same bed, yet both reported a desire to be in the same bed, throughout their individual interviews.

Although she describes a decision to “accept it,” Sally’s frequent discussion regarding the bed suggests otherwise. At the end of the conversation both Sally and Harry reported that they are going to open the topic up for discussion with the nursing home. It is still not certain whether Sally truly desires to be in a single bed as a result of her husband’s medical condition, and yet, the relationship, as previously mentioned is built on open communication.

Focusing on the effects of ED, many of the male participants reported frustration with their erectile difficulties although some participants had come to terms with the loss of their erection. George was the most verbal about his loss. He repeatedly described his continued frustration with his ED. “It was there all the time my second wife lived here” (George, Lines 530-531) and “it’s completely gone now” (George, Line 547). He later suggested when asked whether his desire had decreased as a result of his erectile difficulty, he clarified with excitement, “No! My interest, my interest is as almost as good as it ever was. I don’t know what to do with it” (George, Lines 1261–1262).

The short quotes above suggest something quite powerfully disruptive to the personal well-being of George. Not quoted in this conversation was George’s reported claim that he had never spoken to a physician regarding his ED. At a loss for understanding and a lack of desire to speak to a clinician on the topic of ED, these quotes expose George’s impatience as evidenced by his yearning desire and his lack of knowledge regarding his personal ED condition. In the following quote, again, it appears that he places great pressure on himself, his identity, and his ability to have and maintain an erection. “I figure I’m somewhat less of a man anymore” (George, Line 632).

Chuck also described his frustration with his erectile dysfunction: “Even if I met up with the right lady, I don’t think I could produce. I couldn’t get a hard-on” (Chuck, Lines 600–601). As previously indicated, Chuck described a longing interest to be intimate with a woman and yet, in this excerpt, he quickly minimizes his sexual potential as a result of ED. Not knowing what he is sexually capable of doing suggests a judgment toward himself as a potential lover when reflecting on the possibility of one day meeting “the right lady.”

Both George and Chuck reported the ability to have an erection at the time their wives were still alive, and how shortly after their deaths, both were unable to achieve an erection. This could suggest a psychogenic condition called *widower’s syndrome* (Hedon, 2003), a form of impotence that occurs at the time of a spousal death and lack of use.

Clyde also described frustration and a sense of defeat as he reflected on his desire and his erectile difficulties: “I think about it too but what the hell is the difference, you know. You think about it, ‘Oh boy that might be good.’ That’s the way you are. It’s not the purpose of life anymore” (Clyde, Lines 273–275). This segment suggests that, at one point in time, sexual intercourse was considered a high priority in Clyde’s life. This excerpt could also be alluding to a belief that the purpose of sexual intercourse as a means to procreate and regardless of purpose, without the ability to maintain an erection, the penis for all intents and purposes is useless.

Although many of the male participants described a level of acceptance, albeit most reluctant acceptance, Jackson was the only person who explained his lack of desire from a place of acceptance: “I don’t have a reason to get triggered that way” (Jackson, Line 632). Jackson reported that his erectile dysfunction had not come naturally, but

rather his erectile dysfunction was a result of a suprapubic catheter that was inserted as a result of complications connected to an untreated bladder infection. Since the catheter was placed, Jackson explained, “For all practical purposes, it [his penis] is dead” (Jackson, Line 373). When asked how he experienced the loss of his penile use, Jackson clarified, “I just know there is no sexual possibility and I have to put it out of my mind” (Jackson, Lines 941–942).

From these excerpts, important issues are presented. Jackson’s use of words is profound and yet he described them from a place of acceptance. Literally identifying his penis as “dead” in conjunction with his decision to “put it out of [his] mind” reflects the work Jackson was doing in minimizing any potential grief. The words suggest that he has cognitively chosen to avoid the loss and move on as if his penis never existed.

The women in this study also described their reaction to their husband’s erectile difficulties. For Ginny and Alma, the narratives presented a sort of personal liberation as a result of their husband’s ED. Ginny discussed her feelings toward her deceased husband’s erectile difficulties: “We’ve enjoyed life, sex, being husband or wife, but when he couldn’t perform anything, I knew he couldn’t and I just let it go at that” (Ginny, Lines 256–259). From this extract and the quote below, Ginny described a lack of interest or concern over future sexual intercourse with her husband which affirms her previous comments towards sexuality. She later clarified the evolution of their relationship as a result of her spouse’s difficulties:

He was, I’d say, in his late 60s because on account of health problems, really. And it didn’t bother me. Sometimes he mentioned it and it bothered him more than it did me. I said, ‘Why we enjoyed life when we were young and now let’s enjoy

life without it.' You can live without it. That's the way I look at it (Ginny, Lines 264–267).

Participants varied in their reactions and responses to their own sexual difficulties and to their partners' sexual medical difficulties. Some displayed a more difficult time accepting their condition. For Ginny's husband as well as George and Chuck, they each had a difficult time accepting their impotence. Both George and Chuck asserted how their level of desire had not changed much throughout their lifespan and identified how their erectile difficulties and lack of partner prevented them from fulfilling their sexual needs. All male participants stressed a variety of concerns surrounding sexual expression at an older age and most believed it was not possible due to medical conditions and specifically, erectile dysfunction. The women, however, described sexual intercourse similarly to that of a nice dress, one that can be lived without.

4.2 Desire and Mental Imprisonment

As a result of perceived age and sexual difficulties, many of the participants explained how their needs and desires were limited to only thoughts, fantasies, and dreams. Due to this sort of mental imprisonment, participants conceived no opportunity to move their desire beyond their sexual thoughts. Some reported frustration with this kind of cognitive imprisonment and others accepted their perceived limitation. George explained his frustration and exhaustion, "It's on my mind, but that's as far as it goes, I think. I like sex. I really do. I always did and when I found myself without it, it's kind of tiresome" (George, Lines 906–907). When asked what "tiresome" meant, he explained "It gets old" (George, Line 910) and "It is on my mind and sometimes it gets pretty frustrating" (George, Line 621).

George's comments resonate along with his feelings towards his erectile dysfunction. From these short quotes, it again is suggested that George is not only confined sexually as a result of his erectile difficulties but also haunted by his cognitive captivity and inability to freely put his sexual thoughts into action. As a result, George describes a level of mental fatigue or exhaustion that wears him down emotionally.

As previously mentioned, there were those who felt differently. Jackson described his sexual limitations with a sense of acceptance: "I'm mentally sexually active" (Line 628). Jackson later reflected on his level of desire and explained,

Once in a great while, I will think about something that my wife and I have done that brings back fond memories sexually. I don't have the ability to have an erection or anything like that, but I can just—it's more mental, I guess, than anything else. (Jackson, Lines 660-662).

Two of the women in this study also felt confined to their thoughts regarding sexual desire. Both Bonnie and Sally described occasional thoughts about sex, but reported it to be only thoughts. Bonnie described her acceptance in the absence of sexual engagement and recognizes the thoughts in appreciation as those past experiences resulted in a deeper foundation of intimacy where sex is no longer necessary. "It's a passion and a kind of – what kind of a love do you call it – there's a love there that to me doesn't have to depend on sex. We've been together all of these years" (Bonnie, Lines 493-494). Although Sally is confined to her sexual thoughts related to intercourse, Sally reported still being able to release such cognitive burdens by engaging in other sexual activities with her husband.

Again, for both women and the other men who experienced a sort of cognitive confinement regarding their sexual thoughts, there is certainly a sense of grieving over the loss as they reflected on their sexual freedom in the younger days. Some reflected on the past with bittersweet reluctance. “Sex is the most important thing in your life when you’re young. When you grow old, it’s not important. It’s all in your mind. What the hell” (Clyde, Lines 490-491). Some recognized the evolution of their connection as a result of fulfilling their sexual desires when they were younger. Jackson for example, who had experienced a sexual reawakening with his second wife reported their love making had far surpassed that of his first marriage. As a result, he considered his sexual life fulfilled at the young age of 80 after he became impotent. He, and other participants like him, had lost a great deal including their ability to engage in sexual expression in the way they always knew how. But when they were able to connect to their loved ones in a deeply meaningful way, they were able to appreciate their traditional love making for what it was and move forward with acceptance.

4.3 Confusion and Conflict with Masturbation

To explore the degree in which people expressed their sexuality, questions regarding masturbation were addressed. Specifically, as the conversation on sexual difficulties developed, both male and female participants were asked if they engaged in masturbation to satisfy their sexual needs. From the conversations, it appears that many of the participants held to a level of discontentment with the idea of masturbation for several reasons.

Specifically for Ginny, she was rather confused about what masturbation was and who engaged in such a practice. As the conversation continued it became apparent that Ginny believed masturbation to only be practiced by women who identified as lesbian.

The researcher informed Ginny that people in general are capable of masturbation as a means to sexual gratification. When the researcher was able to clarify the question, Ginny retorted, “I don’t know nothing about it. I’m too old to learn about it” (Ginny, Lines 427–428). Although this quote was used earlier to address how Ginny perceived her age in relation to her sexuality, it is important to address this quote again as an attitudinal indicator of potential fear to learn something new about herself as a sexual being. Both words and tone, Ginny immediately dismissed the topic and the conversation from continuing potentially due to embarrassment.

From the eight participants who identified former practice in masturbation, only one described an interest in continuing masturbation if it were possible. Chuck reported an interest in masturbation but explained how it did not seem possible, “Well if I could, I would but to make up for loss of the other” (Chuck, Line 578).

Masturbation was positively perceived by both Harry and Sally who both explained individually how each would practice masturbation when the other was out of town. They later confirmed cessation of masturbatory practices as a result of entrance into the nursing home. Sally explained, “No, since we came in here that has stopped” (Ginny, Line 446). Both Harry and Sally reported the acceptance of no longer being able to masturbate due to lack of privacy.

Bonnie, Clyde, Buddy, George, and Jackson each described a lifelong disinterest in masturbation. George explained, “I’ve done that but it just don’t work very good” (George, Line 556). When asked if he enjoyed masturbation, he explained, “Not much. It don’t compare with actual sex,” (George, Lines 1266-1270) and later, “I could do that, but I don’t . . . it don’t seem like it appeals to me much. . . . It don’t replace a woman”

(George, Lines 2179-2188). Jackson also described a lack of desire to masturbate across his lifetime, “No. I just never had that desire. I wasn’t overly—I wasn’t sexually active hardly at all” (Jackson, Lines 754-755).

Masturbation was originally perceived by the researcher as an opportunity to fulfill sexual desire; however, it appears some male participants believed masturbation to be a reminder of their dysfunction and their age. For the women, it makes sense to a certain degree how at least three of the women did not disclose an interest for masturbation. Masturbation was not taught in school education, nor was discussed in social circles of friends or parents, as suggested by Sally, Ginny, and Alma.

The sexual script of these individuals were tied to how they perceived themselves as a sexual being, as a woman or as a man, and their age and health. For some of the men, the loss of their erection meant a loss of identity. Their erectile dysfunction represented something more than simply aging. In a sense, it meant a loss of manhood and a sense of control over their mortality. There was also a sense of tension between “what was” and “what is” now for both sexes. In the minds of almost every participant, their sexual expression ended with the loss of an erection. This was also the case for the women who accepted their husbands’ sexual difficulties as their own.

The sexual script was ultimately over. They did not seek out a way to modify their sexual script to meet their new needs. Some participants were tormented by their sexual thoughts because they found no other way to exercise their sexual desires. Some participants merely surrendered to their perception of age and health status—their sexual stories ended as a perceived natural consequence of age and health. There were those

however, who were capable of modifying their sexual script and found new ways to love each other.

Theme 5: Affordance to Sexual Expression

It was important to explore perceptions of opportunity and barriers individually and within the nursing home. Within each interview, the individuals were asked to give their feedback on perceived affordances. Questions and conversations explored privacy, opportunity, and support (see Table 11 for Superordinate Theme 5 and subordinate themes).

Table 11. Superordinate Theme 5 and Related Subordinate Themes

Themes	Sample quotes from interviews
5. Affordances to sexual expression	
5.1 Privacy and staff support	“Everybody here knows we close the door and turn out the light and just have a very low light and we are in each other’s arms.
5.2 Personal Attitude	“We found other ways.”

5.1 Privacy and Staff Support

Privacy, along with dignity, is considered one of the most important components to overall quality of life in nursing homes. It was important, then, to explore whether participants experienced privacy in the nursing home setting, and to what degree was privacy afforded. Along with privacy, opportunity was also explored in relation to whether participants perceived opportunities to engage in sexual expression. Some perceived a great deal of privacy and opportunity and some did not. This section focuses on those participants who perceived privacy as an opportunity, and how staff supported

and provided opportunity for the resident participants. Harry, as previously discussed, engaged in a morning and evening ritual with his wife, Sally:

Usually we have a clock on the ceiling. And when it is 6:00, I'll say "Six" and I'll wait until she starts it, but she may not feel like doing it again. One of us then will say, "Good morning honey, I love you." And the other will answer, "This is the day in which the Lord has made," and so on. We'll talk about what day it is and all of that. We'll maybe talk about what we are going to have to be doing today, or talk about yesterday, or talk about what kind of a night we had. And then after a while, someone will come in wanting to know what we want for breakfast and they'll take it down and then they will come in, someone else will come in and turn the light on, 'Are you ready for bed, I mean get up?' 'Yes.' (Harry, Lines 249–254)

From this excerpt, the details suggest a loving ritual between both Harry and Sally. Prayer was used as means to connect to one another and to their faith. Although just a few minutes (approximately 10 minutes), Harry and Sally reported feeling overall satisfied with the time. Similar to the morning, both Harry and Sally have a night time ritual that was supported by staff. Sally explained:

We, every night just before we are ready to have the aides come and help us get to bed, we close our door and turn the lights out except for one and have about oh, 10 to 15 minutes together, and when we turn our call light on, they come and put us to bed (Sally, Lines 195–198).

When asked if they felt privacy was available for both to be intimate, Clyde reported jokingly, "We can do what we want in it, except murder each other" (Clyde,

Line 592), and Bonnie suggested the same: “I’d say we could pretty much do anything we want to do” (Bonnie, Line 594). Both then clarified, “We can do anything, but we don’t do anything” (Clyde, Line 596). Bonnie then reported with a tone of acceptance, “That’s the way life is when you get to be 91 in a resident facility” (Bonnie, Line 600).

Although considered limited by all participants, privacy was seen as an affordance to a certain degree. Many of the participants recognized the importance of medical needs and nursing responsibilities as an expectation of the nursing home experience. Although privacy was limited, they were able to identify moments and private opportunities to be by themselves and be with each other.

Beyond their bedroom, Sally and Harry both described other opportunities for intimate expression. Sally explained, “Every once in a while, even in the dining room or anywhere, if one of us want to, we say, ‘I love you’, and he’ll say something similar back” (Sally, Lines 287–288). Sally also explained how they also took advantage of the outings provided by the nursing home, to be together and enjoy the community. Bonnie and Clyde also reported participation in the nursing home outings: “We like to go to the movies and shop and people watch.” The majority of the participants, in fact, reported frequent participation in community outings. Many desired to leave the nursing home on occasion.

Opportunities to be with his spouse privately and publicly were also considered very important to Jackson—whose wife could only visit him weekly. Jackson explained:

We like to spend time by ourselves when we go up [to the dining hall] or eat here or go out some place. The few hours that we spend together we like to be together to just talk and play cards (Jackson, Lines 509–511).

From this segment, Jackson identified specific ways in which he and his wife spend their limited time with each other. The activities include simple life discourse and play. For the moments they have, this excerpt demonstrates how Jackson and his wife attempt to make the three hours feel like a typical day together, as if they were never apart.

Prior to coming to the nursing home, George claimed that he had several pornographic movies; however, he believed the nursing home would disapprove and decided to throw them away. After living in the nursing home for approximately a year, George felt comfortable enough to rebuild his collection. He appeared proud to show them to this researcher and even exclaimed, “Not long ago one of them got me to cum [ejaculate]” (George, Line 1003). This was a surprise to him although men with semi-erect or even flaccid penises are capable of achieving orgasm.

George, who lived in a private room, explained how he used his privacy to fulfill his sexual needs in the evening hours. As he walked to show me his collection of DVDs, George explained, “I got some sexy movies over there I watch and sometimes that stirs me up” (George, Line 930). When asked if staff supported his decision to view such movies, he clarified, “They leave me alone pretty well after 11:00pm. And I can watch them later at night. They’re pretty raw, or at least some of them are” (George, Lines 938–948).

From these disclosures, George believed the nursing home would not allow pornographic movies in the nursing home but he did not ask before relocating to the nursing home. His report suggests that he never asked during his time at the nursing home either. He simply became comfortable and confident enough to “risk being caught” with the videos. Intriguingly, there was a sense of excitement experienced by George in

getting caught in the act of watching the films. Again, the disclosure suggests a lack of communication but also quite possibly that communication regarding the films was unnecessary. From George's experience, the staff provided the opportunity of privacy and knocking as a demonstration of acceptance of his sexual needs.

In summary, this theme addresses limited affordances as described by participants. From the perspective of the nursing home residents, affordances to sexual expression were both experienced and perceived by others as part of their nursing home experience. Privacy was afforded to a certain degree in George's case, he was even provided a "privacy please" door hanger by the nursing home staff. Per request, all residents at his facility were able to receive the door hanger. Some resident participants observed others in the nursing home being intimately expressive and defined sexual expression in their own way—a kiss, a hug, a midnight rendezvous, and a long-term decision to move into a home just to be with their ailing partner. Although perception of privacy and opportunity was considered available, many participants (including the ones in this section) reported that a level of privacy was not afforded to them. The perceived lack of privacy is discussed later in Theme 6.

Theme 6: Barriers to Sexual Expression

Both affordances and barriers were investigated. Although affordances were discovered and described, barriers of sexual expression were reported to a greater degree and were found within social situations, institutional settings, and resources. Barriers were also identified with regard to personal knowledge, level of comfort, and perception of access. Questions and conversations, therefore, aimed to comprehend how participants viewed their experience as a nursing home resident and as a sexual being (see Table 12 for Superordinate Theme 6 and the Related Subordinate Themes).

Table 12. Superordinate Theme 6 and Related Subordinate Themes.

Themes	Sample quotes from interviews
6. Barriers to sexual expression	
6.1 Resident knowledge of sexual expression policies	“I don’t know if there is. They never told me about it.”
6.2 Limited opportunity to meet people or date	“And then I don’t know how to get a partner in here if I could do it.”
6.3 Limited privacy	“They (staff) usually will knock, but then just come right on in.”
6.4 Comfort level with sex discussion with staff and doctors	“I’m not very comfortable . . . I would ask the nurse more than I would ask the administrator. Not about sex.”

6.1 Resident Knowledge of Sexual Expression Policies

This theme represented the lack of clear knowledge on resident sexual expression, as reported by resident participants. All ten residents could not clearly identify specific policies, protocols, or procedures regarding resident sexual expression. Some participants, like Alma, speculated policies existed for heterosexual married couples only: “I think that is just—unless they are a husband and a wife—you know” (Alma, Line 584). Chuck also suggested the same, “Nope. Not offhand. They don’t like it available to you unless you are married and if you are married, well you can get a room here for your wife” (Chuck, Lines 662–663). Ginny, Harry, Buddy, Jackson, and Sally reported policies were never discussed with them.

There are several important issues to note within these brief disclosures. Assumptions and guesses are made on the topic of sexual expression in the absence of a clear policy on sexual expression. If it were the case that the nursing homes afforded opportunities for sexual engagement exclusively to married couples, people who were single were limited to either marry or live out their residential lives without a sexual

partner. George and Chuck desired to be with a woman, but were restricted to the women who resided in their nursing home and perceived limited opportunity to meet someone in the community. Although the married couples believed it was appropriate for them to engage in sexual activities, they were unsure of specific policies and, therefore, had to assert their sexual stance with the idea that they may be at risk for discipline. Harry, for example, asserted “When we can, we get together and kiss. We don’t mind being caught doing that” (Harry, Lines 1146–1147).

This theme is also explored in Chapter 5 from the perspective of the nursing staff who participated in this study.

6.2 Limited Opportunities to Meet People or Date

It was important to explore whether participants believed opportunities existed to meet potential partners and/or participate in intimate outings. Lack of transportation and personal vehicles were considered an issue for those interested in meeting new people. Both nursing homes offered a variety of social activities, such as playing bingo, for resident enjoyment. George also identified bingo as one of the social activities offered by the nursing home. He reported bingo was offered two to three times a week for about an hour each time. When asked if George participated, George replied, “I did, but I kind of got—it got a little monotonous” (George, Line 1684). When asked if he was ever attracted to someone while playing bingo, he sadly responded, “No. Usually the only people playing is the people that are living in here. And most of them are old” (George, Line 1688). Later, George was asked if other social opportunities were presented by the nursing home to meet people and he exclaimed, “I don’t know, I’m just kind of wandering around in the dark on that kind of stuff” (George, Line 1084–1085). Again, George was attracted to those younger than he and also someone who resided outside of

the nursing home. The nursing home, according to George, provided little to no opportunities to meet a woman in the community—beyond the nursing staff.

George's concerns were shared by Chuck as well. After Chuck's second wife died, he described a desire to be with someone; however, he could not foresee the possibility: "Well yeah it's been a tough year. I lost two wives and—that I got pleasure from all the time. I don't know. Maybe it was meant that way. I don't know" (Chuck, Lines 811–812). As earlier stated, only four women lived in the resident home where Chuck resided and because of this, he also saw limited opportunities to meet new women.

Of those in relationships, four out of five participants reported interest and frequent engagement in social activities where they would participate with their spouses. Sally also commented how there were no real opportunities to go on a date with her spouse: "Not since we've been here. What could we do on a date?" (Sally, Line 552). She and her husband explained how they used to engage in hobbies such as gardening, cooking, and music. Although they were able to bring their music with them, they both reported how much they missed working together in a garden or cooking in the kitchen—neither of which were offered at the nursing home where they resided.

6.3 Limited Privacy

Although many nursing homes enforce laws that mandate affordances such as privacy rights for residents, realistic limitations exist with regard to the extent of privacy. Nursing homes employ many people to fulfill a variety of unique needs: nursing assistants, social workers, counselors, nurses, physicians, maintenance workers, housekeeping staff, dieticians, cooking staff, administrators, and more. Each of the aforementioned employees, depending on the need, has access and clearance to enter the

resident's room when necessary. All ten resident participants reported privacy was limited and disruptions appeared inevitable.

Few participants accepted the limited privacy, but many reported feelings of frustration with the ongoing disruptions that occurred in a given day. Some participants equated the disruptions to be the reason for limited engagement in intimacy with spouses, and/or with self. Although George enjoyed viewing pornographic videos, he reported discomfort in “upsetting” staff. George explained, “Now there’d be something happening [on the video]—wouldn’t want to upset—but they’re used to kind of things like that, I think. Well it depends on who it is, but some of them wouldn’t mind” (George, Line 993). George reported some staff were supportive of his pornographic collection and some staff disapproved. Because he did not know when staff would come in, he restricted his viewing to the evening hours, “I usually don’t watch them during the early hours” (George, Line 985).

All participants described respect of privacy as limited to a knock at the door upon entrance to their room. When asked of opportunities to be intimate, Clyde simplified, “I don’t know. In the first place, you can’t have any thoughts of sex because anytime somebody might knock on the door and walk right in” (Clyde, Lines 228–230).

Although Harry and Sally deemed their 10 to 15 minutes of privacy as “sufficient” to engage in their evening intimacy ritual, Harry also clarified opportunities for a spontaneous and privately intimate moment with his spouse, Sally, were limited: “That’s the only time we really have that’s intimate. Because other times it would be possible” (Harry, Lines 203–204). When asked to clarify, he suggested, “People [staff]

coming in and out. There is no lock on the doors. No doors have a lock” (Harry, Lines 212–213), and “They’ll knock, but they come in instantly” (Harry, Line 218).

One of the other challenges perceived by Sally, specifically, involved the amount of time she spent together with her husband. According to Sally, there was not much of an opportunity for her to have space and privacy away from her husband. Sally explained, “Through the years, we’ve given each other time of our own when we wanted it. Now, we haven’t been separate from each other for more than two weeks at a time” (Sally, Lines 267–269). Both Sally and Harry described a deep symbiotic fondness for one another and, at the same time, they recognized their human desire to be away from each other for a period of time. As a result of living in the nursing home, they were restricted to their environment and to the confines of the nursing home.

The limited opportunities for privacy, as perceived by residents, appeared to restrict the prospect of spontaneity and autonomy. Also, it could be suggested that a level of acceptance with regard to limited privacy was a result of the establishment. Many participants reported the expectations of the nursing home as a place for medical needs to be treated and privacy was expected to a certain degree but that it would also not be the same compared to living independently.

6.4 Comfort Level with Sex Discussion with Staff and Doctors

In order to understand how residents perceived opportunity to communicate their sexual needs and concerns with staff, it was important to explore level of comfort surrounding sexual discussion with staff, physicians, and family. All ten residents declined to ever discuss sexual concerns with staff, physicians, or family members. Most participants reported discomfort with the idea of discussing their sexual needs and concerns with staff, physicians, and family members. Even though George was a former

friend of the administrator, he admitted, “I’m, not very comfortable—I would ask the nurse more than I would ask the administrator. Not about sex. I’ve known her a long time. I knew her before I come up here” (George, Lines 2023–3034).

Chuck was the only participant who described an interest in discussing sexual desires, needs, and concerns with staff and physicians: “I guess I’m reasonably open to do it. But I don’t know. I haven’t spoken to these ladies [nursing staff] about it” (Chuck, Lines 721–722). When asked if he could identify someone at the nursing home to discuss sexual needs and/or concerns, Chuck explained, “Not necessarily. Well, I take that back. I talked to them about their family relations and their divorces. I don’t know what to say. I can’t put it in words. For some reason or other” (Chuck, Lines 726–728).

For those with erectile difficulties, it was explored whether there was an interest or not in discussing erectile difficulties with a physician or to learn about medication for erectile dysfunction. George considered medication purposeless without an intimate partner. George explained, “I don’t see the point in my condition” (George, Line 2167). He later clarified “I wouldn’t know what to do if I . . . could” (George, Line 2171). Chuck responded quite differently, “Never bothered with it. It just never dawned on me to talk about sex with my doctor” (Chuck, Line 587). Although he never discussed sexual concerns with his physician, he clarified how, as a result of the interview, he was interested in learning more about other alternatives to meet sexual needs: “Well you stirred up my appetite for doing something. You did that. By making suggestions when you asked me whether I had done this or done that and I hadn’t” (Chuck, Lines 750–751).

Comfort level discussing sexual concerns and interests was considered a perceived barrier because not one resident had discussed sexual concerns and/or interests

with those who cared for them, whether it was staff, physicians, or family members. Most reported discomfort with the idea of disclosing personal information to others. Although two participants experienced erectile difficulties after the death of their spouses, one considered discussion meaningless without a partner. George declined to even consider sexual discussion with physician because “I wouldn’t even know what to do if [I could]” (Line 2171). On the other hand, Chuck had never conceived discussion of sexual concerns as a possibility, but he would now consider future discussions as a result of the interview.

Barriers described in this section, regardless if they were perceived or actual, were considered to be true obstacles for those in this study. Some participants were more affected by the barriers than others. Transportation, privacy, opportunity, and access could be considered typical affordances for many individuals in the community; however, for many of the participants in this study, those resources and opportunities were believed to be limited to those outside of the nursing home.

Theme 7: Actual and Perceived Relationships with Nursing Staff and Others

In this study, intimacy was also conceptualized as the perception of connection with others, specifically the staff who cared for the residents and how such care was perceived by the resident participants. Although the majority of the residents positively perceived care from nursing staff as both helpful and considerate, some participants identified the attention as more than a professional caring relationship. It was unclear whether participant narratives were distorted or not; however, because the goal of this phenomenological study was to document perceptions, the researcher was not concerned with validating narratives of residents. The perceptions of all participants were

considered in relation to how they perceived their relationship with nursing staff and others (see Table 13 for Theme 7 and Related Subordinate Themes).

Table 13. Superordinate Theme 7 and Related Subordinate Themes.

Themes	Sample quotes from interviews
7. Actual and perceived relationships with nursing staff and others	
7.1 Perception of nurse care	“I love when a nurse comes up and hugs me and kisses me on the cheek.”
7.2 Perceptions of opportunity involving staff	“I try not to get overboard on the sexuality with the nurses, but . . . I’ve gone a little further with some of them than I have with others.”
7.3 Companionship and isolation.	“If it’s kinfolk, I like a hug from them. Otherwise I don’t really care for it, especially if it’s a man.”

7.1 Perception of Nurse Care

The majority of the resident participants perceived nursing care positively. For many of the resident participants, the decision to move into a nursing home was made because they could no longer care for themselves without difficulty. Although it was a transition for many to switch from independent living to a nursing care facility, most identified the received care as both necessary and enjoyable. Some even described a level of appreciation for the care received by the nursing staff. Care was identified as assistance with daily living tasks (e.g., help using the restroom, changing clothes, showering) and also described as intimate moments used to facilitate personal connection and tenderness (e.g., hug, embrace, kiss). Ginny exclaimed her appreciation for staff kindness:

I love when a nurse comes up and hugs me and kisses me on the cheek. I love that. I think I have done some good by other people when I was younger to deserve this treatment that I’m getting now, because I have seen people in the

nursing home – not particularly this one –but in a nursing home who don't even get a hug (Ginny, Lines 201–205).

Ginny perceived the care as platonic as well as something that should be embraced without worry or fear. She adds,

Not to be meaning anything but the nurses will walk up and kiss us on the cheek and say, “Good morning, Mister,” or “Good morning,” and walk and kiss you on the cheek and give you a hug—but they just go on. So I think that's good. That makes people feel like they are protected (Ginny, Lines 510–513).

She even found herself playing along with another staff member in a joking way when he kissed her:

I don't feel that except with my husband, but if Scott came up behind me and he kissed me on the back of the neck, I'd say ‘Scott, if I was about half your age, you better not try that trick,’ but I was teasing him, you know (Ginny, Lines 237–239).

Both Sally and Bonnie described a similar concept of care, in which staff attempt to express their care and concern for the residents. Sally explained, “There are some aides who are very—express love to us. One particularly . . . she, every morning she gives me a hug and a kiss and many of them do Harry that way, too” (Sally, Lines 691–693).

Jackson, too, described a tender kiss he received on a daily basis by a staff member. After the nurse changed his catheter and massaged his back and legs, Jackson explained, “She got all through and said, ‘Is there anything else I can do for you?’ and I said, ‘No,’ and [she] leaned over and gave me a kiss on the forehead, which was—I thought was very nice” (Jackson, Lines 597–589). Jackson too did not consider staff affection as sexual:

Yeah, and it's nothing sexual by any means, but just a sign that they do think about us that way, and I can't get over the number of people that are so sincerely trying to help us. It's not just an 8 to 5 job for them (Jackson, Lines 604–606).

Contrary to the positive experiences of other participants, Alma perceived the nurse staff as “doing their job” and even described one staff negatively with regard to his affectionate care:

I just—we had one guy that was in here who was an aide and he would always want to kiss you in the night when we would go to bed, and I resented that very much so I told him to stop it (Alma, Lines 250–252).

When asked how she felt about the experience, she clarified, “I just—I felt uncomfortable with it” (Alma, Line 264). She later explained how she reported the staff to the “main boss” and “he put a stop to it” (Alma, Line 268). Although angered by this one particular staff, Alma also ambivalently described other staff affections as part of their duty, “The only time they really want to hold your hand is when you don't feel good and give you—they let you know that they care” (Alma, Lines 338–339).

Participants varied in their response to specific experiences regarding staff affection; however, most perceived such involvements as a positive benefit included in the nursing home experience. Most were appreciative and humbled by the care received. The existence of other perceived experiences such as Alma's was also explored. Alma was in a wheelchair and her experience suggests other concerns, which are discussed in Chapter 6. Moreover, there were others who perceived staff care as an opportunity for an intimate experience beyond that of clinical affection.

7.2 Perception of Opportunity Involving Staff

Although not considered prior to data collection, the stories of three participants presented a theme surrounding the perception of opportunity involving staff and resident. As earlier mentioned, staff would frequently display affection with their residents making them feel “safe,” “protected,” “cared for,” and “loved”—in a platonic and clinical way. For those who perceived the care as sexual encounters, questions and conversations were used to comprehend the impact of nurse affection on the residents. All three participants reported confusion and frustration with nurse affection. George explained, “The trouble is that these nurses in here are flirty and all that, but that’s as far as you take it. It is frustrating.” When asked to elaborate, he clarified:

Well they kid around with me about sex and everything. Yeah. Some of them do. The other day I kissed one of them . . . on the cheek. Yeah, she’s real nice, you know. I don’t press myself on her. She enjoyed that, I think (George, Lines 584–604).

He later identified encounters of nurse affection he considered more than platonic, “We do (hug) a little of that, but not a lot” (George, Line 776), and “I try not to get overboard on the sexuality with the nurses, but . . . I’ve gone a little further with some of them than I have the others” (George, Lines 1980–1981). When asked if he perceived feelings were reciprocated, George explained,

Yeah, once in a while. There was one here that I’d got quite a ways with, but she left. She didn’t tell me she was going to go, and she was hugging and kissing me. She invited me to a patient party, I guessed as the two of us. We never did get there because she left (George, Lines 1989–2002).

George reported feeling distraught when the nurse left and reported there had been no other nurses who displayed that kind of affection.

Harry, too, shared a similar experience with a nurse at his nursing home. Harry described what would be considered a tender love story of a man who noticed a woman and a woman who noticed a man: “She was a beauty and we began to talk about things and we had just a special friendship and we could talk about things, say things that we wouldn’t” (Harry, Lines 301–303). Harry explained how Sally was aware of his feelings toward the nurse and they decided to present his feelings to the nurse:

I told Sally, ‘Sally, I’m about to let her know about how I feel, it’s a shame not to . . . it wouldn’t be right for me to have that feeling and her not know it.’ She said, ‘I think you’re right.’ So one day, the girl was pushing me to the dining room and got down to the corner and nobody was there and I said, ‘Honey, stop a moment.’ She came around, of course, good looking, and I said, ‘Honey, when you walked in that door the first time, I felt like you was the cutest thing west of the Mississippi’ (Harry, Lines 305–312).

After he disclosed his love for the nurse, both he and Sally went to the administrator. After the administrator heard the story, Harry explained how she had said, “That’s beautiful, if you don’t go any further and you told me everything” (Harry, Lines 314–315). Harry then described how he used to bury his face in the nurse’s hair. The administrator, according to Harry, changed her attitude and explained with concern:

‘Now, Harry, that is something else, we don’t allow that in between.’ So we had to back it down. We still got along with each other but it wasn’t long, she left. Boy

that hurt. Now that doesn't happen anymore, it's just the way it is (Harry, Lines 317–320).

Although he promised the administrator that he would stop, he explained, “We didn't stop, we just didn't let her [administrator] know it” (Harry, Line 382). When Harry was asked for a reaction to that experience, Harry exclaimed, “I was surprised at my age that I could still feel that way about women” (Harry, Line 325). When asked to describe what that feeling felt like, Harry clarified, “Warmth, excitement!” (Harry, Line 333). He later reflected with a smile on his face, “I still think of her movements. In many ways she reminded me of Sally when we were going together” (Harry, Lines 348–352).

Although Chuck did not report a specific experience with a member of the nursing staff, both he and George described a desire to be intimately involved with some of the nursing staff. They also perceived a possibility to engage in an intimate relationship. Chuck explained,

I know two or three girls (nursing staff) that have been married and they are in a divorce situation and they tell me they are not going to get married again and I can't believe that. But I still don't make out with them. In the first place, I can't get a hard-on (Chuck, Lines 704-706).

The perception of nurse affections was important to explore with consideration to how residents perceived opportunity for intimacy and relationship with staff. These three men each desired to be with female staff. Chuck reported that he often fantasized about kissing the women who worked at the nursing home. Chuck explained, “I dream sometimes that I make out with them [nurses], but I don't” (Chuck, Lines 627–628). He later clarified, “It isn't always the same person. It's who I was with last or close to last.

That's who it winds up being" (Chuck, Lines 644–645). Although not directly reported, both George and Harry implicitly suggested fantasizing about specific female staff. For both, specific intimate experiences with staff affirmed their fantasies and validated their existence as men.

When their perceived "affairs" with the female nursing staff ended, both George and Harry reported feelings of sadness and loss. Subsequent encounters with other female staff presented all three men with continuous rejection. As a result, these men felt invisible and experienced difficulty with their identity as men. Harry explained, "They [staff] don't pay attention to my body" (Harry, Line 732). George reported feelings of frustration and confusion with nurse affections and explained, "As far as I am concerned, I am just cut off" (George, Line 2152). The feeling of being "cut off" or isolated from the sexual self, others, and a future lover was also expressed in the narratives.

Nurses are trained to be both affectionate and provide medical care. Most choose to become nurses because of their need to help people. From these stories, their affection was greatly appreciated by the residents. Sometimes the level of nurse affection becomes blurred and boundaries are crossed (Campbell, Yonge, & Austin, 2005). It is important to address the ambiguity surrounding the confusion that was experienced by these men. It was unclear whether or not nurse affections were merely a misunderstanding. There are in fact, very few women in Chuck's nursing home and most nurses were female. Both George and Harry were also surrounded primarily by female nurses. These men could have been involved in a relationship with a staff member. When the relationships did not end well, the men experienced a great sense of sadness and heartache.

7.3 Companionship and Isolation

The nursing staff was not the only group of people in contact with the residents. Most resident participants identified friends and caregivers who were also part of their lives and visited them at the nursing home. For some participants, these connections fulfilled the desire to be intimate with another person. For Alma, she only felt comfortable with the touch and connection received from her family. Although Buddy reported many friends, most of them had died: “I’ve still got one friend. He’s a good old boy. He’s got a will to live, which is great” (Buddy, Lines 514–515). In many ways, both Alma and Buddy described a desire to be left alone, with the exception of a select few friends and loved ones—the isolation is, therefore, desired.

Chuck and George both reported feeling isolated from the community at large and the nursing staff who rejected their attempts of intimacy. Chuck explained, “I’ve got several friends [nursing staff] but that’s the end of it. Just friendship” (Chuck, Line 482). George also described a sense of isolation from intimate encounters that also involved a relationship he had with a female friend. He described a woman who was married and frequently visited him at the nursing home. Although he desired to be more than just friends with her, George explained, “She goes out of her way. Way out of her way to see about me. And she tries to do things that I can share in” (George, Lines 1431–1435). He later reflected, “She’s a nice person. Very nice. You can talk to her about anything. She’s too young for me” (George, Lines 1420–1423).

Perceptions of opportunity and friendship were explored. Friendship and family members were valued. For most participants, perceptions of nursing staff care and affections were considered positive, beneficial, and supportive. Those participants who regarded nursing affection positively described thoughts of safety, protection, support,

and platonic love. For the participants who perceived a resident-staff relationship as more than platonic, they shared thoughts of frustration, sadness, isolation, and invisibility when they acted on the desire, rather than leave it as fantasy.

Summary of Member Checks

Transcripts of individual interviews were mailed to each participant as member checks. Each transcript was sent with a self-addressed stamped envelope to the researcher's office. Participants were asked to review and comment on the transcript and to mail responses to the interviewer within two weeks of receipt. Although the researcher did not receive any responses back via mail, the researcher was able to make phone contact with nine out of ten participants. Nursing staff reported on the phone that Ginny was not feeling well and could not answer the phone. Alma reviewed the material and agreed to the transcript without reservation. She also reported that she was interested in the study, but that she wanted to keep the more personal details of her marriage private. She also reported that she was not affected negatively by the experience.

Harry, Sally, Bonnie, Clyde, and Buddy explained how they enjoyed the interview and agreed with all of the transcript and themes without modification. George and Chuck both explained the pleasure in participating in the interview and only added that they hoped their information helps others who are in similar situations. George explained that he was a little embarrassed to read his transcript but appreciated the opportunity to air his feelings about his erectile difficulties. Jackson explained that he was delighted to review his transcript and that his wife thought it was funny that he participated in a sex study. He reported no changes were necessary for the transcript.

Reflexivity and Interpretative Summary

A reflexive journal was used to document elements considered important and possibly related to the narratives. Reflexivity is the awareness that “all knowledge is affected by the social conditions under which it is produced; it is grounded in both the social location and the social biography of the observer and the observed” (Mann & Kelley, 1997, p. 392).

Excerpts from the reflexive journal were helpful in the interpretation of the findings. For example, privacy was seen as a major barrier for almost all participants. Each participant acknowledged limited privacy. It was apparent that privacy was indeed an issue during the interviews. Each time I interviewed the resident participants, the interview was interrupted—every single time. I interviewed each person sequentially. Each interview was interrupted at least once and some interviews were disrupted multiple times. The disruptions were distracting to some of the participants and for some, it appeared not to bother them. A few participants were also embarrassed by the disruptions and apologized repeatedly to the researcher. I cannot imagine how easy it would be to attempt to engage in any type of self-stimulation or foreplay with another person.

Beyond privacy, the narratives of these individuals convey a story of survival, humanity, and acceptance. The nursing home is a constant reminder of mortality—the wailing cries of other residents down the hall and the congested hallways full of human beings sitting in wheelchairs, some barely able to speak. One of the more existential challenges faced by nursing home residents is the experience of incredible loss. It is an inevitable truth that as a person ages, naturally they will experience loss. The nursing home only enhances such an experience. The loss each resident in this study had experienced is tremendous. Friends, lovers, and some of their children had died. Some

chose isolation, given up on other intimate relationships, and chose to live out their final days in the confines of the nursing home. Others desired to be connected intimately to another person again.

The stories of those who yearned for love and intimacy appeared disenfranchised in their attempts to pursue a love they believed appropriate. Harry's fondness for the nurse was met with mocking sweetness until he later revealed his desire to bury his face in the woman's hair. The administrator then treated him as if he had done something wrong. Regardless of the reality of the nursing home environment, some perceived staff care as therapeutic and others perceived staff behavior (kisses, hugs, and sweet words) as intimate opportunities. Although it is unclear how nurse behavior is actually presented with residents, almost every single resident in this study has been kissed (on the cheek, forehead, and on the back of the neck) and hugged by staff—even those in relationships.

The five participants who were married each had a unique perspective of life after transitioning into the nursing home. Sally and Harry both desired to be in a single bed together, and yet medical conditions prevented them from doing so. Additionally, it was Harry who was involved in a romantic relationship with the nurse. Although Sally was apprised of the situation (as reported by Harry), what did she think of their relationship? After decades of marriage, could it be that the couple celebrated Harry's newfound attraction instead of meeting it with jealousy? Although there was no doubt they still desired to be with one another, Sally brings up a point that was not considered. What is it like to live in such a small room with your partner?

Two couples lived together. The rooms were typically crowded with dressers and trunks full of what remained of a person's lifetime. Sally expressed a need to be separate

from Harry, even for just a few days. Prior to moving in, they were together but not always in the same room. Although Bonnie did not need to move in to the nursing home, she did so in order to be closer to her husband. They did not need a single bed, they simply needed to be in the same room. Bonnie chose her husband, perhaps for the very same reason why Jackson yearns to die at the same time as his wife. They could not live without each other. Jackson spoke in great detail regarding his distress over who was going to die first.

My own position in this study potentially influenced how they perceived their current sexual health and state of mind. During my time at the nursing homes, a couple of the participants identified me as attractive. One day, a man in a wheelchair (who was not in the study) in the hallway grabbed my hand as I was walking toward him and motioned with his hand for me to come closer. He then told me that I was beautiful and that he loved me. I saw the loneliness and desperation in those nursing homes. For those who desired to be with another woman, it would appear to be a most foreboding task, and yet, desire was still present. Although there were considerable barriers (environment, privacy, and opportunity) regarding intimacy, much of the negative responses made by the participants dealt with the inner thoughts of the individual residents themselves, and how they perceived opportunity. Some may ascribe to ageist and sexist thinking. It was evidenced to some degree in comments like, “they’re old and ugly,” “I’m too old,” “she’s too young for me,” and “I’m 91!”

Each of these residents shared so unapologetically and courageously with me. I tried to conceptualize exactly how to describe the story of the resident participants. Each person was so unique. Their experiences and interests in sexual expression were vastly

different, yet they each shared a common experience of living in a nursing home. I attempted to capture the essence of their lives honestly and respectfully with each description and connecting quotes.

Summary of Research Findings

Chapter 4 presented the data discovered using the qualitative IPA in order to comprehend the older adult resident experience and their perception of desire, intimacy, sexual attraction, opportunity, and barriers. Ten resident participants – six men and four women – who resided in nursing homes were interviewed to better understand the older adult resident sexual experience. Through the interviews, seven themes and their superordinate clusters or themes were identified: (1) demographic differences related to sexual interest, (2) gender differences and marriage, (3) actual and perceived beliefs of self, (4) updating the sexual script, (5) affordances to sexual expression, (6) barriers to sexual expression, and (7) actual and perceived relationships with nursing staff and others. The following chapter (5) discusses the findings related to the nursing staff participants. Chapter 6 discusses the findings related to literature, future research, and implications for practice.

Chapter 5

Nursing Staff Perspectives

For the purpose of this study, it was important to assess how nursing staff perceived opportunity and access for nursing home residents to engage in sexual expression. It was, moreover, helpful to identify any relative policies and procedures in place that would promote or inhibit sexual expression from occurring. This analysis includes a careful phenomenologically deductive exploration of staff participant interviews. The purpose of these interviews was to explore the beliefs and actions of the staff who work with the residents. This resulted in a summary of suggested practice for nursing homes and nursing home staff.

Data from the staff were sparse due to an unwillingness to participate or because there was not an opportune time to meet. Staff were asked from each nursing home to participate in a focus group. Although the researcher attempted to present this study on several occasions, lack of staff interest was evident. Many staff members during the introductory presentations reported that they were not available during work hours or after work. One from the first nursing home volunteered to answer questions during his smoke break. The second nursing home yielded three staff members, after two failed attempts to conduct a larger focus group during staffing time.

This resulted in an individual interview with one staff member at the first nursing home, Nursing Home A, and a full focus group of three staff participants at the second nursing home, Nursing Home B. A short account of demographics was obtained from each nursing home (see Table 14).

Table 14. Nursing Home Site Information

	Nursing Home A	Nursing Home B
Beds Occupancy (%)	68 beds/73 beds (85% capacity)	200/200 beds (100% capacity) 18 mos. to 2 year waiting list
State Licensed	Yes	Yes
Type of Ownership	Private For-Profit	Federally Funded
Certified Medicaid Provider	Yes	No
Room availability	Private/Semi-private Rooms	Private/Semi-Private Rooms
Staffing and Services (MO avg. of 1.25 hours per resident per day)*	0.85 Less than Average	1.5

*A low number of staff hours per resident per day may indicate less attention to residents.

In this chapter, narratives of nursing staff participants are explored to further elucidate from another perspective, the stories of the resident participants.

Staff Participant Profiles

Nicholas was a 26-year-old, African American man. He has worked as an RN for the past five years and reported enjoying his job. He worked at Nursing Home A.

Shannon was a 38-year-old Caucasian woman. She was one of the four clinical caseworkers at her nursing home. She has worked there for the past seven years. She also was in charge of coordinating community programs and outreach for residents.

Shannon's coordinator position also included coordinating special events and activities for nursing home residents and identifying specific services for individual residents. This

included extending services for an outing to the adult entertainment club for interested residents. She worked at Nursing Home B.

Meghan was a 56-year-old Caucasian female. She was a RN coordinator and has worked in nursing homes for almost 40 years. She worked at Nursing Home B.

Ariel was a 25-year-old Caucasian woman. She was a RN unit manager and has worked for the nursing home for the past three years, but has worked in a nursing home setting for the past six years. She worked at Nursing Home B.

Staff Superordinate Themes

Originally, the focus groups were intended to last approximately 45 to 60 minutes; however, staff participants were unable to step away from their clinical duties for that long. Instead, the individual interview took place during the participant's smoking break and lasted approximately ten minutes. The focus group lasted approximately 15 to 20 minutes. Due to the limited time, the researcher was restricted to ask questions in a more structured way. From their four narratives, eight themes emerged that expand upon the narratives of the resident experience.

Theme 1 described the presence and implementation of policies regarding sexual expression. Theme 2 explored the level of training and education staff received at the nursing home regarding sexual expression. Theme 3 identified perceptions of staff support. Theme 4 centered on social opportunities. Theme 5 centered on staff perceptions of touch and resident sexual expression. Theme 6 emerged as a result of narrative discussions surrounding staff perception of perceived inappropriate sexual behavior. Theme 7 focused on family influence, as perceived by staff participants. Theme 8 involved reflections of staff as sexual beings (see Table 15 for master superordinate themes with Related Subordinate Themes).

Table 15. Nursing Staff Master Superordinate Themes and a Comparison Chart of the Two Nursing Homes.

Themes	Nursing Home A	Nursing Home B
1. Healthy sexuality as a philosophy versus overt policy	<ul style="list-style-type: none"> No covert policy language on healthy sexual expression 	<ul style="list-style-type: none"> Philosophy embedded within the honor to respect the dignity and privacy of residents
2. Staff training as a critical necessity	<ul style="list-style-type: none"> Overt policy on sexually inappropriate behavior 	<ul style="list-style-type: none"> Overt policy on sexually inappropriate behavior
3. Presence of staff support	<ul style="list-style-type: none"> No training 	<ul style="list-style-type: none"> Training on sexual expression – focus on sexually inappropriate behavior
4. Social opportunities and institutional support	<ul style="list-style-type: none"> Two social events for residents to meet and mingle 	<ul style="list-style-type: none"> Several events for residents to meet and mingle
5. Staff perceptions of touch and resident sexual expression	<ul style="list-style-type: none"> No resources made available to residents upon request 	<ul style="list-style-type: none"> Materials made available upon request (e.g. pornographic magazines, calendars, books, dvds, and bus tickets to go to the adult entertainment club)
6. Staff perception of perceived sexual disinhibition		
7. Resident family support		
8. Reflections of self as a sexual being		

1. Healthy Sexuality as a Philosophy versus Overt Policy

Although the researcher requested a policy manual from both Nursing Home A and Nursing Home B, both declined to provide manual. Due to the lack of this artifact, the researcher requested staff to expound on whether specific policies existed with regard to sexual expression. Both staff from Nursing Home A and Nursing Home B described a policy on any type of inappropriate sexual behavior by residents. Shannon from Nursing Home B explained that, although there was a policy on inappropriate sexual behavior, the goal of the policy was to not discipline the resident, but to establish a treatment plan for the resident, and to identify reasons for the sexual aggression. Shannon reported never

knowing anyone who was discharged from the nursing home as a result of inappropriate sexual behavior: “Most of the time we are able to identify reasons for the behavior and we attempt to alleviate the symptoms” (Shannon, Lines 52–53). From this short disclosure, it is noted that staff take the time to investigate complaints and interview reported residents to assess reasons for behavior. This suggests a systemic level of communication where staff and residents work together to address a problem.

Staff from Nursing Home B described policies that covertly covered positive sexual expression by means of honoring privacy, dignity, and autonomy of residents. Shannon emphasized the importance of addressing the basic human needs of each resident, including their sexuality. Although policies were not provided to the researcher, it was made clear by the staff participants in Nursing Home B that training on the topic of sexual expression existed and were practiced by staff. Training and protocol were not reported as tools afforded to Nursing Home A. Nicholas described a need for policies that accurately reflect the needs of the residents regardless of healthy or unhealthy sexual behavior.

2. Staff Training as a Critical Necessity

Literature suggests training is an important component to positive staff attitudes towards resident sexual expression. Conversations and questions in interviews focused on the presence and participation in staff training on resident sexual expression. Nicholas simply stated, “No.” There were no trainings that he received on sexual expression during his time at the nursing home, whether it be how to deal with either negative or positive sexual expression exhibited by residents. He, however, clarified:

Well I think that everybody [staff] is a little ignorant on how much, how much—
how many different avenues there are to sexual expression. Okay—so with their

ignorance comes a lack of appreciation for everybody's needs. So, if we don't know what you need, we don't even know how to help you get that need and we need education (Nicholas, Lines 42–45).

Nicholas' plea for education is indicative of staff beliefs in Nursing Home A, "We need education." From this excerpt ignorance is addressed as a reason for not understanding unique expressions of sexuality presented by nursing home residents. Moreover, because a lack of education exists in Nursing Home A, according to Nicholas, staff lack the ability to appreciate individual sexual needs of residents.

Contrary to Nicholas's experience, Shannon described trainings for both staff and residents at Nursing Home B. She explained, "We have provided an in-service for all of our staff to understand intimacy in the elderly" (Shannon, Lines 51–52). When asked to elaborate on specifically what was taught during the training, Shannon explained:

A lot of times we document sexually inappropriate—because they grab a staff member's behind or different things that you would consider not appropriate because I am not interested in having my behind grabbed, but that there is more meaning to that. That they are maybe—because they are lacking with some intimacy. And then we talked a lot about facts that are out there that just because we age that does not mean we don't still have those desires (Shannon, Lines 52–57).

From this narrative, Shannon described a need for training to educate staff on inappropriate sexual behaviors and the reasons why residents may present such behaviors. She also addressed how staff are trained to positively navigate potential issues with sexual behavior (such as grabbing of the nurse's behind).

Training on Healthy Sexual Expression

Regarding positive sexuality and training, Shannon explained how staff is also trained to address healthy sexual expressions: “Things change with our physical bodies and their ability to perform different acts or just the way our bodies are made but we can still have those feelings of wanting to be intimate and it can’t just be because we all need attention. We are human” (Shannon, Lines 58-61). This extract describes a contradiction with perhaps how staff feel initially when presented with aging sexual expression. The idea of “it can’t be because we all need attention” suggests that staff may tend to believe attention to be the primary reason for a resident’s need to be close and intimately connected with someone. Ariel described her biggest benefit from training as she told a story about a romance that occurred at the nursing home and that needed to be monitored due to the cognitive state of the two residents involved:

We did have one romance and a man and a wife had moved in here and the husband passed away and the wife had it in her head that another neighbor was her husband and we didn’t encourage it but we didn’t discourage it. They were both dementia. They both wanted that intimacy. Nothing inappropriate happened, but they would sit beside each other and just hold hands while they watched TV or whatever, and we alerted both of the families and let them know this was happening, and both families were okay with it. They said, “She lost our dad and she still needs that little bit of intimacy.” It was never inappropriate. They never did anything that crossed a line, but just to be able to hold hands while they watched TV or sit beside each other when they ate. There was the touch. There was that kind of thing but it was never inappropriate and we kept an eye on them

so that it didn't cross a line, but we made sure the families were aware and, in their demented state, to them, this was something that they had a connection with and they cared about, so the families were okay with that as well (Ariel, Lines 110–121).

From this large text, several important concepts are presented. By repeatedly addressing how the individuals were “never inappropriate” suggests that the training involved specific details on what is considered appropriate or not when residents with dementia are involved. It was not explained however what “crossing a line” meant to Ariel or to any of the staff in the room. In this excerpt it is clear that Ariel as a staff member was trained to address “inappropriate” behavior and to be mindful of any seemingly dangerous acts. Protocol is also presented in this excerpt as Ariel described her obligation to maintain communication with family members. From this excerpt again, it is important to identify a restriction for the couple to freely engage in a romantic relationship. Appropriate behaviors were identified as hand holding and sitting next to each other.

In summary, this theme illuminates the affordances of having specific training on aging sexual expression. Although it appears Nursing Home B staff were trained to focus on assessing for sexually inappropriate behaviors, the education and training they received allowed for staff to identify normal sexual behaviors as well. Nicholas believed staff were more inclined to judge resident sexual expression because they had not had specific training on healthy aging sexuality. A need for more specific policies on sexual expression were reported by all staff. Dementia was reported as a concern for both nursing homes; however, from the romance story described above, those in Nursing

Home B were trained to approach the sexual needs of those with dementia in a positive and respectful way that encouraged self-expression and dignity.

3. Presence of Staff Support

It was important to understand how staff participants perceived their position in relation to supporting the intimate needs of residents. Nicholas described ways in which his peers supported resident sexual expression. Nicholas clarified,

Okay we have cultural things, like, if there's a man and a woman who want to be together, like, we've got people who met here, they didn't know each other and one really can't even speak and the other one just loves her to death, so whenever we can we get them together in the hallway so they can have a conversation or even in their rooms. Things like that (Nicholas, Lines 21–25).

Nicholas considered it his duty as a nurse to uphold the value system of the residents he served. From this excerpt, Nicholas suggests that residents are not allowed to be alone together in each other's rooms, and therefore, staff support residents by facilitating social events for residents to meet in the hallway. Other participants were asked to expand on how they perceived staff support. Shannon explained again how the in-service truly helped her understand the diverse needs of the residents she serves and how to support them better:

So yeah, our in-service has just really went over a lot of new information that is out there that helped us broaden our thoughts when we see our loved ones come in our home. And I think the last thing I will say to that is during our XXX-centered care moment with new employees, we talk about how important it is that if we see a resident and their spouse holding hands—whatever their loved one is holding hands or even kissing, that in your head you can think of how sweet and

how cute but not to voice that. If you do, say, ‘Oh, you all make such a wonderful couple. How many years has it been?’ To go with it that way versus making it feel as though they are old and still showing affection—that it’s different or to make fun of because to them it’s just as any of us. We show love for much more years—many more years than we have (Shannon, Lines 65-73).

The in-service training at Nursing Home B provided staff information on how to approach couples in a respectful and dignified way. From Shannon’s quote, we gain a deeper understanding of how staff in the past have treated residents who expressed love for each other. Mocking and joking in this manner suggests residents are seen as “other than” and not seen as adults or human beings with sexual and intimate needs. This type of supportive training, is therefore, especially helpful to those residents who wish to express their intimate needs publicly. Jackson resided in Nursing Home B. He described numerous times in his interview how staff would admiringly comment on his relationship with his wife. This narrative also suggests the existence of such positive behaviors by staff in the past. The training presented an opportunity for staff to recognize the importance of honoring the residents as human beings instead of mocking their displays of affection with playful terms of endearment.

Shannon also identified how staff have supported residents’ needs by providing them with resources to celebrate their sexual desires. “We have helped get subscriptions [*Playboy* magazines and videos] when they have asked” (Shannon, Line 191). She further explained,

That is their right and that privacy, too, is important for all of us here and to respect others’ wishes. So we try. Just kind of like maybe thinking in your own

home, if you had your children and that is something you chose to do with your loved one. It would not have been out in the open for my own children to view. So, it's kind of something similar. I think that we approach them with and say 'Yes, please, have all the material you want. It's all yours, but with respect to others around.' (Shannon, Lines 213–218)

Nursing homes are occupied by a variety of individuals with unique cultural belief systems. Shannon identified both a need to celebrate one's sexual health and, at the same time, respect the other residents in the nursing home community. Magazines, calendars, videos, and so on were made available to residents and, at the same time, residents were asked to use discretion for the sake of the community. Meghan suggested a similar concept of assistance and respect for others in the nursing home.

We will assist them in getting the things started or whatever, but they also have a responsibility as far as keeping it in their own room. Their own side of the room. They have to keep their curtain pulled unless their mate so desires to partake. They have to have their door closed. If they want to display something on their wall that is prominent—a photo of some sort—it has to be placed on a wall where it is not visible from a hallway so if family members with children are visiting, they couldn't see those types of pictures on the wall and, so far, they have been receptive to that. The ones who do choose to do those things (Meghan, Lines 205–211).

The staff who participated in this study identified an obligation to assist residents with their sexual needs. Training was also identified as a tool kit for staff to learn how to be more supportive of the sexual needs presented by residents. Every participant

described how residents must be supported with regard to their sexual needs and sexual expression. Support also seemed to both assist those who desired to meet their sexual needs and to also maintain the dignity and respect of other residents, whether in the room or in the nursing home. As a result, the resident community is supported when most people are protected and individual rights are honored.

4. Social Opportunities and Institutional Support

Staff participants were asked to describe presence of social opportunities afforded to residents. Shannon explained, “There are no limitations to positive healthy sexual expression. We aim to serve the needs of our residents and that includes honoring them as sexual beings” (Shannon, Lines 14-15). This excerpt reveals a progressive stance toward aging sexuality and yet in the following quote, healthy sexual expression is explained with limitations when Meghan clarified a specific policy regarding cohabitation, “We allow for married individuals to share a room” (Meghan, Line 19).

This short but powerful remark suggests that cohabitation in this particular nursing home is specific to married heterosexual couples only. Reason for this observation is made because in the state this study took place, same-sex couples were not allowed to marry. Although non-married couples could not cohabit, heterosexual or same-sex could cohabit, Meghan described a guest room for loved ones in the community who could stay and visit their resident:

Overnight—yeah an overnight room and it’s considered our guest room, very similar to a motel room and we do have at least one neighbor, possibly more, that has a friend of the opposite sex who comes to visit him and they spent the night in that room together (Meghan, Lines 27–29).

Again this excerpt illuminates an environmental tone suggesting two loved ones could “visit” in a temporary, motel-like setting, where one would check-in and check-out after a brief rendezvous.

When asked if the overnight room was only for heterosexual married couples, both Meghan and Shannon clarified, “No, so long as they are consenting adults” (Meghan, Line 33). This was the first time relationships outside of marriage were presented in a positive way. The overnight room was offered to any one resident and another person to be together, regardless of orientation or marital status. Based on the quote above, it is also important to address that individuals with diminished cognitive capacity are the only group of people not allowed to utilize the overnight room, regardless of purpose (whether it be sexual or to simply sleep next to a spouse who does not reside at the home).

When asked if the nursing home provided social engagements for nursing home residents to meet and be intimate, Nicholas explained,

No. Never. I’ve never seen it. We have a Valentine’s Day party, we have a crown the king and the queen of Valentine’s Day and crown the queen of the state fair. We did that this year, so we have those kinds of things, but it’s only twice a year (Nicholas, Lines 143–145).

Nicholas’s report of activities goes along with the stories of George, Harry, and Sally, who also described limited opportunities for social and intimate engagement in the nursing home. Shannon, Meghan, and Ariel reported several affordances sponsored by the nursing home, including Internet and limited restrictions on personal items deemed for sexual purposes. Meghan explained, “We have some that have Internet access and

they go to sites that are quite shocking at times. It's something that they want and they need. They had had—I call them the girlie calendars” (Meghan, Lines 183–185).

Other opportunities to socialize in an intimate way included the prospect of connecting residents with the local adult entertainment club.

There was one individual, because he was a frequent at those years ago, he just kind of started talking about it and thought would it be a possibility. Not that it's not a possibility, but we have opened it up and expressed that we will help. We do provide free tickets with our OATS transportation (Shannon, Lines 223–226).

Although Shannon suggested no one had taken the opportunity, Nursing Home B continues to inform residents of the activity. Ariel also described other opportunities for private socialization in Nursing Home B:

We have these spaces for privacy and how important it is to know that this is how residents can use this space and they can use it for two full hours or they can have the space overnight. And give examples of who can stay and who would maybe want to stay in this room or whatever. And they are receptive to it and it gets used, but probably not as often as we would think (Ariel, Lines 260–263).

Meghan also identified a specific couple who were encouraged and supported by the nursing home and nursing staff,

We had one couple and we loved them to pieces. They were an older Polish couple and we called them papa and mama but, about once every six or eight months, papa would ask the nurses to push their beds together because they had twins and he would smile and say, ‘Papa going to get lucky tonight.’ They would share some intimate times. It only happened like once every eight months or so,

but they still had that and they were in their 90s. They were 90. We would push their beds together (Meghan, Lines 311–316).

From the interviews, Nursing Home A offered less social opportunities to residents than Nursing Home B. Nicholas considered the nursing home responsible for creating opportunities for residents to engage in social activities and to assist the sexual needs of all residents. Nursing Home B described a variety of social affordances provided to nursing home residents. Both groups were questioned as to whether more social engagements could be offered and both described a need to continue to increase opportunities for staff to engage other residents.

5. Staff Perception of Touch and Resident Sexual Expression

Although policies and trainings were explored, it was equally important to identify personal attitudes toward resident sexual expression. Shannon reported how it was their (residents') right to express themselves in a way that connected them to their humanity and to recognize how changes in the body and age did not solidify a person's sexual identity:

Things change with our physical bodies and their ability to perform different acts or just the way our bodies are made; but we can still have those feelings of wanting to be intimate and it can just be because we all need attention. We are human. And just a touch of an arm. Just lying next to someone, when we mentioned that there are family members that utilize that room—these wives, many of them say, “Well he hasn't been able to—things like that—for years,” but it doesn't matter to them. That touch, just lying and spooning is what they are interested in because they don't feel a connection if they don't get that (Shannon, Lines 58–65).

The most powerful words from this excerpt were, “It can just be because we all need attention.” Behaviors that might be considered sexually suggestive in the nursing homes need to be evaluated from a humanistic perspective. From Shannon’s story, she, too, perceived the need for human beings, regardless of age, to be connected to each other.

Nicholas shared similar thoughts regarding the power of touch:

I personally know that to give a hug for 20 seconds or something like, that you release oxytocin. Oxytocin creates this feeling of being wanted—well-being—of being needed and being wanted. Those things all add to your quality of life (Nicholas, Lines 83–86).

Nicholas’s account of the power of touch can be found in the literature. Hertenstein, Verkamp, Kerestes, and Holmes (2006) found tactile stimulation played an integral role in attachment, intimacy, connection, and emotional communication. Hertenstein et al. (2006) suggested a mere 20 seconds was sufficient to decrease blood pressure, pulse, and increase a sense of connection with the other human being.

When questioned about how he perceived residents and their willingness to connect with one another, Nicholas described a distrusting dilemma for the women and men in the nursing home. He believed residents were fearful of being intimate with one another. “I think they are scared to touch each other” (Nicholas, Line 103). When asked to elaborate, Nicholas clarified:

They don’t want people to think of them—with the older ladies, they don’t want to be whores. They don’t want to be floozies. They don’t want to be all these things. And then you got the men who are, like, “Well I just want to hold your

hand,” and they are, like, “No. No. I don’t want to be affiliated with you like that.” (Nicholas, Lines 107–110)

When asked if he felt differences were present among those identified as women and those identified as men, Nicholas stated, “Well, the men want intercourse. And the women want companionship. Okay? So there is a huge difference. So if the man wants to hold your hand, then that means the woman feels like she has to give him sex” (Nicholas, Lines 118–124). This excerpt speaks to the generational attitude of the resident community. Most nursing homes are occupied by individuals 65 years of age and older. The portrayal of resident suspicion presented by Nicholas strengthens the rationale for educating and training both staff and residents on aging sexuality in the nursing home.

All staff participants described a need for touch and identified education as the key variable in how they perceived the power of touch. Moreover, participants identified differences in how individual residents perceive sexual desire and intimacy. The interesting perspectives of these staff participants illuminate the importance of their position as caregivers. They recognized sexual expression to be a resident right and a human necessity. Touch was considered to have healing powers, as Montagu (1986) asserted decades ago. Although touch was reported as important by staff, they also identified a state of resident reluctance to connect with each other. This was suggested to be due to a fear of sexual expectation by the male residents as perceived by the women. Education to staff and residents on healthy sexual expression and courting would be greatly beneficial in this case for all parties involved.

6. Staff Perception of Perceived Sexual Disinhibition

Perceptions of sexual disinhibition or inappropriate sexual behavior among older adult residents also emerged as a result of these interviews. In order to explore sexuality,

it appeared relevant to identify both positive and negative perceptions of sexual expression. From the narratives, Nicholas suggested approximately “60% of our residents don’t remember a conversation for 5 minutes” (Nicholas, Lines 132–133), and identified a need to educate residents as a reaction to how some residents have attempted to communicate their sexual needs inappropriately:

I’ve had a lot of inappropriate behavior because of lack of or inability to express sexual needs from residents. Like, say you’ve got a resident that’s 70 years old that was molested when they were a kid, and they will talk about it and that causes some deviant behavior. ‘Like, like, hey, I will take care of you and I will buy you a house,’ and do this and do that. And of course, they can’t do any of those things, but this is what they have done in the past to do what they needed to (Nicholas, Lines 71–75).

Nicholas’s account of inappropriate sexual behavior illuminates the unique stories of the residents as people with their own perfectly imperfect story. Specifically, he suggests that residents who may have experienced trauma as a kid might attempt to “buy” affection from the others. Although it was confusing when he suggested that talking about a molestation antagonized the person to act out in a deviant way, it may be surmised from his story that some people who have had trauma in their background know only how to emotionally connect to others through manipulation and deceit. In these cases, Nicholas stressed again the importance of educating staff on how to manage sexual behaviors, deviant or otherwise.

Meghan described how deviant behavior may be treated in the nursing home.

If it was not consensual or we (then) have had traumatic brain injury or whatever their issue might be and they are not making appropriate choices in things that they do and how they interact with the staff or whatever—then it becomes a medical issue or psychiatric issue and we would send them out to get treatment, but we would not dismiss them completely (Meghan, Lines 282–285).

From her description, it is suggested that informed consent is the most critical component for staff to assess when dealing with resident sexual behavior. In cases where informed consent appears questionable due to a medical or psychiatric issue, the individual is treated rather than discharged from the nursing home.

All staff expressed concern for the possibility of sexual disinhibition, as a nursing home offers a unique setting where many people reside in closed quarters. Participants also explained how staff and the nursing home have assisted individual cases but also clarified how important it was to examine the reason for inappropriate sexual behavior, and to hopefully identify how to alleviate the symptoms.

7. Resident Family Support

Some staff participants described the role family plays in resident sexual expression. Questions were asked to elaborate on how family influenced whether residents expressed themselves sexually or not. The transition from family member to caregiver can be quite an arduous task for loved ones and the family resident. It may be especially difficult for family members to watch their fathers or mothers engage in intimate relationships with people of the opposite sex or otherwise.

When asked whether it mattered if both parties were high functioning and able to consent, Ariel explained, “If they [residents] are the responsible party and they (family) don’t agree, then legally we have to do it” (Ariel, Line 142). Shannon suggested,

“Sometimes family steps in and says, ‘Uh huh,’ and then we have to relocate another resident or something. Those things have happened” (Shannon, Lines 136–138). She later elaborated, “They [family] just don’t comprehend the fact that we can change, too, with our desires or maybe we have repressed them” (Shannon, Lines 153–154). Shannon identified education as the key component to alleviating the stress of the caregiver and resident during these times. “We have to provide education” (Shannon, Line 151–152). From Shannon’s story, the nursing home staff play an integral part in the communication between resident and family members, especially in cases of sexual acts.

Shannon was asked how family members would feel about social opportunities for residents to engage in intimate encounters such as the adult entertainment club, she explained:

Again it was just one resident that kind of suggested or kind of thought and we said, “Heck yes.” His family is aware. His family has taken him, so he is getting that. That is our role, is to be able to support whatever it is that they want. Just as—you talk about intimacy and things that can be hard to really work with the resident or have staff members there with him—but we always have family that will come to help out (Shannon, Lines 236–241).

Earlier addressed, family members were not always supportive of their family residents and their sexual needs; however, as Shannon explained, there are some family members who are supportive and proactive in the pursuit of facilitating the sexual needs of their family resident members.

When asked whether staff agreed with how policies and procedures managed family members and resident sexual expression, Shannon explained, “99% of the time,

and it's because we've had this training and because, if they have a question, they are going to their supervisor and saying, 'What should I do?' if they are not quite sure" (Shannon, Lines 126–128). She then clarified specific situations where conflict in procedure resulted in further training:

We have also had situations, not just of opposite gender connections, but the same gender. Connections that you have to tread lightly on, not only because if there is not dementia playing a role in it or if it's just early stages of dementia. So they really can relay to you that they know what is transpiring, that they are both welcoming the expression and because, if they are not their own responsible party, we legally have to inform family of this and sometimes a family struggles with that. Because maybe they were in an opposite sex relationship prior. Or maybe it's because they have known of something that has transpired and it is painful. We still make sure that both parties are welcoming and then we do our best to just say, 'They continue to want to be together.' (Shannon, Lines 128–136)

Shannon's story depicts once again the complexity of managing such a diverse group of people with varying degrees of cognitive functioning, their families, and caregivers.

From these excerpts, it can be seen that not only are family members in control of a resident's finances and spokesperson for the resident, but also they have the power to control the resident's intimate life. Family members have the ability to approve or deny relationships that occur in the nursing home. If they believe it to be inappropriate, or "out of character," then they have the power to end the opportunity by means of relocating the resident from one hall to another, or completely relocating the resident to a different facility. Although family members were not involved in this study, it was informative to

hear of both positive and negative reactions to resident sexual expression, as presented by family members.

8. Reflection of Themselves as Sexual Beings

Although unintentional, a theme emerged as a result of these interviews that related to how staff participants perceived themselves as older sexual beings. Most of them were young but many reflected on their future as an older sexual being. Nicholas explained,

Like to me, even having a conversation with a woman is sexually fulfilling.

Period. So when a guy gets that or when a woman gets that from a guy, it doesn't matter the age gap. It doesn't matter. As long as there is the interaction, it is fulfilled. Then it is fulfilled (Nicholas, Lines 54–57).

Nicholas identified the sensual act of conversation as sexually fulfilling—something he perceived to occur regardless of age and time. “As long as there is the interaction, it is fulfilled” (Nicholas, Line 56).

Meghan identified how she perceived herself as a sexual being and whether her children viewed her as a sexual being:

Quite frankly, I am getting older and so I am understanding it a lot more because my kids are all grown and I have the whole empty nest thing and it's my husband and I reconnecting after years of being too busy, so I kind of get it now. My kids are, 'Gross my parents are kissing. How sick is that' (Meghan, Lines 85–88).

Meghan further elaborated,

'They are almost in their 60s. That's gross.' But yeah, it doesn't change. The way you feel doesn't change and I can imagine that when I am in my 90s, I am still

going to think he is pretty hot stuff. So yeah. I get it. The older I get, the more I get it (Meghan, Lines 92-94).

Children tend to have a difficult time thinking of their parents as a sexual beings. A mere kiss or embrace could send children gagging in discomfort similar to the experience of Meghan. Meghan, however, did not consider herself to be asexual. More importantly, she conveyed an expression of excitement regarding her new-found reconnection with her husband as a result of the empty nest. As she described, she now understood what it was like to be on the other side of the lifespan with regard to how younger individuals perceived her as a sexual being or not.

Shannon also agreed with Meghan's perceptions of age and sexuality as she described how she felt towards her parents:

I think I am at an age too where I am getting that also because I remember the feelings with my parents, and going, 'Do they still do that?' And really truly, I can't imagine that they really. So, then as I get older and my children are growing and getting older, I think, 'Yeah, that's just a part of keeping that connection and the intimacy and making sure that you continue to want to do things together.' I love hearing these residents and their stories about the fun things they did prior to having children and then the travel (Shannon, Lines 96-103).

When discussing sexual desires and age, it might be expected that one would gradually reflect on his or her own mortality in relation to what may be one day considered "too old," specifically when the discussion focused on sexual expression. Each staff participant identified a desire to be considered a sexual being across his or her

lifespan and some even identified the irony in how they originally perceived their own parents and grandparents as sexual beings.

Interpretative Summary

It is important to address how difficult it was to bring together a sufficient number of staff participants for the focus groups. The study was presented several times to the staff at each nursing home. When handed the brochure for the study, many staff giggled, but most claimed they were too busy. It is likely that reluctance to participate indicates discomfort with the topic. These few sparse voices may not represent the general staff positions, but do give some insight and voice to this hard-to-research area of inquiry. Although small in sample, these staff are inspiring and the programs set in place at Nursing Home B are progressive in comparison to many nursing home settings, as evidenced by the social outings to the adult club and the private room, for example.

From their stories, it is apparent how much these individuals care about their residents and their quality of life. They addressed how important it was to see residents as human beings, as sexual beings in need of love and human connection. Their resounding message of humanity and passion for their residents is presented throughout this chapter. For some, they were able to identify their own mortality and reflect on how their sexuality is or one day would be scrutinized because of their age and future status as a resident.

Summary of Research Findings

Chapter 5 presented the data that was revealed using a qualitative interpretative phenomenological analysis in order to illuminate the older adult resident experience and staff perceptions of opportunity, attitude, staff support, training, and policies surrounding resident sexual expression. Four staff participants, one man and three women, who

worked at two different nursing homes were interviewed to better understand the older adult resident sexual experience. Through the interviews, eight themes were identified and explored including, (1) healthy sexuality as a philosophy versus overt policy, (2) staff training as a critical necessity, (3) presence of staff support, (4) social opportunities and institutional support, (5) staff perceptions of touch and resident sexual expression, (6) staff perception of perceived sexual disinhibition, (7) resident family support, and (8) reflections of self as a sexual being.

From these themes it is clear that a disparity in reports of experience exists between staff and residents. Those differences and similarities will be discussed in Chapter 6 along with a discussion of how the data informed each of the research questions in this study. Chapter 6 will also discuss the findings related to the research literature, future research, and describe implications for future practice.

Chapter 6

Discussion

Summary of the Study

The design of this qualitative study involved both phenomenology and interpretative phenomenological analysis. As there is little research on the specific voices of nursing home residents, I wanted to create a platform for those voices to be heard. I used the stories of nursing home residents as a way to construct themselves through the act of storytelling. The essence of their experiences as a sexual being were analyzed using IPA. I also included themes developed from narratives of four nursing home staff to describe opportunity for residents to participate in sexual engagement, to define policies and practices that existed in each nursing home, and to explain whether those policies or practices facilitated or hindered residents from sexual engagement.

I began this study with four central research questions:

1. How and under what circumstances do the older adult residents and staff feel comfortable with resident sexual expression in nursing home settings?
2. What barriers and affordances to sexual expression are experienced by older adult residents in nursing home facilities?
3. What differences and similarities in expressed attitudes exist between and within residents and staff on the topic of older adult resident sexual expression?
4. How do older adult residents and attending staff perceive opportunity and constraints in expressing a sexual self within the cultural context of a residential facility?

I have pursued these questions with the hope of adding to the research knowledge in older adult sexual expression in nursing homes.

The goal of the study was to focus on the experiences of the four women and six men who resided in a nursing home, reflecting on their sense of self as a sexual being and intimate expression. Additionally, the meanings residents attribute to those aspects of their personhood were explored. The aim was to compare and contrast each individual account, and to successfully capture their process of self-identification as a sexual being (or loss of such identity) as a result of aging, illness, relationship status, and nursing home environment. Also solicited was the perspective of staff on their experience with residents and expressing sexual needs.

Each participant's account was clearly unique, yet was not static; the perception of self as a sexual being inevitably had evolved over time for all participants. In summary, the purpose of this phenomenological qualitative study was to explore the unique attitudes, values, and experiences of older adult residents and staff regarding the issue of physical and relational intimacy and sexual expression in a nursing home residential setting.

The nursing home residents' voice and experience is essential, as older adult resident populations continue to grow along with the aging of the baby boomer generation. By 2030, all baby boomers still living will be the same age or older as the average age (66 to 84 years of age) of individuals who currently reside in a nursing home (Knickman & Snell, 2002). The number of elderly in 2030 is theorized to be two times larger than the current elderly population (Knickman & Snell, 2002). This chapter presents a review of my interpretations, discusses practices that might encourage a

greater understanding of nursing home residents sexual expression, examines the limitations of the study, and concludes by making suggestions for future research.

RQ1. How and under what circumstances do the older adult residents and staff feel comfortable with resident sexual expression in nursing home settings?

Interview questions and conversations were used to explore comfort on the topic of and expression related to sexual intimacy presented by residents. It was important to explore the topic with both residents and staff as they are in a constant state of interaction. Moreover, individuals who move to a nursing home are there because they are in need of assistance and are no longer able to independently care for themselves. This places a huge responsibility on staff members as caregivers. More importantly, it is an incredibly courageous decision (if a choice existed) to move into a nursing home.

Autonomy and the pleasures of a normal daily lifestyle take on an incredible transition as people move from their own home to a nursing home. Comfort in doing personal and private things are equally challenged. Daily activities such as using the restroom, bathing, and changing oneself become shared responsibilities with nursing staff, who are at least initially considered strangers. Activities such as masturbation, mutual touching, embracing, kissing, intercourse, and other types of sexual engagement also become challenges and may be perceived as too risky to engage in for many individuals transitioning to a residential community setting such as a nursing home.

Autonomy and Privacy Lost

In this study, every resident addressed the transition moving to the nursing home as a challenge for a variety of reasons. Harry described how it took him aback when he was first asked to change in front a stranger and use the restroom. Although he reported discomfort at first during the transition period, Harry became accustomed to having staff

assist him in very private situations and having candid conversations and using direct language regarding his bowels and other once private discussions. His report reflects a shared experience described by almost every resident in this study. Specific conversations on the topic of sexual expression were potentially considered one of the only private pieces they had left of themselves and for themselves.

Comfort with Sexual Discussion

As a result, nine out of ten residents also described discomfort with discussing sexual interests or needs with staff, physicians, or any other person. Harry was the only person who described comfort discussing sexual issues and needs with others. This reported comfort is highlighted during the time he described disclosing his personal feelings of attraction and love for a nurse to his wife, children, the nurse herself, and the administrator at the nursing home. Throughout his narrative, it has to be said, it is clear that Harry is a very open and expressive person. This made his story unique somewhat from others as he was so honest and open with his attraction for both men and women and his excited revelation of “falling in love” with another person at 90.

Regarding specific sexual issues and concerns with others, all residents declined ever discussing such matters. Most participants reported discomfort with the idea of discussing their sexual needs and concerns with staff, physicians, and family members. Especially for those with erectile difficulties, it was important to explore whether any of the men had addressed their erectile dysfunction with a physician, to be educated on the topic of erectile dysfunction, or to learn about options, including medication for erectile dysfunction. Again, all declined. Some reported they were fearful of potential side effects of medications such as Viagra, but again no one had ever discussed erectile dysfunction,

or medications with a physician. In the cases of Chuck and George, both participants experienced erectile difficulties after the death of their spouses. If they were to have addressed the issue with a physician, they may have been assessed for *widowers syndrome*, a common type of impotence that is psychogenically-based and one that occurs at the time of spousal death (Hedon, 2003).

The lack of comfort experienced by the residents is indicative of two things. First, sexuality and sexual expression are typically considered private matters. Sexual discourse with physicians would seem typical if there was a specific issue that was presented or addressed by the staff, but these individuals reported no initiation of discussion on the topic. The discomfort in addressing issues with physicians is supported by other research on the topic. Huang, Luft, Grady, and Kupperman (2009) suggested that many older adults refrain from seeking services for sexual issues out of fear or embarrassment.

Secondly, many participants described feeling burdensome to their caregivers and reported that they did not want to waste physician's time with their sexual concerns. Gott and Hinchliff (2003b) reported that older adults often feel they would be a burden to their physician and that other time would be better used with younger individuals. Physicians may also be at fault for not addressing specific sexual needs of people in general, but specifically to their elderly patients. Much research on the topic has been addressed since the 1980s. From Croft's study (1987), who demanded a change in physician protocol to attend to the sexual needs of older adults—to Taylor and Gosney (2011), who argued over two decades later for the same type of services.

Implications make the same request. Both nursing home staff and physicians alike, need to take the sexual health of their older adult patients seriously. Older adults

are less inclined to engage in discourse related to sexual issues (Croft, 1987; Taylor & Gosney, 2011). Healthcare providers must take responsibility and advocate for their patient's sexual health. Resident discomfort on the topic could also be indicative of their physician's discomfort and avoidance of the discussion. More seriously, the absence of discourse on sexual issues only recapitulates the ageist stereotype that older adults are asexual.

She Sees Me for Me

At first I was surprised to hear how almost every participant was uncomfortable discussing the topic and yet, they volunteered to participate in this study. After much reflection, however, it appears that I might have been the only person to ever ask them about sex. Although the conversation may have been uncomfortable at times, the topic validated their human experience. These residents probably felt more normal with this conversation than with the daily shower assistance. I spoke to George as a man and Ginny as a woman and all of the other residents who were part of this study. I was an interested outsider who saw them as insightful human beings rather than a burdensome, old person in need of care and ongoing assistance. This idea of "burdensome" was earlier reflected by the residents themselves.

Internalized Ageism

There may also be a belief system connected to internalized ageism which would challenge the idea of attending to one's sexual needs and concerns as an older person, and moreover, communicating such needs. Due to social stigma and internalized ageism (whether perceived or experienced), older adults have difficulty addressing sexual concerns with others. First presented in Chapter 2, Kaas' (1981) *geriatric sexuality*

breakdown syndrome theory described the presence of internalized ageism among older adults as a result of psychological vulnerability, continued receipt of ageist messages, and it is strengthened by the natural response of the aging body. Although older adults may be actively sexual, they may consider their sexuality and active engagement as inappropriate because of their age (Doll, 2010).

Comfort with Sexual Engagement

Regarding comfort with sexual engagement at the nursing home, three out of ten resident participants reported comfort with sexual expression. The other participants described discomfort as a result of obvious limitations that come with the clinical environment of the nursing home (limited privacy, interruption, limited resources, and limited opportunity). For the two who described engaging in mutual sexual expression, they also reported discomfort with time. For Harry and Sally, they allowed themselves ten to 15 minutes of mutual sexual engagement. They had agreed that 15 minutes was “sufficient” for them and that they did not want to ask for more as the nursing staff were busy and needed to continue with their daily routine, which included assisting Harry and Sally in and out of bed (depending on the time). Gott and Hinchliff (2003b) reported that many older adults believe themselves to be a burden to their healthcare professionals and caregivers.

Residents who reported sexual engagement with their partners or via self-stimulation, reported comfort with staff knowledge of sexual engagement. Those who described present sexual engagement also suggested how such sexual engagement may be considered a risk. For example, it was Harry who said, “I’m okay with being caught doing that,” when he spoke of kissing his wife in the cafeteria. This thought would

suggest a level of comfort and confidence in himself, with staff, and also suggests a relaxed nursing home environment. Additionally, it could suggest something rather sweet and innocent, as if the resident and his partner were two kids kissing under the stairwell at the high school prom. On the other hand, it could be surmised that Harry felt willing to take the risk as it was his basic human right to demonstrate affections with his partner.

This sense of “getting caught” is especially interesting as it relates to the story of George and his reported risky activity of viewing pornographic movies and the potential for “getting caught.” Again, there is a layer of youthful energy as he reflected on his experience of being up late at night and watching movies that were forbidden, as if he were watching dirty movies in the dark while his parents slept. This was further evidenced from his report of watching the movies in the evening hours as a way to decrease the chance of staff discovering him and his viewing activity. From his narrative, George suggests a hint of sexual excitement as he discussed how staff had walked in while he was viewing his movies and then also suggesting that they probably were equally interested in watching the videos as well.

These examples are telling of how the system of thinking may be different if residents were knowledgeable of specific policies on positive sexual expression. From the narratives of both staff and residents, it is further suggested that a lack of knowledge regarding specific intimacy policy could be another reason for residents discomfort with sexual expression as well staff discomfort. No participants reported a clear understanding of policy or procedure regarding sexual expression. It would make sense, then, why some would inhibit their sexual needs.

Comfort via Knowledge

Education and training were considered very important to the staff participants in relation to how comfortable they were with resident sexual expression and how prepared they felt to handle resident sexual needs. The staff participants in this study all reported comfort with the sexual expression of residents and identified several opportunities for residents to engage in sexual intimacy. Nicholas was the only staff participant from his nursing home, and he reported discomfort presented by his colleagues. He also suggested a lack of education and training as the reasons for their discomfort.

There is a great deal of research on the topic of sexual expression and training as it relates to comfort level among the nursing staff (Bouman & Arcelus, 2001; McAuliffe, Bauer, & Bay, 2007). Literature also exists on the effects of training and knowledge of policy on permissive sexual expression by the resident. Both residents and staff who engaged in an educational training on older adult sexual functioning reported an increase in sexual interest and confidence (among older adult residents) and increase in comfort level among nursing staff (Bouman & Arcelus, 2001; Bouman et al., 2007; Willert & Semans, 2000). It would not be surprising to see comfort level increase after residents were trained on aging sexual expression and/or oriented to specific sexual expression policies and procedures of the nursing home.

In summary, residents' comfort level with sexual expression varied from person to person. Having almost all independence and privacy taken away or at least heavily limited, residents were inclined to believe themselves to be hardly an individual much less a sexual being. Feeling like a burden already, sexual expression was the least comfortable topic to address with staff or physicians as they deemed themselves too old

to engage in sexual expression. In a nursing home setting, staff felt sexual expression to be a human right of the residents and reported comfort with resident sexual expression as long as it was consensual and appropriate.

RQ2. What affordances and barriers to sexual expression are experienced by older adult residents in nursing home facilities?

In order to understand how the residents perceived the world they lived in and whether that world felt supportive of their sexuality was explored. Questions and conversations were explored to address how they perceived opportunity and whether barriers existed that would prevent, or have prevented, them from engaging in sexual expression. Staff were also asked to address how the institution supports the sexual needs of their residents and whether they believed barriers were in place that would prevent residents from fully expressing their sexual selves. Perception of affordances and barriers varied both with staff and residents; however, more barriers were reported by residents than staff. Affordances reported in this study were privacy, staff support, opportunity, and resident attitude.

Privacy and Supportive Staff

Although privacy was considered limited, all residents expressed a certain degree of privacy that was honored. For Harry and Sally, they were able to identify a time to engage in an intimate ritual each morning and evening. This was not something the nursing home offered, rather, it was something that was supported by nursing home staff specifically. In the case of personal enjoyment, even George described an opportunity to view pornographic films. Although he was unsure whether all staff approved of his activities, he was able to identify a time in the evening where he could watch them without much interruption.

Resident couples also described how the nursing homes attempted to make it feel more like home by offering full-sized beds for the couples to sleep in together. Staff confirmed this report. Other research literature on the topic of resident access to bed accommodations identified the opposite—only single beds were provided to couples and each person had to sleep in his or her own bed (Hajjar & Kamel, 2004). Another affordance as perceived by residents was the acceptance presented by staff. The resident couples described how they felt their sexual needs were overall supported by staff. By providing residents with opportunities for privacy, the couples felt they were supported by both staff and the nursing home. Much research has discussed favorable attitudes towards couples who reside in the nursing homes compared to individuals who are single (Gordon & Sokolowski, 2004). Specifically, couples are considered “cute” and often treated in a mocking way when expressing their affection. This was also evidenced by Shannon’s narrative when described how new training encouraged staff to cease making comments that could be considered embarrassing or undignified to residents in similar situations.

Positive Attitude as an Affordance

It is important to highlight that attitude plays a great role in whether opportunity is perceived or not. Although it is not something the nursing home provides as it is a personal characteristic of the individual, a resident’s positive attitude is important to identify as an affordance. Some residents maintained a positive attitude which allowed them to openly express themselves in confident, affirming ways to each other and to staff. For example, both Harry and Sally found a way to communicate their needs to staff. They were able to coordinate with staff to create an opportunity to enjoy each other privately in

their room. Their courage and confidence also helped them to be expressive with each other in public areas in the nursing home (e.g., cafeteria).

The attitude of those residents who actively engaged in intimate expression in addition to those who continued to desire their spouses was also considered an opportunity for residents. By maintaining a happy, positive attitude towards life and their partners, each couple found a way to connect and communicate their love with each other. As Kaas (1981) suggested, *geriatric* occurs to those whose personalities are susceptible to pressure or who are unable to identify their self-worth when challenged by the social mores of society. One of the biggest indicators of preventing *geriatric sexuality breakdown syndrome* is a positive attitude and confidence of one's abilities and one's self-worth (Kaas, 1981).

Barriers

Several barriers observed in this study including resident knowledge of sexual expression policies and practices, confusion with nurse affections, limited opportunities to meet people or engage in dating activities, privacy, comfort level discussing sexual matters with staff and physicians, and more personally, how one perceived themselves as attractive beings.

Lack of Knowledge

The barrier of knowledge was previously addressed, but should be clearly identified in RQ2. Lack of knowledge prohibits individuals from understanding their rights, affordances, and opportunities. For the residents in this study, no one could clearly identify a specific policy or protocol on positive sexual expression. In fact, some of the participants believed sexual expression only to be accepted by the nursing home

community *if* the residents were married. Many of the women already believed that sexual intimacy was only appropriate if between a husband and wife, so they may have assumed it was policy. From the reports of the staff, it is also evident why some residents believed married couples were the only people afforded the right to be sexually expressive. According to both Nursing Home A and Nursing Home B, only married couples were allowed to cohabitate. In the state where the study took place, same-sex couples did not have the right to marry; therefore, only heterosexual married couples were allowed to reside in the same room.

Another interesting finding of this study was the disparity in reported opportunities made by staff versus residents. Nursing Home A reported at least a few social events where residents could gather and interact with other residents. Nursing Home B identified several opportunities including, personal use of pornographic materials (e.g., DVDs, calendars, and magazines) and access to Internet and cable for pornographic viewing or socializing on the web. They also have available, a specific room for residents (consenting residents only) to privately socialize with another person overnight. Finally, Nursing Home A also provides access to transportation so that interested residents can go to the local adult entertainment club.

Although several opportunities were reported by staff in this study, residents did not report such opportunities, with the exception of George who had his own collection of adult films (again from Nursing Home A). Again, it was not certain to George whether these items were allowed by the nursing home. This discrepancy in communication makes for a concerning dilemma for both staff and residents at both homes. Beyond opportunities to go to the store or to the local botanical garden, residents from Nursing

Home A reported no other opportunity. As for Nursing Home A, Shannon reported that all resources were made available to residents upon request. It was never explored whether residents were informed of such resources. Considering at least two participants in this study from Nursing Home B desired such access, it seems communication is most certainly lacking and that the nursing home should take initiative and continue outreach to residents throughout their time at the nursing home on available resources.

Flirting and Confusion

Two men reported to have experienced confusing encounters with staff. Chuck suggested that female staff often hugged and kissed him which created a sense of confusion for Chuck and George. When considering the death of his wife and his desire to be connected yet again with someone, it makes sense that both men would look to female staff as potential dates.

George had also agreed that staff who knew of his evening viewing of pornographic movies approved, but clarified that some staff behaved in ways that confused George. Although he did not describe them as a hindrance, it is conceivable to think of staff behavior as a sort of mental hindrance when George explained how staff were “flirty” and that the flirtation ended with “rejection.” He explained that often staff would kiss and hug him and show affection, but that left George confused as he would often fantasize about these women and hope that they would share mutual affection for him.

The experiences of George, Chuck, and Harry suggest a possibility that perhaps it was not just in their minds. Residents in the nursing home vary in age, lived experiences, and are human beings after all. It is conceivable that older adult residents are attractive,

witty, kind, interesting, funny, and more. Suggesting that older adult residents are not sexually attractive only perpetuates the ageist thinking surrounding older adults.

The Sea of Fish has Grown Shallow

Some residents were able to creatively identify opportunities (although limited in several ways) and yet, for some single residents, the limitations of both opportunity to meet new people and to participate in dating were described as frustrating and hopeless. Inevitably, the continued lack of social opportunities decreased the individuals' perception of hope for another chance at love. For George and Chuck, specifically, they identified this barrier as one of the most significant dilemmas they had yet to experience in the nursing home. Both individuals lost their wives and became impotent while residing in the nursing home.

Privacy was also considered a significant barrier to residents. The setup of a standard nursing home room is often open and occupied by multiple residents, making it quite difficult for any resident to have private space and distance himself or herself from each other (Hajjar & Kamel, 2004). Those with roommates had very little privacy, but even those who occupied single rooms, the privacy was extremely limited and disruptions were constant throughout the day. The Resident Bill of Rights emphasized the civil liberties of the residents to include "personal dignity, individuality, and privacy, and to hold private visits with spouses" (Resident Rights, 2002).

These constructs were reported by both the residents and the staff in this study; however, what the Resident Bill of Rights does not clarify is the degree of privacy or length of private visits. In the case of Harry and Sally, they limited their opportunity of privacy and intimacy with each other to a minimum of ten minutes not to exceed 15

minutes every morning and evening. Although the time was not mandated by the nursing home, the residents believed it was the only opportunity they had for intimacy—an agreement made between nursing staff and the couple. This perception of limitation and lack of privacy was experienced negatively by several residents. These findings are consistent with Mulligan and Palguta (1991), who explained that couples who reside in nursing homes are highly susceptible to feeling frustrated and emotionally and physically deprived as a result of lack of privacy and/or negative staff and family attitudes towards sexual expression.

Restrictive Ethos and Focus on Problematic Behavior

Although the nursing staff explained how they continued to support their residents sexual needs, the ethos of both Nursing Home A and B suggest a less than favorable environment for any individual residing there. Opportunities were addressed as resident rights; however, again comments were made that suggested otherwise. To start, both nursing homes clarified and were able to cite specific policies regarding sexually inappropriate behavior. In Nursing Home B, resident's rights are addressed, but staff were also trained to monitor behaviors for inappropriateness. From this perspective, the focus suggests inappropriate sexual behavior as the primary type of sexual expression in need of monitoring and potential intervention. For example, in Chapter 5, Ariel presented a romance story between two residents with cognitive impairments. The story tells of how training had helped her assess for appropriate behavior and monitor for anything problematic. She consistently suggested that they had not crossed a line, which is to suggest there was a line to be crossed. From the excerpt, handholding and sitting next to each other were more or less asexual acts, and, therefore, deemed appropriate.

Again, another layer of judgment ethos exists in relation to how staff perceived cohabitation. It was discerned from Nursing Home A and B that only heterosexual married couples were “allowed” to cohabit in the same room; an affordance typically offered to most people across their lifespan and yet, when they enter a nursing home, it becomes a privilege and benefit. This rule does not apply to Nursing Home B’s overnight room, which was made available to any consenting couple. Restrictions further limit those with cognitive abilities, even if married. Separation of couple’s occurred at both nursing homes if one or both were present with cognitive impairment for both legal and safety reasons.

In support of both homes and their focus on negative behavior, Kettl (2008) reported that sexual misbehavior is a common occurrence in the nursing home. He further stated, younger female nursing staff are frequently the target of said behaviors by residents and as a result this leads to early resignations. Consequently, nursing homes are required by administration to instruct staff on how to navigate inappropriate sexual behavior demonstrated by residents (Kettl, 2008). These findings portray both a complexity in structure of the environment and psychological perception of the individual who resides within the environment. When a person decides to move into a nursing home, it is more likely a decision of medical need and convenience. The residents in this study did not desire to move into the nursing home, but were forced to after several attempts of living on their own proved too difficult.

Similar to staying at a friend’s house, they felt like guests in the nursing home. As a result, the interest in opportunity to voice a thought or opinion regarding sexual expression seemed unnecessary, as intimacy was not considered the primary reason for

their stay. This constant state of tension exists where hospitality is challenged by the hospital setting. Residents are often enticed by “home away from home” mission statements with the knowledge that privacy and independence will potentially be limited to some degree as a natural result of the nursing home environment. When a person transitions into a nursing home, it is conceivable that they may have already surrendered their independence to a certain degree. In fear of becoming too much of a burden, these resident participants chose silence.

Lack of Self-Attraction

Self-attraction was dismissed by almost every participant in this study and is considered a barrier to sexual interest and expression. The men in this study all identified themselves as attractive in past tense. Although their bodies aged, it was not until they experienced difficulties related to age did they begin to perceive themselves as less than attractive. They too found other qualities of themselves as attractive. Intellect for Jackson and Harry as just a couple examples from the participants in this study. Regardless of gender, appearing well-groomed was expressed as the central focus for appearance appreciation to exist.

It is interesting to find that none of the women ever identified themselves as sexy or beautiful. A lifelong disinterest in viewing themselves as very attractive could be representative of what the word “sexy” meant to these women. Sexiness meant bigger breasts to Bonnie and a thinner body and celebrity status to Ginny. The term had to be modified three times. First, they were asked if they were sexy. When they dismissed the term, they were asked if they ever perceived themselves as beautiful. They answered “no.” Finally, the women were asked how they viewed themselves, all to which they

described how they attempted to look “nice.” Nice was described as a tube of lipstick for Alma and a voice for Ginny.

Moreover, Ginny was a 92-year-old woman who uses an ambulatory device to get around and who resides in a nursing home. Even in this stage of life, Ginny is concerned with her body shape. This dismissive stance of self-attraction and body image for each of these women is indicative of the ways in which women have been trained to judge their bodies across the lifespan. These women grew up during an amazing time. As a kid, they could have heard of Amelia Earhart’s first solo flight across the Atlantic Ocean. Birth control and tampons were invented. They saw flappers, pin-up models, and playboy bunnies. They were around when women were sent to work while the men went off to war and then pushed back into the home when the men came back. They saw women’s liberation and the civil rights movement. Sexual objectification of women went from the kitchen to a full permeation of social media exploitation. In the end, when one would imagine a time where you could reflect on your life with great beauty and respect, these women couldn’t even identify a time when they saw themselves as beautiful.

In summary, barriers were reported in greater numbers than affordances for the resident participants. Staff support, privacy, and a positive attitude were seen as affordances. An incredible number of barriers surfaced from the data, most of which could be prevented if communication strengthened between the nursing home, the staff, and the residents. Clear communication about resident sexual expression could alleviate the pressure staff experiences when attempting to navigate resident sexual expression. It could also unburden the feelings experienced by residents who desire to learn more about

aging sexuality and to meet new people. The environment of the nursing home would progress from less of a hospital-like setting to a person-centered setting.

RQ 3. What differences and similarities in expressed attitudes exist between and within residents and staff on the topic of older adult resident sexual expression?

The nursing home is considered a permanent place of residency for these residents. It was important then to explore expressed attitudes of both residents and staff on how they felt about resident sexual expression in the nursing home. Between residents, a varied response to resident sexual expression was stated. These responses seemed to be related to culturally specific characteristics presented by each resident. Generational differences, gender, age, and educational background seemed to be contributing factors in how one perceived sexual expression.

Ascribed Gender Role and Sexual Attitude

When and how a participant first learned about sex was important to explore in this study. Participants became knowledgeable of sex from peers, family members, and the school system. There are several important issues to note within those brief disclosures. U.S. sex education began in the 1930s – about the time when a few of these residents were in school. In the 1930s and 1940s (when all residents were school aged), sex education varied among schools but were mostly designed to adhere to the ascribed gender roles and morals of that time. Parents and teachers alike were taught to instill gender roles based on heteronormative, Victorian social mores (Wetherill, 1961). Biological components of reproduction in the form of “birds and bees” were addressed, as sex, but were not allowed to be addressed from a “human perspective” based on human desire and sexual engagement (Carter, 2001). At this time, sexually transmitted diseases became a serious social issue as a result of war (Carter, 2001); however,

contraceptive devices were illegal in most states and, therefore, were not discussed as part of the curriculum. Same-sex orientation was considered a form of sexual deviancy and only discussed as such.

Females during this time and age were taught to not engage in premarital sex or become pregnant as it would ultimately lead to the demise of their reputation and the reputation of their parents (Wetherill, 1961). Females were also taught to never commit adultery and to embrace future responsibilities as a house wife (Wetherill, 1961). Young males were encouraged to not engage in premarital sex and were instructed to be the financial providers of their future family unit. Contrarily, a social double bind existed. In the 1930s and 1940s, American society gave boys greater permission to pursue sexual contact, but women who engaged in sexual acts lost social standing and became less attractive to boys as long-term partners (Carter, 2001).

These values instilled at such an early age were also presented by some of the women and men in this study. Alma, who ended her academic career after receiving her high school diploma, only wished to say the “birds and bees” when I attempted to reference sex as a word or “boyfriends” versus lovers. When questioned about her experiences with lovers, she poignantly asserted that she had only dated and that meant dating and not premarital sex “first comes the marriage and then the baby carriage and not the baby carriage and then the marriage” (Alma, Lines 174-175).

These generational differences also account for how marriage and divorce are perceived by the older adult community. For example, both Alma and Ginny described a complete disinterest in marrying again. As earlier stated in Chapter 4, both women defined marriage as a life-long commitment, to continue even after the death of their

spouse. This belief was supported by DeLamater and Moorman (2007) who suggested how “many older people consider sexual intimacy to be only or most appropriate in marriage; thus death and divorce leave many older Americans without a sexual partner” (p. 5).

Gender-Specific Attitudes toward Marriage and Death

Researchers have consistently found gender differences in sexual attitudes (Fisher, 2012). Specific differences exist in how many women and men approach sexual expression, marriage, and death. “Men tend to be more permissive with regard to their attitudes toward sex, and they are more accepting of casual sex. Men are also more likely than women to view sex as an activity that does not have to take place within the context of a committed relationship” (Fisher, 2012). This may be the case for George and Chuck. From their narratives, the men were most eager to find a future lover, while at the same time conflicted with the thought of not being able to perform sexually. Although it appeared that these men were not specifically looking for a relationship but for someone willing to engage in sexual activities, it could be theorized that these men hold similar permissive attitudes.

Carr (2004) addressed the old adage “women mourn, men replace” as she described several gender differences regarding marriage and death. Carr further clarified “the implication of this characterization is that heartbroken widows mourn the loss of their irreplaceable late husbands, whereas widowed men quickly find a helpmate and confidante to take the place of their late wives” (p. 1051). This theory addressed what was previously mentioned in this chapter. The widowers in this study described a need to be with someone intimately and, for Chuck, to act as a “helpmate.” From Carr’s study,

she found widowers were more likely, however, to remarry, but not for the reason of replacing their deceased wives. Interestingly, she also found that widows who perceived their marriage as challenging were less likely to remarry for fear of repeating former relational patterns. Again, Ginny and Alma both addressed this reason as cause to never marry again.

Relational Considerations for Women

Relational considerations presented by the women are important to address in this study. Sexual attitudes may be influenced by a variety of personal factors associated with low sexual desire for women, include: relationship duration, the perceived quality of the relationship, emotional intimacy, communication between partners, partner sexual dysfunction, and transition to caregiver status (Birnbaum, Cohen, & Wertheimer, 2007; Drummon et al., 2007; Gruszecki, Forchuk, & Fisher, 2007; Hayes et al., 2008).

For example, Alma suggested, “If that is what they want to do, then that’s fine” (Alma, Line 597). Although Alma’s response could be a result of her generational upbringing, it could also be due to her experience as a wife and the perceived quality of that relationship. As previously stated, both Alma and Ginny, described their marriages as difficult and not worth attempting again. This attitude toward themselves and to those who desired were presented. The rest of the participants approved of resident sexual expression.

Regarding low sexual desire and attitudes toward sex, McCabe and Goldhammer’s study (2012) found that women experienced sexual difficulties only after their partner began to have sexual difficulty. This finding corresponds with the narratives presented by the women in this study. Every women in this study reported an increase in

lowered sexual interest as a result of their partner's sexual difficulties and for some— immediate approval to no longer engage in sexual activities. It is important to address, however, that every woman held the attitude that men are generally more sexual and have stronger sexual appetites than women. According to Sally, "I like sex, but it doesn't overwhelm me. Well, I shouldn't put it that way either. But, anyway, I noticed that, ummm, I'm just not as sexually-minded as he is" (Sally, Lines 366-367). Research has also found that older women tend to believe that waning desire and other sexual problems are simply natural consequences of aging (Vares, Potts, Gavey, & Grace, 2007). This attitude was maintained by every woman in this study.

Education and the Arts

As mentioned in Chapter 4, those who received higher education reported permissive and tolerant attitudes toward sexuality and sexual expression of others. Although research was not found regarding a correlation between education and permissive attitudes toward older adult sexual expression, other research on education in general as an indicator of permissive attitude was present in the literature (Smith & Son, 2013). A report presented by Smith and Son (2013) found that post-high school education was generally related with more sexually permissive attitudes in comparison to those with a high school degree. The narratives explored in this study presented similar findings. Those with high school degrees or less were least permissive; those with a college background were more permissive about sexual expression.

Permissive Staff Attitudes

The staff participants in this study also described an affirming attitude toward resident sexual expression. All staff participants believed residents need to express

themselves in a way the resident deems sexually fulfilling. Of course, with that said, staff discerned the needs of healthy consenting residents versus those who were diagnosed with degenerative cognitive diseases.

Nicholas described himself to be open-minded and permissive of resident sexual expression; however, he clarified that other staff do not share similar thoughts. Nicholas explained that he believed a lack of education and training on the topic of aging sexual expression was the reason for negative attitudes of his peers. This description of attitude and education among staff was described in many studies. Specifically, Walker et al. (1998) identified lack of education and attitudes toward aging sexual expression as specifically related to negative sexual expression presented by residents. These findings support the belief system that education and knowledge increase not only a positive experience in the nursing home but the positive sexual experience of nursing home residents.

The very opposite was presented in several studies including the finding that staff who are not trained tend to rely on their own religious, ethnic, and other personal beliefs to decide what is right for residents (Bauer et al., 2012; Rosenweig, 2012). It could be a matter of personal beliefs that staff agree and support intimate acts of nursing home residents; however, that was not explored in this study.

It is important to clarify again that only four staff were available to address attitudes associated with affirming supportive needs. These four were people who wanted to participate in the study and saw the importance in addressing the sexual needs of staff.

They are not alone, however. In an interview, Daniel Reingold (as cited in Young & Hobsin, 2013), President and CEO of Hebrew Nursing Home Reingold stated,

Growing old is a process of loss: losing your friends, losing your spouse, losing your mobility, losing your memory. But the sense of touch is the last to go. Some research shows that the sense of touch never goes, even if a person is in a coma.

And so why would we not want to encourage the pleasure of intimacy?

(<http://hereandnow.wbur.org/2013/08/01/nursing-home-sex>)

In summary, both positive and negative attitudes varied from person to person in this study. Overall, a person's individual experience as a man or a woman had a great impact on how they experienced the world as a sexual being. Gender differences were also associated with either positive or negative attitudes toward sexual expression. Differences and similarities in expressed attitudes existed among residents. Gender role heavily influenced whether a person desired to be intimate in their older years. The women were much more accepting of their lives without traditional intimacy. The men on the other hand were frustrated with their inability to achieve an erection and their ailing bodies.

The quality of the relationship also swayed a person's view of future relationship, love, and desire. Two women and one man believed their last relationships to be too difficult to entertain the idea of becoming intimate with another person again. The couples were able to identify new ways to be intimate and loving. Again, staff reported that residents should be able to address their own sexual needs as a human right. Both Reingold and the staff in this study identified the very human need of intimacy and connection that should be afforded to older adults and embraced by nursing homes and society as a whole.

RQ 4. How do older adult residents and attending staff perceive opportunity and constraints in expressing a sexual self within the cultural context of a residential facility?

Questions were asked to explore whether residents and staff believed constraints or opportunities existed with regard to a resident's ability to express a sexual self. The disparity in perception of opportunities and constraints may speak to a potential miscommunication of available resources to residents, or, in fact, residents, although entertaining thoughts of sexual play and enjoyment, may actually have difficulty requesting such opportunities or actively engage in said activities in the nursing home. Staff from Nursing Home B reported several opportunities for nursing home residents to engage in intimate play with self and/or with others.

Opportunities

Nursing Home A and B reported opportunities for residents to express themselves in an intimate way. Although there are no locks on the doors at either nursing home, doors are "allowed" to be shut. Again, it must be addressed that a shut door is also seen as a privilege. Doors, of course, are not allowed to lock due to safety concerns. Some of the residents described how they express themselves in an intimate and sexual way: Sally and Harry with those moments of privacy together and the casual kiss and embrace in public settings; George and the videos; and Bonnie and Clyde who embrace and kiss as they see fit without concern.

Privacy

Privacy remains to be an incredible constraint for those who desire to be intimate with their spouse or with themselves. Although George presented a "do not disturb" sign that he had received upon request by staff, he reported that staff often did not honor the sign.

Familial Support or Hindrance

Staff members agreed that family members as one of the greatest influenced on whether residents are allowed to engage in sexual expression at the nursing home. Regardless of nursing home practices associated with resident sexual expression, communication with the family members to make decisions on behalf of residents is considered a right of the family. Many families are presented with conflicting feelings on the topic. Although some nursing homes understand the need to be intimate, family members ultimately decide whether a resident is able to be intimately expressive or not. This reality is presented in several studies where family has intervened (Bauer, 2014; DeLamater & Moorman, 2007).

From the narratives of those involved in the focus group, several reports of family intervention were discussed. Nursing Home B specifically addressed how it is protocol to contact family members if a family resident is acting sexual in any way, from full sexual engagement to handholding. Not all families are dismissive of their loved ones sexual interests. Unfortunately, it remains a challenge for both families and nursing homes. Depending on the attitudes of caregivers, residents may be restricted from having partners, restricted from engaging in sexual activities, and denied privacy (Bentrott & Margrett, 2011; Hajjar & Kamel, 2004; Lindau et al., 2007; Pope, 1997).

Nursing Home B appeared to be moving toward a modern mindset of aging sexual expression. Although no particular nursing staff participant could identify specific policies on resident sexual expression, they considered sexual expression as included in the philosophy of the nursing home, which would coincide with the Resident Bill of

Rights. Moreover, the narrative of Nicholas also resonated with the historical literature on the need for education and training on sexual expression for both residents and staff.

In summary, many constraints and opportunities were addressed, however, it remains to be known how much communication existed between staff and residents regarding resources and opportunities presented by the nursing home. Staff suggested that upon request resources were available but how and when were the residents informed? Although medical needs were met, the resident's rights of dignity, privacy, and autonomy are challenged day in and day out with limited privacy and opportunities. Most nursing home residents are no longer in charge of themselves and instead like an adolescent, have their family members and the nursing home making decisions on their behalf. This suggests again the importance of communication between nursing home, residents, and family so that residents may retain as much privacy and autonomy as possible.

Implications for Nursing Homes

Results of this study have implications for nursing home practice and potentially can be used to persuade nursing homes to increase their training and knowledge for nursing home staff and residents. On the basis of this current study, many residents perceived more limitations than affordances concerning personal sexual expression and engagement in sexual practices. The lack of knowledge on specific policy and comfort with sexual discussion may also act as a barrier for residents to feel fully supported and comfortable in expressing their sexual selves. This study illuminates the need to increase education, training, and awareness of aging sexual expression and how such expression may be embraced and supported by the nursing home facility and staff. Overall quality of

life, therefore, may be enhanced if positive sexual expression is incorporated into specific policy and practice.

Some older adults may be ambiguous or unconcerned regarding their own sexual expression while they are in a nursing home because they perceive that nursing home settings are inherently ageist and do not embrace older adult sexual expression as part of quality of life or because they believe the nursing home is not considered an appropriate setting for sexual fulfillment to occur. Nursing homes, therefore, may be interested in offering more social opportunities for residents to meet others in the nursing home or outside in the community. Nursing homes that were also attentive to the needs of the residents may also reevaluate privacy procedures and even collaborate with residents on how they wish to engage in sexual expression. For example, in the case of George, it might be beneficial for him to have staff who not only encourage the viewing of pornographic movies, but also collaborate with him to select a better time to watch the videos.

Nursing homes are full of unique individuals with vastly different backgrounds. It would behoove nursing homes to consider sexual expression as a part of resident quality of life. This study suggests there is an uncommunicated need for residents to express themselves in a way that encourages autonomy, independence, and sexual expression. Every single resident in this study described a disinterest or discomfort in communicating their needs to staff, which could suggest to nursing homes that more communication on the topic is needed. Of course, the findings from this small sample study cannot be presumed to make a sweeping statement for all residents in all nursing homes.

Ideal Policy

From this study, glaring gaps in communication between the nursing home, the staff, and the residents, suggest a need to adopt a specific policy and procedures manual on the topic. Nursing homes would also greatly benefit from connecting with those nursing homes that have already modified their program to include specific overt policies concerning resident sexual expression.

As earlier mentioned, the Hebrew Home in New York, is well known for their progressive human-affirming stance toward resident sexual expression. The policy manual entitled, *Policies and Procedures Concerning Sexual Expression at the Hebrew Home at Riverdale* (Dessel & Ramirez, 2013) and the guideline book entitled *Sexual Consent Guidelines* (2011) are available on the nursing home's website, <http://www.riverspringhealth.org/sexual-expression-policy.aspx>. This is the only US policy on resident sexual expression that was found. British Columbia's guideline resource *Supporting Sexual Health and Intimacy in Care Facilities: Guidelines for Supporting Adults Living in Long-Term Care Facilities and Group Homes in British Columbia, Canada* (2009) is another helpful resource for nursing homes to review.

According to Dessel and Ramirez (2013), a comprehensive policy reform would include (1) a clear and concise definition and guideline for addressing matters of consent to sexual activity, (2) a transparent description of resident rights, staff responsibilities, and the responsibilities of the nursing home, (3) a protocol on discourse between the nursing home staff and older adults in assessing sexual activity.

In addition to these, I would suggest an organizational component of the policy to include hiring or training a staff member to: (1) individually meet with residents upon

orientation to discuss sexually-related rights of residents and to present sexually-related opportunities offered by the nursing home, (2) communicate sexually-related opportunities to residents on an ongoing basis, (3) evaluate sexual needs of clients on a routine basis through surveys, (4) create a library of sexually-related videos and literature for resident use including romance novels, (5) provide condoms and literature on sexually transmitted infections and diseases to residents who are actively sexual, (6) encourage residents to request information regarding sexual issues with physician, (7) facilitate community-based events and activities for residents to socialize with other nursing homes, elderly agencies, and retirement communities, and (8) facilitate in-home activities and workshops on the topic of sexual expression (e.g. a party where someone comes in to talk about masturbatory tools and lubricants).

Finally, as a requirement for all parties involved, I would suggest a comprehensive sex positive training for both staff and residents to learn current information on the topic of aging sexual expression. This training may be done individually or in a group setting with residents but should be done as a group with staff as it is important for all staff members to be on the same page where residents and sexual expression are concerned. Educational interventions would also be included for staff and residents who display negative attitudes toward sexual expression.

Limitations of this Study

Qualitative research offers an incredible opportunity for individual voices to be heard; however, the data are neither generalizable nor comprehensive. The voices of these ten brave individuals cannot account for every older adult who resides in a nursing home. Specifically, these individuals resided in two small Midwestern towns. It could be assumed that a more diverse group of people could produce very different data.

Additionally, there are many women in their 70s and 80s who embrace their sexuality (Doll, 2012). In this study, the idea of sexual expression was not considered beyond thought and two considered sex unimportant across their lifespan.

Although it is essential for narratives to be explored from the actual voice of the participant, a potential weakness that may exist in this study involves self-reporting. The women in particular were not as forthcoming as had been anticipated, and it is conceivable that, if participants believed reporting of sexual behavior did not align with social expectations, than they might have censored themselves as a result. Moreover, in the case of Bonnie and Clyde, it must be addressed that one or both of them may have censored themselves as a result of interviewing together.

Another limitation considered was attrition of the professional caregivers. The researcher made several attempts to schedule interviews with two different staff (not part of the study) but both did not show up for the interview. When the study was presented to the nursing staff at Nursing Home A, most were hesitant to stay for the presentation. The lack of interest and hesitation by staff may suggest discomfort with the topic of resident sexual expression. The four staff voices may not represent the general staff positions but do provide some insight and voice to this hard-to-research area of inquiry.

Not only were staff participants limited to a total of four staff, the interviews were incredibly short. Less than ten minutes with Nicholas and less than 20 minutes with the focus group. Although a great deal of information was presented during those interviews, I imagine the depth of conversation would have grown tremendously if more time was made available. The staff participants were extremely helpful and it must be said that

their work is a beautiful daily challenge. I appreciated every minute they sacrificed to be with me.

Recommendations for Future Research

These ten rich narratives narrow the gap between quantitative research on the topic of older adult resident sexual expression and the scarce qualitative literature. The existing gap in research literature could be further narrowed with a focus on the impact that erectile difficulties and loss of partner have on sexual expression for older adults, given that it is a frequent interpersonal occurrence for nursing home residents. Based on this study, beneficial research avenues could include a qualitative study on single resident men and women with a focus on how social opportunities are afforded by nursing homes, or perhaps an exploratory study on the influence of a comprehensive sexual policy on the nursing home community and individual residents. Finally, it would be greatly beneficial to do the same study at the Hebrew Home as it would offer the greatest insight into how healthy intimacy affirming policies affect the well-being of the residents.

Given the current scarcity of psychological attention to residents in relation to their sexual health, any future research that facilitates an understanding of the experience of residing in a nursing home and that gives voice to the resident population is unquestionably needed.

Conclusion

This study took place in a nursing home setting where residents were personally asked questions regarding their sexual interests, desires, concerns, and worldviews of sexuality in general. Staff were also questioned about resident sexual expression and whether they perceived challenges and affordances for the resident community to engage in sexual expression. The study itself was difficult to begin. After eleven rejections, two

finally agreed to participate in the study. Even after the administrators approved the study, several attempts were made to collect staff participants before a total of four staff agreed to participate. Staff are consistently challenged to maintain a balance between the medical necessities and the personal needs of every resident. It is understandable how difficult it was to find the time to participate in this study, and for that, I am grateful. But to the fact that I could only acquire four staff is telling. It illuminates the history of this particular research focus. There is limited research, both quantitative and qualitative, on the topic of aging sexual expression, nevertheless, aging sexual expression in the nursing homes. Without the research to support the need to strengthen communication and policy on healthy aging sexual expression, the desires of the residents will continue to be challenged.

This study may be used to expand the knowledge of aging sexual expression specific to the resident community for nursing home administrators, staff, residents, and family members. Qualitative resources within the nursing home resident experience have primarily focused on the perspective of the staff member. This study was able to take place in a nursing home setting where residents were personally asked questions regarding their sexual interests, desires, concerns, and views of sexuality in general. It included idiographic narratives of individual residents and expounded on their stories as sexual beings, or better yet, human beings shaped by varying experiences, generational influences, and gender ascription.

This study expanded the literature on aging sexual expression specific to the resident experience. For staff in the field of nursing home care, the findings help to validate the worldviews of resident experiences and the challenges staff face when

navigating sensitive topics and interactions with family and residents. Additionally, these findings can benefit nursing homes and caregiver advocates attempting to incorporate policies and procedures concerning sexual expression by providing a foundation for understanding the conditions in which sexual expression is perceived by residents as either opportunities or hindrances. This study suggests an importance of a supportive residential environment; one that honors the medical care and traditional quality of life standards while also embracing the individual human needs and desires of those that live there.

Finally, in addition to providing readers with specific resources on how to create policy and procedures to address sexuality as a quality of life component, it also suggests the need for nursing homes to hire or train a staff to act as a sexual quality of life representative (SQOLR). This person would act as a liaison for the residents, somewhat like an ombudsman, but specifically focused on advocating on behalf of the sexual needs of the residents, informing residents of their sexual rights, training staff on aging sexual expression specifically related to the nursing home experience, and acting as community organizer developing activities and events for those residents who desire to socialize in a more intimate setting. To suggest open-minded items, a mere condom, could change the climate of the entire nursing home into a proactive, intimacy affirming residence.

Studies on the topic of resident sexual expression continue to report the same idea—residents need to be embraced as individuals and as sexual beings. It is time to bring forth action and change. Specific policies, practices, procedures, and trainings must occur to challenge ageism and stereotypes of those residing in nursing homes.

REFERENCES

- Aday, R. H., Kehoe, G. C., & Farney, H. A. (2006). Impact of senior center friendships on aging women who live alone. *Journal of Women and Aging, 18*(1), 53–73.
http://dx.doi.org/10.1300/J074v18n01_05
- Ainsworth, M. D. (1985). Attachments across the lifespan. *Bulletin of the New York Academy of Medicine, 61*, 792–812. Retrieved from <http://link.springer.com/journal/11524>
- Ambert, A.-M., Adler, P. A., Adler, P., & Detzner, D. F. (1995). Understanding qualitative research. *Journal of Marriage and Family, 57*, 879–893.
<http://dx.doi.org/10.2307/353409>
- American Association for Retired Persons (AARP). (2004). *Sexuality at midlife and beyond; 2004: Update of attitudes and behaviors*. Washington, DC: Author.
- American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders: DSM-5* (5th ed.). Arlington, VA: American Psychiatric Publishing.
- Archibald, C. (2002). Sexuality and dementia in residential care—whose responsibility? *Sexual and Relationship Therapy, 17*, 301–309.
<http://dx.doi.org/10.1080/14681990220149103>
- Ashdown, B. K., Hackathorn, J., & Clark, E. M. (2011). In and out of the bedroom: Sexual satisfaction in the marital relationship. *Journal of Integrated Social Sciences, 2*, 40–57. Retrieved from <http://www.jiss.org/>
- Atlanta Legal Aid Society. (n.d.). *Sexuality in the nursing home*. Retrieved February 9, 2015, from <http://www.atlantalegalaid.org/fact20.htm>

- Basson, R. (2001). Female sexual response: The role of drugs in the management of sexual dysfunction. *Obstetrics & Gynecology*, 98, 350–353.
[http://dx.doi.org/10.1016/S0029-7844\(01\)01452-1](http://dx.doi.org/10.1016/S0029-7844(01)01452-1)
- Bauer, M. (1999). The use of humor in addressing the sexuality of elderly nursing home residents. *Sexuality and Disability*, 17, 147–155. <http://dx.doi.org/10.1023/A:1021424401601>
- Bauer, M., Fetherstonhaugh, D., Tarzia, L., Nay, R., Wellman, D., & Beattie, E. (2012). “I always look under the bed for a man.” Needs and barriers to the expression of sexuality in residential aged care: The views of residents with and without dementia. *Psychology and Sexuality*, 4, 269–309. <http://dx.doi.org/10.1080/19419899.2012.713869>
- Bauer, M., McAuliffe, L., Nay, R. & Chenco, C. (2012). Sexuality in older adults: Effect of an education intervention on attitudes and beliefs of residential aged care staff. *Educational Gerontology*, 39, 82–91. <http://dx.doi.org/10.1080/03601277.2012.682953>
- Bauer, M., Nay, R., & McAuliffe, L. (2008). Catering to love, sex and intimacy in residential aged care: What information is provided to consumers? *Sexual Disability*, 27, 3–9. <http://dx.doi.org/10.1007/s11195-008-9106-8>
- Baumeister, R. F. (2000). Gender differences in erotic plasticity: The female sex drive as socially flexible and responsive. *Psychological Bulletin*, 126(3), 347-374.
- Baumeister, R. F., Catanese, K. R. & Vohs, K. D. (2001). Is there a gender difference in strength of sex drive? Theoretical views, conceptual distinctions, and a review of relevant evidence. *Personality and Social Psychology Review*, 5(3), 242-273.

- Beeber, A. S. (2011, December 1). The burden of family caregiving never ends. [Blog post]. Retrieved from <http://www.rwjf.org/en/culture-of-health/2011/12/the-burden-of-family-caregiving-never-ends.html>
- Ben Nattan, M. (2007). Perceptions of nurses, families, and residents in nursing homes concerning residents' needs. *International Journal of Nursing Practice, 14*, 195–199. <http://dx.doi.org/10.1111/j.1440-172X.2008.00687.x>
- Ben-Zeév, A. (2012, March 18). Love after death: The widows' romantic predicaments [Blog comment]. Retrieved from <https://www.psychologytoday.com/blog/in-the-name-love/201203/love-after-death-the-widows-romantic-predicaments>
- Bentrott, M. D., & Margrett, J. A. (2011). Taking a person-centered approach to understanding sexual expression among long-term residents: Theoretical perspectives and research challenges. *Ageing International, 36*, 401–417. <http://dx.doi.org/10.1007/s12126-011-9110-7>
- Berg, B. L., & Lune, H. (2012). Types of interviews. *Qualitative research methods for the social sciences* (8th ed). Upper Saddle River, NJ: Pearson.
- Birnbaum, G. E., Cohen, O., & Wertheimer, V. (2007). Is it all about intimacy? Age menopausal status, and women's sexuality. *Personal Relationships, 14*, 167-185.
- Black, B., Muralee, S., & Tampi, R. R. (2005). Inappropriate sexual behaviors in dementia. *Journal of Geriatric Psychiatry and Neurology, 18*, 155–162. <http://dx.doi.org/10.1177/0891988705277541>
- Bland, S. H., Krogh, V., Winkelstein, W., & Trevisan, M. (1991). Social networks and blood pressure: A population study. *Psychosomatic Medicine, 53*, 598–607. <http://dx.doi.org/10.1097/00006842-199111000-00002>

- Blash, D. L. (2010). *Faith in counseling: A qualitative examination of the experiences of African American college students with the integration of religion and spirituality into counseling* (Doctoral dissertation). Retrieved from ProQuest Dissertations and Theses database. (AAT No. 3432857)
- Boeije, H. (2002). A purposeful approach to the constant comparative method in the analysis of qualitative interviews. *Quality and Quantity*, 36, 391–409.
<http://dx.doi.org/10.1023/A:1020909529486>
- Bouman, W. P., & Arcelus, J. (2001). Are psychologists guilty of ageism when it comes to taking a sexual history? *International Journal of Geriatric Sexuality*, 16, 27–31. [http://dx.doi.org/10.1002/1099-1166\(200101\)16:1<27::AID-GPS267>3.0.CO;2-S](http://dx.doi.org/10.1002/1099-1166(200101)16:1<27::AID-GPS267>3.0.CO;2-S)
- Bouman, W. P., Arcelus, J., & Benbow, S. M. (2007). Nottingham study of sexuality and ageing (NoSSA II): Attitudes of care staff regarding sexuality and residents: A study in residential and nursing homes. *Sexual and Relationship Therapy*, 22, 45–61. <http://dx.doi.org/10.1080/14681990600637630>
- Bowers, H., Clark, A., Crosby, G., Easterbrook, L., Macadam, A., MacDonald, R., & Smith, C (2009). *Older people's vision for long-term care*. Retrieved from <http://www.jrf.org.uk/sites/files/jrf/older-people-vision-for-care-full.pdf>
- Boyd, C. O. (2001). Phenomenology the method. In P. L. Munhall (Ed.), *Nursing research: A qualitative perspective* (3rd ed., pp. 93–122). Sudbury, MA: Jones and Bartlett.

- Breland, L. (2014). Lost libido, or just forgotten? The legal and social influences on sexual activity in long-term care. *Law & Psychology Review, 38*, 177–192.
Retrieved from <http://www.law.ua.edu/pubs/lawpsychology/>
- Brown, L. (1989). Is there sexual freedom for our aging population in long-term care institutions? *Journal of Gerontological Social Work, 13*(3), 75–93.
http://dx.doi.org/10.1300/J083V13N03_07
- Burack, O. R., Weiner, A. S., Reinhardt, J. P., & Annunziato, R. A. (2012). What matters most to nursing home elders: Quality of life in the nursing home. *JAMDA: Journal of Post-Acute and Long-Term Care Medicine, 131*, 48–53.
<http://dx.doi.org/10.1016/j.jamda.2010.08.002>
- Cahill, S., South, K., & Spade, J. (2010). *Outing age: Public policy issues affecting gay, lesbian, bisexual and transgender elders*. New York, NY: Policy Institute of the National Gay and Lesbian Task Force.
- Campbell, J. R., Yonge, O., & Austin, W. (2005). Intimacy boundaries between mental health nurses & psychiatric patients. *Journal of Psychosocial Nursing and Mental Health Services, 43*(5), 32–39.
- Carpenter, L. M., Nathanson, C. A., & Kim, Y. J. (2009). Physical women, emotional men: Gender and sexual satisfaction in midlife. *Archives of Sexual Behavior, 38*, 87-107.
- Carr, D. (November, 2004). The desire to date and remarry among older widows and widowers. *Journal of Marriage and Family, 66*, 1051-1068.

- Carter, J. B. (2001). Birds, Bees, and Venereal Disease: Toward an Intellectual History of Sex Education. *Journal of the History of Sexuality* 10(2), 213-249. University of Texas Press. Retrieved April 1, 2015, from Project MUSE database.
- Centers for Disease Control and Prevention. (2013). *Reported STDs in the United States: 2013 national data for chlamydia, gonorrhea, and syphilis*. Retrieved from <http://www.cdc.gov/nchhstp/newsroom/docs/std-trends-508.pdf>
- Champagne, F. A. (2008). Epigenetic mechanisms and the transgenerational effects of maternal care. *Frontiers in Neuroendocrinology*, 29, 386–397.
<http://dx.doi.org/10.1016/j.yfrne.2008.03.003>
- Cherry Holt Care Home. (2007). *Statement of purpose*. Retrieved from http://www.fbccarehomes.com/js/plugins/filemanager/files/Cherry_Holt_SOP.pdf
- Chew, K.-K., Bremner, A., Stuckey, B., Earle, C., & Jamrozik, K. (2008). Sex life after 65: How does erectile dysfunction affect aging and elderly men. *The Aging Male*, 12, 41–46. <http://dx.doi.org/10.1080/13685530802273400>
- Cottone, R. R., & Tarvydas, V. M. (2002). *Ethical and professional issues in counseling* (2nd ed.). Upper Saddle River, NJ: Merrill Prentice Hall.
- Creswell, J. W. (1998). *Qualitative inquiry and research design: Choosing among five traditions*. Thousand Oaks, CA: Sage.
- Creswell, J. W. (2003). *Research design: Qualitative, quantitative, and mixed method approaches* (2nd ed.). Thousand Oaks, CA: Sage.
- Croft, L. H. (1982). *Sexuality in later life: A counseling guide for physicians*. Boston, MA: Bristol-Wright.

- Davies, N. (2011) Promoting healthy ageing: The importance of lifestyle. *Nursing Standard*, (25)19, 43-49.
- DeLamater, J., & Karraker, A. (2009). Sexual functioning in older adults. *Current Psychiatry Reports*, 11, 6–11. <http://dx.doi.org/10.1007/s11920-009-0002-4>
- DeLamater, J., & Moorman, S. M. (2007). Sexual behavior in later life. *Journal of Aging and Health*, 19, 921–945. <http://dx.doi.org/10.1177/0898264307308342>
- DeLamater, J., & Sill, M. (2005). Sexual desire in later life. *Journal of Sex Research*, 42, 138–149. <http://dx.doi.org/10.1080/00224490509552267>
- Dessel, R., & Ramirez, M. (revised 2013). Policies and procedures concerning sexual expression at the Hebrew home in riverdale. *Hebrew Home in Riverdale*. Retrieved from www.hebrewhome.org
- DiMeo, P. J. (2006). Psychosocial and relationship issues in men with erectile dysfunction. *Urologic Nursing Journal*, 26, 442–453. Retrieved from <https://www.sun.org/unj>
- Doll, G. A. (2003). *Pioneering change: Sexuality in nursing homes education module to promote excellent alternatives in Kansas*. Manhattan: Kansas Department for Aging and Disability Services. Retrieved from <http://www.kdads.ks.gov/>
- Doll, G. A. (2012). *Sexuality and long-term care: Understanding and supporting the needs of older adults*. Baltimore, MD: Health Professions Press.
- Drageset, J., Kirkevold, M., & Espehaug, B. (2011). Loneliness and social support among nursing home residents without cognitive impairment: A questionnaire survey. *International Journal of Nursing Studies*, 48, 611–619. <http://dx.doi.org/10.1016/j.ijnurstu.2010.09.008>

- Drummond, J. D., Brotman, S., Silverman, M., Sussman, T., Orzeck, P., Barylak, L., & Wallach, I. (2013). The impact of caregiving: Older women's experiences of sexuality and intimacy. *Affilia: Journal of Women and Social Work, 28*, 415–428. <http://dx.doi.org/10.1177/0886109913504154>
- Erlandsson, K., Dsilna, A., Fagerberg, I., & Christensson, K. (2007). Skin-to-skin care with the father after cesarean birth and its effect on newborn crying and prefeeding behavior. *Birth: Issues in Perinatal Care, 34*, 105–114. <http://dx.doi.org/10.1111/j.1523-536X.2007.00162.x>
- Esposito, G., Yoshida, S., Ohnishi, R., Tsuneoka, Y., Rostagno, M. D. C., Yokota, S., Kuroda, K. O. (2013). Infant calming responses during maternal carrying in humans and mice. *Current Biology, 23*, 739–745. <http://dx.doi.org/10.1016/j.cub.2013.03.041>
- Everett, B. (2008). Supporting sexual activity in long-term care. *Nursing Ethics, 15*(1), 87–96. <http://dx.doi.org/10.1177/0969733007083937>
- Felluga, D. (2011). *Modules on Freud: On psychosexual development. Introductory guide to critical theory*. Retrieved from <http://www.purdue.edu/guidetotheory/psychoanalysis/freud.html>
- Fischer, C. T. (2009). Bracketing in qualitative research: Conceptual and practical matters. *Psychotherapy Research, 19*(4/5), 583-590. [doi:10.1080/10503300902798375](https://doi.org/10.1080/10503300902798375)
- Fischer, L. L. (2010). *Sex, romance, and relationships: AARP survey of midlife and older adults*. Retrieved from http://assets.aarp.org/rgcenter/general/srr_09.pdf

- Fisher, T. H. (2012). What sexual scientists know about gender differences and similarities in sexuality. *Society for the Scientific Study of Sexuality*.
- Foos, P. W., & Clark, M. C. (2011). Adult age and gender differences in perceptions of facial attractiveness: Beauty is in the eye of the older beholder. *Journal of Genetic Psychology: Research and Theory on Human Development*, 172, 162–175.
<http://dx.doi.org/10.1080/00221325.2010.526154>
- Fowler, M. D. M. (Ed.). (2010). *Guide to the code of ethics: Interpretation and application*. Retrieved from <http://www.nursesbooks.org/ebooks/download/CodeofEthics.pdf>
- Frey, J. H., & Fontana, A. (1991). The group interview in social research. *Social Science Journal*, 28, 175–187. [http://dx.doi.org/10.1016/0362-3319\(91\)90003-M](http://dx.doi.org/10.1016/0362-3319(91)90003-M)
- Geertz, C. (1973). *The interpretation of cultures: Selected essays*. New York, NY: Basic Books.
- Gentili, A., & Mulligan, T. (1998). Sexual dysfunction in older adults. *Clinics in Geriatric Medicine*, 14, 383–393. Retrieved from <http://www.geriatric.theclinics.com/>
- Gleeson, M., & Timmins, F. (2004). The use of touch to enhance nursing care of older person in long-term mental health care facilities. *Journal of Psychiatric and Mental Health Nursing*, 11, 541–545. <http://dx.doi.org/10.1111/j.1365-2850.2004.00757.x>
- Goldstein-Lohman, H., & Aitken, M. J. (1995). Influence of education on knowledge and attitude toward older adult sexuality. *Physical & Occupational Therapy in Geriatrics*, 13(1/2), 51–62. http://dx.doi.org/10.1080/J148v13n01_03

- Gordon, M., & Sokolowski, M. (1 September, 2004). Sexuality in long-term care: Ethics in action. *Annals of Long-Term Care*, 12(9).
- Gott, M., & Hinchliff, S. (2003a). How important is sex in later life? The views of older people. *Social Science & Medicine*, 56, 1617–1628. [http://dx.doi.org/10.1016/S0277-9536\(02\)00180-6](http://dx.doi.org/10.1016/S0277-9536(02)00180-6)
- Gott, M., & Hinchliff, S. (2003b). Barriers to seeking treatment for sexual problems in primary care: a qualitative study with older people. *Family Practice*, 20,6 690-695. doi: 10.1093/fampra/cm612
- Grewen, K. M., Anderson, B. J., Girdler, S. S., & Light, K. C. (2003). Warm partner contact is related to lower cardiovascular reactivity. *Behavioral Medicine*, 29, 123–130. <http://dx.doi.org/10.1080/08964280309596065>
- Groenewald, T. (2004). A phenomenological research design illustrated. *International Journal of Qualitative Methods*, 3(1), Art. No. 4. Retrieved from http://www.ualberta.ca/~iiqm/backissues/3_1/pdf/groenewald.pdf
- Gruszecki, L., Forchuk, C., & Fisher, W. A. (2005). Factors associated with common sexual concerns in women: New findings from the Canadian contraceptive study. *Canadian Journal of Human Sexuality*, 14, 1-13.
- Hajjar, R. R., & Kamel, H. K. (2004). Sexuality in the nursing home, Part 1: Attitudes and barriers to sexual expression. *Journal of the American Medical Directors Association*, 5(Suppl. 2), S42–S47. [http://dx.doi.org/10.1016/S1525-8610\(04\)70092-4](http://dx.doi.org/10.1016/S1525-8610(04)70092-4)

- Hancock, B. (2002). *Trent Focus for research and development in primary health care: An introduction to qualitative research*. Retrieved from http://faculty.cbu.ca/pmacintyre/course_pages/MBA603/MBA603_files/IntroQualitativeResearch.pdf
- Hanna, A. F., & Suplee, P. D. (2012). Don't cross the Line: Respecting professional boundaries. *Nursing*, 42(9), 40–47. <http://dx.doi.org/10.1097/01.NURSE.0000418612.68723.54>
- Hargrave, T. D. (1999). “Expanding the discourse of care: Family constructed biographies of nursing home residents”: Commentary. *Families, Systems, & Health*, 17, 337–340. <http://dx.doi.org/10.1037/h0089874>
- Hayes, R. D., & Dennerstein, L. (2005). The impact of aging on sexual function and sexual dysfunction in women: A review of population-based studies. *Journal of Sexual Medicine*, 2, 317–330. <http://dx.doi.org/10.1111/j.1743-6109.2005.20356.x>
- Hayes, R. D., Dennerstein, L., Bennet, C. M., Sidat, M., Gurrin, L., & Fairley, C. K. (2008). Risk factors for female sexual dysfunction in the general population: Exploring factors associated with low sexual function and sexual distress. *Journal of Sexual Medicine*, 5, 1681-1693.
- Hebrew Home at Riverdale. (2011). Sexual consent guidelines. *The Weinberg Center and Hebrew Home of Riverdale*, 1-2.
- Hedon, F. (2003). Anxiety and erectile dysfunction: A global approach to ED enhances results and quality of life. *International Journal of Impotence Research*, 15(S2), S16-S19. [doi:10.1038/sj.ijir.3900994](https://doi.org/10.1038/sj.ijir.3900994)

- Heidegger, M. (1996). *Being and time* (J. Stambaugh, Trans.). Albany: State University of New York Press. (Original work published 1953)
- Hertenstein, M. J., Verkamp, J. M., Kerestes, A. M., & Holmes, R. M. (2006). The communicative functions of touch in humans, nonhuman primates, and rats: A review and synthesis of the empirical research. *Genetic, Social, and General Psychology Monographs*, *132*, 5–94. <http://dx.doi.org/10.3200/MONO.132.1.5-94>
- Hillier, S. M., & Barrow, G. M. (2014). *Aging, the individual, and society* (10th ed.). [Kindle DX edition]. Retrieved from <http://www.amazon.com>
- Hillman, J. L. (2000). *Clinical perspectives on elderly sexuality. Issues in the practice of psychology*. New York, NY: Kluwer Academic/Plenum.
- Hillman, J. L., & Stricker, G. (1996). Predictors of college students' knowledge of and attitudes toward elderly sexuality: The relevance of grandparental contact. *Educational Gerontology*, *22*, 539–555. <http://dx.doi.org/10.1080/0360127960220603>
- Hinrichs, K. L. M., & Vacha-Haase, T. V. (2010). Staff perceptions of same gender sexual contacts in long-term care facilities. *Journal of Homosexuality*, *57*, 776–789. <http://dx.doi.org/10.1080/00918369.2010.485877>
- Holmes, D., Reingold, J., & Teresi, J. (1996). Sexual expression and dementia. Views of caregivers: A pilot study. *International Journal of Geriatric Psychiatry*, *12*, 695–701. [http://dx.doi.org/10.1002/\(SICI\)1099-1166\(199707\)12:7%3C695::AID-GPS546%3E3.3.CO;2-3](http://dx.doi.org/10.1002/(SICI)1099-1166(199707)12:7%3C695::AID-GPS546%3E3.3.CO;2-3)

- Huang, A. J., Luft, J., Grady, D., & Kuppermann, M. (2009). The day to day impact of urogenital aging: Perspectives from racially/ethnically diverse women. *Journal of General Internal Medicine, (25)2*, 45–51. doi:10.1007/s11606-009-1135-1
- Hudson, W. H., Murphy, G. J., & Nurius, P. S. (1983). A short-form scale to measure liberal vs conservative orientations toward sexual expression. *Journal of Sexual Research, 19*, 258–272. <http://dx.doi.org/10.1080/00224498309551186>
- Joller, P., Gupta, N., Seitz, D. P., Frank, C., Gibson, M., & Gill, S. S. (2013). Approach to inappropriate sexual behaviour in people with dementia. *Canadian Family Physician, 59(3)*, 255–260.
- Kane, R. A., Kling, K. C., Bershadsky, B., Kane, R. L., Giles, K., Degenholtz, H. B., & Cutler, L. J. (2003). Quality of life measures for nursing home residents. *Journals of Gerontology, Series A: Biological Sciences and Medical Sciences, 58*, 240–248. <http://dx.doi.org/10.1093/gerona/58.3.M240>
- Kaas, M. J. (1981). Geriatric sexuality breakdown syndrome. *International Journal of Aging and Human Development, 13*, 71–77. <http://dx.doi.org/10.2190/4A16-06AH-HL5A-WKC3>
- Katz, M. B. (1986). *In the shadow of the poorhouse: A social history of welfare in America*. New York, NY: Basic Books.
- Kettl, P. (25 August, 2008). Inappropriate sexual behavior in long-term care. *Annals of Long Term Care, 16(12)*, Retrieved from <http://annalsoflongtermcare.com/content/inappropriate-sexual-behavior-long-term-care>

- King, J. H. (2014). Deconstructing the *DSM-5*: Assessment and diagnosis of sexual and gender-related disorders. *Counseling Today*, 56(8), 12–15. Retrieved from <http://ct.counseling.org/>
- Knaplund, K. S. (2008). The right of privacy and America's aging population. *Denver University Law Review*, 86, 439–456. Retrieved from <http://www.denverlawreview.org/>
- Knickman, J. R., & Snell, E. K. (August, 2002). The 2030 problem: Caring for aging baby boomers. *Health Services Research*, 37(4), 849–884. doi: 10.1034/j.1600-0560.2002.56.x
- Koch, P. B., Mansfield, P. K., Thureau, D., & Carey, M. (2005). “Feeling frumpy”: The relationships between body image and sexual response changes in midlife women. *Journal of Sex Research*, 42, 215-223.
- Kockelman, J. J. (Ed.). (1967). *Phenomenology: The philosophy of Edmund Husserl and its interpretations*. Garden City, NY: Anchor Books.
- Kontula, O., & Haavio-Mannila, E. (2009). The impact of aging on human sexual activity and sexual desire. *Journal of Sex Research*, 46, 46–56. <http://dx.doi.org/10.1080/00224490802624414>
- Kurлович, L., & Wallace, M. (1999). The Mini Mental State Examination. *Best Practices in Nursing Care to Older Adults*, 3. Retrieved from <http://www.mountsinai.on.ca/care/psych/on-call-resources/on-call-resources/mmse.pdf>

- Laflin, M. T. (1996). Promoting the sexual health of geriatric patients. *Topics of Geriatric Rehabilitation, 11*(4), 43–54. <http://dx.doi.org/10.1097/00013614-199606000-00008>
- Laganà, L., & Maciel, M. (2010). Sexual desire among Mexican-American older women: A qualitative study. *Cultural, Health, & Sexuality, 12*, 705–719. <http://dx.doi.org/10.1080/13691058.2010.482673>
- Lawrence v. Texas, 539 U.S. 558, 564-65 (2003).
- Leiblum, S. R., & Seagraves, R. T. (1989). Sex therapy with aging adults. In S. R. Leiblum & R. C. Rosen (Eds.), *Principles and practices of sex therapy: Update for the 1990s* (pp. 352–381). New York, NY: Guilford Press.
- Levine, S. B. (1998). *Sexuality in mid-life*. New York, NY: Plenum Press.
- Lincoln, Y. S., & Guba, E. G. (Ed.). (1985). *Naturalistic inquiry*. Thousand Oaks, CA: Sage.
- Lindau, S. T., Schumm, L. P., Laumann, E. O., Levinson, W., O’Muirheartaigh, C. A., & Waite, L. J. (2007). A study of sexuality and health among older adults in the United States. *New England Journal of Medicine, 357*, 762–774. <http://dx.doi.org/10.1056/NEJMoa067423>
- Lindsay, J. R. (2010). The need for more specific legislation in sexual consent capacity assessments for nursing home residents: How grandpa got his groove back. *Journal of Legal Medicine, 31*, 303–323. <http://dx.doi.org/10.1080/01947648.2010.505835>
- Loue, S. (2005). Intimacy and institutionalized cognitive impaired elderly. *Care Management, 6*, 185–190. <http://dx.doi.org/10.1891/cmaj.6.4.185>

- Madsen, P. (2010, October 14). My mother and her vibrator [Blog post]. Retrieved from <http://www.psychologytoday.com/blog/shameless-woman/201010/my-mother-and-her-vibrator>
- Mahieu, L., & Gastmans, C. (2012). Sexuality in institutionalized elderly persons: A systematic review of argument-based ethics literature. *International Psychogeriatrics*, 24, 346–357. <http://dx.doi.org/10.1017/S1041610211001542>
- Marson, L. (2009). Sexual reflexes. *Encyclopedia of Neuroscience* (pp. 3682–3686). http://dx.doi.org/10.1007/978-3-540-29678-2_5375
- Masters, W. H., & Johnson, V. E. (1966). *Human sexual response*. New York, NY: Bantam Books.
- Masters, W. H., Johnson, V. E., & Kolodny, R. C. (1994). *Heterosexuality*. New York, NY: Harper/Collins.
- McCabe, M. P., & Goldhammer, D. L. (2011). Demographic and psychological factors related to sexual desire among heterosexual women in a relationship. *Journal of Sex Research*, 49(1), 78-87. doi:10.1080/00224499.2011.569975
- McGilton, K. S., & Boscart, V. M. (2007). Close care provider-resident relationships in long-term care environments. *Journal of Clinical Nursing*, 16, 2149–2157. <http://dx.doi.org/10.1111/j.1365-2702.2006.01636.x>
- Merriam, S. B. (2002). Introduction to qualitative research. In S. B. Merriam (Ed.), *Qualitative research in practice: Examples for discussion and analysis*. San Francisco, CA: Jossey-Bass.
- Merton, R. K., & Kendall, P. L. (1946). The focused interview. *American Journal of Sociology*, 51, 541–557. <http://dx.doi.org/10.1086/219886>

- Miles, S. H., & Parker, K. (1999). Sexuality in the nursing home: Iatrogenic loneliness. *Generations*, 23(1), 36–43. Retrieved from <http://generations.metapress.com/content/120835/>
- Molloy, R. J. (2006). *Using law and regulation to protect nursing home residents when their government fails them*. New York, NY: Long Term Care Community Coalition Report. Retrieved from http://www.ltccc.org/publications/documents/Using_Law_and_Regulation_to_Protect_Nursing_Home_Residents_Updated_sept82006.pdf
- Montagu, A. (1986). *Touching: The human significance of the skin* (3rd ed.). New York, NY: Harper & Row.
- Mori, R., Khanna, R., Pledge, D., & Nakayama, T. (2010). Meta-analysis of physiological effects of skin-to-skin contact for newborns and mothers. *Pediatrics International*, 52, 161–170. <http://dx.doi.org/10.1111/j.1442-200x.2009.02909.x>
- Moustakas, C. (1994). *Phenomenological research methods*. Thousand Oaks, CA: Sage.
- Mroczek, B., Kurpas, D., Gronowska, M., & Karakiewicz, B. (2013). Psychosexual needs and sexual behaviors of nursing care homes residents. *Archives of Gerontology and Geriatrics*, 57, 32–38. <http://dx.doi.org/10.1016/j.archger.2013.02.003>
- Mulligan, T., & Palguta, R. R., Jr. (1991). Sexual interest, activity, and satisfaction among male nursing home residents. *Archives of Sexual Behavior*, 20, 199–204. <http://dx.doi.org/10.1007/BF01541944>
- Munhall, P. L. (1994). *Revisioning phenomenology: Nursing and health science research*. Burlington, MA: Jones & Bartlett Learning.

- Muzacz, A. K., & Akinsulure-Smith, A. M. (2013). Older adults and sexuality: Implications for counseling ethnic and sexual minority clients. *Journal of Mental Health Counseling, 35*(1), 1–14. Retrieved from <http://www.counseling.org/publications/counseling-journals>
- Nakhtnikian, G. (1964). Introduction. In E. Husserl, *The idea of phenomenology* (W. P. Alston & G. Nakhtnikian, Trans.). The Hague, Netherlands: Nijhoff.
- National Council of State Boards of Nursing. (2014). *A nurse's guide to professional boundaries*. Retrieved from https://www.ncsbn.org/ProfessionalBoundaries_Complete.pdf
- Nay, R. (1992). Sexuality and aged women in nursing homes. *Geriatric Nursing, 13*, 312–314. [http://dx.doi.org/10.1016/S0197-4572\(05\)80377-5](http://dx.doi.org/10.1016/S0197-4572(05)80377-5)
- Nay, R., & Garratt, S. (Eds.) (2009). *Older people: Issues and innovations in care* (3rd ed.). Chatsworth, NSW, Australia: Elsevier.
- Nobre, P. J., & Pinto-Gouveia, J. (2006). Dysfunctional sexual beliefs as vulnerability factors for sexual dysfunction. *Journal of Sex Research, 43*, 68-75.
- North American Menopause Society (NAMS). (n.d.). *Decreased desire*. Retrieved on February 4, 2015, from <http://www.menopause.org/for-women/sexual-health-menopause-onLine/sexual-problems-at-midlife/decreased-desire>
- O'Brien, M., & Lynch, H. (2011). Exploring the role of touch in the first year of life: Mothers' perspectives of tactile interactions with their infants. *British Journal of Occupational Therapy, 74*, 129–136. <http://dx.doi.org/10.4276/030802211X12996065859247>

- Parsons, Y. (1995). Private acts, public places. *Contemporary Longterm Care*, 18(3), 49–55. Retrieved from <http://www.levinassociates.com/company/ContemporaryLongTermCare>
- Pensler, R. L. (1993). *Basic IRB review: Institutional review board guidebook*. Retrieved from http://www.hhs.gov/ohrp/archive/irb/irb_guidebook.htm
- Ponterotto, J. G. (2006). Brief note on the origins, evolution, and meaning of the qualitative research concept “thick description.” *Qualitative Report*, 11, 538–549. Retrieved from <http://www.nova.edu/ssss/QR/>
- Pope, M. (1997). Sexual issues for older lesbians and gays. *Topics in Geriatric Rehabilitation*, 12(4), 53–60. <http://dx.doi.org/10.1097/00013614-199706000-00007>
- Pope, M., & Barret, B. (2002). Counseling gay men toward an integrated sexuality. In L. D. Burlew & D. Capuzzi (Eds.), *Sexuality counseling* (pp. 149–176). Hauppauge, NY: Nova Science.
- Pope, M., & Schulz, R. (1990). Sexual behavior and attitudes in midlife and aging homosexual males. *Journal of Homosexuality*, 20(3–4), 169–177. http://dx.doi.org/10.1300/J082v20n03_11
- Pope, M., & Wierzalis, E. A., Barret, B., & Rankins, M. (2007). Sexual and intimacy issues for aging gay men. *Adultspan Journal*, 6, 68–82. <http://dx.doi.org/10.1002/j.2161-0029.2007.tb00033.x>
- Powell, R. A., & Single, H. M. (1996). Focus groups. *International Journal for Quality in Health Care*, 8, 499–504. <http://dx.doi.org/10.1093/intqhc/8.5.499>

- Ragno, J. G. (1996). Successful redirection of the sexually disruptive resident. *Activities, Adaptation & Aging, 21*(1), 37–42. http://dx.doi.org/10.1300/J016v21n01_04
- Reingold, J. (1997). Rights of nursing home residents to sexual expression. *Clinical Geriatrics, 5*, 52–57. Retrieved from <http://www.clinicalgeriatrics.com/>
- Resident Rights, 42 C.F.R. § 483.10 (2002).
- Roach, S. M. (2004). Sexual behaviour of nursing home residents: Staff perceptions and responses. *Issues and Innovations in Nursing Practice, 48*, 371–379.
<http://dx.doi.org/10.1111/j.1365-2648.2004.03206.x>
- Rosenzweig, A. S. (2012). *The harsh realities of Alzheimer's care: An insider's view of how people with dementia are treated in institutions*. Santa Barbara, CA: Praeger.
- Rossi, A. S. (Ed.). (1994). *Sexuality across the life course*. Chicago, IL: University of Chicago Press.
- Routasalo, P. & Isola, A. (1996). The right to touch and be touched. *Nursing Ethics, 3*, 165–176. <http://dx.doi.org/10.1177/096973309600300209>
- Ryan, F., Coughlan, M., & Cronin, P. (2007). Step-by-step guide to critiquing research. Part 2: Qualitative research. *British Journal of Nursing, 16*, 738–744.
<http://dx.doi.org/10.12968/bjon.2007.16.12.23726>
- Schroeder, C., & Neil, R. M. (1992). Focus groups: A humanistic means of evaluating an HIV/AIDS programme based on caring theory. *Journal of Clinical Nursing, 1*, 265–274. <http://dx.doi.org/10.1111/j.1365-2702.1992.tb00115.x>
- Schwandt, T. A. (2001). *Dictionary of qualitative inquiry* (2nd ed.). Thousand Oaks, CA: Sage.

- Seeman, T. E. (2000). Health promoting effects of friends and family on health outcomes in older adults. *American Journal of Health Promotion, 14*, 362–370.
<http://dx.doi.org/10.4278/0890-1171-14.6.362>
- Seidman, I. (2013). *Interviewing as qualitative research: A guide for researchers in education and the social sciences* (4th ed.). New York, NY: Teachers College Press.
- Sim, J. (1997). Collecting and analysing qualitative data: Issues raised by the focus group. *Journal of Advanced Nursing, 28*, 345–352. <http://dx.doi.org/10.1046/j.1365-2648.1998.00692.x>
- Smith, J. A. (Ed). (2008). *Qualitative psychology: A practical guide to research methods* (2nd ed.). Thousand Oaks, CA: Sage.
- Smith, J. A., & Osborn, M. (2008). Interpretative phenomenological analysis. In J. A. Smith (Ed.), *Qualitative psychology: A practical guide to research methods* (2nd ed., pp. 53-80). Thousand Oaks, CA: Sage.
- Smith, T. W., & Son, J. (April, 2013). Trends in public attitudes about sexual morality. *NORC at the University of Chicago*.
- Sprankles, J. (2013, February 6). *Sexy senior Betty White: Famous older women still workin' it*. Retrieved from <http://www.sheknows.com/entertainment/articles/984357/betty-white-and-others-still-sexy-as-seniors>
- Street, D., Burge, S., Quadagno, J., & Barrett, A. (2007). The salience of social relationships for resident well-being in assisted living. *Journal of Gerontology, Series B: Psychological Sciences and Social Sciences, 62*, S129–S134.
<http://dx.doi.org/10.1093/geronb/62.2.S129>

- Tabak, N., Shemesh-Kigli, R. (2006). Sexuality and Alzheimer's disease: Can the two go together? *Nursing Forum*, 41, 158–166. <http://dx.doi.org/10.1111/j.1744-6198.2006.00054.x>
- Taylor, A., & Gosney, M. A. (August, 2011). Sexuality in older age: Essential considerations for healthcare professionals. *Age and Ageing*, 0, 1-6.
doi:10.1093/ageing/afr049
- Trafford, A. (2009). *As time goes by: Boomerang marriages, serial spouses, throwback couples and other romantic adventures in an age of longevity*. New York, NY: Basic Books.
- U.S. Census Bureau. (2012). *Table 73: Group quarters population by type of group quarter and selected characteristics: 2009*. Retrieved from <http://www.census.gov/compendia/statab/2012/tables/12s0073.pdf>
- U.S. Social Security Administration. (2002). Title of article. *Social Security Bulletin*, 64(1). Retrieved from <http://www.socialsecurity.gov/policy/docs/ssb/v64n1/index.html>
- U.S. Social Security Administration. (2009a). *History of Social Security*. Retrieved from <http://www.socialsecurity.gov/history/briefhistory3.html>
- U.S. Social Security Administration. (2009b). *Older Americans Act of 1965*. Retrieved from http://www.ssa.gov/OP_Home/comp2/F089073.html
- Vancouver Coastal Health Authority. (15 July, 2009). *Supporting Sexual Health and Intimacy in Care Facilities: Guidelines for Supporting Adults Living in Long-Term Care Facilities and Group Homes in British Columbia, Canada*.

- Vares, T., Potts, A., Gavey, N., & Grace, V. M. (2007). Reconceptualizing cultural narratives of mature women's sexuality in the Viagra era. *Journal of Aging Studies, 21*, 153-164.
- Walker, B. L., & Harrington, D. (2002). Effects of staff training on staff knowledge and attitudes about sexuality. *Educational Gerontology, 28*, 639-654.
<http://dx.doi.org/10.1080/03601270290081452>
- Walker, B. L., Osgood, N. J., Richardson, J. P., & Ephross, P. H. (1998). Staff and elderly knowledge and attitudes toward elderly sexuality. *Educational Gerontology, 24*, 471-489. <http://dx.doi.org/10.1080/0360127980240504>
- Walsh, S. A. (2009). Conducting research with the elderly: Ethical concerns for a vulnerable population. *Southern Online Journal of Nursing Research, 9*(4), Art. No. 4. Retrieved from <http://snrs.org/sojnr>
- Wasow, M., & Loeb, M. B. (1979). Sexuality in nursing homes. *Journal of the American Geriatrics Society, 27*, 73-79. Retrieved from [http://onlinelibrary.wiley.com/journal/10.1111/\(ISSN\)1532-5415](http://onlinelibrary.wiley.com/journal/10.1111/(ISSN)1532-5415)
- Werner, C. A. (2011). *The older population: 2010*. Retrieved from <http://www.census.gov/prod/cen2010/briefs/c2010br-09.pdf>
- Wetherill, G. G. (1961). Sex education in the public schools. *The Journal of School Health, The American School Health Association 31*(7).
- Whipple, B. (2002). Women's sexual pleasure and satisfaction: A new view of female sexual function. *The Female Patient, 27*(8), 39-44. Retrieved from <http://www.femalepatient.com>

- White, C. B. (1981, August). *A scale for the assessment of attitudes and knowledge regarding sexuality in the aged*. Paper presented at the 89th Annual Convention of the American Psychological Association, Los Angeles, CA.
- Wiley, D., & Bortz, W. M., II (1996). Sexuality and aging—usual and successful. *Journals of Gerontology, Series A: Biological Sciences and Medical Sciences, 51*, M142–M146. <http://dx.doi.org/10.1093/gerona/51A.3.M142>
- Willert, A., & Semans, M. (2000). Knowledge and attitudes about later life sexuality: What clinicians need to know about helping the elderly. *Contemporary Family Therapy, 22*, 415–435. <http://dx.doi.org/10.1023/A:1007896817570>
- Yeh, C. J., & Inman, A. G. (2007). Qualitative data analysis and interpretation in counseling: Strategies for best practice. *Counseling Psychologist, 35*, 369–403. <http://dx.doi.org/10.1177/0011000006292596>

APPENDICES

Appendix A: Call for Facilities



Department of Counseling and Family Therapy

8001 Natural Bridge Road

St. Louis, Missouri 63121-4499

Telephone: 314-516-5782

Fax: 314-516-5784

Researcher Telephone: 314-255-3289

E-mail: amr7b2@umsl.edu

CALL FOR FACILITIES

My name is Angie Schubert and I am a doctoral student in the Division of Counseling and Family Therapy at the University of Missouri-St. Louis, conducting research under the supervision of Dr. Mark Pope. While in college, I worked as a CNA at a local nursing home in Illinois. I came to appreciate each and every resident and grew to know of their wisdom that only time and experience can teach. From their stories, I found out that so many residents still remained desirous and intently expressed their desire to be sexually expressive and to be loved and to love another. As a CNA, I wanted to learn how to approach my residents with respect and at the same time honoring them as sexual beings who desire and love. Much research has shown how tremendously beneficial it is for people in later stages of life to maintain a healthy sexual lifestyle. Moreover, effective professional development trainings on sexual expression, physiological characteristics of the aging body, and positive sexuality can result in higher levels of empathy from staff to residents, increased awareness of individual resident needs, decreased ageist responses to aging sexuality of both the residents and staff, and can result in a higher quality of life of residents.

I am asking you to participate in my research study on sexual expression of residents in nursing homes and how whether that interest is effected as a result of living in a nursing home. I am also looking at how current nursing home policies effect the overall sense of comfort with and willingness to engage in sexual expression. There is little research on the topic of sexual expression and interest from the individual perspectives of the nursing home residents. I believe your facility will greatly advance the knowledge in the nursing home field on this particular topic. If your facility chooses to participate, you will be asked to provide information on any nursing home policies on sexual expression, how long your nursing home facility has existed, and whether you hold state accreditation. Two facilities will be selected from a random sampling. Those facilities must have been established for 10 years or longer, and hold state licensure. One nursing home with a policy on sexual expression will be selected and one nursing home without a policy on sexual expression will be selected. For the facility that has a policy, I will request a copy of the policy manual.

If your facility is selected, I will propose the research to your residents and staff. Then, I will interview four to six self-nominated residents about their experiences and stories of love, desire, intimacy, and sexuality. I will also like to ask up to six staff to participate in a small focus group to discuss their experiences with sexual expression and desire among nursing home residents. These interviews will be confidential and will take place in a private room selected by the participants. I expect the resident interviews to take approximately 45-60 minutes each and the focus group to take approximately 60-90 minutes.

I will audio-record the interviews and focus group so that I can listen to it later. A typed copy of the interview will be made and the audio-recording will be erased. I will use a pseudonym on the typed interview to conceal participant identity. As a token of appreciation, I will offer your facility a free 3-hour professional development training on aging sexuality, if desired. If you have any questions or concerns regarding this study, or if you would like your facility to participate, you may contact me, Angie Schubert, at (314) 255-3289 or email me at amr7b2@umsl.edu. You may also contact my dissertation advisor, Dr. Mark Pope, at (314) 516-7121. I want to thank you in advance and I look forward to our time together.

Sincerely,
Angela M. Schubert, M.Ed, LPC
Doctoral Candidate
University of Missouri – Saint Louis

Appendix B: Call for Resident Participants



Department of Counseling and Family Therapy

8001 Natural Bridge Road

St. Louis, Missouri 63121-4499

Telephone: 314-516-5782

Fax: 314-516-5784

Researcher Telephone: 314-255-3289

E-mail: amr7b2@umsl.edu

CALL FOR PARTICIPANTS

Dear Potential Participant,

My name is Angie Schubert and I am a doctoral student in the Division of Counseling and Family Therapy at the University of Missouri-St. Louis, conducting research under the supervision of Dr. Mark Pope. While in college, I worked as a CNA at a local nursing home in Illinois. I came to appreciate each and every resident and grew to know of their wisdom that only time and experience can teach. From their stories, I found out that so many residents still remained desirous and intently expressed their desire to be sexually expressive and to be loved and to love another. Society needs voices like yours to bring awareness on the natural fact that love, desire, intimacy, and sexual interest continues throughout a person's life. Did you know that much research has shown that people well into their 80s still remain sexually active and while the way in which sexuality and desire is expressed changes over time, there still remains a great desire to be sexually and intimately connected?

I am asking you to participate in my research study on sexual expression of residents in nursing homes. I want to understand how sexual expression is affected as a result of living in a nursing home. There is little research on the topic of sexual expression or information on individual perspectives of the nursing home residents themselves. I believe your input is important and valuable and can make a difference. If you choose to participate, I will interview you about your experiences and stories of love, desire, intimacy, and sexuality. These interviews will be confidential and will take place in a private room selected by you. I expect the interviews to take approximately 45-60 minutes. Your participation is voluntary and you may choose not to participate in this research study or to withdraw at any time without penalty.

I will audio-record the interview so that I can carefully listen to it later. A typed copy of the interview will be made and the audio-recording will be erased. I will use a fake name on the typed interview to conceal your identity. Identifying information about individuals will be removed. If you have any questions or concerns regarding this study, or if you would like to participate, you may contact me, Angie Schubert, at (314) 255-3289. You may also contact my dissertation chair, Dr. Mark Pope, at (314) 516-7121.

I want to thank you in advance and I look forward to our time together,
Angie Schubert

Please write out your name and room # and place an 'X' in the YES or NO box to signify whether you will or will not participate in the study. If you choose YES then I will meet with you later to discuss a time to do the interview. Thank you again for your courage and your story. I very much look forward to meeting with you. If you need any hearing assistance to participate in this study, please let me know. Your story matters and your perspectives are important.

Name: _____ Room # _____

I wish to participate in the study.

YES

NO

Appendix C:

Call for Staff Participants



Department of Counseling and Family Therapy

8001 Natural Bridge Road

St. Louis, Missouri 63121-4499

Telephone: 314-516-5782

Fax: 314-516-5784

Researcher Telephone: 314-255-3289

E-mail: amr7b2@umsl.edu

CALL FOR PARTICIPANTS

Dear Potential Staff Participant,

My name is Angie Schubert and I am a doctoral student in the Division of Counseling and Family Therapy at the University of Missouri-St. Louis, conducting research under the supervision of Dr. Mark Pope. While in college, I worked as a CNA at a local nursing home in Illinois. I came to appreciate each and every resident and grew to know of their wisdom that only time and experience can teach. From their stories, I found out that so many residents still remained desirous and intently expressed their desire to be sexually expressive and to be loved and to love another. Society needs voices like yours to bring awareness on the natural fact that love, desire, intimacy, and sexual interest continues throughout a person's life. Did you know that much research has shown that people well into their 80s still remain sexually active and while the way in which sexuality and desire is expressed changes over time, there still remains a great desire to be sexually and intimately connected?

I am asking you to participate in my research study on sexual expression of residents in nursing homes. I want to understand how sexual expression is affected as a result of living in a nursing home. There is little research on the topic of sexual expression or information on individual perspectives of the nursing home residents themselves. I believe your input is important and valuable and can make a difference, as it will offer the chance to highlight the lived positive sexual experiences of nursing home residents. Moreover, you will have the chance to share your perspective of how policy and practice are presented in the nursing home. Staff members with a **minimum of five years** in nursing home practice will be offered the opportunity to participate. If you meet the criteria and are interested, your name will be placed in a drawing of other staff members and up to six names will be drawn to participate in one roundtable discussion called a focus group. I expect the focus group to take approximately 60 minutes to 90 minutes. Your participation is voluntary and you may choose not to participate in this research study or to withdraw at any time without penalty. Those who are selected to be in the focus group will be asked to sign a consent form requesting each participant to maintain confidentiality of what is discussed.

I will audio-record the interview so that I can carefully listen to it later. A typed copy of the interview will be made by the professional transcriber. After the transcription with pseudonyms are identified, the audio-recording will be erased. I will use a fake name on the typed interview to conceal your identity. Identifying information about individuals will be removed. If you have any questions or concerns regarding this study, or if you would like to participate, you may contact me, Angie Schubert, at (314) 255-3289 or email me at amr7b2@umsl.edu. You may also contact my dissertation chair, Dr. Mark Pope, at (314) 516-7121.

I want to thank you in advance and I look forward to our time together,

Angie Schubert

Appendix D:**Informed Consent for Participation in Research Activities—Residents****Department of Counseling and Family Therapy**

8001 Natural Bridge Road

St. Louis, Missouri 63121-4499

Telephone: 314-516-5782

Researcher Telephone: 314-255-3289

Fax: 314-516-5784

E-mail: amr7b2@umsl.edu

Informed Consent for Participation in Research Activities

Attitudes toward Aging Sexual Expression in Nursing Homes: An Exploration of the Older Adult Resident Phenomenon

Participant _____ HSC Approval
Number _____Principal Investigator _____ PI's Phone
Number _____

Dear Resident Participant,

My name is Angela Schubert and I am a doctoral student in the Division of Counseling and Family Therapy at the University of Missouri - St. Louis. I am conducting a phenomenological qualitative research study on the attitudes of elderly nursing home residents on sexual expression, desire, and interest in intimacy. I am also looking at how sexual interest and behaviors of residents are perceived and received by both residents and nursing home staff. Please read this form and ask any questions before agreeing to be in the research. Your participation in this research is voluntary. By signing in the space provided below, you give your consent for me to use the information from the interview in my study. You are free to end the interview at any time or to not answer any particular question without affecting your current or future relations with the University or current residence including enduring consequences of any kind.

The interviews will occur at your convenience and will take 45-60 minutes, depending on the amount of time that you agree to provide. The interview will be audio taped in order to be transcribed for study purposes. You will be asked to review the transcript of your audio taped interview for content accuracy. Upon completion of this research study you will be contacted and asked to verify your interview. The use of pseudonyms in the study will conceal your identity. I plan to interview a minimum of eight to ten other participants for this research. I may follow up with you after I transcribe all of the interview, so you have a chance to confirm and clarify your responses on a given question.

There are no identified benefits except that your voice will illuminate the phenomenon of resident sexual experience. If your facility has a gift shop you may have the chance to have your name placed in a raffle to win a \$25.00 gift card to the gift shop. It is possible (but not probable) that you might have negative feelings come up about your interest and attitude towards sexual expression and intimacy. If this happens, you can choose to not answer certain questions or you can end the interview. Please know that I will not share any information you tell me with the nursing home staff or facility. The only exception to this is if you tell me that you plan to harm yourself or someone else; in that case, I am required by law to notify the proper authorities. I will not ask any questions about harm, and you are asked not to make such statements. The only persons who will know your identity as a research subject are you and I—no identifying information will be disclosed about you without your written permission.

By agreeing to participate, you agree that your data may be shared with other researchers and educators in the form of presentations and/or publications. In all cases, your identity will not be revealed. In rare instances, a researcher's study must undergo an audit or program evaluation by an oversight agency (such as the Office for Human Research Protection). That agency would be required to maintain the confidentiality of your data. In addition, all data will be stored on a password-protected computer and/or in a locked office. Research data will be stored in a locked file in my home office. Audio tapes from this interview will be destroyed within twelve months.

At the end of the study, you may request a copy of the executive summary of findings and themes; however, to protect all participants a full report will be accessible upon request one year from the time the study was conducted. Please ask any questions you have now. If you have questions later, you may contact me at (314) 255-3289 or Dr. Mark Pope, Dissertation Chair, at (314) 516-7121.

I have read the above statement and have been able to express my concerns, to which the investigator has responded satisfactorily. I will also be given a copy of this consent form for my records.

I believe I understand the purpose of the study, as well as the potential benefits and risks that are involved. I give my permission to participate in the research described above.

_____	_____	_____
Participant's Signature	Date	Participant's Printed Name
_____	_____	_____
Researcher's Signature	Date	Researcher's Printed Name

Appendix E:

Demographic Questionnaire—Resident



Department of Counseling and Family Therapy

8001 Natural Bridge Road

St. Louis, Missouri 63121-4499

Telephone: 314-516-5782

Researcher Telephone: 314-255-3289

Fax: 314-516-5784

E-mail: amr7b2@umsl.edu

Demographic Questionnaire

Name: _____ Facility: _____

Email: _____ Phone: _____

1. Age _____ 2. Date of Birth _____ 3. Race/Ethnicity _____

4. Is this your first nursing home facility? _____

5. What is your educational story? _____Grade school _____High school _____Some
high school _____Some college _____Finished college _____Post College

6. What was your last paid job? _____

7. What was your last volunteer job? _____

8. What is your gender (choose all that apply)?

_____Male

_____Female

_____Trans male/Trans man

_____Trans female/Trans woman

_____Transgender

_____Not listed. Please specify.

9. Do you think of yourself as:

_____Lesbian, Gay, or Homosexual

_____Straight or heterosexual, that is, not gay or lesbian

___ Bisexual

___ Not sure

___ Not listed above. Please specify. _____

10. Do you have at least one boyfriend or girlfriend? _____

11. When and how did you find out about sex?

12. What do you do to feel sexy?

13. How long have you resided at this facility? _____

14. Do you share a room with someone? _____

15. Are you related to your roommate? _____

Appendix F:

Informed Consent for Participation in Research Activities—Staff



Department of Counseling and Family Therapy

8001 Natural Bridge Road
 St. Louis, Missouri 63121-4499
 Telephone: 314-516-5782
 Researcher Telephone: 314-255-3289
 Fax: 314-516-5784
 E-mail: amr7b2@umsl.edu

Informed Consent for Participation in Research Activities Attitudes toward Aging Sexual Expression in Nursing Homes: An Exploration of the Older Adult Resident Phenomenon

Participant _____ HSC Approval
 Number _____

Principal Investigator _____ PI's Phone
 Number _____

Dear Staff Participant,

My name is Angela Schubert and I am a doctoral student in the Division of Counseling and Family Therapy at the University of Missouri - St. Louis. I am conducting a phenomenological qualitative research study on the attitudes toward elderly nursing home residents on sexual expression, desire, and interest in intimacy. I am also looking at how sexual interest and behaviors of residents are perceived and received by both residents and nursing home staff. Please read this form and ask any questions before agreeing to be in the research.

This interview will occur at a scheduled time most convenient for all participants and will take 60-90 minutes, depending on the amount of time that you agree to provide. The interview will be audio taped in order to be transcribed for study purposes. You will be asked to review the transcript of your audio taped interview for content accuracy. The use of pseudonyms in the study will conceal your identity. The focus group will consist of approximately five to six other staff members. I may follow up with you after I transcribe all of the interview, so that you have a chance to confirm and clarify your responses on a given question.

There are no identified benefits except that your voice will illuminate the phenomenon of resident sexual experience. If your facility has a gift shop you may have the chance to

have your name placed in a raffle to win a \$25.00 gift card to the gift shop. It is possible (but not probable) that you might have negative feelings come up about your interest and attitude toward aging sexual expression and intimacy. If this happens, you can choose to not answer certain questions or you can end the interview. Please know that I will not share any information you tell me with the nursing home staff or facility. The only exception to this is if you tell me that you plan to harm yourself or someone else; in that case, I am required by law to notify the proper authorities. I will not ask any questions about harm, and you are asked not to make such statements. The only persons who will know your identity as a research participant are you, the participants in the focus group, and I—no identifying information will be disclosed about you without your written permission.

Your participation in this research is voluntary. You are free to leave the focus group at any time or to not answer any particular question without affecting your current or future relations with the facility. By agreeing to participate, you approve that your data may be shared with other researchers and educators in the form of presentations and/or publications. In all cases, your identity will not be revealed. In rare instances, a researcher's study must undergo an audit or program evaluation by an oversight agency (such as the Office for Human Research Protection). That agency would be required to maintain the confidentiality of your data. In addition, all data will be stored on a password-protected computer and/or in a locked office. Research data will be stored in a locked file in my home office. Audio tapes from this interview will be destroyed within twelve months. At the end of the study, you may request a copy of the executive summary of findings and themes; however, to protect all participants a full report will be accessible upon request one year from the time the study was conducted. Please ask any questions you have now. If you have questions later, you may contact me at (314) 255-3289 or Dr. Mark Pope, Dissertation Chair, at (314) 516-7121.

I have read the above statement and have been able to express my concerns, to which the investigator has responded satisfactorily. I will also be given a copy of this consent form for my records.

I believe I understand the purpose of the study, as well as the potential benefits and risks that are involved. I give my permission to participate in the research described above.

_____	_____	_____
Participant's Signature	Date	Participant's Printed Name

Participant Title		
_____	_____	_____
Researcher's Signature	Date	Researcher's Printed Name

Appendix G:**Cover Letter for Member Check****Department of Counseling and Family Therapy**

8001 Natural Bridge Road

St. Louis, Missouri 63121-4499

Telephone: 314-516-5782

Researcher Telephone: 314-255-3289

Fax: 314-516-5784

E-mail: amr7b2@umsl.edu

Cover Letter for Member Check

Dear Participant,

Thank you for your participation in my dissertation research. Currently, I am conducting member checks to increase trustworthiness for the data analysis. A member check is simply a way of allowing you the chance to verify the accuracy of the transcript. Your participation with the member check may be lengthy. Please take a moment to review the attached document that categorizes themes that emerged during analysis and send comments in a response email. Comments should reflect your opinion regarding the accuracy of the themes from your point of view.

Thank you very much for this last effort at assisting me in this project. After successfully defending this dissertation I can mail you a copy of the executive summary of the findings and themes. A full report of the study will be accessible one year from the time the study was conducted. I appreciate your contributions.

Sincerely,

Angela M. Schubert, M.Ed, LPC
Doctoral Candidate
University of Missouri – Saint Louis

Appendix H:

Interview Questions



Department of Counseling and Family Therapy

8001 Natural Bridge Road

St. Louis, Missouri 63121-4499

Telephone: 314-516-5782

Researcher Telephone: 314-255-3289

Fax: 314-516-5784

E-mail: amr7b2@umsl.edu

Interview Questions

Introduction

My study is looking at the policies, practices, and climate within Nursing Home environments around sexual intimacy opportunities. Thank you for your willingness to share some observations and thoughts on this topic.

Individual Resident Participant Interview Questions

1. There is sometimes an innate need to be physically connected to another person. How comfortable are you when people touch you?
2. If you have or had a partner, in what ways has your sexual relationship evolved or changed as you have aged?
3. Where do you find your pleasure?
4. Can you describe your interest in self-stimulation?
5. What do you dress up for? Perfume, make-up, etc.?
6. How do you play out your fantasy?
7. What are some messages you have received about intimate expression in the nursing home? Both pro and con...
8. In what ways are people here involved in romantic relationships? How does that work for them? If any, what kind of issues do they experience in expressing their care for one another?
9. What are some ways that you and the people you know express their sexual selves? How willing are people to talk about this with one another? With staff? With Family?

10. If applicable, how have your relationships changed since you moved into a nursing home? Especially in terms of touching and sexual expression?
11. What positives, concerns, or questions do you have about fulfilling your continuing sexual needs?
12. What interventions or information can I provide you on the topic of sexual expression in older adults?

Semi-structured Focus Group Questions

1. What policies are in place for relational privacy?
2. Is there an educational training for new staff and continued learning workshops on sexual expression for the rest of the staff?
3. If you have received training on sexual expression in the nursing home, was it part of your employee orientation or was there something that occurred in the nursing home that brought on the need for the training?
4. Tell me about how the opportunities for sexual expression work here at this nursing home. If possible share some stories of people that you are aware of that might illustrate your explanation.
5. Are you satisfied with current policy and practice?
6. To what extent do staff members agree on how to handle romances and/or sexual needs of residents?
7. If there is a policy in place, how is it implemented in the nursing home?
8. What are some of your experiences with interventions or observations of sexual expression among the residents?
9. How do you understand the power of touch?

Appendix I: Master table of Superordinate Themes and Subordinate Themes

Themes	Sample quotes from interviews
1. Actual and perceived sexual beliefs of self	
1.1 Identity as a sexual being and spouse	I'm partly bisexual.
1.2 Self-attraction	I think I am attractive. I always thought I was a good-looking man. I don't know really that I do feel sexy. I try to look nice. I don't always succeed in that.
1.3 Interest in intimacy and interpersonal attraction	I trained one and I don't want to train another one. I like females as well as I ever did.
2. Updating the sexual script	
2.1 Personal reaction to sexual difficulties	No! My interest, my interest is as almost as good as it ever was. I don't know what to do with it.
2.2 Desire and mental imprisonment	It's on my mind, but that's as far as it goes, I think. I think about it too but what the hell is the difference, you now. You think about it, oh boy that might be good.
2.3 Confusion and conflict with masturbation	I could do that, but I don't . . . it don't seem like it appeals to me much. . . . It don't replace a woman.
2.4 Intimacy evolved	We found other ways of fulfilling that need.
3. Affordances to sexual expression	
3.1 Privacy, staff support, and opportunity	Everybody here knows we close the door and turn our light out and just have a very low light and we are in each other's arms.
3.2 Resident attitude toward sexual expression	They've (residents) got to touch each other.
4. Barriers to sexual expression	
4.1 Resident knowledge of sexual expression policies	I don't know if there is. They never told me about it.
4.2 Limited opportunities to meet people or date	And then I don't know how to get a partner in here if I could do it.
4.3 Limited privacy	They (staff) usually will knock, but then just come right on in.

Themes	Sample quotes from interviews
4.4 Comfort level with sex discussion with staff and doctors	I'm not very comfortable . . . I would ask the nurse more than I would ask the administrator. Not about sex.
5. Actual and perceived relationships with nursing staff and others	
5.1 Perception of nurse care	I love when a nurse comes up and hugs me and kisses me on the cheek.
5.2 Perception of opportunity involving staff	I try not to get overboard on the sexuality with the nurses, but . . . I've gone a little further with some of them than I have the others.
5.3 Companionship and isolation	If it's kinfolk, I like a hug from them. Otherwise I don't really care for it, especially if it's a man.