TEN

Sexual expression and sexual practices in long-term residential facilities for older people

Feliciano Villar

Introduction

This chapter deals with how sexual issues are dealt with, both by residents and professionals, in long-term facilities for older people. Sexuality is a valuable dimension of humanity that may be maintained until a very advanced age (Lindau et al., 2007), and even in the presence of severe illness and dependency at least some older adults continue to be interested and involved in sexual behaviours (Benbow and Beeston, 2012).

A particularly challenging situation in this regard is when a person enters a long-term care (LTC) facility, an event marking a turning point in the older person’s life. Although it is true that for some older people living in LTC facilities sex does not hold (or no longer holds) an important place in their life, and they simply do not miss it at all (Villar et al., 2014a), other residents see themselves as sexual beings who still experience sexual needs (Bauer et al., 2013), and consequently issues regarding sexual activities can occur in this setting (Lester et al., 2016).

In this chapter, we outline the study in Box 1. We then first identify the barriers that institutionalised older people might face with regard to the expression of sexual interests. We will explore barriers related to the profile of older people living in those contexts, to the attitudes of residents and staff, to the culture of care held in LTC facilities. Second, we will examine how sexual expression might be especially challenging among specific populations of older adults living in institutions, with particular attention being paid to people with dementia and LGBT (lesbian, gay, bisexual, transgender) residents. Finally, some practical implications as regards sexual expression and sexual rights of older people living in LTC settings will be considered.
In the exposition, the intersection between those topics and ageing, gender and sexual diversity issues will be emphasised. These factors are by themselves systems of inequalities, as they have material consequences and influence life chances (Veenstra, 2011; Calasanti and King, 2015). In our view, their effect in a closed context such as a LTC facility, in which living options are limited and deeply influenced by staff and institutional practices, might intensify inequalities and increase the risk to curtail sexual rights of certain collectives.

Throughout the chapter, I will illustrate certain ideas with some of the results and examples extracted from qualitative research on these issues conducted by Montserrat Celdrán, Rodrigo Serrat, Josep Fabà and myself. This forms part of a project that has been carried out in LTC facilities in Spain by interviewing both staff and residents (see Box 1). The case of Spain is particularly interesting in relation to sexuality in older age for at least two reasons. First, despite secularism being dominant among younger generations, traditionally Spain has been a deeply Catholic country. As is well known, Catholicism is particularly conservative with respect to sexual issues (Curran, 1992). Second, older people now living in LTC facilities in Spain belong to the post-Spanish Civil War generation. They grew up and spend their youth in Franco’s dictatorship, a regime which severely axed civil liberties and rights, including sexual ones. Formal sexual education did not exist and open expressions of sexuality, particularly for women, were deemed dirty and sinful (Pérez, 1994). So, we should take into account such cultural and generational particularities when reading older people’s responses coming from our research.

**Sexual expression in LTC institutions**

The sexual dimension of older residents is often ignored in LTC facilities and, when it appears, is considered more a problem or a potential source of conflict than the expression of a natural human need and a question of rights (Tarzia et al., 2012; Villar et al., 2014a). The reasons for this are diverse and interrelated, but three areas of difficulty which hamper older residents from maintaining intimate and sexual relationships in LTC facilities can be distinguished: those related to the social profile and health status of residents, those derived from social attitudes towards sexuality in older age, and those linked to the organisational culture and models of care that are prevalent in LTC facilities.
Box 1: The study

In 2012 a research team based on the University of Barcelona and composed by Feliciano Villar, Montserrat Celdrán, Rodrigo Serrat and Josep Fabà, designed a research project aimed at exploring the attitudes towards sexuality in Spanish LTC facilities. The project, initially funded by the Spanish Institute for Older People and Social Services (IMSERSO) has two stages:

Stage 1
We interviewed 47 residents and 53 professionals (including technical staff and nursing assistants) belonging to five different LTC facilities located in Barcelona and the surrounding area. The interview consisted of some introductory questions regarding sexuality and ageing, such as barriers to residents’ sexual expression (Villar et al., 2014a), and perceived needs in this area (Villar et al., 2017). Subsequently, researchers presented some vignettes in which older people were depicted engaging in different sexual behaviours. Participants had to reflect on the situations, saying what they thought and how they would react themselves in the circumstances. Vignettes included masturbation (Villar et al., 2016a, 2016b), heterosexual sexual relationships (Villar et al., 2015a), people disclosing a non-heterosexual sexual orientation (Villar et al., 2015b, 2015c) and sexual relationships involving residents with dementia (Villar et al., 2014b).

Stage 2
Based on the results of stage 1, the research team (with the inclusion of gerontologist Teresa Martínez) designed a questionnaire in which vignettes presenting sexual situations also included different staff reactions. Participants had to indicate what is normally done in their institution (common practice) and what, in their opinion, should be done (best practice). Reactions included both supportive and restrictive practices. As well as the ones presented in stage 1, the questionnaire also included vignettes regarding same-sex sexual relationships and inappropriate sexual behaviours, such as exhibitionism or a staff member experiencing fondling. We also applied a questionnaire on person-centered care and an inventory on institutional policies regarding sexuality.

The questionnaire was applied to 2,300 staff members, including directors, technical staff and nursing assistants (at this stage people living in LTC facilities did not participate), from 152 different institutions across the country. The design and sample size allowed for determining personal and institutional predictors of staff practices. First results have been published in 2018 (see Celdrán et al., 2018; Villar et al., 2018).
Difficulties in relation to social profile and health status of residents

The profile of older people living in residential settings is clearly one factor that accounts for the lower incidence of sexual practices. For instance, Caffrey et al. (2012) estimated that around 70% of Americans living in long-term institutions are women, most of whom are widowed or single, a situation that makes it difficult to find available sexual partners, at least for heterosexual women. A similar situation is found in other countries, such as the UK (ONS, 2014) or Spain (Tobaruela, 2003), where the percentage or women in LTC facilities is similar, or even greater.

It should also be noted that, even for older people living outside institutional settings, having a partner has a decisive influence on sexual activity, although there are gender differences here: men without a partner reported being sexually active far more frequently than women without a partner (Papaharitou et al., 2008), a result that is also replicated among older Spanish people (Palacios-Ceña et al., 2012).

A further issue is that older people living in institutional settings, at least in Spain (Tobaruela, 2003), present a high prevalence of chronic diseases (including cognitive impairment) and dependency, which could impair their sexual drive and make it particularly difficult to express their sexual interest and needs. As a nurse, aged 38, reported, “Many people here are not independent enough to go to the toilet by themselves ... so they can’t get involved in sexual matters; they would even need help to masturbate!” (Villar et al., 2014a: 2523).

It should also be taken into account that the high rate of chronic illnesses goes hand in hand with an extraordinarily high use of medication (Dwyer et al., 2010).

Polymedication in older adults is associated with adverse consequences, some of them in the sexual domain (Hillman, 2008). Unfortunately, these consequences for sexual drive and sexual behaviour are not normally assessed or even taken into account by health professionals. Even when older people in LTC facilities experience health issues that impair (or impede) their ability to have sexual intercourse or to masturbate, they may still experience sexual needs and the desire for some kind of physical intimacy, for example, in the form of touching, hugging or kissing (Ehrenfeld et al., 1999). However, there are other barriers that may make even these forms of sexual expression difficult.
Social attitudes toward sexuality in older age

Societal values and beliefs regarding sexuality, and particularly ageist erotophobia, that is, anxieties concerning older people as sexual beings or denial of their sexual capacities or rights (Simpson et al., 2017), have an impact on – and could be a barrier to – a person’s ability to maintain sexual activity once he or she moves to a LTC facility.

In countries such as Spain, most people belonging to older generations have received limited or no information and education at all concerning sexual issues (Vázquez & Moreno, 1996). They have grown up in a political regime that restricted liberties and rights and was heavily influenced by extreme Catholic views. A context in which sex, and particularly sex without a reproductive aim, was condemned, and definitely considered as not appropriate in later life.

Such negative views of sexuality may particularly affect the sexuality of women, in whom virtue in most religious denominations, including Catholicism (Curran, 1992; Davidson et al., 2004), was traditionally associated with a lack of initiative in the sexual domain and lack of involvement in non-procreative sexual activities. Furthermore, when it came to sexuality in later life, and despite new social images of sexually active older women (see, for example, Montemurro and Siefken, 2014), older women were traditionally stereotyped as frigid and asexual. The internalisation of such scripts in older generations could account for the findings of Lindau et al. (2007), who noted that women, far more frequently than men, tended to report that sex in older age is ‘not important at all’ and to mention lack of interest as a motive for sexual inactivity.

Therefore, it comes as no surprise that older adults themselves might be a source of barriers to their peers’ sexuality, or that this effect is particularly intense in the closed setting of LTC facilities, where residents share time, space and activities. As one of the residents interviewed by Villar et al. (2014a: 2522), a woman aged 73, said “Every new thing becomes a public affair and sexuality also becomes public. There are no secrets and sex needs secrecy, so people hold themselves back, because nobody likes to be the target of gossip.”

In this context, peers’ real or anticipated negative reactions towards sex might act as a form of social control that denies the expression of sexuality among residents, or at least leads to them remaining hidden. For instance, residents and staff (Villar et al., 2015a), were asked to imagine what they would feel and how they would react if they caught a heterosexual couple having sex in their room. We found that residents were much more prone than professionals to judge
this situation adversely and to express negative emotions. While staff mainly mentioned emotions associated with regret (in other words, they should not have interrupted), residents’ most common emotions were unpleasantness and shame. In some cases, they expressed intense rejection. For instance, a male resident, aged 79, said:

‘They should be ashamed of doing such things at their age, or outside their own home ... or whatever – publicly, you might say. That’s what I’d think. May God forgive them because it wouldn’t ... Well, it’s not something I would like to come across.’ (Villar et al., 2015a: 1058)

However, since in younger generations religion is less important, at least in Spain, and attitudes towards sex are more open and liberal than in previous generations (Rowntree, 2014), attitudes toward sex in later life may change. Once these generations grow older and some of them enter LTC facilities, it is likely that sexual issues will become more central. Some studies show, accordingly, that younger people express concerns about the capacity of aged care institutions to recognise their expectations about sexuality (Jönson and Jönsson, 2015).

Social views regarding sexuality in older age not only influence older people’s attitudes but also those of their relatives. Families may find it difficult to accept that their older relative (for example, their father or mother) has sexual needs and is sexually active. This denial, or even rejection, could be particularly strong if the older person is widowed and/or if he or she lives in a LTC facility (Gilmer et al., 2010), where it may act as a barrier and lead staff to discourage (or at least not to support) sexual relationships within the institution for fear of how relatives will react.

Organisational culture and concepts of care

One of the most influential factors that may impede sexual relationships within LTC facilities is the organisational culture of the institution. The key issues here are how the institution and its staff conceive of their task, which philosophy of care is promoted and how it is enacted, what kinds of rights residents are afforded, and the extent to which sexuality is acknowledged to be a need and/or right within the structure of organisational beliefs and practices.

In that respect, the traditional (and dominant) conception of care within LTC institutions is based on the medical model, in which the professional is conceived of as a dispenser of care; as such, it is
professionals who decide the type and extent of care required by residents. There is thus a tendency to function in a paternalistic way, with the emphasis on controlling behaviour rather than supporting residents’ autonomous choices, and with efficiency being the fundamental criterion for achieving quality. Residents thus become patients with needs that have to be met; they should be protected (sometimes from themselves) and are given little room for deciding about their daily lives and the care they receive (Morgan, 2009).

Within this type of care model there are a number of ways in which residents’ sexuality may be dealt with. One is to restrict or punish sexual expressions among residents, treating them as problem behaviours to be eliminated. Such a stance is likely to be adopted if the institutional philosophy is based on certain religious or conservative values. Alternatively, sexuality may simply be ignored, with staff acting as if residents have no sexual interests (Doll, 2012). Thus, most LTC facilities have no formal policy guidelines for dealing with residents’ sexual expressions, have no trained staff for managing them, and fail to set aside private spaces in which sexual practices could be engaged in (Shuttleworth et al., 2010).

**Staff attitudes**

Implicit models of care are also important because they have an impact on staff attitudes about residents’ sexuality, a factor that the literature has identified as a key barrier to – or potentially a facilitator of – sexual expressions. Thus, when staff perceive that their institution is restrictive they are more likely to feel uncomfortable dealing with sexual issues and to act in a controlling way (Roach, 2004).

The attitudes of professionals are, however, quite diverse. Many of them show respect towards residents’ sexual expression, whether in the form of heterosexual relationships (Villar et al., 2015a), masturbation (Villar et al., 2016a) or homosexual relationships (Villar et al., 2015b), and they try not to interfere in such expressions. Such attitudes may reflect a wider generational change, as reflected in the following comment by a staff member, a woman aged 36, regarding masturbation: “It’s the resident’s body and he can do as he pleases. Times change, and people of my generation don’t see it as a sin, or as something shameful that must be kept hidden” (Villar et al., 2016a: 825).

Nevertheless, negative attitudes are also quite common and take different forms, condescending or paternalistic stances being quite frequent (Bauer, 1999). Thus, particularly in the case of partnered heterosexual sexual expressions, staff tend to romanticise them, as ‘cute’
or ‘amusing’. However, such infantilising attitudes are less likely when demonstrations of sexual arousal and desire are explicit (Ehrenfeld et al., 1999).

Joking, mocking or gossiping with workmates are also frequent reactions among staff. This is not always an overt rejection of residents’ sexual expression, as at times it may be a way of reducing the tension, discomfort or embarrassment that is provoked by the situation (Bauer, 1999). As well as being a lack of respect of residents’ right to privacy, such reactions could discourage residents to rely on staff as a source of help and advice on sexual issues.

Our own research has shown that, although open restriction (for example, reprimanding) of sexual expression is not the norm in Spanish LTC facilities, support of sexual expression is also uncommon (Villar et al., 2015a, 2016a). This suggests that staff have little awareness of the key role they play in terms of supporting and guaranteeing residents’ rights (Gilmer et al., 2010). In addition, the wide range of staff reactions highlights the lack of clear and previously agreed institutional policies (Lester et al., 2016). Sexual issues are thus dealt with in an ad hoc way, thereby promoting uncertainty among both professionals and residents (Cook et al., 2017).

**Privacy**

In the medical approach to care, many nursing homes emphasise the need to standardise staff work and resident activities in order to ensure the smooth running of the institution, regardless of the impact this may have on residents’ expression of sexuality and intimacy. Thus, residents are subjected to schedules that they have not chosen and spend many hours in common spaces and in the company of (although not necessarily interacting with) other residents.

Similarly, LTC facilities are often designed in the manner of hospitals, prioritising control and quick access to residents’ rooms over the maintenance of their privacy. In addition, most rooms are shared and in many instances there are no locks on doors, the justification being that professionals need to be able to enter quickly in the event of an emergency and should face no barriers in their regular monitoring of residents’ activities (Eckert et al., 2009; Morgan, 2009).

In this context, obtaining the privacy needed for sexual relationships is very difficult. In fact, a lack of privacy is the most frequent barrier mentioned by professionals and residents of the Spanish LTC facilities participating in our studies (Villar et al., 2014a). As one of the staff members, a nurse aged 47, said:
‘I think the fact of sharing a room and that rooms have no lock doesn’t help ... Even the bathrooms are shared. Your room is supposed to be your private space, but even there you can’t be sure that nobody is going to come in ... you don’t have a single space you can call your own ... that doesn’t exist in a residential home.’ (Villar et al., 2014a: 2522)

Such a lack of privacy affects partnered sexual relationships, but it also makes it difficult to engage in other sexual behaviours that do not involve a partner, such as masturbation. In a context where, as argued above, establishing a partnered sexual relationship is extremely difficult, masturbation might be a readily available form of sexual release and a way of compensating for and channelling residents’ sexual needs (Villar et al., 2016b). However, the lack of private spaces leaves little room for masturbating without concerns.

Diversity and expression of sexual interests in residential settings

If, as noted above, the expression of sexual needs may be difficult for healthy heterosexual residents living in a LTC facility, then it is even more challenging for some of their peers whose situation is somewhat different. In the next two sections I will briefly examine the case of two groups: older adults with dementia and non-heterosexual older adults.

People with dementia

Sexuality among older residents with dementia is a source of practical and ethical dilemmas among staff (Tarzia et al., 2012). The literature on this topic has highlighted two interrelated issues: (a) the effects that dementia may have on the expression of sexuality and the presence of inappropriate sexual behaviours (ISB); and (b) the effects of dementia on a person’s cognitive capacities and personality structure, which could undermine his or her ability to make decisions about sexuality.

Dementia and ISB

Regarding dementia, it is well known that, alongside cognitive impairment, behavioural disturbances are likely to manifest at some stage. These behavioural disturbances sometimes affect the sexual
Intersections of ageing, gender and sexualities

conduct of people with dementia, leading to what has been labelled as inappropriate sexual behaviours (Ward and Manchip, 2013), which includes hypersexuality, sexual aggression, unwanted groping of other people or use of foul language. In the context of LTC facilities, the presence of ISB, although relatively infrequent, is likely to impinge on the rights of staff and other residents, thus residents with ISB need to be monitored and adequately managed.

Beyond the clinical implications, ISB could also be a response to unmet intimacy needs that do not disappear simply because the person has dementia; in this respect, these behaviours may constitute strategies (albeit dysfunctional) for interacting with others (Tune and Rosenberg, 2008). Although behaviours of this kind may result in negative interactions, such an outcome may, for the person with dementia, be preferable to no interaction at all, particularly where little is done to enable interaction among residents, as in certain LTC facilities. Examining the meaning of ISB from the residents’ perspectives and considering possible ways of channelling such behaviours in an acceptable manner might be a reasonable response. However, professionals, in line with the medical model of care, often try to avoid risks. This may lead them to consider any manifestation of sexuality among people with dementia, regardless of whether it is appropriate or not, as a symptom of the illness that should be controlled rather than as the expression of a need or the exercise of a right (Ward et al., 2005).

Dementia, abuse and consent

Memory and language impairment, as well as possible changes in personality, make it more difficult for the person with dementia to make decisions and communicate his or her preferences. In the case of sexual expressions involving other people, it may be difficult to determine the extent to which the person with dementia really wants or consents to the relationship, and there is an undeniable risk that they may abuse other residents (or even staff) or be abused by them.

In these situations most institutions and professionals opt to minimise risks and preclude any sexual expression among people with dementia as a way of protecting them from abuse; this has been called the ‘extreme cautionary stance’ (Villar et al., 2014b). Thus, expressions of sexuality in dementia are, by default, an object of suspicion and are treated as a symptom of disease, as a woman, aged 54, doctor and director of an LTC facility, said when was interviewed by Villar et al. (2014b: 406):
‘You have to be sure that there’s not an abuse of authority. Because people with dementia often have frontal impairments, and then they’re sexually disinhibited … they’re not aware of what other people are doing with them, and maybe … so, we have to protect the weakest, don’t we?’

This kind of paternalistic, restrictive and overprotective attitude may become particularly intense when only one person in a partnered relationship has dementia, and it may also be enhanced by relatives’ opinions. Thus, institutions may be afraid of being sued by relatives, should the latter discover that their family member with dementia is having sexual relationships, or simply fear that the family would remove their relative (and the corresponding funds) from the institution.

Although well-meaning, attitudes of this kind deprive people with dementia of the right to make their own decisions on sexual issues, or at least to be involved in those decisions. Importantly, research suggests that people with dementia do retain the capacity to express their own values and preferences consistently, particularly when the stage of dementia is mild or moderate (Mak, 2011). The use of non-verbal cues (for example, body language or facial expressions) is particularly useful in this respect, and such cues may offer a reliable sign of how a person with dementia is experiencing a sexual situation.

**Specific issues facing older LGBT people**

In addition to the barriers already outlined above, older LGBT people living in LTC facilities have to face specific challenges that do not affect their heterosexual peers and suppose a further challenge to their sexual rights.

One of these springs from the fear of being discriminated against (Westwood, 2015). Most likely due to their lifetime experience of abuse and rejection, older LGBT generations express a recurrent concern that they will be mistreated and discriminated against in healthcare settings, including LTC facilities. Specifically, they fear being neglected, judged or abused by healthcare providers, or being rejected or ostracised by roommates or other residents (Stein et al., 2010; White and Gendron, 2016). This may lead many of them, even if they were open about their sexual identities when living in the community, to ‘go back into the closet’, denying or hiding their sexualities. As a result, they may experience even stronger feelings of isolation and loss than are commonly felt by older people when entering a LTC setting.
Intersections of ageing, gender and sexualities

Studies of attitudes among residents in Spanish LTC facilities support these concerns. Faced with a hypothetical situation in which a fellow resident discloses his or her gay or lesbian sexual identity, only a minority of the participants interviewed by Villar et al. (2015b) reacted with support or acceptance. Indeed, most of those interviewed expressed negative attitudes, ranging from extreme rejection (one male resident said: ‘[I’d think] that he’s a disgusting pig who should be kicked out’) to simply keeping one’s distance, as a woman aged 79 said:

‘Very, very bad ... I’d try to keep away from her ... I’d try to avoid being with her. [I’d tell her] “I don’t like your behaviour and I don’t like your attitude.” I’d ask her to stay away from me.’ (Villar et al., 2015b: 1009)

Although most residents stated that they would have no problem sharing communal areas with gay or lesbian residents, the vast majority said that they would not (or would be reluctant to) share a room. It should be noted, however, that these results might not be replicated in other samples, since acceptance (and legal recognition) of LGBT people varies enormously across cultures, communities and religious perspectives. It is also likely, at least in some countries, that the next generation of older people, who have already lived through the normalisation of non-heterosexual sexual identities, will hold less prejudiced attitudes (Herek and McLemore, 2013).

As for staff approaches to LGBT residents, although some discriminatory practices have been reported among social and health service professionals (Addis et al., 2009; Hinrichs and Vacha-Haase, 2010), other studies that focused on staff working in LTC facilities have found that respect and acceptance are not uncommon (Villar et al., 2015c). However, despite any positive dispositions of staff towards LGBT residents, heteronormative assumptions are widespread, which could lead to reinforce the invisibility of LGBT residents and the failure to recognise their distinctive social and care needs and, consequently, the failure to apply supportive practices. Such a situation might entrench inequality on the grounds of a well-meaning intention of ‘treating all the residents in the same way’ (Simpson et al., 2016; Willis et al., 2016).

**Conclusion and practical implications**

The research reviewed in this chapter shows that sexual expression among older adults living in LTC facilities is far from being accepted or even respected. Residents’ sexual expressions (and even intimate
relationships) are limited or at least monitored by staff who perceive such behaviour as potentially problematic or even pathological.

We have also seen how such difficulties also intersect with variables such as gender or sexual orientation, increasing the difficulties for certain collectives to exert sexual rights. For instance, as older women are thought to be more passive and uninterested in sex than men, their sexual expression in a LTC facility could be seen as particularly problematic for both staff and relatives. Similarly, LGBT older people living in LTC facilities perceive and suffer discrimination by peers, leading many of them to hide their sexual orientation to avoid further segregation.

The literature on this topic has highlighted the importance of developing formal and clear institutional guidelines on sexuality (Lester et al., 2016) and of facilitating staff training on sexual issues (Villar et al., 2017). Initiatives of this kind would help to ensure not only a consistent approach to issues of sexuality in the daily functioning of institutions, but also respect for the rights of all individuals, including those residents who are not interested in sex. The progressive presence of person-centred model of care substituting traditional medical models makes us optimistic in this respect. However, a truly person-centred model of care would need to ensure the application of two fundamental principles in relation to sexuality.

First, residents are bearers of rights, including sexual rights, which should be explicitly supported and guaranteed by staff. Their guiding principle should therefore be beneficence rather than non-malficence. In other words, the ability to exercise sexual rights should be taken for granted until proven otherwise, even among persons with dementia. This position implies certain risks (for example, potential abuse), but then so does the cautionary stance I have discussed earlier (that is, the risk of increased dependency, curtailed – or even violated – citizenship rights and non-justified discrimination).

Second, LTC facilities should be conceived of neither as hospitals nor hotels, but places where people live. They are the residents’ homes, and as such all efforts should be made to create a personalised setting in which people’s lifestyles, decisions and privacy are respected as far as possible. Those who enter a facility of this kind have had previous lives (including previous sexual lives) that should be known about (to the extent that the individual wants it to be) and respected, thus encouraging a sense of continuity. This means that any decision about residents’ sexual practices should ultimately lie with them, or at the very least their views and personal histories should be taken into account.
This does not mean that all older people living in LTC facilities wish to be sexually active, or that staff should be pressuring them to express their sexual desires. What is argued is that sexuality should not be a neglected dimension of residents’ lives, but a right and an inextricable part of each person’s life, just as it was before he or she entered the LTC facility. In this respect, creating the conditions in which a person can retain his or her sexuality, and supporting it if necessary, makes sense not merely because of the benefits this may bring, but also because it represents an ethical imperative of care.

References


Sexual expression and sexual practices in long-term residential facilities for older people


Simpson, P., Almack, K. and Walthery, P. (2016) “‘We treat them all the same”: the attitudes, knowledge and practices of staff concerning old/er lesbian, gay, bisexual and trans residents in care homes’, *Ageing & Society*, 1–31, DOI: 10.1017/S0144686X1600132X.


