

Sexuality and Intimacy Policies among Assisted Living Residents: Balancing Safety and Protection

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Abstract: The topic of sexuality and intimacy in assisted living (AL) communities, especially among residents with dementia, presents complex and sensitive challenges. As the elderly population grows, an increasing number of older adults, including those with cognitive impairments, are moving into AL communities. These environments are designed to foster independence while providing necessary care, creating a unique context for addressing the sexual and intimacy needs of residents. Sexuality is a fundamental aspect of human experience, significantly contributing to overall well-being and quality of life. For residents with dementia, cognitive decline, physical limitations, and changing social dynamics can profoundly impact their ability to express and fulfill sexual needs, while their rights to autonomy and intimate relationships remain uncertain. AL staff play a critical role in negotiating these needs, balancing protection with the residents' safety. Policies and procedures in AL communities significantly influence how administrators and staff manage residents' sexuality and intimacy. This study explores the policies and procedures that AL staff use regarding the sexual needs of residents with dementia. Through semi-structured interviews with 22 respondents, including top management, middle management, and direct care workers (DCWs), the study analyzed the impact of AL policies on residents' sexual autonomy. Findings reveal that lack of formal policies leads to case-by-case management of residents' sexual needs, heavily influenced by staff attitudes, work experience, and family concerns. Themes such as family involvement, training, experience, consent, and informal policies emerged as both bridges and barriers to intimacy. The study underscores the need for well-defined policies and training to support staff in balancing safety and protection.

Keywords: Assisted living, Dementia care, Intimacy policies, sexual autonomy

1. Introduction

Balancing safety and protection is a central concern in the care of residents living with dementia. Dementia can impair an individual's ability to make informed decisions about their sexual behavior, raising questions about consent and the potential for exploitation (Armstrong, 2006). Assisted living staff play a critical role in negotiating the sexual needs of residents, balancing their protection with the residents' rights to intimacy (Archibald, 2003). Policies and procedures established by AL communities significantly influence how administrators and staff make decisions regarding the management of sexuality and intimacy for residents, both with and without dementia. These policies must address the ethical and legal considerations involved in protecting vulnerable individuals while respecting their personal rights and desires. AL administrators face the challenge of navigating the expectations of families who may be concerned about the safety and well-being of their loved ones. This delicate balance between autonomy and protection requires best practices and a deep understanding of the needs of residents with dementia (Barmon et al., 2017; Bender. et al., 2020).

This article aims to explore the policies and procedures that AL staff use to negotiate the sexual needs of assisted living residents with dementia. It will identify practices that staff utilize to balance protection and control, providing insights into how AL administrators manage these complex issues. This study seeks to contribute to a more informed and compassionate approach to sexuality and intimacy in assisted living communities (Boumans, et al., 2022; Burgess et al., 2018; Burgess et al., 2022).

1.1 Aim and Objectives

1. To understand how policies and procedures put in place by the AL communities shape decisions made by administrators in the management of sexuality and intimacy needs of residents living with and without dementia.
2. To identify practices AL staff, utilize to balance protection and control among persons living with dementia.
3. To examine how AL administrators negotiate and balance the autonomy of residents living with dementia with the expectations of families' need for protection.

1.2 Policies and Procedures in Assisted Living

Research has shown that policies and procedures regarding sexuality in AL communities are often inconsistent. A study by (Braun & Clarke, 2006) highlights that many AL communities lack clear guidelines on how to handle sexual expression among residents, leading to ad hoc decision-making by staff. The absence of formal policies can result in a range of responses, from supportive to restrictive, depending on the personal beliefs and comfort levels of individual caregivers (Braun & Clarke, 2006). Other studies emphasize the need for comprehensive sexual health policies that include staff training and education. Policies should outline appropriate responses to sexual behaviors, establish protocols for addressing consent and capacity issues, and provide guidance on balancing residents' safety with protection from potential harm (Carpenter, 2015; Cohen-Mansfield, 2021). Clear and consistent policies can help staff navigate complex situations and ensure that residents' rights are respected.

1.3 Autonomy and Protection in Dementia Care

Balancing autonomy and protection is a central concern in the care of residents with dementia. Dementia can impair an individual's ability to make informed decisions about their sexual behavior, raising questions about consent and the potential for exploitation. Cook et al. (2021) suggests that a person-centered approach, which emphasizes understanding the unique needs and preferences of each resident, is essential in promoting autonomy while safeguarding well-being. The concept of "relational autonomy" is particularly relevant in dementia care. This approach recognizes that autonomy is not solely about individual independence but involves relationships and interdependence with others (D'cruz, 2020). In practice, this means that caregivers must consider the resident's social context, including family dynamics and past relationships, when making decisions about sexual and intimate needs.

Families often have significant concerns about the sexual behavior of their loved ones with dementia in AL communities. Research indicates that family members may have conflicting feelings, ranging from support for their relative's need for intimacy to anxiety about potential risks and social stigma (Di Napoli, 2013; Eshmawey, 2022; Rubaiyat et al, 2024). These concerns can influence how families interact with AL staff and shape their expectations regarding the management of sexuality and intimacy. Dobbs et al. (2022) found that open communication between AL staff and families is crucial in addressing these concerns. Educating families about the importance of sexual expression for overall well-being and the measures in place to ensure safety can help alleviate anxieties and build trust. Collaborative approaches that involve families in care planning can also enhance the support provided to residents (Grigorovich et al., 2022)

The attitudes and practices of AL staff play a critical role in how sexuality and intimacy are managed in AL communities. Staff may experience discomfort or uncertainty when addressing sexual behaviors, particularly when there is a lack of training or clear policies. Ho and Goh (2022) highlighted the need for comprehensive training programs that equip staff with the knowledge and skills to handle sexual expression sensitively and appropriately. Additionally, fostering a culture of openness and support within the workplace can help staff feel more confident and competent in addressing these issues (Huang, Y et al., 2022; Kemp et al., 2020).

2. Methods

This study employed a descriptive qualitative research approach to examine how the structure of assisted living (AL) communities, specifically their policies and procedures, influences residents' sexual autonomy. A qualitative design was chosen to facilitate an in-depth exploration of AL administrators' and staff experiences and perspectives regarding the negotiation of residents' sexuality and intimacy issues. To ensure a diverse representation of AL communities, a purposive sampling method was used. With assistance from Senior researchers, seven AL communities across the metropolitan Atlanta region were selected. This sampling strategy included a mix of urban and suburban locations, as well as corporate small, medium, and large communities, to capture potential variations among different types of AL communities. This diversity was crucial for a thorough assessment of differences among the communities and to ensure comprehensive coverage for the research (Makinde & Anjorin, 2018; Mekunye & Makinde, 2024).

Within these seven communities, 22 respondents were purposively selected, comprising three administrators or care workers from three levels of management in each community. The sample included seven top management administrators, eight middle management administrators, and seven direct care workers (DCWs). Top management participants included chief executive officers, chief administrators, chief operations officers, and executive directors. Middle management participants included department heads, supervisors, or coordinators overseeing specific departments, while DCWs were staff directly involved in providing direct care and support to residents. Although the initial target was 21 participants, an additional middle management

administrator was included from Retirement Haven (a pseudonym) due to the facility's large size, bringing the total to 22 respondents.

In each AL community, three different interviews were conducted, with four interviews conducted at Retirement Haven. This approach aimed to gather a wide range of insights and perspectives, thereby enhancing the comprehensiveness of the findings. The interviews focused on the decision-making processes related to residents' sexuality and intimacy. Sample sizes were determined based on the principle of data saturation, which is achieved when additional interviews no longer yield new information.

2.1 Data Collection

The researchers utilized a semi-structured interview guide for data collection. Due to the overall health risks in AL homes that limited accessibility, virtual semi-structured interviews through Zoom were conducted by the researchers. Data collection was completed in seven diverse AL communities that varied by characteristics apt to influence policies, including size, location, ownership, fees, sex ratio, race and availability of a memory care unit.

2.2 Data Analysis

The researchers digitally recorded, reviewed, and transcribed verbatim all the interviews before importing them to NVivo 12 (QSR International). The researchers used a qualitative thematic analysis method to analyze the transcripts. This method involves reading through the transcripts and identifying patterns in meaning across the data to derive themes (Makinde & Obikoya, 2024; Makinde & Adisa, 2024). The researchers created initial codes by reading and re-reading transcripts and independent line-by-line coding (Makinde, 2024). The researchers grouped the codes into potential themes that captured a central idea, summarized in a single sentence. The researchers searched for similarities, differences, and developed trends in the data and labeled similar concepts and categorized them into codes until saturation was reached. The researchers continued reviewing the manuscript and, in the process, added codes and deleted other codes throughout the remainder of the coding process to capture all participant statements within the codes.

During the coding phase, The researchers collapsed and expanded codes until distinct conceptual categories emerged to derive significant themes and sub-themes related to sexual autonomy in AL [Nilsson et al., 2022; Ojo et al., 2023]. The researchers explored connections between the themes in a bid to produce a holistic representation of residents' rights in AL as they pertain to sexuality and intimacy. The themes identified included policies and procedures, safety of residents, family concerns, and the quality of life of older adults in AL. The next step involved focusing on specific care cases based on the administrators' feedback. For instance, what were the specific conditions under which certain procedures were applied, and how did they affect the residents' perceptions of sexual rights? The researchers then linked these contexts and outcomes to negotiating and balancing the residents' autonomy. I used the qualitative analysis software, NVivo 12, to aggregate, store, manage and facilitate the coding and analysis of data.

The researchers applied the codes to narrow the notes into themes surrounding how administrators negotiate and understand issues of sexuality and intimacy for AL residents with and without dementia. The themes identified include training, policies, consent, safety/risk, family concerns, reporting and redirecting. The researchers organized these codes by identifying how they are linked to other open codes such as family involvement in handling sexuality issues and the existence of policies governing the negotiation of sexuality issues. The authors identified connections between the AL characteristics, gender, marital status, and the policies applied when negotiating cases where one resident developed an interest in another. For example, DCWs embraced their professional experience as the most substantial training regarding intimacy issues in AL (Peisah et al., 2021; Ojo & Olanipekun, 2023). They cared more about the safety and well-being of the residents and focused on residents understanding the risks that could emerge when they got involved in sexual relationships. The gender of the AL residents also emerged as one of the major themes. Females were considered more vulnerable and more likely to be at risk in the relationship than men.

3. Results and Discussion

Table 1 Assisted Living Sampling Strategy

	Urban	Suburban	Total
Corporate large	2	1	3
Corporate medium	1	1	2
Corporate small	1	1	2
Total	4	3	7

Table 2 Participant Characteristics

		Upper Management	Middle Manager	Direct Care Worker
Job title	Executive director	4	0	0
	Chief Operations Officer	2	0	0
	Regional Vice President	1	0	0
	Director of Nursing	0	1	0
	Head of Nursing	0	1	0
	Assisted Living Director	0	1	0
	Primary Care Manager	0	1	0
	Resident Care Manager	0	1	0
	Administrator	0	2	0
	Resident Services Manager	0	1	0
	Direct Care Worker	0	0	7
Age (years)	25-34	0	2	1
	35-44	2	4	3
	45-54	3	1	2
	55-64	2	1	0
	65-74	0	0	1
Gender	Male	2	1	0
	Female	5	7	7
Race	Black	1	3	7
	White	6	3	0
	Asian	0	2	0
Marital Status	Married	5	4	3
	Single	2	3	2
	Widowed	0	1	1
	No response	0	0	1
Training	Master's Degree	1	3	0
	Bachelor's Degree	4	3	0
	HS Diploma*	0	0	3
	Some College or associate degree	1	2	2
	Trade/Vocational	1	0	0
	No response	0	0	2

*High School Diploma

Table 2 show the participants demography in seven diverse AL communities that varied by size, location, ownership, fees, sex ratio, race and availability of a memory care unit. I interviewed 2 middle managers in one facility, Regional Vice president (n=1), Executive Director (n=4), Chief Operations Officer (n=2), Middle Level managers (n=8) and Direct Care Workers (n=7). Given the large number of informants by level of management and by assisted living (AL) communities, pseudonyms was used for each AL and job level to provide a bit of clarity when seeing the data. In addition, the capacity (large, medium, or small) and the location (urban or suburban) is included to help the reader make sense of the data. Again, there was little to no variation in policies and procedures negotiating sexual autonomy based on capacity or location.

3.1 Bridges and Barriers

Since AL communities continue to be a strong option for residential long-term care for growing numbers of older adults with or without dementia, it is critical to determine residents' expectations and experiences of sex and intimacy in these communities. The context of AL provides the potential for both bridges and barriers [34,35] to intimacy for residents with dementia. Bridges allow for intimacy while barriers restrict it. Themes that fall into these categories are family concerns, experience/training/ consent and formal policies,. The same theme can operate as either a bridge or a barrier.

1. Family Concerns
2. Experience
3. Training
4. Consent
5. Informal Policy

3.1.1 Family Concerns

Staff treat family concerns as vital. Family concerns most often regard the health and safety of the loved one in AL but can also concern resistance to parental sexuality. As intimacy may raise health and safety issues, family concern can operate as either a bridge or a barrier. Goosby and Robert shared their experiences:

Bridge

"When family was consulted, their concern was only if their mother was happy with it. We explained that she is comfortable. We told them how they hold hands and sit together all the time. This made the family happy. In fact, the daughter talked to the male resident and assured him that it was okay that they were friends" - Goosby, DCW, Good Living Home.

Family involvement is a key to the goals of AL communities. Whether sexual relationships are discouraged, promoted, or ignored is a decision forged by a resident's family along with AL staff, often independent of the residents' choice. Administrators value family for two reasons: First, family reinforces an environment that is homely. This is crucial for a good working relationship between the staff, residents, and family. Second, AL communities are a business and family members are the clients. A cordial working relationship ensures continuity of the business and referral of future residents. Finally, family approval makes it easier for staff to negotiate sexual relationships without reservations.

Barrier

Despite family concerns sometimes being a bridge, these concerns may also act as a barrier if a family member does not approve of the sexual relationship. Some family members struggle with the idea that their relative is in a relationship. Leroy and Jennie told their stories:

"I stopped involving family. Family don't understand what happens here. They are quick to argue how their mother can never do this or that. There is this female resident who is widowed and had something good going with a male resident who was divorced. When the family found out, they were furious. I tried to explain to the son how intimacy was a good thing for his mother's mental health. The following day, he came to transfer his mother to another facility". - Leroy, senior administrator, Golden Place

These quotes signify three points. First, despite the residents being the consumer of AL services, administrators aim to satisfy family over residents' needs (Ojo & Olanipekun,2023; Pinho & Pereira, 2019). Second, administrators selectively notified families of residents' sexual behavior. This might be because there are no formal policies that uniformly deal with family concerns in regard to different types of residents' behavior. Finally, from administrators' illustrations, it appears that residents' families, who are mostly the children of residents, become paternalistic by protecting their parents against sexual activities, something their parents did to them when they were growing up. Consequently, cultural and family norms appear to override residents' rights to sexual autonomy.

3.1.2 Experience

Bridge

Work experience is the application of past practical knowledge in negotiating sexual needs of residents. Whereas experience is mostly used by DCWs to distract residents' sexual desires, there were incidents when work experience is used as a bridge. Sarah, a DCW at Century Court illustrates how experience can be used as a bridge to intimacy.

“Through experience, we know how to deal with it. Sometimes we report to the administrators but sometimes we just deal with it. So, I do it using my past experience. Sometimes I allow them to interact, like, I mean have intimacy to calm them down. You, know some of them get messy if you deny them little things. I just allow them to make it easier for me and for everyone”.- Sarah, DCW, Century Court.

Barrier

Despite work experience sometimes being a bridge, it may also raise a barrier to intimacy. Administrators acknowledge DCWs work experience and empower them to make decisions in negotiating the health and safety of residents. In fact, most AL communities rely almost exclusively on the work experience of their staff. Alison and Esi share their experience.

“I have more than 10 years of experience. That is a lot. I have also worked in four different communities. Some things only complicate the work. For example, managers or family ask too many questions like consent, safety, and health risks. We can choose to involve family and managers and answer these questions, or we can choose not to talk about it. When my shift is busy, I don't talk about it. I distract them. But you know I could deny them today and tomorrow I give them a chance which is a good thing”.
- Esi, DCW, Silver Springs

These quotes highlight several issues. First there is the state and family. State regulations and family concerns require AL communities to provide a peaceful homelike environment which will promote residents health and safety, rights, autonomy, independence, and quality of life. Staff strive to achieve these requirements by concentrating on having a peaceful environment with little or no conflicts. However, they ignore the residents' rights and autonomy. Secondly, the DCW demonstrates how she inconsistently deals with residents' sexual desire. Intimacy is a continuing human need for most people. Staff misconceptions and negative attitudes about sexuality and aging pose a barrier to sexual fulfillment for residents. Finally, there is consensus between administrators and DCWs on handling residents' sexuality using past experience.

3.1.3 Training

Training is the act of teaching employees skills that empower them to carry out their tasks efficiently. Despite its significance, training in negotiating sexuality and intimacy is limited. However, some AL have training programs. These communities illustrate how training can empower staff to improve residents' quality of life. This includes staff having a positive attitude towards work and towards intimacy for residents. For example, Josephine, an upper manager at Good Life Gardens, describes the “model of care” training.

Bridge

“We do a little bit of training on sexuality. We could probably expand on that. And I know that a lot of our model of care training, especially in memory care, is a very high-touch environment. So, providing intimacy between humans is what we do. You know, people think sexuality and intimacy are synonymous. I see intimacy as very different. I see that you know more about connection. People's spiritual needs and need for connection with other people. Eye contact, touch, and hugs, and all those things are included in our training module” - Josephine, senior administrator, Good Life Gardens

This quote demonstrates positive attitudes towards training while also showing a lack of relevant training modules. Sexuality and intimacy seem to be an area that is not given training priority. In fact, there are no federal standards for staff training in AL communities [Rector et al., 2020]. Consequently, Georgia's regulations do not directly talk about sexuality and intimacy but rather highlight residents' rights (Roelofs, et al, 2015; Roelofs., 2021). Regulations that are specific to sexual and intimate needs of residents may be useful. Furthermore, some of the decisions DCWs make, are born out of negative attitude towards sexuality and ageism. Training staff on these issues, as it appears in the above quote may lead to better attitudes. There is a need for additional research on training of staff in negotiating the sexuality of residents.

Barrier

The researchers identify training as a barrier when administrators do not encourage training in their communities. Further, most staff prefer experience to training (Souza; et al., 2020; Sorinmade et al., 2021). Leroy, an upper manager at Golden Place, discusses the lack of training and use of experience in his AL: I tell you what, training isn't as necessary as experience, wisdom and common sense. Do you know how someone dies? We have a lot of unique cases. Residents leave their apartments without clothes and walk through the building with dementia. Or when a male resident walks into the dining room with only his shoes and socks. Can you deal with that? It's hard to get prepared for. It's hard to put down on paper. Could you train for that? I'm

sure you can't, but academics only think of training. I would take someone's common sense, experience, good judgment, and discernment.

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There is a lot going on in this quote. One could easily see creating a training document that specifies how to handle death, considering the clientele are older and all will eventually die. Likewise, how to handle uncomfortable scenarios such as having an undressed resident in public spaces could also easily be included in training documents. So, his rationale for preferring experience to training doesn't hold up. It turns out, Leroy does not have a college education. He got where he is through years of practical work experience. This may play into his disparagement of training and education.

3.1.4 Consent

Bridge

Consent in this context demonstrates the approval given by a resident for a sexual relationship. Further probing reveals that consent is only expected from the female resident. Anna and Josephine describe how consent is a barrier. It is all around sexual health and sexual relationship. I mean, we know basic resident rights like residents are allowed to have sex and allowed to have privacy and engage in intimacy and sexual practices as long as there is consent. If there is no consent, then we will not allow it to happen because that may lead to abuse of the woman. (Anna, upper management, Good Living Home)

"As a CEO, I allow them the freedom to get into relationships. Our residents are not regulated. They make their own choices. When you pay attention to issues of exploiting residents, getting authorities to intervene in any way would take a lot of effort. So, we work with what is suitable for all of us. There are exceptions if one of them doesn't consent, but the woman's consent is required. Both residents must consent to the relationship. Still, you know, cautioning residents, in my opinion, doesn't work because they do not always have the most nuanced understanding of things" (Josephine, upper management, Good Life Gardens).

In principle, both quotes suggest that intimacy is possible with consent. But who is defining that consent and ensuring it is obtained? What does consent look like when at least one resident has dementia? These quotes appear to pay lip service to the idea of consent but consent, as demonstrated by staff, is used as a barrier that denies residents sexual autonomy. Administrators choose what works for them and it often results in decisions that avoid conflict instead of honoring the residents' sexual needs. These decisions in most cases violate residents' rights. Further, staff discuss consensual relationships and justify raising a barrier to the relationship on the grounds of fear of exploitation and/or abuse.

Barrier

If dementia is a concern for the staff, then protection from potential abuse takes precedence over the sexual needs of residents. Also, staff consensually insist on consent even with the knowledge that issues of consent for residents with dementia are complex. First, there is the inability for residents with cognitive impairment to consent to sexual relationships. This impediment may mean denied opportunity for companionship and intimacy. Second, AL environment runs counter to the cultural prescription that sex is a private act between consenting adults (Tetrault et al., 2022). Even with consent, staff find other reasons to inhibit intimacy. There is evidence of gendered social norms when it comes to consent, as illustrated by Anna especially for residents with dementia (Tijani, et al., 2023; Tunde et al., 2024). Men are seen as predators and not needing protection while women are seen as the victims. Concerns over the capacity of residents to consent is gendered.

"We know basic resident rights like residents are allowed to have sex and allowed to have privacy and engage in intimacy and sexual practices as long as there is consent. If there is no consent, then we will not allow it to happen because that may lead to abuse of the woman". - Anna, senior administrator, Good Living Home

3.1.5 Informal Policies

Bridge

Staff relied on informal policies to negotiate sexual needs of residents. Middle managers and senior administrators had clearer guidelines that were more limiting, while DCWs claimed to use their experience—allowing or denying opportunities to relationships. Also runs at a risk of projecting their own feelings or thoughts on the subject matter either positive or negative.

Policy regarding intimacy is one of the key questions of this research. I recorded mixed responses on the existence of policies within different ALs. Staff from three ALs, Cardinal Home, Golden Place, and Good Living Home, say they have informal practices, rather than formal policies, that are occasionally applied when negotiating the intimate and sexual behaviors of residents. The informal practices apply in most contexts allowing residents the freedom to engage in sexuality and intimacy activities if both parties consent and if there is no risk involved. Most administrators stated they had extensive experience dealing with intimacy among older adult residents and had standard informal practices for negotiating sexual behaviors. The absence of formal intimacy policies is consistent across assisted living communities. Despite the growing recognition of the importance of fostering intimacy and social connections, a structured framework or set of policies to support and facilitate intimacy remains largely absent from the institutional landscape. Kelly and Sarah demonstrate:

“We don't have formal policies written for residents' sexual freedom or rights except for sexual misbehavior, where it would be sexual harassment for staff. Of course, we protect employees and staff from sexual harassment. Those are well written policies in our HR Manual. But again, we have very little in writing. We do a background check if anyone has anything in their background that would be more of a past inappropriate behavior sexually.” - Kelly, upper management, Cardinal Home)

Barrier

Despite a growing recognition of sexuality in older adults, staff confirmed that their ALs do not have policies and procedures to manage sexual needs of residents, which ultimately constitutes a disservice, if not a violation, of residents' rights. In fact, lack of policies creates an environment with little intimate human connections among residents. Apart from admission and discharge policies which administrators described as formal policies, the only other formal policy is an HR policy on sexual harassment of staff. Negotiation of sexuality and intimacy then, is handled informally on a case-by-case or staff-by-staff basis depending on prior experience. In the second quote, the DCW contradicts herself first intimating freedom then providing requirements that impede residents' intimacy when they don't comply. Staff from Century Court, Silver Springs, the Retirement Haven, and the Good Life Gardens stated they had no policies that negotiated sexuality and intimacy in their varied ALs. They relied on work experience gained for several years.

3.2 Intimacy negotiation mode

Strategies are the conscious actions AL staff take in regard to residents' potential intimacy. Staff use different strategies to negotiate residents' sexual needs. Four strategies that staff utilize in either raising barriers or lowering bridges (Waterschoot et al.,2022). These strategies are watchful oversight, over surveillance, redirecting, and reporting.

Strategies

1. Watchful oversight

Watchful oversight and oversurveillance are closely related but differ in magnitude. Watchful oversight is the act of monitoring residents' behavior. Watchful oversight involves regular observation, sometimes with intervals. For example, staff monitor residents' behavior on a 24-hour basis at regular intervals of one to two hours. This can include walking in on residents while they are in their rooms.

“You know, we have varying levels of intimacy, and sometimes, like you said it is sexuality or sexual penetration. They just cohabit together, and, you know, enjoy each other's company. For example, watching TV together, holding hands all the way down to sexual intercourse, depending on the person. But this freedom is observed and whatever goes on is notified. We get a lot of notifications of residents found on top of each other in bed. But we have trained our staff not to interrupt. And it may just end with us. But we must know what is going on.” (Robert, administrator, Silver Springs).

Robert acknowledges the many notifications received suggesting how pervasive watchful oversight is, and that it leads to a serious loss of privacy but does not necessarily lead to a denial of intimacy. He also uses the term “trained” which I found means informal practices of talking to staff on “dos” and “don'ts”. Staff's watchful oversight practices are often contradictory to the stated values of AL. Decisions regarding residents'

autonomy rest on evaluations and attitudes of staff—and sometimes in consultation with family, ignoring residents' choice. Monitoring of residents was done both in common space (tv room) and in the private rooms. Other researchers found interferences included an unlocked-door policy, the presence of roommates, regular room checks by staff, and staff access to medical and health-related information.

2. Over surveillance

Oversurveillance involves continually monitoring residents' behavior beyond the interval inspections. Oversurveillance, as presented in this study is about protecting residents and even staff from another resident engaging in impulsive, inappropriate behavior. Staff justify oversurveillance as part of their responsibility to safeguard the health and well-being of residents. Responsibility is often referenced as a stand-alone word as it is a major aspect of AL communities' philosophy. Robert shares how watchful oversight as a strategy could lead to a bridge. Sunita, shares how the oversurveillance strategy can cause a barrier to intimacy—possibly for good reason as it introduces a scenario involving residents with cognitive impairment.

“Some of them act on impulse. For example, there is this male resident who I can say acts on impulse. He just suddenly grabs a female resident's boobs or slaps their butt. He does that to staff as well. We as staff can deal with it but we have to protect residents from abuse...yes it is abuse. So, we have to constantly watch him and if you see him making a move, you quickly step in to distract his thoughts. Administrators tell us to have our eyes on him all the time” - Sunita, DCW, Retirement Haven.

This quote shows that the lack of privacy goes beyond watchful oversight at times and can include questioning of residents. Through oversurveillance, residents' are likely to have difficulty adjusting to a shared environment especially one that mandates 24-hour oversight/surveillance. Almost every aspect of a resident's behavior is noted and recorded, even if only mentally by staff. Regarding sexuality, staff surveillance makes this value more ideological than practical. Residents' behavior is noted in logs and reported to families, and observations of behavior are discussed at staff meetings.

3. Redirecting

Staff use the redirecting strategy to deny residents opportunities for sexual relationships. Redirecting is the act of distracting residents' sexual desires. Staff use this strategy to make residents forget their intentions regarding sexual interactions. As staff monitor residents' behavior, they will redirect any sexual behavior to divert them. DCWs justify redirecting as a means of meeting AL's goal of responsibility, to satisfy both administrators and family members. Yvette and Goosby explain:

“So, it is not frequent. I do have one resident who tells me about liking, well, loving another resident. But I just try to redirect him to something else. I have not notified it. The experience I have, I know what to do. But it is not that he physically touches them or does anything in their space. He also says it to other residents. When he says it, I will hear him like across the room expressing his sexual desire and looking at her. You know what I mean right? So yeah, I would step in and distract him. You know they forget easily because of their cognitive impairment. But if it continues, we will probably have to relocate one of them.” - Yvette, DCW Good Life Gardens.

It appears that DCWs' attitudes towards residents' sexual needs are primarily negative. It will disrupt the harmony of the community and create more work for staff. These attitudes are also influenced by family and administrators. In fact, such attitudes often lead staff to perceive attempts at sexual expression as inappropriate behavior. Additionally, sociocultural and health biases may be present against older adults residing in AL communities who participate in sexual activity (Ayeleat al., 2024). Sexual expression varies from intimacy to intercourse. Sexuality and intimacy are manifested in various ways, including intercourse. But even the basic intimate behaviors like touch, hand holding, and other less physically intense expressions were redirected by staff denying residents opportunities to companionship.

4. Reporting

Reporting is a strategy that staff used to notify management/administrators of residents' inappropriate behavior. DCWs report incidents of sexual behaviors to administrators, and administrators report to family members. Reporting is intended to cover DCWs' or the administration's bases. This strategy can lead to a bridge or a barrier depending upon the family.

“We have house rules that control behavior. If the resident continues to have inappropriate behavior, I will notify the administrator. We must protect other residents. So, as direct care workers, that is what we do. We don't report to families. Administrators will decide.” Sarah, DCW, Century Court.

These quotes from different DCWs in different AL communities are quite similar. In fact, it confirms my findings that there are similarities in operations of varied ALs. Through surveillance, DCWs constantly monitor residents' behavior and notify administrators what they label as inappropriate behavior. They described any attempt at sexual expression as inappropriate behavior. There are no policies to guide staff on "what should or should not" be allowable sexual expression. What they described as procedures in place are informal practices that can be changed on a case-by-case or staff-by-staff basis.

Children may not want to think of their parents as sexual beings. Some residents' children struggle to accept the idea that their mother may be intimate with someone new. However, family plays a big role in the continued stay of the resident in the AL. In protecting the privacy and autonomy of a resident, administrators risk alienating family members. This may lead to family members transferring their relative to another community, leaving the AL with a vacant bed. This scenario is avoided as it infringes into the financial intake of the community. Also, as family members help in marketing the AL by referring future residents, administrators will not want to risk alienating family. Finally, family involvement in AL help to enhance a homelike environment which is good for residents. These factors influence staff's negotiation of intimacy. Clearly, staff use strategies that favor the family, and the AL community rather than the resident.

5. Conclusion

The study examined how the structure of assisted living communities' policies and procedures impact the sexual autonomy of residents with dementia from the perspective of AL staff. Despite residents' desire for intimacy, there were no formal policies that directly addressed sexuality. Lack of formal policies lead staff to address residents' sexual desires on a case-by-case and staff-by-staff basis. This is exacerbated by the reliance on individual work experience rather than formal training. Overall, while some strategies lead to bridges, most of the strategies lead to barriers, though some themes emerged as both barriers and bridges. The researchers' findings suggest that staffs' attitudes, concern for the safety and health of residents, and family concerns over parental intimacy, may bias against AL residents' right to sexuality and intimacy. This is despite the current cultural attitudes shifting to encourage individuals to remain sexually active over the life course.

For persons with dementia living in long-term care communities, intimacy can reduce feelings of isolation and anxiety. Intimacy may just mean having a confidant whom you can hold hands and share concerns, or someone patting on your shoulder for assurance. The lack of formal policies intensify the conflict between protection and safeguarding. There is a clear need for well-defined policies and procedures that support staff in balancing autonomy and protection. Understanding the perspectives of residents, families, and staff is essential in creating an environment that respects the rights and needs of individuals while ensuring their safety and well-being. Future research should continue to explore innovative approaches to policy development, training, and family engagement to enhance the quality of care in assisted living communities.

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