Sexuality in Nursing Homes
Practice and Policy
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ABSTRACT
Older adults' sexuality and sexual expression are often overlooked in nursing home and residential care settings. Despite cultural beliefs that this population is asexual, sexual activity occurs frequently among residents in long-term care. This study, using written survey instrumentation, examines the scope of resident sexuality, staff reactions to sexual behavior, and the policies and guidelines used in 91 nursing homes to address residents' sexual activity. Eighty-five percent of respondents reported that sexual activity had occurred in their homes, and staff reactions to sexual activity were based on general guidelines. Many responses indicated that sexual expression of residents was considered non-normative. Issues of consent, especially concerning residents with dementia, and residents' right to privacy were addressed using existing general policies. Survey results demonstrate a need for specific policies and staff training regarding sexual expression to be developed with the input of nurses, family members, and residents. [Journal of Gerontological Nursing, 39(7), 30-37.]

Thomas (pseudonym), a nursing home resident with alcohol-related dementia, was well liked by other residents and staff and fairly competent in taking care of himself. After several months of residence, he was accused of groping and propositioning a female resident on three separate occasions. The woman he accosted said “no,” and he complied each time, but the nursing staff was concerned he might turn his attention to residents incapable of denying his advances. The nurses ordered psychiatric consults to determine Thomas’ ability to make sound decisions and asked administrators if they could have him discharged to avert any potential danger.

This true story illuminates the complexity of sexual expression in long-term care and how it may cause disruption in the life of nursing home residents. Al-
though nursing homes are highly regulated environments, minimal guidance on sexual issues is provided through state and federal regulations. It is unclear why resident sexuality has not been addressed when guidelines for other resident rights are well determined and how long-term care administrators and staff can resolve situations. Ageism may lead policy makers and caregivers to believe that older people are asexual (Langer, 2009) and therefore have no interest in sexual expression. This article focuses on the types of sexual expression demonstrated by residents in nursing homes and the reactions to those expressions by caregivers, family members, and the organization. Implications for policy and staff training are discussed.

BACKGROUND AND SIGNIFICANCE

Sexuality is sometimes mistakenly thought to encompass only sexual intercourse. Many definitions of sexuality have been offered, and all include a broad range of activity, behaviors, and attitudes. Kamel (2001) stated that sexuality involves the whole experience of the person’s self, including the ability to form relationships with others, feelings about oneself, and the impact of physiological age-related changes on sexual functioning. Sexuality is closely linked with intimacy. Hillman (2000) claimed that sexual intimacy is the interpersonal relationship between people who may or may not be engaging in sexual activity, placing an emphasis on the emotional experience and feelings of closeness. This definition works well within a life span perspective, as many aging adults may choose more passive forms of sexual expression such as touching and other methods of achieving closeness.

Recent research has shown that a majority of older adults continue to maintain an interest in sexuality throughout their lives (AARP, 2005; Bretschneider & McCoy, 1988; Gott & Hinchliff, 2002; Laumann et al., 2006; Leiblum, Baume, & Croog, 1994; National Council on Aging, 1998). People in nursing homes report sexual desires in equal proportions to noninstitutionalized older adults (Hubbard, Tester, & Downs, 2003; Lichtenberg & Strzepek, 1990). Residents with dementia may continue to express sexual feelings and frustrations (Doyle, Bisson, Janes, Lynch,
A study on sexuality and women in nursing homes found that sex in late life is associated with pleasure, tension reduction, communication, mutual tenderness, passion, affirmation of one’s body and its functioning, a sense of identity, and security when facing hazards and losses (Nay, 1992).

A number of barriers exist for resident sexual expression in nursing homes. The lack of a partner is a primary deterrent, especially for heterosexual women (Hajjar & Kammel, 2003). Men comprise only 30% of the nursing home population (U.S. Census Bureau, 2007). A lack of privacy is another leading factor (Bauer, 1999; Commons, Bohn, Godon, Hauser, & Guthiel, 1992; Ehrenfeld, Tabak, Bronner, & Bergman, 1997; Gibson, Bol, Woodbury, Beaton, & Janke, 1999; Tunstall & Henry, 1996). Hajjar and Kammel (2003) reported that privacy issues extend beyond shared rooms. For example, resident rooms may be unlocked at all times, or staff may fail to knock or wait for approval to enter the room.

Clinical staff may attribute their uneasiness with residents’ sexual behavior to the possibility of legal action against them and the facility. They may also fear that the sexual activity is not voluntary (Loue, 2005), thinking it may have been coerced by one of the partners. Sexual expression between two residents seems to mobilize paternalistic tendencies in staff. This is especially evident in the conviction that individuals with dementia are not capable of consent (McCartney, Izeman, Rogers, & Cohen, 1987).

In the past several years, a sexuality training program for nursing home staff was prepared and subsequently evaluated by an academic unit of a Midwest university (Jankowiak, 2008). The hour-long training was followed with focus group sessions with the staff 6 months later. This qualitative study revealed dramatic changes in staff attitudes and behaviors regarding resident sexuality. These changes included improved staff sensitivity indicated by waiting for a response to a knock before entering a closed door, the use of “Do Not Disturb” signs, and creative scheduling so that roommates could have something else to do to afford privacy for the couple desiring intimacy. Before continuing that work, researchers decided to complete this study.

### STUDY AIMS AND RESEARCH QUESTIONS

The purpose of the current study was to gauge (a) the scope of sexual expression in nursing homes, (b) whether these expressions are viewed as problematic by nursing staff and administration, (c) the family and staff reactions resulting from these behaviors, and (d) whether the facilities had policies in place to guide staff actions. It was viewed as a pilot project to determine if further examination was warranted.

The researcher’s previous exposure to nursing homes led to the belief that intimacy and sexual ex-
expression were not frequently discussed and that trainings regarding this human need were not delivered in nursing home settings. One of the goals of this study was to confirm or refute that hypothesis giving an indication of the need for training materials.

As indicated by the previous literature review, the research on resident sexual expression has been limited. Some work was done in the early 1990s, but then a large gap developed with only recently some attention—mostly in the consumer sector—being paid to sexual expression in nursing homes. This dearth of research may indicate that academic researchers may also hold stereotypical notions of resident sexual expression. With the current attention to culture change and quality of life for residents, more interest in the affirmation of resident needs are likely to be evident.

**METHOD**

**Study Design and Sample**

A survey was conducted with all nursing homes in Kansas. After an initial e-mail circulation announcing the study, postcards were sent that included information for accessing the online survey. The survey was administered through the Axio system at the participating university. The research study was approved through the institutional review board. All participants supplied informed consent before beginning the questionnaire.

The designated sample included either the administrator or social worker from all 340 nursing homes in the state of Kansas. Although it can be expected that frontline service providers, including nurses, or that residents or their families might have more complete information regarding sexual activities, it was believed the administrators and social workers would provide the perspective that was needed to better understand current attitudes and policies.

**Instrument**

The survey consisted of 42 multiple choice or yes/no questions that were designed to gauge the extent of sexual expression in nursing homes, the resulting actions that occur because of this expression, and the existence of policies regarding sexual expression. Some of the quantitative results from that instrument are reported here, but the emphasis will be on the qualitative responses or comments that participants provided at the end of each question.

**Data Analysis**

These comments were grouped into themes and rated for priorities. For instance, in a question asking staff to comment about family reactions to resident sexuality, the majority of responses referred to family embarrassment. Fewer reported that resident families were supportive of their parents’ actions. Although the original research was intended to determine the scope and frequency of resident interactions, the comments are recounted as they provide understanding and relevance to this important topic.

**RESULTS**

**Respondent Characteristics**

Ninety-one of the 340 surveys were completed, yielding a response rate of 27%. Forty-five percent of the survey participants were from nonprofit nursing homes, with the remaining 55% from for-profit homes; 33% of all the nursing homes were under chain management. Sixty-two percent of the homes had 60 or fewer residents. Only 16% had special care dementia units.

**Types of Sexual Expression**

Hashmi, Krady, Qayum, and Grossberg (2000) categorized and described types of “inappropriate” sexual expression, which were used to develop questions for the survey instrument. The labeling of this list as “inappropriate” reaffirms a cultural bias against older adult sexuality. These forms of expression most
likely would not be considered inappropriate in younger people or when occurring in less public places. Although this list does not encompass all of the variations of sexual expression in nursing homes, they have been known to cause disruption in the facility and be more likely to demonstrate the need for policy or education. In an effort to avoid respondent bias, we did not label this question as “inappropriate” expression.

The survey asked “Have the following sexually related activities involving residents come to your attention?” Respondents could answer yes or no in response to the following options:
- Sexual talk, such as a person using sexually explicit language or verbal propositioning.
- Sexual act, such as masturbation, groping, fondling, or intercourse.
- Implied sexual act, which may include reading pornography or requesting unnecessary genital care.
- False allegations or abuse, such as a resident accusing staff or another resident of sexual abuse, due to his/her disorientation or delusions.
- Romantic relationships.

The majority of the respondents (85%) reported that residents had engaged in sexual talk (Figure 1). An equal percentage said that sexual acts had been exhibited in their homes. Implied sexual acts were less frequent but still experienced by the majority (60%). Still fewer (31%) reported that false allegations or abuse had been observed. Sixty-six percent said that residents in their facilities had formed romantic relationships. These results confirm that most nursing homes experience varying forms of resident sexuality, one of the study aims.

Staff and Family Responses to Resident Sexual Expression

Most (68.9%) said that nursing staff would seek out a supervisor if they were aware of sexual expression or activity. Other popular responses included “try to respectfully help the resident” (51.1%) and “follow the facility policy” (41.1%). Fewer (32.2%) said that they would respond with disgust, ignore the issue (27.8%), or panic (20%) (Figure 2).

Nearly all of the short-answer responses to this question about staff response to resident sexual expression indicated that a staff member would check with someone else or would “redirect the resident.” One respondent indicated that new nursing staff may be taken by surprise when they see these incidents and will typically go to one of their peers before bringing the matter to a supervisor. Staff members are often upset by sexual expression when they perceive themselves to be the targets of attention and advances. Many of these responses indicate that sexual behaviors are seen as non-normative and are treated as problems.

When asked how family members or responsible parties reacted to resident sexuality, the majority of family members (60%) were reported to be supportive of the facility’s actions. Six respondents (6.6%) wrote that family members felt embarrassed and humiliated by their loved one’s behavior. Twenty-five percent said that family members were not supportive of any sexual activities or intimacy for their loved one.

Dementia and Consent Issues

When asked how staff should involve family members if a resident with dementia is in a sexual relationship, respondents were divided in their opinions. Some said that residents with dementia should never engage in “this kind of behavior,” and that they should be redirected. One respondent, obviously familiar with her/his organization’s policy on consent, stated, “If a resident has dementia I felt that they cannot enter the act and be able to predict the consequences, voluntarily participate, or assess the risks and/or benefits of the act.” Others placed full responsibility for these decisions on families, to protect the facility and themselves against legal action. Many thought that family involvement should be determined on a case-by-case basis.

A few respondents felt strongly that a diagnosis of dementia does not preclude a person from forming connections with other residents or having physical contact with them. These respondents indicated that they would attempt to persuade and guide families toward acceptance of the situation. Nearly all believed that families must be notified, stating that with care planning, a “person of interest” needs to be aware of skin tears, changes of medication, and any other significant change in the life of their loved ones. Certainly an
intimate relationship would be considered a significant change.

Not only did most respondents perceive the need to keep family members of residents with dementia informed about sexual activities, 40% of the respondents believed it would be necessary to notify family members if two competent residents were sexually active. Written comments revealed that respondents were reluctant to inform family but felt obligated to do so, based on regulations implying that individuals serving as durable powers of attorney must be notified of “significant changes.” One respondent wrote, “Change the regulation and I won’t tell anyone!” Many respondents wrote that they would not inform family if residents requested so, but it was unclear whether residents were required to volunteer this request or if staff asked residents prior to notification.

GLBT Residents

Twenty-two percent of the survey participants were aware of a gay, lesbian, bisexual, or transgendered (GLBT) individual in the facility. However, only 3 respondents indicated that they collected information on admission about resident sexual orientation. Of those that do not, several respondents said that they would include this information in the care plan if the family mentioned it, and others indicated it is not required by the Minimum Data Set or mandated by federal guidelines. Said one respondent: “We currently use the same process as the military. Don’t ask, don’t tell.”

Other responses may indicate a cultural bias. One respondent wrote, “This is a rural area. Most are heterosexual.” Another concluded, “We have residents that have behavior issues, and we know or knew when we admitted them that they have a history of talking inappropriately or that they masturbate. We have not had any issues with gay, lesbian, etc.” This final comment equates non-heterosexual orientation with problematic behavior.

Policy

Twenty-six percent of the survey respondents reported that their nursing home has a policy addressing sexuality. When asked to provide the policy, most cited the right to privacy, which is a resident right for all nursing homes, but was not created specifically to cover sexuality issues. Other responses representative of policy included the following:

- “Mutual consent must be present. We are to provide privacy to the best of our ability and we will perform any assistance within the scope of our regular duties.”
- “Resident have the right to practice what their sexual orientation is. They have the right to privacy and confidentiality. As a facility we are to be supportive and honor our residents’ wishes.”
- “Our policy is not real [sic] specific but it states that if a person wishes to be sexually active it is fine, as long as all parties involved give consent.”
- “Partners may share rooms if they both agree. We will not discriminate by race, creed, or sexual orientation. Residents have the right to privacy.”
- “Our policy is related to married couples only as we are a Christian and a church-related facility. The policy is discussed with residents prior to admission so that those with other beliefs can choose to go elsewhere.”

The responses regarding policy creation indicated that primarily upper management, including the administrator, social workers and board members, were responsible. Only one person reported that direct care staff, nurses, residents, families, or ombudsmen were included in the development of such a policy.

Nursing staff respond to resident sexuality in many ways if the nursing home has no policy. Forty percent said that staff members are trained to respond appropriately to resident sexual activity. Fifteen percent have asked outside consultation for assistance, and 12% reported that existing facility policies or regulations are used to address the issue. The prevailing response was to determine action on a case-by-case basis (58%).

The results confirm the scope of sexual expression in nursing homes, the ways that nursing staff administration and families respond to resident sexual expression, and the lack of specific policies meant to guide these responses. Based on these findings it is clear that more focus should be directed toward training and education for all parties involved.

DISCUSSION

This study shows that residents express their sexuality in many different ways and that sexual activity occurs in most nursing homes. Although the survey did not ask respondents to identify any of these sexual expressions as inappropriate, short-answer responses revealed that many staff view resident sexuality as problematic. These findings demonstrate the necessity to educate staff that sexual expression is normal human behavior at all ages.

It is clear that staff lack appropriate knowledge regarding the effects dementia may have on resident sexuality. Although staff and family members may assume that individuals displaying sexually inappropriate behaviors are “sick” or “dirty,” structural changes within the brain may account for the decrease of sexual inhibition in individuals with dementia. Sexual disinhibition may not be the most drastic behavioral change related to dementia, but it is seen across all dementia types and stages of severity (Alagiakrishnan et al., 2005). Nurses need to help clinical staff understand the pathology of dementia and its consequences regarding sexuality.

Well-meaning caregivers often turn to families to learn residents’ social histories when they are unable to
convey this information themselves, including morals and social norms to which the residents adhered. However, this may be of little consequence, as family members may not have been aware of an elder’s true feelings. Younger individuals may project Puritan beliefs on their loved ones (Sherman, 1999), whereas older adults may have suppressed their sexual feelings or secretly acted on them. It is important that staff take the time to understand the needs of the person that the resident has become—this is the person-centered approach advocated by nursing homes today (Doll, 2012). Occasionally, this person does not match the historical perspective presented by family members.

It was evident that the respondents thought advocacy for residents was paramount, as they expressed distress about consent and the protection of privacy. Although 40% stated they would tell family members if two consenting adults were engaging in a romantic relationship, they revealed in the short-answer responses a preference for disclosure not to be compulsory. They recognized that residents should be free to make these decisions without the knowledge of family members but believed that regulations bound them to reveal the information. A review of federal regulations revealed that reporting this information to family is not mandatory (Centers for Medicare & Medicaid Services, 2011).

Furthermore, although the right to engage in an intimate relationship was readily acceptable, the rights of those considered incompetent are difficult to navigate. The ability to consent can be clearly defined, and nursing staff may struggle to balance the benefits of a caring relationship with issues of consent in residents with dementia.

It is clear that having some guidelines that address sexual expression are better than having none at all. Without policies, staff members are left to blunder through situations as best they can, and residents are not afforded the privacy or respect they deserve in their sexual expression.

Twenty-six percent of respondents claimed that their facility had policies in place to address resident sexuality. However, when asked to reveal what those guidelines were, only two or three facilities appeared to have purposely developed them. Others were simply applying existing policies regarding general resident rights and privacy or those related to abuse, neglect, or exploitation. Residents, nurses, family members, and ombudsmen did not contribute to these policies, which is a critical oversight. Sexuality must be purposely addressed through policy development and staff training. These rules and understandings must be flexible enough to meet individual needs while being structured enough to meet acceptable regulatory standards and help control potentially harmful behaviors.

**NURSING IMPLICATIONS**

Nurses play a critical role in addressing these issues. Their attitudes and actions regarding resident sexuality can foster policy changes, acceptance of, and dignity for residents’ sexual rights. Many nurses cite barriers to more liberalized practices regarding resident sexuality (Reynolds & Magnan, 2005). These include embarrassment, beliefs regarding older adult asexuality, inadequate training and education, and lack of role models in the workforce. An obvious solution is to make changes in nursing curricula. Another is for nurses to play leading roles in the development of policies and practices in the facilities they serve. This is an important issue for future study.

For many years, only one nursing home in the country—the Hebrew Home at Riverdale in New York—openly communicated its resident sexuality policy. It is likely that other facilities have developed policies that are not as well known. Research that examines these rules and their outcomes would shed light on the administrative and nursing response to and interaction with residents on these issues.

**LIMITATIONS**

Due to sample restrictions, our findings may not be generalizable outside of the Midwest. In addition, the study reflects the insights of our participants—nursing home administrators and social workers. Future work should seek to attain the perspective of other groups associated with residents’ sexuality, in particular, frontline nursing staff, family, and residents themselves.

Although survey instruments are useful tools, qualitative research may be especially well suited to elicit the emotional side of this important issue. The use of Hashmi et al.’s (2000) categories for the development of the list of sexual expression for the survey may have been shortsighted. Qualitative research would be less restricting and more informative in reporting the range of expressions staff members find in their facilities.
CONCLUSION
When staff members at the study’s parent university reveal they are conducting research on sexuality in nursing homes, they are inevitably asked, “Does that really happen?” Their response is “Shouldn’t it?” Sadly, asexuality is often erroneously viewed as an inevitable effect of aging and more so, institutionalization. Aging is sometimes viewed as a series of losses. Sexuality should not have to be one of them.

REFERENCES

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