Management of Sexual Expression in Long-Term Care: Ombudsmen’s Perspectives

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Purpose: This study investigates sexual expression management in long-term care settings based on cases requiring intervention from ombudsmen. Although the literature frequently mentions a lack of policies governing sexual expression in these settings, there is little information available on management of situations when they occur. This study addresses these missing elements through the perspective of resident advocates. Design and Methods: 31 in-depth interviews using a multiple case study approach were conducted with long-term care ombudsmen in 6 states. A thematic analysis was performed on the interview transcripts. Results: Ombudsmen intervened in cases based on dilemma or conflict due to risk, risk associated with dementing illness, limited knowledge, privacy, and values. The theoretical framework of the total institution was utilized to interpret the results. Implications: The results underscored the importance of resident advocates to support residents’ rights. This research also highlights the importance of workforce training and examination of the institutional impact on resident sexual expression. Formulation of standards of practice for ethically complex situations is also critically important.

Key Words: Intimacy, Resident advocates, Nursing homes

Older adults have long been considered asexual in American culture, particularly those individuals living within institutional care (Langer, 2009; Walz, 2002). Contrary to this cultural belief, older adults have been found to be sexual throughout life wherever they are living (Lindau et al., 2007; Miles & Parker, 1999; Reinisch, 1991). Literature investigating sexuality in long-term care suggests that sexual expression occurs in facilities, but few care facilities have implemented policies or training programs directing staff response to residents’ sexual expression (Ehrenfeld, Bronner, Tabak, Alpert, & Bergman, 1999; Fairchild, Carrino, & Ramirez, 1996; Low, Lui, Lee, Thompson, & Chau, 2005; Shuttleworth, Russell, Weerakoon, & Dune, 2010; Tabak & Shemesh-Kigli, 2006). Because nearly 46% of adults aged 65 and older will spend time in nursing home care (Spillman & Lubitz, 2002), it is important to have a holistic picture of elders’ needs, including intimate needs, and their support in these settings.

Sexuality can be broadly defined as the quality or state of being sexual. Drench and Losee (1996) conceptualized sexuality as a combination of sex drive, sexual acts, and the psychological aspects of relationships, emotions, and attitudes. Expressions of sexuality in long-term care have encompassed a broad range of actions, including sexual intercourse, flirtation and affection, passing compliments, proximity and physical contact, and maintenance of physical appearance (Hubbard, Tester, & Downs, 2003).

A study done by the American Association of Retired Persons (AARP, 2005) among people aged 45 and older found that 86% of respondents, in the 6 months prior to survey, engaged in sexual
activities: kissing, hugging, sexual touching/caressing, sexual intercourse, self-stimulation, or oral sex. Seventy-five percent of those aged 70 and older reported engaging in these same activities (AARP, 2005). In this study, increasing age predicted decreased sexual activity and was related to declining health and lack of partner (AARP, 2005).

People living in nursing home care have reported sexual desires in equal proportions to noninstitutionalized older adults (Hubbard et al., 2003; Lichtenberg & Strzepek, 1990). Though sexual intercourse is infrequent in nursing homes, intimate relationships and sexual feelings are often experienced. Intimacy, a sense of closeness and familiarity with another, has been closely tied to the experience of sexuality (Robinson & Molzahn, 2007). Residents with dementia have also continued to express sexual feelings and frustrations (Hellen, 1995; Kuhn, 1994). A study on sexuality and women in nursing homes (Nay, 1992) found that sex in late life is associated with pleasure, tension reduction, communication, mutual tenderness, passion, affirmation of one’s body and its function, a sense of identity, and security when facing hazards and losses.

There are a number of hindrances for older adults in long-term care who wish to express their sexuality. Elders in nursing homes often face challenges such as lack of partner, health concerns, limited privacy, negative staff attitudes, loss of self-esteem, cognitive loss, mental illness, family concerns, and legal/liability potential for the facility (Hajjar & Kamel, 2003; Lantz, 2004). Reasons for lack of privacy have included roommates, staff failing to knock on doors, or resident gossip (Hajjar & Kamel, 2003; Reingold & Burros, 2004). In many cases, staff members have construed sexual acts as behavioral problems rather than expressions of love and intimacy (Miles & Parker, 1999). However, behaviors may be encouraged by nursing home management when they are privately expressed, considered culturally safe, and are not difficult to manage. When these same behaviors are expressed in public or when caregivers are involved, they have been viewed as less acceptable and interpreted as problematic (Archibald, 1998).

Long-term care facilities, particularly nursing homes, have much in common with total institutions. Goffman (1961, p. xiii) defines a total institution as “a place of residence and work where a large number of like-situated individuals, cutoff from the wider society for an appreciable period of time, together lead an enclosed, formally administered round of life.” Within this framework, residents of these facilities comply with an institutional regime. Their whole lives, including their sexuality, are under observation (Parkin, 1990). Nursing homes have been described as “homes,” which may suggest that personal expressions, such as sexuality, are private concerns. However, these facilities have been considered a part of both the private and public domains (Parkin, 1990). Though sexuality is a private issue and one of personal self-determination, the characteristics of the total institution within care settings have stripped people of their “freedom of action” (Goffman, 1961). Sexuality has been an issue within these settings because of the close proximity in which people live (Parkin, 1990).

Management of sexual expression may be further confounded by multifaceted resident needs. When sexual expression intersects with issues of consent and avoidance of abuse or moral and ethical issues (Tarzia, Fetherstonhaugh, & Bauer, 2012), it often produces complex situations. There has been little guidance concerning decision-making capacity to enter into intimate relationships (Tenenbaum, 2009). For staff members and the facility, there has been conflict between honoring a resident’s autonomy and ensuring that a resident is not exploited (Tabak & Shemesh-Kigli, 2006). In the context of individuals with intellectual disability and cognitive impairment, Lyden (2007, p. 5) stated that there are “no universally accepted criteria regarding capacity to consent to sexual behavior.” Criteria for assessing consent have varied in different states and in common law, as well as within nursing home regulations (Lyden, 2007). This lack of uniformity in the definition of consent means the needs of sexually active cognitively impaired residents may not be addressed. It has been easier to believe that older adults are asexual than to handle the complexity of the issues (Lyden, 2007; Mayers & McBride, 1998).

The literature related to sexuality in nursing homes has several consistent messages. The first is the lack of clear policies or regulations directing response to residents’ sexual expression in formal care settings (Tabak & Shemesh-Kigli, 2006). In addition, numerous articles recommended that facilities implement training programs to help sensitize staff members to this subject (Ehrenfeld et al., 1999; Fairchild et al., 1996; Low et al., 2005; Shuttleworth et al., 2010) though there was little evidence that this is common practice. Evaluation
research on newly initiated staff training suggested that staff members’ attitudes changed with education (Mayers & McBride, 1998). Literature supported that sexuality training and policies for staff are not the norm in long-term care; thus, it is unclear how sexual expression is managed overall.

The purpose of this study was to initiate an in-depth investigation of the management of sexual expression in institutional care based on interviews with long-term care ombudsmen. Ombudsmen are an understudied group and provide unique perspectives on the issue of sexuality in care settings. Unlike past research looking at the issue at the facility level, this study examines cases requiring ombudsmen intervention. This study contributes to the discussion of person-centered care regarding the issue of resident sexual expression.

**Design and Methods**

Qualitative research methods were employed for this study to gain a complex, detailed understanding of the issue (Creswell, 2007). The process of qualitative research allows for serendipitous discovery where one “cannot know ahead of time which cultural logics or formulations will emerge as interesting or which associations and connections should be pursued until one immerses oneself in a particular cultural milieu” (Kaufman, 2002, p. 69). The original intent of this research was to explore ombudsmen’s attitudes and how these beliefs affected outcomes of cases. In collecting the data, other themes became evident. Using qualitative research design allowed the researchers to develop detailed descriptions of sexual expression cases that required ombudsmen intervention. Researchers employed a multiple case study approach to garner specific depictions of cases from the individual ombudsman’s perspective, to gain a better understanding of why situations come to ombudsmen, and to obtain insight into their resolution.

Study procedures were approved by the Kansas State University Institutional Review Board. Participants shared case details but intentionally omitted names of the resident(s) and facilities to maintain confidentiality. To protect the identity of those interviewed, the states will not be identified.

**Participants**

Under the umbrella of the Administration on Aging, the long-term care ombudsmen program was mandated in all states in 1978 following amendments to the Older Americans Act (The National Long-term Care Ombudsman Resource Center [NORC], 2012). Long-term care ombudsmen are advocates for residents in nursing homes, board and care homes, and assisted living facilities and are trained to resolve problems and complaints (NORC, 2012).

Ombudsmen were selected because their viewpoints have seldom been studied and because the researchers were interested in the types of sexual expression requiring intervention. It was assumed that these cases were more complex than those handled at the facility level due to the need for third party consultation. Learning more about these cases may aid in developing resources for homes to prevent the need for intervention through adequately addressing residents’ needs. Studying ombudsmen also gave the researchers a unique opportunity to cover a broad range of facility types in multiple regions of the country using maximum variation sampling (Patton, 2002).

Selection of participants for this study was done deliberately in combination with a random selection process (Patton, 2002). All states were asked to volunteer for the study through correspondence with state leaders. Six states out of those expressing interest were then selected to represent different regions of the country: the Midwest, East Coast, West Coast, Southeast, and Northwest. States were selected in terms of their willingness to participate in the project and to achieve a mix of both urban and rural populations. The first part of the study involved a 2010 survey, not addressed in this article, of 282 paid ombudsmen in the six participating states. The response rate for this study was 48% ($n \approx 136$ of $n = 282$ surveyed). From the submitted surveys, individuals from each state were randomly selected for interviews. The ombudsmen completed informed consent to participate in the interviews. The participation rate in interviewing was high: the number asked was $n = 34$ and $n = 31$ participated. The few individuals who did not wish to participate in the interviews were dropped from the study and another participant from the same region was randomly selected from those remaining. Refer to Supplementary Material for participant characteristics. Eight of the interviews were conducted in person over a month’s time as a way to test the interview schedule (Supplementary Figure 1). All other interviews were done over the phone within a 6-month timeframe.
**Data Collection**

This qualitative study employed face-to-face and telephone interviewing as the primary data collection methods. All sessions were audiorecorded to allow the interviewer to engage in active listening. Telephone interviewing provided an opportunity to include a nationwide, diverse pool of interviewees. Participants were asked prior to the interview to recall cases where residents’ sexuality was central, giving them a chance to review field notes and reports. An interview schedule was developed using knowledge found in literature and the professional experience of the researchers (Weiss, 1994).

Eight of the interviews were completed in person, and the rest of the interviews ($n = 23$) were done over the phone by two members of the research team. To develop a rapport with participants, the interviewer started by asking ombudsmen about the nature of their work and a typical day. Interviewers then inquired about specific cases involving sexual expression, followed by topics involving residents’ romantic relationships and issues of dementia and consent. To conclude the interview, participants were asked to talk about their motivations for working in this field. The interviews lasted an average of an hour; the shortest was 35 min and the longest was 2 hr.

**Data Analysis Strategies**

Audiotapes from these interviews were transcribed and initially sorted by the main content areas laid out in the interview schedule. NVivo software was used for data management. The researchers took what Weiss (1994) called an issue-focused approach to data analysis, looking at the issue of resident sexuality in care facilities through specific cases described by long-term care ombudsmen. Following the initial sorting of the data, the primary investigator began coding by reading the data with the following questions in mind: “Why did ombudsmen need to be involved in the case?” and “How was the case managed?” Using these questions, the researchers engaged in open coding, identifying themes and categories of interest (Weiss, 1994).

When all interviews were read and coded, the primary researcher examined “excerpt files,” or collections of content from many interviews dealing with the same issue, to look for similarities and differences and process the meaning of the coded data (Weiss, 1994). Through reviewing the excerpt files, the open codes began to demonstrate patterns that yielded the final five themes. Once the primary categories were in place, the co-researcher read through transcripts related to cases involving sexuality, asking the same questions the primary researcher had initially. The researchers met frequently to discuss the codes and establish agreement on the primary categories.

Integration to current theory was then formalized, and key quotes from the respondents were selected to exemplify the concepts found. To increase the trustworthiness of the data, the researchers employed member checking (Creswell, 2007) by sending an initial draft of the findings to all the ombudsmen who participated in the interview process. Because responses from the interviewed individuals supported the researchers’ findings, no changes were made to the thematic categories.

**Results**

The study revealed that cases involving the sexuality of residents and requiring ombudsmen intervention involved complex challenges such as moral and ethical dilemmas. Of the 31 ombudsmen interviewed, only 2 reported that they had not been involved with a case related to resident sexual expression. One of these individuals was new to her position. A total of 114 cases were noted in the transcripts. Of these cases, 85% (97) occurred in nursing homes or skilled nursing facilities, 8.7% (10) in assisted living facilities, 5.3% (6) in board and care homes, and 0.8% (1) in a neurobehavioral unit. Included in this report are data from cases that occurred in nursing homes. The initiator of cases was not noted in all instances; however, of those stated, staff members did a majority of the initiation followed by residents. Although ombudsmen noted many other instances where they provided information and referral related to the sexual expression of residents, these situations did not turn into cases.

Thematic review of interview transcripts found that the cases requiring ombudsmen intervention involved conflict or dissatisfaction by the initiator. The source of the conflict or dissatisfaction brought to the ombudsmen clustered around five areas: risk, risk associated with dementing illness, limited knowledge, lack of privacy, and values. The ombudsman’s role and the ultimate solution varied greatly, depending on the circumstances of the case.
When risk, resident safety, or the safety of others was involved, ombudsmen intervened. Intimate relationships and the expression of sexuality may lead to personal danger, a threat to another person’s rights, or danger to others living in the facility. Ombudsmen are key players in resolving ethically complicated situations as this example shows.

Long-term care facilities must look out for residents’ safety. Intimacy can be risky. If somebody does provide them with privacy, most of the time I’m just more concerned one of them will fall off the bed and hurt themselves. It happened where a man fell off the bed and broke his knee. It is a care planning issue to help people be safe in what they choose to do.

Protection from disease is another safety consideration. For instance, the potential for transmission of sexually transmitted disease in care settings is often overlooked. “It really does not cross their [facility staff’s and residents’] minds that if they cannot get pregnant that they could have other issues.”

For the currently served generation, safe sex education was not standard practice. Ombudsmen assist in preparing facility staff to educate residents about sexually transmitted disease and safer sex practices. In addition, ombudsmen may become involved when confidentiality of personal information is in conflict with the protection of others.

In our inner city nursing homes this happens where two people are in an intimate relationship and one of them is HIV positive and will not tell the other. We have an obligation to protect the one who is not positive. So we sit that person down who is infected and encourage them to tell their partner so they can make an informed decision.

We warn them that we have an obligation to inform their partner if they do not. The actions of one resident may put other residents at risk. For example, a resident living in a nursing home began dating people she met on the internet. These individuals, who were under the influence of drugs and had criminal backgrounds, began visiting her in the nursing home. This situation put other residents at risk.

A final salient theme emerged regarding the challenges facilities face when residents have a criminal background as a sex offender.

There was a registered sex offender in the nursing home who on two different occasions graphically asked a young mentally ill resident to expose herself to him. We tried to get everyone involved in that one. Nobody knew what to do with him. The facility moved the other resident to a sister facility, and he was then supposed to be monitored. He’s right next to the nurse’s station. Someone has to be with him one on one if there are certain events going on in the building like kids coming to sing or a party. At this point in time, this is not screened for when a person moves in. A home could admit someone and not know until his parole officer comes looking for him.

The potential risk to others in serving sexual offenders in long-term care is daunting. Ombudsmen did not have a clear idea of how to help care facilities manage this risk.

Risk Associated With Dementing Illnesses

Because of consent issues, residents with dementing illnesses involved in romantic relationships or sexual expression are more vulnerable to the threat of abuse. Ombudsmen are frequently contacted to consult on these cases. Conflicts between a person’s individual freedoms, rights, and protection often underlie these situations. Questions arise concerning the assessment of whether residents with dementia are able to consent or should be allowed to engage in intimate relations. Medical history and records, personal interviews, involvement of other medical professionals and psychiatrists, and substitute decision makers such as family members or medical powers of attorney were all used to assess capacity. An ombudsman’s ultimate goal is to consider the situation from the resident’s perspective and advocate for their best interests. This is difficult to achieve when the issue of consent is ambiguous.

The following examples illustrate the complexity of the issue: “There is sometimes a blanket assumption by facilities and family members that a diagnosis of dementia automatically means a person cannot make decisions for themselves [sic]. It’s much more than that.”

And

It is really a case-by-case situation. I kind of get my own feeling, my own assessment of where their cognition level lies. It’s a collaborative thing between the facility and psychiatric services. It is ultimately important to determine if the person is responding favorably or unfavorably to the relationship or intimate encounters in question.
When residents with dementia are married, additional complications can arise, especially if only one spouse lives in the care facility. A common role of the ombudsman is to provide education and support for the nondemented partner. When patterns of former intimacy are changed because of the disease, sometimes the spouse does not understand these changes.

The husband would come to visit and he thought it was her duty to have sex with him and it upset her. He basically forced her to have sex with him and when he left she would be terribly disturbed and upset. The staff did not know what to do.

The ombudsman provided the husband support and education and offered him alternatives for expressing intimacy that were more acceptable to his wife.

When a married resident forms an extramarital relationship within the facility, it can cause anger, hurt, and confusion for the nondemented partner. The staff may also be unsure about their role in the situation. These situations become especially complicated because the spouse, as the primary decision maker, has the right to move the resident to another facility or attempt to stop the relationship from continuing. Ombudsmen are critical in offering support and education about dementia for all involved.

Limited Knowledge

Many of the cases revealed a component of misunderstanding and lack of education in the facility staff, residents, and the residents’ families or support systems. For the ombudsmen, this lack of knowledge resulted in the need to provide education for staff, family, or residents; to conduct in-services related to resident rights and sexuality; or to review facility protocols as they relate to sexual expression.

Facility staff may have a misunderstanding of the ombudsman’s role and contact an ombudsman to aid the staff member in validating their personal rights over a resident’s rights. For example, a resident may proposition a staff member or grope staff during care. In this situation, ombudsmen explain their role as an advocate for the resident and then refer the staff member to their facility’s human resources department. At the same time, it gives the ombudsman an opportunity to suggest ways to address unmet needs of residents.

Residents’ sexual expression, similar to the previous example, is often perceived by staff as a behavior problem rather than an indication of an unmet need. This leads to the initiation of cases for ombudsmen.

A common situation is a facility that has a resident who likes to masturbate either in their room or in public and the staff walk in on the person while he or she is in the act. They bring it to our attention and they want us to fix the resident as if he or she is broken. They do not view this act as a resident’s right, but as a behavior problem. I help them recognize the resident’s right to privacy. It’s really the staff’s problem of being uncomfortable and not knowing how to respond.

In addition to staff members, the residents’ support system may also feel a great deal of discomfort with their loved one’s sexual expression. Ombudsmen play a pivotal role in supporting the residents and easing the family’s concerns.

Numerous examples demonstrate “institutionalizing,” where the organizational structure dictates that residents act a certain way. These messages are sent through cues such as fixed dining schedules, bath times, bed times, and various other restrictions.

One of the barriers is when a resident does not think they can have a relationship. A lady will say, “Well, I have a boyfriend but we do not do anything.” as if it is wrong or dirty or they are not allowed. So I educate residents by saying it is up to you whether you have a relationship or not. They do not even feel that it is even possible because of where they live and the restrictions they perceive to exist.

In this case, the resident felt that her relationship might be against the rules. Ombudsmen are critical in helping residents understand their rights.

Lack of Privacy

Privacy is another issue that brings cases to ombudsmen for intervention. Cases typically involve a conflict between the environment or the organizational setting and a person’s privacy in sexual expression. The primary issue is obtaining physical privacy in a setting where most of the space is public.

Privacy is a major deterrent for residents who wish to be intimate or form romantic relationships. Getting private uninterrupted time with each other is hard, especially in a nursing home. There are mostly common areas and shared rooms. All the common areas where everyone is coming through, the privacy issue would be the main hindrance.
Ombudsmen reported that skilled nursing facilities are required to provide a private space for residents who wish to be alone together. Often, this is complicated by residents' lack of knowledge about this option, fear of asking staff members for accommodation with a space, the home's failure to interpret the requirement this way, lack of options in the home for a private space, and staff and resident gossip. Intervention in these situations resulted in homes being more accommodating to the residents involved.

An administrator called me and said, “I have a problem,” and of course a man and woman wanted a room. She was panicked because she did not have a room to provide them. I encouraged her to speak with the residents about what kind of privacy they wanted, and they just wanted to cuddle together, which was making a roommate uncomfortable. The administrator was able to accommodate their need in a small living area in the building.

Even when private quarters are provided, staff struggle with respecting those boundaries. Nursing home regulations guide staff members to knock on resident rooms and wait for a response before entering. Through the interviews, it was evident that this is not always followed. One ombudsman shared a success story where staff knew a couple was intimate during the day and created a plan to ensure their privacy. The staff honored the couple’s privacy by avoiding interruptions at the times of day the couple wished to be intimate and by knocking and waiting for a response before entering.

Staff and resident gossip are an additional threat to privacy in long-term care settings. Ombudsmen provide extra advocacy for residents who are targeted by other residents and staff in a facility. In one situation, an ombudsman responded to a complaint of a woman who was upset because another resident was supposedly involved in a sexual relationship. The complaining resident was jealous of the relationship and wanted it stopped. This complaint would not have been initiated had the woman lived in the community, but because of the “microcosm that’s a nursing home or assisted living home, and no matter how careful or discreet two people try to be, everyone knows.”

Cohabitation is one solution for accommodating privacy; however, this right is not guaranteed for unmarried couples in nursing homes. Ombudsmen may become involved to advocate for these residents’ desires.

A couple met in the nursing home, both competent, and they wanted to be roommates. For a variety of reasons, the couple did not want to get legally married. But administration ended up letting them cohabitate. It provides them both with support. They can now put a signal on their door that alerts staff that they do not want to be bothered. I was just a cheerleader in this case, but it worked.

Values

Ombudsmen are trained under a paradigm that supports suspension of personal values to employ professional, nonjudgmental values with clients. Nonetheless, the value systems of residents, family members, staff members, and ombudsmen themselves all enter into the dynamics of cases where sexuality is involved. Situations that push traditional societal norms or are counter to religious values are more likely to require ombudsmen intervention. One ombudsman said:

I worked with a couple living in a religiously affiliated home who had formed a relationship and wanted to share a room. The facility was very uncomfortable with this because of the idea of premarital sex, since the couple was unmarried. I informed the home that the residents had a right to sexual expression, but the residents had signed agreements when they moved in that they would abide by the Christian values of the organization. They decided to have a religious ceremony, not a legal ceremony. That was enough for the facility and they were able to room together.

In terms of values, cases involving the infidelity of residents, nonheterosexual individuals, or family discord are controversial. When a relationship involves two competent residents but one is married, staff members may become uncomfortable and reach to the ombudsman for support. Residents have the same rights in these circumstances as people living in the community: the right to “make a bad choice.” Ombudsmen may act on behalf of the resident in dealing with those who are concerned or upset by the resident’s act.

Residents’ sexual orientation was also a source of value conflict. For example, it is often difficult for the facility community to deal with openly gay or lesbian residents. To receive fair treatment within the facility, ombudsmen advocate for residents targeted by these value conflicts.

We had an openly gay, younger man move into an assisted living. He liked to wear lipstick, cross dress, and paint his nails. The residents were upset
because he was gay. They whispered about it. I got called to advocate for the gay resident. Things got better when the other residents learned that the man’s parents were prominent figures of the community.

Facility staff and other residents are challenged as elders are increasingly more upfront about their sexual identity. Ombudsmen play a key role in workforce training to help promote sensitivity to sexual diversity.

Ombudsmen may act to ensure the resident’s voice is heard when a resident’s family does not support his or her decisions. For example, an individual was in a relationship with a man of a different race. Her family publicly and vehemently demonstrated their distaste for the relationship. Although the ombudsman acted on the resident’s behalf, the family ended up moving her to another facility.

Intervening in these situations requires ombudsmen to suspend their values and support the residents’ rights. Some ombudsmen felt that their ability to look beyond their own values was natural for them, whereas others found that they are unable to do this in some situations and asked their coworkers to respond instead.

Discussion

Interpretation of the data in this study is influenced by the particular positionality of the investigators. The primary investigator is a white, female social worker and long-term care administrator. The coinvestigator is a white woman with a PhD in life-span development. These factors played a role in the interpretation of the information in this study. Through these lenses, the investigators found that ombudsmen’s cases related to residents’ sexual expression in long-term care settings are initiated based on conflict or dissatisfaction due to risk, risk associated with dementing illnesses, limited knowledge, privacy issues, and values. Study results support the literature that found long-term care facilities do little workforce training and that few organizations have policies to support and respond to residents’ sexual expression (Ehrenfeld et al., 1999; Fairchild et al., 1996; Low et al., 2005; Shuttleworth et al., 2010; Tabak & Shemesh-Kigli, 2006). Limited workforce training and policy in these settings contribute to the primary findings of conflict and dissatisfaction, and initiate the need for advocacy from long-term care ombudsmen.

Goffman’s (1961) total institution theory has lent further understanding. Long-term care settings, particularly nursing homes, have much in common with total institutions (Goffman, 1961) and “people processing organizations” (Hasenfeld, 1972) where residents must comply with an institutional regime (Parkin, 1990).

A key principle of the total institutional framework is the recognition that the institution suppresses residents’ civil liberties. Total institutions restrict people’s rights to self-determination, autonomy, and freedom of action (Goffman, 1961). Sexuality and intimacy are human needs, which continue throughout life (Lindau et al., 2007; Miles & Parker, 1999; Reinisch, 1991), thus are considered civil liberties. Placement in an institutional setting and the vulnerabilities residents face (such as physical frailty and cognitive losses) further complicate their sexual expression. The role of the ombudsman is critical to advocate for the residents’ rights.

Restrictions on residents’ autonomy can be clearly seen in the example of a resident who felt that having a boyfriend was not allowed. Institutional cues resulted in the impression that an intimate relationship was against the rules. Goffman (1961) found that the total institution establishes an authority over the residents, directing their behavior, and this authority is emphasized by regulations and judgments by staff members. The results support that staff values and related judgment influence the management of residents’ sexuality. Staff’s attitudes and opinions on sexual expression or sexual orientation fuel conflict that may lead to ombudsman intervention. Conflicts can also arise from the values and attitudes of family members, as well as their expectations of the institution’s response to residents’ sexual expression.

Lack of privacy is a further institutional barrier that deters residents from being intimate. Within Goffman’s (1961) total institutional framework, people’s actions are under constant surveillance. In a care facility, surveillance may include the building’s construction, video cameras, and periodic staff checks. Lack of privacy has been identified as a consistent barrier to residents’ sexual expression (Hajjar & Kamel, 2003; Lantz, 2004; Reingold & Burros, 2004), and this study supports that finding. Staff failure to knock before entering private living quarters, semiprivate rooms, and gossip all serve as reminders of constant surveillance. Institutions justify the need for high levels of surveillance to comply with strict regulations, reduce organizational risk, and ensure residents’ safety.
Risk and threats to residents’ safety are difficulties within these settings. It is challenging to balance these threats with the ombudsman’s obligation to advocacy. Protecting residents from sexual abuse or mistreatment (especially when residents have cognitive losses), working with sexual offenders living in institutions, preventing the spread of infectious disease, and the collective rights of residents in a community continue to be areas of difficulty that further support the need for third party advocates.

**Implications**

This research has implications for the long-term care system. First, ombudsmen play important roles in supporting resident rights. This underscores the importance for continued adequate funding for this program. In addition, workforce training to aid staff members’ responses to resident sexual expression is needed. Finally, long-term care facility planners and designers should consider cost-effective enhancement of residents’ physical privacy, lack of which is a barrier to sexual expression. This research also found consistently difficult case types for ombudsmen. Working with sexual offenders and advocating for residents with consent issues are ethically complex cases and were found in all states studied. It is important for the long-term care system to begin discussions and formulate standards of practice on these issues.

Additional studies are needed from the staff, resident, and family perspective to learn more about management of sexual expression in long-term care and to achieve triangulation. Future studies are needed to better understand the influence specific housing types have on the management of resident sexual expression. In addition, further investigation into the patterns in cases by national regions is needed.

This study, through application of the total institutional framework, revealed that the current system poses many barriers to residents’ sexual self-expression and autonomy. It is important to acknowledge that the long-term care system is currently working toward person-centered care practices, a movement called *culture change*, which fosters resident autonomy and choice. This raises two important questions. Will adopting culture change allow freedom of sexual expression? Will the move away from the total institution through culture change improve resident control in other areas of their lives? Future research investigating various care settings as total institutions is necessary to gain a holistic picture.

**Conclusions**

This study confirmed that resident sexual expression may present complex ethical dilemmas. Long-term care ombudsmen are effective advocates in these situations. Additionally, much work is needed to improve the autonomy and self-determination of elders living in institutional settings. Viewing the facility from the perspective of Goffman’s (1961) total institution aided in understanding the role the system itself plays in the management of sexuality. Continued research is needed to explore other perspectives on this issue and to further investigate the role the total institution has on resident sexuality and other self-expression.

**Supplementary Material**

Supplementary material can be found at: [http://gerontologist.oxfordjournals.org](http://gerontologist.oxfordjournals.org).

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