Research Project Portfolio

Volume 1

University of Nottingham
School of Medicine
Division of Psychiatry and Applied Psychology

Doctorate in Clinical Psychology

2017

GREAT SEXPECTATIONS: OLDER ADULTS' PERCEPTIONS ABOUT HOW TRANSITIONING TO A CARE HOME MIGHT IMPACT ON EXPERIENCES OF SEXUALITY

Anna Hooper, BSc (Hons), PGDip, PGCert

Submitted in part fulfilment of the requirements for the
Doctorate in Clinical Psychology

Acknowledgements

The seeds of this project would not have grown without the support of my supervisors, Dr Roshan das Nair, Dr Nima Maghaddam, and Dr Danielle De Boos. My experience with this project has embodied the saying, 'the whole is greater than the sums of its parts', and I really could not have completed this work without you.

I am also extremely grateful to the multitude of people who invested their time to aid the development of this project. I am particularly appreciative to all those who supported with participant recruitment and to the participants themselves. Thank you for seeing value in this research.

I would like to extend my thanks to Jones Transcription services for their professional and timely response to my numerous requests and demands, without whom this project would have taken many more moons to complete.

Finally, the most significant thank you is offered to my Mum. Her contribution to this work has been immeasurable. She found motivation and inspiration when mine was running low, sent surprise packages of nutritional brain food (jelly sweets), provided invaluable proofreading skills, and most importantly did what only Mums are best placed to do - told me to shut up and get on with it. So thank you, Mum. You are amazing in every way, and I could not have got through this without you.

Table of contents

Portfolio total word count – 21,794

Tables and Figures

Appendices

1. Portfolio Abstract

Portfolio Abstract

Introduction

Older adults' sexuality has been linked with a number of factors associated with wellbeing. Despite sexual practices changing across the lifespan, sexuality remains an important part of the identity of older adults. The ageing population of the United Kingdom is placing increasing demands on care homes, yet despite the recognised benefits of older adults' sexuality best practice guidelines for care homes either fail to comment on residents' sexuality or provide recommendations which are too minimal or vague to operationalise. Most research exploring older adults' sexuality in care homes has focussed on the views of health and social care practitioners who report on their lack of willingness to engage with residents about their sexuality needs. Research which attempts to explore older adults' sexuality in care homes from the perspective of residents favours quantitative research methods, an approach which arguably fails to acknowledge the changes in sexual expression which occur with age. Furthermore, the lack of consensus regarding the conceptualisation of the term 'sexuality' across the literature limits the extent to which research findings can be synthesised. This research sought to contribute to understandings of older adults' sexuality experiences in care homes from a first-person perspective by adopting a prospective planning approach to explore prognostications about how transitioning to a care home might impact upon experiences of sexuality and participants' hopes and fears regarding care provision. To increase the interpretability of findings and contextualise responses, the definition of sexuality from the perspective of older adults was also considered.

Methods

Semi-structured interviews were conducted with ten participants to explore three broad questions: (1) How do older adults define 'sexuality'? (2) What

impact might a care home have on sexuality experience? (3) How would individuals like sexuality to be acknowledged by care services? Face-to-face and telephone interviews were audio recorded, transcribed, and analysed using a hybrid inductive/deductive thematic analysis approach at a mixed manifest/latent level.

Results

Participants defined sexuality as a multifaceted component of self-identity which held individual meaning and changed across the lifespan. Participants' definitions of sexuality were compared with the World Health Organisation's (WHO) working definition of sexuality, and areas of difference and similarity were identified. Participants anticipated that becoming a resident of a care home would prompt significant (and often negative) changes with regards to how they could experience sexuality. Participants wanted services to demonstrate attempts to minimise the environmental impact on sexuality and promote positive experiences in a manner that was responsive to individual need.

Discussion

While used as an ageless term, 'sexuality' has different understandings and applications across the lifespan and remains an important part of the identity of older adults. Findings from this study indicated that participants expected to embody the role of the non-sexual resident when transitioning into a care home, changes in identity which were predicated on living in an environment which was predicted to neither acknowledge nor facilitate positive sexuality experiences.

Abstract word count – 479

2. Statement of Contribution

Statement of Contribution

The lead author proposed the broad topics of healthcare settings and sexuality as the original research concept. The study was then developed and refined through discussions with Dr Roshan das Nair, Dr Nima Moghaddam, and Dr Danielle De Boos. The lead author adopted responsibility for applying for ethical approval, the processes of participant recruitment, data collection and analysis, and the thesis write-up. The data analysis process was supported by the co-authors who provided regular research supervision throughout the development of the project.

3. Journal Paper

Great Sexpectations: Older adults' perceptions about how transitioning to a care home might impact on experiences of sexuality[1]

Anna Hooper, Nima Moghaddam, Roshan das Nair, Danielle De Boos

The University of Nottingham, United Kingdom

Correspondence to Dr. Danielle De Boos, B09, YANG Fujia Building, Jubilee Campus, Wollaton Road, Nottingham NG8 1BB, UK.

E-mail: Danielle.Deboos@nottingham.ac.uk

Telephone: (+44)115 82 32204

[1] This paper has been prepared in accordance with guidelines set for authors intending to submit to the Journal of Sexual and Relationship Therapy. These guidelines are available via http://www.tandfonline.com/action/authorSubmission?show=instructions&journalCode=csmt20

Great Sexpectations: Older adults' perceptions about how transitioning to a care home might impact on experiences of sexuality

3.1 Abstract

Our aim was to explore older adults' prognostications about how transitioning to a care home might impact upon sexuality experiences. By examining future hopes and concerns we intended to identify implications for prospective planning and the respect of individuals' sexuality in care home settings. Semi-structured interviews were conducted with ten participants to explore how older adults define 'sexuality' and their views on how becoming a resident of a care home may impact on sexuality experience. Face-to-face and telephone interviews were audio recorded, transcribed, and analysed using a hybrid inductive/deductive thematic analysis approach. Results suggested participants viewed sexuality as a multifaceted dimension of self-identity experienced differently across the lifespan. The care home environment was viewed as significantly impacting on the extent to which participants felt they could express their sexuality as an imagined resident, and implications for services were identified. We conclude by emphasising the important role sexuality is anticipated to have for care home residents.

Keywords: *Sexuality, Care homes, Residential care, Qualitative research, Older adults, Thematic Analysis*

3.2 Introduction[2]

Sexuality is often referred to as a multifaceted and ageless concept, attracting varying definitions across the literature.[3] Sexuality has been described as "the dynamic outcome of physical capacity, motivation, attitudes, opportunity for partnership, and sexual conduct" (Galinsky, McClintock & Waite, 2014, p.83) and "a process of integrating emotional, somatic, and intellectual and social aspects in ways that enhance one's own self" (Balami, 2012, p.267). The World Health Organisation (WHO) define sexuality as encompassing sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy, and reproduction (WHO, 2015).

Older adults'[4] sexuality has been linked with a number of factors associated with wellbeing, including positive mental health, physical health, and quality of life (Bach, Mortimer, Vandeweerd, & Corvin, 2013; Lee, Nazroo, O'Connor, Blake, & Pendleton, 2016; Robinson & Molzahn, 2007).[5] Due to issues such as ill health, age-related libido loss, and widowed and single status, sexual intercourse may occur less frequently across this population (Gott & Hinchliff, 2003; Rheaume & Mitty, 2008). However, Gott and Hinchliff (2003) found that when penetrative sex was no longer available, older adults viewed physical intimacy (through touch and cuddling) as central to wellbeing. Sitting and talking, making oneself attractive, and saying loving words were also classified as important sexual activities amongst older women (Johnson, 1996). Older adults favouring forms of intimacy other than penetrative sex to satisfy sexual need is regularly reported on across the literature, suggesting sexuality experiences

[2] The footnotes presented within the journal paper are presented in different fonts to differentiate between those intended to be retained for the journal paper in its submission-ready format (Times New Roman font) and those intended to signpost the reader to the extended paper or appendices (Verdana font).
[3] For further discussion regarding the definition of sexuality, please refer to section 4.1.1.
[4] In the United Kingdom (UK), 'older adult' refers to people 65 aged years or above (Age UK, 2017; Office for National Statistics, 2014).
[5] The link between sexuality and positive health has been further commented on within section 4.1.2.

change with age (DeLamater & Koepsel, 2015; Fileborn et al., 2017; Travis, 1987). Despite changing sexual practices across the lifespan, the need for sexual expression remains and sexuality continues to be an important part of the identity of older adults (Langer, 2009; Popeo, Sewell, Johnson, & Abrams, 2014).[6] While researchers are increasingly attending to the topic of older adults' sexuality, the representativeness of study findings has been queried due to the poor response rates and self-reporting biases inherent to sexuality research (Taylor & Gosney, 2011). Furthermore, researchers often fail to position their use of the term 'sexuality', limiting the extent to which study findings can be synthesised.

Numbers of older adults in the UK are expected to increase by 48.9% over the next two decades (Age UK, 2017), placing increasing demands on care services. In 2012, older adults represented over 95% of care home residents (Age UK, 2014) and economists predict that by 2054, to keep pace with demographic pressures the number of care homes in the UK will need to have increased by 140% (Wittenberg, Comas-Herrera, Pickard, & Hancock, 2004). Despite the acknowledged benefits of recognising individuals' sexuality across the lifespan and forecasted increased numbers of care home residents, research regarding the impact of care environments on sexuality experiences from an older adult perspective is sparse.

The majority of sexuality and healthcare research has focused on views of health and social care practitioners. While healthcare professionals acknowledge the importance of sexuality in later life, they rarely initiate these discussions with their patients considering it outside their scope of practice (Ayaz, 2012; Garrett, 2014; Gott, Hinchliff, & Galena, 2004; Haesler, Bauer, & Fetherstonhaugh, 2016). The view of older adults as 'sick' (Darnaud, Sirvain, Igier, & Taiton, 2013) and assumptions of the asexual older person (Gott & Hinchliff,

[6] Further discussion regarding older adults' sexuality has been provided within section 4.1.3.

2003; Royal College of Nursing, 2011) have been identified as reasons why healthcare services may neglect older adults' sexuality. The asexuality of older adults becomes especially poignant in care homes, where sexual expressions are often regarded as behavioural issues rather than indicators of unmet needs (Cornelison & Doll, 2013). Guidance for care home services also neglects the topic of sexuality. Sexuality is not referenced within the National Service Framework for Older People (Department of Health, 2001), and although guidelines on the mental wellbeing of older adults in care homes suggest staff should consider individual need in relation to sexuality (National Institute for Health and Care Excellence (NICE), 2013), guidance is minimal and vague. The topic of sexuality was also absent from a recent government briefing regarding key recommendations on the health of older people in care homes (NICE, 2015).

Literature on sexuality from care home residents' perspectives is limited, particularly amongst older adults. Existing research predominantly focuses on sexual behaviour (Baldissera, Bueno, & Hoga, 2012; Gott & Hinchliff, 2003; Lindau et al., 2007; Rheaume & Mitty, 2008). While quantitative research accounts regarding sexual practices offer some understanding of behaviour, they are limited in being able to provide an account of individual experience. These data can be misleading, guiding the reader to conclude that sexual activity reduces with age due to sexuality becoming a less important aspect of the self. To the contrary, research suggests older adults in care services continue to view sexuality as important. Bullard-Poe, Powell and Mulligan (1994) surveyed men in care homes and found participants drew associations between intimacy and quality of life. Mahieu and Gastmans' (2014) literature review explored residents' views of aged sexuality in institutionalised care. They included 25 studies with varying methodology, all of which consistently concluded on the relevance of sex and sexuality for older residents. Their review findings also highlighted the lack of research on this topic; only one of their included studies was from the UK, and this was an observational report of behaviour

(Ward, Andreas Vass, Aggarwal, Garfield, & Cybyk, 2005) rather than an exploration of meaning-making from the perspective of residents.

While the evidence base is in its infancy, existing research suggests care homes curtail residents' sexual expression (Wylie, Wood, & McManus, 2013). The nature of the care home environment is reported to pose barriers to sexuality expression, for example adapted equipment such as beds can threaten intimacy in couples (Bowden & Bliss, 2009). While sexual intercourse occurs less frequently in older adult populations, they value intimacy and touch, elements that can be difficult to initiate in care settings due to aspects such as communal living, uninviting institutional spaces and single beds (Lemieux, Kaiser, Pereira, & Meadows, 2004). Other barriers to sexual expression include: a lack of privacy; lack of a willing partner; staff attitudes; feelings of unattractiveness; chronic illness; and loss of interest (Richardson & Lazur, 1995). The combination of environmental restrictions, physical problems associated with ageing, cultural expectations, and staff ignorance of older adult sexuality can make sexuality expression difficult for care home residents.

A prospective planning approach

The influence of potential service-users on healthcare provision has never been so prominent. Best practice guidelines increasingly emphasise the role of patient choice when it comes to accessing healthcare services (British Medical Association, 2013; Department of Health, 2015; Social Care Institute for Excellence, 2014), requiring individuals to subscribe to care services based on projections of future needs. The Care Act (2014) encourages service providers to liaise with local populations about their needs and aspirations to inform care, and current guidance for nurses regarding older adults' sexuality in care homes stipulates that care systems should "focus on the perspectives of individuals within the context of their unique lives

and experiences" (Royal College of Nursing, 2011, p.2). Furthermore, our previous meta-ethnography found residents of healthcare settings experienced 'adapted sexuality' (Hooper, De Boos, das Nair, & Moghaddam, 2016), suggesting residents themselves may not be best positioned to construct positive sexuality experiences in care settings due to experiences having already changed. Therefore, to explore the topic of older adults' sexuality and care services, we adopted a prospective planning approach.

Study aim

The study aim was to explore the views of older adults regarding how transitioning to a care home might impact on sexuality experiences and their hopes and fears regarding care delivery.

3.3 Methods

Epistemology[7]

This research was conducted from a pragmatic approach. Pragmatists do not view the positivist paradigm as superior to other modes of inquiry (Rorty, 1982), and Cameron described pragmatism as a "practical approach to a problem" (2011, p.101). Therefore, pragmatists adopt a 'what works' approach, rather than favouring particular research designs.

Design

Qualitative research methods were selected to best answer the research aim. Qualitative research seeks to understand processes and the nature of the research problem, allowing the researcher to explore meaning of experiences rather than quantity of observed characteristics (Harper & Thompson, 2012; Kopala & Suzuki, 1999; Strauss & Corbin, 1994).

[7] Further discussion regarding epistemology has been provided within section 4.2.1.

Data collection

Data for this study were collected via interviews conducted by the lead author. As sexuality is not an area that many people openly discuss (Bouman, Arcelus, & Benbow, 2006), semi-structured one-to-one interviews were selected to enable the interviewer to take a sensitive yet responsive conversational style intended to maximise participant disclosure.[8] The interview schedule was structured around three broad questions: how do participants define 'sexuality' and what elements do they consider important?; what impact might becoming a care home resident have on sexuality experience?; and how do participants want sexuality to be recognised by care home services?[9] The first question was answered against a deductive framework based on the WHO's (2015) construct of sexuality to establish the applicability of this definition for older adults and contextualise subsequent responses.

Participants[10]

We recruited participants who could communicate in English, were aged >65 years, and consented to participate. To promote heterogeneity, participants were recruited using both snowball and purposive sampling (Biernacki & Waldorf, 1981; Tongco, 2007). Several national and local services and age-related charities advertised the study to potential participants. Participant recruitment closed when data sufficiency was achieved and emerging themes and interrelations were no longer revised on the basis of new data and a coherent and plausible theoretical understanding was developed (Dey, 1999).

[8] Further information regarding the semi-structured interview schedule has been detailed within section 4.2.2.
[9] The semi-structured interview schedule is provided within Appendix F.
[10] Further discussion regarding the participant recruitment process has been provided within section 4.2.3.

Ethical Considerations[11]

The study was approved by the Research Ethics Committee of the Faculty of Medicine and Health Sciences, University of Nottingham (reference J09102014SoMPAPsych).[12]

Data analysis

Interviews were audio recorded and transcribed. Transcriptions were read and reread by the lead author. Scripts were analysed using the six-phase process of thematic analysis (TA) described by Braun and Clarke (2006).[13] As is common with TA, a mixed manifest-latent level approach to analysis was taken (Braun & Clarke, 2012).[14] Themes identified were representative of the data set as a whole, a strategy recommended when investigating an under-researched area to gain a sense of important themes (Braun & Clarke, 2006).

Data analysis was undertaken from a dual inductive and deductive approach.[15] Whilst a theoretical (deductive) approach was taken to establish a sexuality definition, transcripts were coded via a data-driven (inductive) process (see Fereday & Muir-Cochrane, 2006). Emergent codes and themes were reviewed by the research team through a reiterative process and a thematic map was developed.[16] The criteria for good thematic analysis as set out by Braun and Clarke (2006) and Yardley's (2000) evaluative criteria were considered throughout the research process.[17]

---

[11] Ethical considerations have been expanded upon within section 4.2.4.
[12] Evidence of the ethical approval granted by the University of Nottingham is provided within Appendices A-C.
[13] The rationale for thematic analysis and further information regarding its application has been provided within section 4.2.5.
[14] Further explanation regarding manifest and latent level coding has been provided within section 4.2.6.
[15] For further information regarding the mixed inductive/deductive approach taken to analysis, refer to section 4.2.7.
[16] Further information regarding the development of codes and themes has been provided within section 4.2.8.
[17] Quality assurance has been further considered within section 4.2.9.

Impact of the researcher[18]

Thematic analysis positions the researcher as active within the research process, as inherent biases unavoidably influence data interpretation (Braun & Clarke, 2006). To facilitate the identification of interpretational biases the lead author maintained a reflective journal and accessed supervision with co-authors to identify areas where such influence was apparent.

3.4 Results and Discussion[19]

Data sufficiency was concluded after seven transcripts were analysed.[20] However, to minimise the risk of discontinuing recruitment prematurely, ten participants were interviewed. Two men and eight women from across England participated. Ages ranged between 65-75 years (*mean=70*). One man and one woman identified as gay, the remainder as heterosexual. All participants were White British. Five participants reported being in long-term relationships; of the single participants, two were widowed. Interviews lasted between 30-80 minutes and were face-to-face (*n=5*) or via telephone (*n=5*). To protect anonymity, participants were assigned pseudonyms based on gender identity (M1-M2; F1-F8).

Defining sexuality

Eight themes captured participants' sexuality definitions. Whilst some illustrative quotes are provided, additional examples are offered in Table 1.

[18] The impact of the researcher has been further considered within section 4.2.10.
[19] The results and discussion sections have been provided concurrently. A rationale for this approach has been detailed within section 4.3.1.
[20] Data sufficiency versus data saturation has been considered within section 4.3.2.

Exists in a society

> *"It isn't just that you're male or female; it isn't just that you're homosexual or not, it's a question of how you act to project that image into society."* (F8)

Perceptions of sexuality were reported as being positioned within (and influenced by) societal norms and expectations. The impact of society was referenced directly:

> *"I can't separate myself out from being a gay man within a straight society."* (M2)

and indirectly, where constructions of sexuality were entangled with assumed societal discourse:

> "*In the media [sexuality is] about people trying to find a position on a scale of gender between men and women … It seems to me to be that's what society is beginning to talk about."* (F3)

Changeable

> *"As we get older the sexual part becomes less and less important." (F4)*

Sexuality was perceived as having fluidity and being susceptible to factors including generational change, change across the lifespan, circumstance, and individual experiences. Sexuality needs were described as changing with age, away from sexual relationships and towards concepts such as intimacy and gender identity; underpinning the notion of ageing sexuality. Ageing sexuality was also paired with invisible sexuality:

Table 1. Other illustrative quotes for themes and sub-themes of the definition of sexuality.

Theme	Sub-themes	Example quote
Exists in a society		"It seems to me to be that's what society is beginning to talk about much more." (F3)
Changeable	Relationship status	"I'm single so I don't really think of that too much." (F5)
	Sexuality over time	"People look at somebody my age and think well he's completely past it." (M1)
	Individual	"It is bound to be an individual thing because there are so many shades of everything." (F6)
	Circumstantial	"I quite like to play the dippy woman. Although I leap in the car and I'm very, very aggressive. I'll flick a 'V' or stick a finger up at anybody... Totally unfeminine in the car." (F6)
Integral to self	Important	"The physical sexual side of love is always very important." (F1)
	Identity	"Sexuality to me is more than the outside of a person - it's what's inside." (F5)
	Being human	"I think we've all got a degree of sexuality." (F5)
Constructed with words	Displacement	"The dog comes and sits on the sofa beside me and I like that." (F1)
	Not sure	"I can't give you clear definition because I don't think I have a clear image of what it means." (F8)
	Not a recognised word	"Sexuality isn't a word that was used throughout my life." (F6)
	Not discussed or thought about	"I've never really discussed sexuality with anybody in particular. Erm. I just don't know really." (F1)
Could be harmful		"There are some men who encroach on your personal space, and that's really uncomfortable." (F3)
Sexual relationships	Sexual orientation	"I would describe myself as a raging heterosexual." (M1)
	Heteronormative	"You perhaps wouldn't consider doing anything other than marrying a person of the opposite sex." (F6)
	Sex	"I mean the first thing that springs to mind is physical sexuality." (F2)
	Attraction and desire	"I should think that's part of it, being attracted to some people." (F1)
Positive feelings	Love	"And love, but love can be in very many different ways." (F2)
	Comfort and support	"It's that place of safety and comfort and even in times of struggle." (M2)
Demonstrating sexuality	Gender	"Well I think it is a gender issue. An actual physical gender issue." (F8)
	Touch	"It's not a sexual thing, it's, you know, can be tactile, you know, hugs and things like that." (F5)
	Not sexual	"I haven't had much of a sex life, but I still feel like a sexual being." (F1)
	Appearance	"If you're discussing sexuality you need to allow people to be comfortable however they look." (F3)
	Being recognised	"They were doing a survey... they were asking 'Are you married or single' and I said neither... I'm not married, I'm not single, I live with my partner, he is a he and I want that on the form." (M2)
	Gender identity	"[Sexuality is] how I look at life and people and relationships from a feminine point of view." (F7)
	Intimacy	"I think they fit quite well, intimacy and sexuality." (F5)

"When you're my age you're quite invisible to lots of people. You're just an old, old person kind of thing." (F6).

The understanding of ageing sexuality emphasises the importance of talking to receivers of care services to understand individual perspectives. Recognising the shifting meaning of sexuality with age provides an opportunity to positively interrupt the widely accepted binary interpretations of either 'sexy seniors' or asexuality amongst older adults (Sandberg, 2013), arguably the first step towards building healthcare services which actively recognise the value of sexuality for service-users.

The situationally variable nature of sexuality also formed part of its understanding. One participant emphasised the importance of femininity yet contradictorily described being:

"...totally unfeminine in the car, effing and blinding." (F6)

The changeable nature of sexuality was reiterated when participants used their relationship status to frame which aspects of sexuality were relevant:

"I'm single so I don't really think of [sex] too much." (F5)

Integral to self

"I prefer the word identity [to sexuality] because identity comes, it's nearer to the sense that this is something that isn't something attached to me. It isn't something about me. It is me." (M2)

Sexuality was considered an inherent component of the human condition, impacting on experiences including self-esteem and self-identity. A deficit approach towards sexuality was described, where unfulfilled sexuality experiences were associated with incompleteness. Reports of the integral role of sexuality corroborated the first element to the WHO's definition of sexuality as a "central aspect of being human throughout life" (2015, p.5).[21]

Constructed with words

Language was recognised as an important mediating factor in the construction of sexuality. Commonly sexuality was initially conflated with sex, positioning it as an irrelevant or unspoken subject:

> *"Because you haven't got a partner you don't talk about [sexuality]."* (F7)

One participant reflected on the barriers posed by the interchangeable use of sex and sexuality:

> *"The problem with the word [sexuality] is that it tends to revolve around sex, the idea of sex acts, rather than a whole person."* (M2)

When describing sexuality, participants also used third person anecdotes and parallel examples, e.g., citing relationships with pets to describe the importance of touch. We interpreted this as demonstrating the unspeakable nature of sexuality and the ways compensatory experiences may be sought when sexuality needs cannot be fulfilled directly. Some participants questioned the

[21] A more detailed comparison of findings against the WHO's working definition of sexuality has been provided within section 4.3.3.

accuracy of their descriptions of sexuality, supposing that there was a right answer which matched a pre-existing definition. Other participants reported that the word 'sexuality' was not part of their discursive repertoire. Often participants reported never having thought about sexuality (intra- and interpersonally). Despite these 'not-knowing' positions, all participants were able to comment on the meaning of sexuality when invited to evaluate the relevancy of the WHO's sexuality definition. One interpretation of this discrepancy was that by presenting participants with a frame of reference, they were encouraged to reflect on sexuality in ways which had not previously been prompted because of the nature of sexuality as a neglected topic in everyday discourse. Participants' uncertainty of verbalising their views on sexuality mirrored the noted absence of sexuality within conversations between healthcare professionals and their patients (Dyer & das Nair, 2013); the lack of shared narrative about sexuality maintains its position as a neglected (and therefore sensitive) topic.

Could be harmful

> *"I think people look at somebody of my age and think "well he's completely past it so he's no danger to me."* (M1)

Sexuality was described as having the potential to be a negative experience and feared ramifications from publicly expressing sexuality were reported:

> *"There are people who feel uncomfortable, you know. Nobody shoves [expressions of sexuality] down anybody's throat. If people are uncomfortable then you don't do or say anything that will upset people."* (F4)

Sexual relationships

"Sexuality… I suppose it's the desire within us to have physical relationships." (M1)

Sexual orientation, sexual intercourse, and sexual attraction were viewed as components of sexuality. A heteronormative approach to sexual relationships was communicated; participants either assumed sexual relationships would be between men and women, or spoke directly about society's heteronormative approach. While sexual intercourse was associated with sexuality expression, participants did not view sex as being important from an older adult perspective:

"The physical side of sex or sexuality is not anything like as important as it used to be." (M1)

Several biopsychosocial factors have been associated with the reported diminished levels of sexual activity with age.[22] According to Kaas (1978), decreased sexual activity predisposes changes in sexual expression and identity. Therefore, the reduced opportunity to engage with sexual relationships as an older person may account for the reported decreased importance of sex and the internalisation of the asexual identity regardless of individual experiences:

"You see yourself less as a sexual person who's going to have sex I think as you get older. That's not to say that you don't." (F3)

[22] See section 4.1.3 for further information regarding the factors associated with reduced sexual activity amongst older adults.

Whilst sex was acknowledged as relating to sexuality, other aspects from the WHO's definition relating to sexual relationships were excluded from participants' understanding of sexuality, such as fantasy and eroticism, and reproduction which was viewed as a consequence of, yet distinct from, sexuality.

Positive feelings

Sexuality expression within relationships was associated with positive feelings including comfort and support, safety, and love; aspects not captured by the WHO's definition. Sexuality expression outside of relationships (e.g., demonstrating gender identity through appearance) was also associated with emotional wellbeing:

> *"It's important to me how I look and appear, but not that people say anything, but it makes me feel good."* (F7)

Demonstrating sexuality

> *"Sexuality can be how you present yourself."* (F5)

A behavioural dimension to sexuality was referenced, specifically how sexuality could be demonstrated and enacted in the absence of sex; indeed, the notion of sexuality being 'not sexual' was a noted sub-theme:

> *"It isn't sex. Sexuality and sex are two different things."* (F7)

Participants viewed sexuality expression as including touch, appearance, intimacy, gender, and gender identity. The WHO's definition also includes gender-roles, however participants viewed this as separate from sexuality. The women interviewed described femininity as integral to sexuality; masculinity was not emphasised within men's narratives. In addition to demonstrating sexuality, having demonstrations acknowledged was important to participants. The sub-theme 'being recognised' was particularly salient for gay participants, who both described wanting their sexual orientation acknowledged:

> *"When somebody stopped me on the street and they were doing a survey … They were asking about "Are you married or single?" … I'm not married, I'm not single, I live with my partner, he is a he and I want that on the form.'"* (M2)

> *"[My partner] will say "No, no, we're not related" and just leave it … I would be more likely, if it was me that was addressing it, to say "No, no, we're a couple"."* (F4)

The perceived impact of the care home on sexuality[23]

Participants' views regarding the perceived impact of the care home on sexuality were predicated on their previously specified sexuality definitions. We identified six themes that represented participants' views on how becoming a resident of a care home might impact on sexuality experiences and hopes and fears regarding care provision. While some illustrative quotes are provided, additional examples are offered in Table 2.

[23] Please see section 4.3.4 for further information.

Table 2. Other illustrative quotes for themes and sub-themes to represent the perceived impact of care homes on sexuality experience.

Theme	Sub-themes	Example quote
Negative feelings towards care homes		"What comes to mind when I think of a care home? I suppose horror really." (M1)
Changed relationships	Compromises	"If the people that they always have been intimate with are no longer there … I know care homes do pedicures and manicures, that must be really rather nice … the touch of skin is very important." (F8)
	You become 'one'	"Mostly people go in as a single person, either having no partner, or having left a partner at home because they're not at a point in their lives where they need that kind of care." (F4)
	Can't initiate	"You physically might not be able to take the first step for example in initially touching or greeting." (F1)
	Care home community	"You won't know the [other residents] so whether you would form a relationship I don't know." (F5)
	Moderated by others	"If you're a person with no supportive family you would have a very different experience from someone who's got a sister, a brother, a son, a daughter, all of them coming in and saying 'Oh, this dressing gown's looking a bit ragged Mum, I'll get you a new one' because they would know that would matter to you." (F6)
	I don't know what to do, I've got an audience	"Would the same show of affection be there if there were other visitors in that room?" (F5)
Impeding culture	Boundaries and rules	"If they are sexually active I don't see any problem with that, but I don't know if it's allowed." (F5)
	Not part of the job	"Staff are so busy thinking about the more practical things that they are not so engaged with the emotional side." (F4)
	Environmental barriers	"There can be barriers just by the layout of the physical environment … It's when you've got these large lounges where people are sitting round. It doesn't endear any kind of relationship." (F4)
Loss of the sexual self	Necessary intimacy	"It's not the same kind of contact or intimacy that you have in a family or partnership relationship, but it has to be done as a matter of fact thing." (F3)
	Get over it and get on with it	"The necessity of it you just get over it and just get on with it really." (F1)
	Patients instead of people	"You do have the person in front of you, but you, in those sort of, when you're dealing with a physical need, the fact that you need the care is, it doesn't matter who that person is." (F3)
	Everything becomes past	"I think you would just have to shut, to some extent, shut that side of your thoughts down." (F6)
	Possibilities change	"If relationships develop within the care home environment then I image that the people there are capable only of holding hands. Maybe stroking hair I don't know." (F6).
	It's too private	"[My relationships have] been a very personal thing. So I certainly, I wouldn't indulge in, I wouldn't talk to other people about anything that I had done or indeed that I wanted to do." (M1)

Table 2 Continued.

Theme	Sub-themes	Example quote
The sexual resident	Touch	"I want to know that if my partner comes he can hold my hand … It may just be him coming in and stroking my hand. Stroking my face." (M2)
	Sexuality still relevant	"If I creaked into an old people's home and just found a soul-mate I wouldn't say, oh no I'm too old mate." (F6)
	Need it more	"I think the more stressful a situation you're in the more important that intimacy becomes." (F8)
	Sex	"Just because people are older, there's no reason why they shouldn't, you know, have a sex life." (F1)
	Togetherness	"If I was in a relationship with somebody I would certainly hope that we'd have the opportunity to be together." (F1)
Sexuality and care provision	Facilitate sexuality	"Staff should encourage, they shouldn't frown, which some of them do, on the thought that, you know, two elderly people want to make a late in life relationship." (F4)
	Ask questions	"That's part of knowing and understanding me isn't it? If they don't ask me then they don't know what I appreciate and what I would like." (F7)
	Should be like home	"They're homes but you aren't allowed your own individuality." (F6)
		"I think things like [soft furnishings], they change the way you feel about things." (F1)
	Can't prospective plan	"Unless I've been in that environment I can't really anticipate what I would feel like." (M1)
	Looking like me	"You've got no partner … sexuality is going to be about maintaining your image." (F4)
	Agents of sexuality	"Unless you have piles of money and you can really find a place that you can completely express who you are." (M2)

Negative feelings towards care homes

> *"Some [care homes] seem to reduce people to nothing don't they? They are just old things to be abused."* (F6)

There was consensus that becoming a resident should be feared or avoided, a position acknowledged as an important contextual factor which may have circumscribed hopes or amplified fears regarding participants' sexuality experiences as an imagined resident.

Changed relationships

Participants anticipated an inevitable change in sexuality experience as a direct result of becoming a resident of a care home. They predicted being dependent on others to maintain aspects of sexuality (e.g., provision of pornography, lipstick, etc.). Participants also anticipated that relatives and staff would make decisions about whether residents could have intimate relationships, irrespective of their wishes:

> *"There are things like families thinking well, I don't want him taking advantage of my mother because she's got more money than he has."* (F6)

The care home was viewed as a public arena, impacting on the extent participants thought they would be comfortable to express sexuality:

> *"[Being in a care home] affects intimacy anyway because it becomes a great public place for intimacy and that's hard."* (M2)

"I could imagine some people would be, 'Oh I don't know what to do here, I've got an audience.'" (F6)

The impact of being incorporated into a new community was reflected upon. Some spoke positively about the potential for new relationships:

"Widowed and widowers, and they meet up with someone [in the care home] and they get married and that seems lovely." (F1)

However, when participants positioned themselves as potential residents, the new community was predicted to be discriminatory towards sexuality expression and participants expected to be personally and sexually incompatible with other residents.

The assumed inevitability of being a single occupant impacted on how participants thought about relationships in care homes:

"That's the floor for dementia patients, that's the floor for the people who can still walk… So if you're a married couple and you've got different needs… no, he's on that floor, she's on that floor." (F6)

The association between being a single person and care home residency was reflected upon with a sense of loss:

"It's like a sort of living bereavement really." (F2)

As an imagined resident, participants expected physical disability to limit sexuality expression within relationships, resulting in the need for compromise:

> *"I can't at the moment think that there would be a time when I wanted [sexual intimacy] to stop. But if it be that it does then my thoughts are that a gentle non-sexual intimacy would become very important."* (F8)

Impeding culture

> *"I know that when I'm in an institution [sexuality expression has] already changed, and what intimate expressions are – in quotes and out of quotes – allowed, and that may not be something that is spoken, it's in the walls*." (M2)

The anticipated culture of the care home impacted on participants' expectations of sexuality expression as a resident. The anticipated increased dependence on staff to facilitate intimate relationships was associated with unfulfilled experiences, as facilitating sexuality was not seen as part of staff's role. Participants thought the intangible nature of sexuality (and therefore the inability to objectively demonstrate good practice) might also limit the extent to which care homes considered sexuality:

> *"The focus would be on the physical, oh, we can show them clean toilets, we can show them what's coming out of the kitchen, we can show them that our décor is clean and carpets hoovered regularly. How do we demonstrate that we have appropriate conversations? Much more difficult."* (F6)

This reflection may offer some explanation regarding the noted absence of sexuality within practice guidelines.

The physical environment also contributed to the perceived impeding culture of care homes. For example, the expectation of single occupancy furniture was described as inhibiting opportunity for sexuality expression:

> *"I would think [the care home environment] renders [sexuality] well-nigh impossible really … I mean nearly all these places have just got single beds in a small room. None of these places are conducive really to sitting comfortably beside somebody."* (F2)

The anticipated rules of the care home impacted on imagined experiences:

> *"It would be wonderful to be in a bath all by myself with nobody around … But I can see that from a safety point of view can't happen which is very sad."* (F8)

Participants also questioned whether expressions of sexuality would even be permitted:

> *"I mean if you've always had a picture of a nude woman on your wall I don't see why you shouldn't be able to have a nude woman on your wall in a care home, or nude ornaments or anything like that. And I suspect that some places wouldn't like that."* (F8)

Loss of the sexual self

> *"I think I would feel impotent, and I don't mean that physically."* (M1)

Participants thought sexuality would become a 'past life' after transitioning to a care home:

> *"I think [residents are] all too tired to bother. Drugged up to their eyeballs."* (F2)

The combination of the private nature of sexuality and public nature of the care home resulted in some participants expecting sexuality to become past because they would not be able to communicate their needs:

> *"I want to know where the care home is that when you walk into the door and you're having that first assessment done, 1) that they talk to you and not the person with you, 2) they see you as a customer and 3) they ask you these questions about yourself. Oh no we can't ask those questions, they're a bit private, you know."* (M2)

Others hoped to intentionally neglect their sexual-self as a coping mechanism:

> *"If you're forever sad about what you're not having for a long time then that doesn't help. It doesn't help you settle, it doesn't help you be, you know, be content."* (F3)

The role of 'resident' was associated with the role of 'patient', which was expected to further nullify the sexual-self:

> *"If you were very, very, in need of very great level of physical care, I can't imagine whether you would think about [sexuality] at all."* (F6)

In response to this 'patient' role, participants expected staff to adopt a practical care approach which failed to recognise residents as sexual beings:

> *"I have seen staff come in and not say a word, shove a pill in [the resident's] mouth and go out again."* (F2)

> *"I'm not sure that the care which is needed accommodates the sort of sexuality that I imagine lasts with you as you get older."* (F8)

The anticipated required assistance with intimacies such as washing and dressing was also expected to render the sexual body void and threaten the value of physical intimacy.

Participants' anticipated shift from sexual-being to patient paralleled findings from a recent study which found when individuals took a caring role for their partner they perceived a change in function of the body from sexual to practical, which impacted on sexuality experiences (Drummond et al., 2013). The asexuality experienced by individuals in the care-giver/care-receiver dynamic has been accounted for by sexual attractiveness; being a carer/cared for has been found to reduce sexual

attractiveness and decrease the desire for sexual relationships (Kaas, 1978). Travis (1987) suggests healthcare services should be attending to these perceived losses of sexual attractiveness to promote positive sexuality experiences. Based on our findings, services could promote residents' views of their sexual attractiveness by encouraging the expressions of sexuality participants deem important as older adults, such as maintaining demonstrations of gender-identity through appearance, and facilitating non-sexual touch and intimacy when sexual contact may not be desired or possible.

To consider sexuality as a dynamic and changeable construct, theoretical models of self-identity may have some applicability, particularly given participants' agreement of sexuality as an integral component of the self. Our previous research proposed that Kiecolt's (1994) model of self-identity and stress offered some theoretical explanation regarding the reported changes in sexuality expression in healthcare services (Hooper et al., 2016), and our current findings appear consistent with this assertion.[24] Participants anticipated that transitioning into a care home would prompt the loss of the sexual self in place of becoming a patient. Based upon Kiecolt's theory, stressors associated with changing roles (from person to patient) and being situated in an environmental context that neither acknowledges nor facilitates sexuality prompts the change in self-identity from sexual to non-sexual, reinforcing the concept of the asexual older resident.

The sexual resident

> *"[Sexuality] helps to describe the person that you are. It's all part of what the person is."* (F3)

[24] A more detailed account of Kiecolt's (1994) model of stress and self-identity and its application to the research findings has been provided within section 4.3.5

Whilst sexuality was expected to be less attended to as a resident, the sense that it might become more integral to wellbeing was described:

> *"I would still welcome the presence of the people that I love, and physical contact you know. However possible. I can't, I sort of think, you might even need it more in a way."* (F1)

Participants described the importance of touch and non-sexual intimacy in establishing togetherness:

> *"The touch of another person, sight of another person, the hearing of another person I think now would be very important to me as I get older."* (F8)

Participants also wanted sexual relationships to be possible:

> *"I want a right to my sex life too, if I still have these feelings."* (M2)

The hope that sexual relationships would be facilitated by care home staff was in discord with earlier conclusions that sex was a less integral component of sexuality as an older person. One interpretation of this discrepancy is that the unspeakable nature of sexuality and the notion of the asexual older person impacted on participants' communication of positive sexuality experiences during initial questioning. The avoidance of talking about sex amongst this age group is problematic for health services, as research suggests if people avoid talking about the subject, they fail to seek

advice regarding sexual problems which has implications for health and wellbeing (Roney & Kazer, 2015). The mutual dismissal of sexuality by older adults and healthcare practitioners risks reinforcing the asexuality of older residents and maintaining sexuality as an unacknowledged component of older adults' self-identity.

Sexuality and care provision

As residents, participants wanted to be acknowledged as sexual beings. Kiecolt's (1994) model of self-identity and stress suggests that stressors which threaten residents' sexual identity should be minimised, and factors which promote the person as a sexual being encouraged to reduce the vulnerability to self-identity change. Participants anticipated care homes' effectiveness in facilitating sexuality as being related to privacy:

> *"I don't see why you can't sit and hold hands and be empowered to close the door." (*F8)

staffs' willingness to acknowledge residents' sexuality:

> *"I think the easiest way to bring [up sexuality] is in a conversation … I would imagine the training they did get would be on the physical 'Oh, have you done your lifting, safe lifting qualification' and that kind of thing, but actually that probably wouldn't be the thing that would be important to me."* (F6)

practically facilitating sexuality; and understanding generational perspectives, such as the heteronormative society:

> *"The group of people that are arriving in the care homes … the vast majority of them will have conformed to a straight male or female orientation. I know that hasn't been going on inside them but society has forced that upon them … If you're not the norm I don't think you would get any consideration at all."* (F8)

One participant spoke strongly about care homes explicitly communicating openness towards varied sexual orientations:

> *"I want gay and lesbian people and bi-sexual people and trans people to feel that they can come out if they want to, and they will be supported. That's what I want and I think that has to be said in the brochure. That has to be said on the statement in the front door."* (M2)

Having a homely environment was also described as impacting on sexuality. Participants likened their homes to extensions of their sexual-self:

> *"You're projecting your own image, your own self, whatever that self might be."* (F8)

However, opportunities to project sexuality onto the care environment were expected to be limited. Participants wanted furniture that facilitated contact between people (e.g. double beds, sofas), the ability to individualise space, and soft furnishings.

Women reported that maintaining the outward expression of femininity would be significant in maintaining their sexual identity:

> *"I've certainly said to my daughter, when I'm in a home you just make sure I have my hair done and my nails painted, so I must somehow think that that's important forever."* (F8)

Some participants described various 'agents of sexuality', factors viewed as assisting or inhibiting sexuality: activities were described as facilitators of relationships; sharing a meal was associated with intimacy; and service costs were correlated with quality of care.

3.5 Limitations and Implications for Future Research

Participants emphasised the importance of sexuality as prospective care home residents. However, our transparency at the point of recruitment arguably attracted a participant group of older adults willing to talk about this topic. Whilst not the intention of this research, the generalisability of findings to wider populations can certainly be questioned on this basis.

The prospective care planning approach taken provides another point for consideration. We believe our findings provide a useful baseline for understanding the anticipated needs of future residents with regards to sexuality and care home environments from a perspective that has direct applicability with regards to how healthcare services currently operate in the UK. However, expanding upon this work by replicating the study with a residential population would provide an insightful comparison point to further explore older adults' sexuality experiences in care home settings.

While our heterogenous sampling method promoted breadth of data, findings suggested some emerging variance in views based on participants' sexual orientation. Themes around the importance of external demonstrations of sexuality were more salient across the narratives of gay participants, differences which later generated varying suggestions for best practice care delivery. For example, the value of directly acknowledging sexuality by showing posters representing lesbian, gay, bisexual, and transgender (LGBT) communities was emphasised. However, due to our small sample size these differences can only be minimally attended to. Additional research into the views of LGBT residents on the construct of sexuality and care homes would add a valuable perspective to this topic.

3.6 Conclusions

Sexuality is a multifaceted term experienced and expressed differently across the lifespan and clearly remains an important aspect for older adults. Due to its reported dynamic nature, older adults perceived that becoming a resident of a care home would prompt significant (and often negative) changes with regards to how they could experience sexuality. Our findings highlighted a discrepancy between what participants wanted versus what was viewed as possible or likely in relation to their sexuality experiences in care homes. As potential residents, participants wanted services to demonstrate attempts to minimise the environmental impact on sexuality and promote positive experiences in a manner that was responsive to individual need.[25] However, as a neglected area of research, our understanding of the impact of care homes on older

[25] The clinical implications of the research findings have been expanded upon within section 4.3.6.

adults' sexuality experiences remains in its infancy and further exploration of this topic is required.

Journal paper total word count – 6,007

3.7 References

Age UK. (2014). *Later life in the United Kingdom.* Retrieved from http://www.ageuk.org.uk/Documents/EN-GB/Factsheets/Later_Life_UK_factsheet.pdf?dtrk=true

Age UK. (2017). *Briefing: The health and care of older people in England 2017.* Retrieved from http://www.cpa.org.uk/cpa/docs/AgeUK-Briefing-TheHealthandCareofOlderPeopleinEngland-2015.pdf

Ayaz, S. (2012). Sexuality and nursing process: A literature review. *Sexuality and Disability*, *31*(1), 3–12.

Bach, L. E., Mortimer, J. A., Vandeweerd, C., & Corvin, J. (2013). The association of physical and mental health with sexual activity in older adults in a retirement community. *Journal of Sexual Medicine*, *10*(11), 2671–2678. http://doi.org/10.1111/jsm.12308

Balami, J. S. (2012). Ageing and sexuality: A neglected issue among care home residents. In N. E. Peterson & W. Campbell (Eds.), *Handbook on Sexuality*. New York, NY: Nova Science Publishers, Inc.

Baldissera, V. D. A., Bueno, S. M. V., & Hoga, L. A. K. (2012). Improvement of older women's sexuality through emancipatory education. *Health Care for Women International*, *33*(10), 956–972.

Biernacki, P., & Waldorf, D. (1981). Sampling: Problems and techniques of chain referral sampling. *Sociological Methods & Research*, *10*(2), 141–163.

Bouman, W. P., Arcelus, J., & Benbow, S. M. (2006). Nottingham study of sexuality &

ageing (NoSSA I). Attitudes regarding sexuality and older people: a review of the literature. *Sexual and Relationship Therapy*, *21*(2), 149–161.

Bowden, G., & Bliss, J. (2009). Does a hospital bed impact on sexuality expression in palliative care? *British Journal of Community Nursing*, *14*(3), 122, 124–6.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*(2), 77–101.

Braun, V., & Clarke, V. (2012). Thematic analysis. In *APA handbook of research methods in psychology, Vol 2: Research designs: Quantitative, qualitative, neuropsychological, and biological.* (Vol. 2, pp. 57–71). Washington, DC: American Psychiatric Association. http://doi.org/10.1037/13620-004

British Medical Association. (2013). *Understanding the reforms. Choice and any qualified provider*. Retrieved from https://www.bma.org.uk/-/media/Files/PDFs/Working%20for%20change/Shaping%20healthcare/Understanding%20the%20NHS%20reforms/understandnhsreforms_choice_aqp_apr2013.pdf

Bullard-Poe, L., Powell, C., & Mulligan, T. (1994). The importance of intimacy to men living in a nursing home. *Archives of Sexual Behavior*, *23*, 231–236.

Cameron, R. (2011). Mixed methods research : The five Ps framework, *The Electronic Journal of Business Research Methods*, *9*(2), 96–108.

Care Act, 2014. (c.23). London: The Stationery Office.

Cornelison, L. J., & Doll, G. M. (2013). Management of sexual expression in long-term care: Ombudsmen's perspectives. *Gerontologist*, *53*(5), 780–789. http://doi.org/10.1093/geront/gns162

Darnaud, T., Sirvain, S., Igier, V., & Taiton, M. (2013). A study of hidden sexuality in elderly people living in institutions. *Sexologies*, *22*(4), 93–99.

DeLamater, J., & Koepsel, E. (2015). Relationships and sexual expression in later life: A biopsychosocial perspective. *Sexual and Relationship Therapy*, *30*(1), 37–59. http://doi.org/http://dx.doi.org/10.1080/14681994.2014.939506

Department of Health. (2001). *National Service Framework for Older People*. Retrieved from https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/198033/National_Service_Framework_for_Older_People.pdf

Department of Health. (2015). *NHS Constitution for England*. Retrieved from https://www.gov.uk/government/publications/the-nhs-constitution-for-england/the-nhs-constitution-for-england

Dey, I. (1999). *Grounding grounded theory*. San Diego, CA: Academic Press.

Drummond, J. D., Brotman, S., Silverman, M., Sussman, T., Orzeck, P., Barylak, L., & Wallach, I. (2013). The impact of caregiving: Older women's experiences of sexuality and intimacy. *Affilia: Journal of Women & Social Work*, *28*(4), 415–428. http://doi.org/http://dx.doi.org/10.1177/0886109913504154

Dyer, K., & das Nair, R. (2013). Why don't healthcare professionals talk about sex? A systematic review of recent qualitative studies conducted in the United Kingdom. *Journal of Sexual Medicine*, *10*, 2658–2670.

Fereday, J., & Muir-Cochrane, E. (2006). Demonstrating rigor using thematic analysis: A hybrid approach of inductive and deductive coding and theme development. *International Journal of Qualitative Methods*, *5*(1), 80–92.

http://doi.org/10.1063/1.2011295

Fileborn, B., Hinchliff, S., Lyons, A., Heywood, W., Minichiello, V., Brown, G., … Crameri, P. (2017). The Importance of Sex and the Meaning of Sex and Sexual Pleasure for Men Aged 60 and Older Who Engage in Heterosexual Relationships: Findings from a Qualitative Interview Study. *Archives of Sexual Behavior*. http://doi.org/10.1007/s10508-016-0918-9

Galinsky, A. M., McClintock, M. K., & Waite, L. J. (2014). Sexuality and physical contact in national social life, health, and aging project wave 2. *Journals of Gerontology - Series B: Psychological Sciences and Social Sciences*, *69*(8), 83–98. http://doi.org/10.1093/geronb/gbu072

Garrett, D. (2014). Intimacy for older people. *British Journal of Nursing*, *23*(6), 327–332.

Gott, M., & Hinchliff, S. (2003). How important is sex in later life? The views of older people. *Social Science & Medicine*, *56*(8), 1617–1628.

Gott, M., Hinchliff, S., & Galena, E. (2004). General practitioner attitudes to discussing sexual health issues with older people. *Social Science & Medicine*, *58*(11), 2093–2103.

Haesler, E., Bauer, M., & Fetherstonhaugh, D. (2016). Sexuality, sexual health and older people: A systematic review of research on the knowledge and attitudes of health professionals. *Nurse Education Today*, *40*, 57–71. http://doi.org/10.1016/j.nedt.2016.02.012

Harper, D., & Thompson, A. R. (Eds.). (2012). *Qualitative research methods in mental health and psychotherapy*. Chichester: John Wiley & Sons Ltd.

Hooper, A., De Boos, D., das Nair, R., & Moghaddam, N. (2016). First-person narratives around sexuality in residential healthcare settings: a meta-ethnographic synthesis. *Sexual and Relationship Therapy*, *31*(2), 207–229. http://doi.org/10.1080/14681994.2015.1131256

Johnson, B. K. (1996). Older adults and sexuality: A multidimensional perspective. *Journal of Gerontological Nursing*, *22*(2), 6–15.

Kaas, M. J. (1978). Sexual Expression of the Elderly in Nursing Homes. *The Gerontologist*, *18*(4), 372–378. http://doi.org/10.1093/geront/18.4.372

Kiecolt, K. J. (1994). Stress and the decision to change oneself: A theoretical model. *Social Psychology Quarterly*, *57*(1), 49–63.

Kopala, M., & Suzuki, L. A. (Eds.). (1999). *Using qualitative methods in psychology*. London: Sage Publications.

Langer, N. (2009). Late Life Love and Intimacy. *Educational Gerontology*, *35*(8), 752–764.

Lee, D. M., Nazroo, J., O'Connor, D. B., Blake, M., & Pendleton, N. (2016). Sexual health and well-being among older men and women in England: Findings from the English Longitudinal Study of Ageing. *Archives of Sexual Behavior*, *45*(1), 133–144. http://doi.org/10.1007/s10508-014-0465-1

Lemieux, L., Kaiser, S., Pereira, J., & Meadows, L. M. (2004). Sexuality in palliative care: patient perspectives. *Palliative Medicine*, *18*(7), 630–637.

Lindau, S. T., Schumm, L. P., Laumann, E. O., Levinson, W., O'Muircheartaigh, C. A., & Waite, L. J. (2007). A study of sexuality and health among older adults in the United States. *The New England Journal of Medicine*, *357*(8), 762–774.

Mahieu, L., & Gastmans, C. (2014). Older residents' perspectives on aged sexuality in institutionalized elderly care: A systematic literature review. *International Journal of Nursing Studies*, *52*(12), 1891–1905. http://doi.org/10.1016/j.ijnurstu.2015.07.007

National Institute for Health and Care Excellence. (2013). *Mental wellbeing of older people in care homes.* Retrieved from http://publications.nice.org.uk/mental-wellbeing-of-older-people-in-care-homes-qs50#close

National Institute for Health and Care Excellence. (2015). *Older people in care homes*. Retrieved from https://www.nice.org.uk/advice/lgb25/chapter/Introduction

Popeo, D. M., Sewell, D. D., Johnson, K. K., & Abrams, J. M. (2014). Addressing sex and sexuality with older adults: An opportunity to learn and practice effective communication techniques. *The American Journal of Geriatric Psychiatry*, *22*(3), 5–6.

Rheaume, C., & Mitty, E. (2008). Sexuality and intimacy in older adults. *Geriatric Nursing*, *29*(5), 342–349.

Richardson, J. P., & Lazur, A. (1995). Sexuality in the nursing home patient. *American Family Physician*, *51*(1), 121–124.

Robinson, J. G., & Molzahn, A. E. (2007). Sexuality and quality of life. *Journal of Gerontological Nursing*, *33*(3), 19–29.

Roney, L., & Kazer, M. W. (2015). Geriatric sexual experiences: The seniors tell all. *Applied Nursing Research*, *28*(3), 254–256. http://doi.org/10.1016/j.apnr.2015.04.005

Rorty, R. (1982). *Consequences of pragmatism: Essays, 1972-1980*. Minneapolis, MN:

University of Minnesota Press.

Royal College of Nursing. (2011). Older people in care homes: sex, sexuality and intimate relationships. Retrieved from http://www.rcn.org.uk/__data/assets/pdf_file/0011/399323/004136.pdf

Sandberg, L. (2013). Just feeling a naked body close to you: Men, sexuality and intimacy in later life. *Sexualities*, *16*(3–4), 261–282. http://doi.org/http://dx.doi.org/10.1177/1363460713481726

Social Care Institute for Excellence. (2014). *Dignity in Care.* Retrieved from http://www.scie.org.uk/publications/guides/guide15/factors/choice/

Strauss, A., & Corbin, J. (1994). Grounded theory methodology. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (pp. 273–286). Thousand Oaks, CA: Sage.

Taylor, A., & Gosney, M. A. (2011). Sexuality in older age: Essential considerations for healthcare professionals. *Age and Ageing*, *40*(5), 538–543. http://doi.org/10.1093/ageing/afr049

Tongco, M. D. C. (2007). Purposive sampling as a tool for informant selection. *Ethnobotany Research and Applications*, *5*, 147–158. http://doi.org/http://hdl.handle.net/10125/227

Travis, S. S. (1987). Older adults' sexuality and remarriage. *Journal of Gerontological Nursing*, *13*(6), 8–9.

Ward, R., Andreas Vass, A., Aggarwal, N., Garfield, C., & Cybyk, B. (2005). A kiss is still a kiss? The construction of sexuality in dementia care. *Dementia*, *4*(1), 49–72. http://doi.org/10.1177/1471301205049190

Wittenberg, R., Comas-Herrera, A., Pickard, L., & Hancock, R. (2004). *Future demand for long-term care in the UK*. York: Joseph Rowntree Foundation.

World Health Organization. (2015). Sexual health, human rights and the law. Retrieved from http://apps.who.int/iris/bitstream/10665/175556/1/9789241564984_eng.pdf

Wylie, K. R., Wood, A., & McManus, R. (2013). Sexuality and old age. *Bundesgesundheitsbl*, *56*(2), 223–230. http://doi.org/10.1007/s00103-012-1602-4

Yardley, L. (2000). Dilemmas in qualitative health research. *Psychology and Health, 15*, 215-228.

4. Extended Paper

4.1 Extended Introduction

4.1.1 The Challenges of Defining Sexuality

The emergent definition of sexuality over time is difficult to accurately depict. The majority of the historical accounts of sexuality are inherently limited as a result of the societal frameworks from which data had been interpreted. For example, homosexuality has both been documented as representing an illness (see Spitzer, 1981) and a crime, perspectives which have impacted on how this aspect of sexuality has been understood and reported upon across the literature. When exploring the timeline of sexuality research, the nineteenth century appeared to mark the beginning of the modern study of sexuality. At this time the topic of sexuality was largely dominated by the medical model approach which focussed on sexual health. As a consequence, most of the sexuality research completed during this period had a physical or biological focus and had been conducted by physicians. This medical dominance was continued into the mid-twentieth century until Alfred Kinsey's research into human sex and sexuality marked a pivotal point in sexuality history and prompted the exploration of the topic which went beyond that of a moral or medical understanding (Bullough, 1998). Kinsey's research focussed on obtaining behavioural accounts of sexual practices (see Kinsey, Pomeroy, & Martin, 1948; Kinsey, Pomeroy, Martin, & Gebhard, 1953). While Kinsey's work was revolutionary in the history of sexuality research, the term 'sexuality' was positioned as being interchangeable with, and equivalent to sexual behaviour. Some researchers continue to conflate sexuality with specific acts of sexual behaviour. In these instances, sexuality appears to be most commonly cited to refer almost exclusively to sexual orientation (for example, Briddock, 2014; Sit & Ricciardelli, 2013). Langer's position that "sexuality refers to an individual's self-perception of being

attractive as a sexual partner" (2009, p.753) provides another example where the term is understood as relating to sexual acts. Behavioural accounts of sexuality provide some insightful descriptors of how sexuality can be enacted. However, they are limited in that they fail to provide any account of how or why these various behaviours may occur. Furthermore, it is widely acknowledged that an individual's beliefs and context will inform how their sexuality may be enacted. For example, religiosity has been cited as a determinant of sexual behaviour. Orthodox Judaism, traditional Catholicism and traditional Protestantism have been found to be alike in their condemnation of masturbation, abortion, homosexuality, and premarital and extramarital coitus (Hogan, 1982). On this premise, research perspectives which only examine observable behaviours arguably fail to provide the full understanding of sexuality required to make sense of individual experiences.

Sexuality has not always been cited as a term which is synonymous with sexual practice or behaviour. In contrast, many modern researchers have defined sexuality as a symbolic term which is representative of a number of much broader biopsychosocial concepts. These constructs of sexuality present the term as being a collective of ideas, rather than as relating to specific aspects of human behaviour. For example:

> *"Sexuality is a very individual concept that cannot be easily defined or categorized and which includes feelings, values, beliefs, and experiences related to one's sexual preferences. It is expressed within a context of communicating with an "other", as well as personally expressing oneself as a sexual being."* (Redelman, 2008, p.367)

> *"Sexuality is an essential human characteristic that includes social, emotional, and physical components."* (Ayaz, 2012, p.3)

> *"Sexuality is a broad multi-dimensional construct which encompasses relationships, romance, intimacy (ranging from simple touching and hugging, to sexually explicit contact), gender, grooming, dress and styling."* (Bauer, Fetherstonhaugh, Tarzia, Nay, & Beattie, 2014, p.1)

These definitions propose the use of the term as a multifaceted concept which goes beyond accounts of sexual practice.

When exploring the development of the definition of sexuality, the meaning of the term across the literature appears to depict sexuality as being along a continuum. At one polar end, authors refer to sexuality as the description of observable sexual acts and coital relationships. Literature which portrays sexuality in these terms often links sexuality with categoric descriptors (for example, homosexual, heterosexual, bisexual, or asexual). At the other end of the continuum, sexuality is described by social constructionist accounts which position sexuality as a complex and individual phenomenon which is influenced by social norms, culture, and personal experiences (Laws & Schwartz, 1977). The ambiguous nature of 'sexuality' and its changing meanings across the literature make it difficult to synthesise findings. Furthermore, the lack of a clear and consistent definition of sexuality amongst researchers poses a barrier in terms of theoretical understandings of sexuality. Therefore, existing research on sexuality is either atheoretical or reflects the application of disciplinary theories which have been modified to include sexuality (Goettsch, 1989), and much needed clarity is required regarding the use of terminology in this area. Due to the uncertainly of the constituents of the term 'sexuality' across

the literature, as a research team we intentionally abstained from endorsing a specific definition and instead opted to include understanding participants' interpretations of the word as part of our research aims. However, it is acknowledged that the researcher's prior values, beliefs, and interpretations can influence research findings and therefore biases cannot be entirely prevented (Jootun, McGhee & Marland, 2009). Therefore, while a definition of sexuality for the purposes of this research has not been specified, for further information regarding the lead author's position regarding defining sexuality please refer to section 4.2.10.

4.1.2 Sexuality and Health

Current literature increasingly acknowledges the important influence sexuality has with regards to individual wellbeing, and it is becoming widely-recognised as an important issue for the healthcare agenda. Sexuality has been noted as an important factor in relation to many presenting concerns in clinical practice, including: self-identity; self-esteem; social relationships; social engagement; mental health problems including depression and anxiety; and quality of life (Barnard, 2009; Buffington, Luibhéid, & Guy, 2013; Burri, Spector, & Rahman, 2012; Heath & White, 2002; Langer, 2009; Mayers, Heller, & Heller, 2003; Pasko, 2010; Stevenson, 2010). According to neurobiological research, sexual behaviours involve endocrine systems which are capable of decreasing hypothalamic–pituitary–adrenal axis activity and consequently modulate the autonomic nervous system. It is proposed that the oxytocin release which occurs with sexual activity stimulates feelings of warmth and acts as a natural anti-stress neurotransmitter which accounts for the link between loving relationships and the health benefits which are widely

reported across the literature (Galinsky, McClintock, & Waite, 2014; Redelman, 2008).

The widely acknowledged link between sexuality and health benefits makes sexuality an important topic to consider for the promotion of overall well-being. Evidence from the Institute for Public Policy Research (2008) suggests that many older adults experience poor mental wellbeing, described as including experiences of dissatisfaction, loneliness and depression, and low levels of life satisfaction. These problems become even more prominent amongst populations of older adults in care homes, where research suggests that older care home residents frequently report on poor quality of life and poor wellbeing (Kane et al, 2003; Scocco, Rapattoni & Fantoni, 2006). Despite the acknowledged links between sexuality and wellbeing, guidance for services regarding how to acknowledge residents' sexuality and maintain positive sexuality experiences in the care home remains minimal and vague. Indeed many best practice guidelines neglect the topic of sexuality entirely. These include the National Service Framework for Older People (Department of Health, 2001), NICE's (2015) key recommendations for local authorities and partner organisations on the health and care of older people in care homes, The My Home Life's (2012) quality framework for best practice guidelines for care homes, and the British Geriatrics Society's (2011) inquiry into the quality of healthcare support for older people in care homes report. Sexuality is cited within NICE's guidelines on the mental wellbeing of older adults in care homes:

> *"Staff working with older people in care homes should identify and address the specific needs of older people arising from diversity, including gender and gender identity, sexuality, ethnicity, age and religion."* (2013, p.18)

However, the absence of clear parameters from which to inform service practice reduces the clinical utility of these guidelines. Therefore, despite the commonly reported link between sexuality and health, practice guidelines for services need development in order to reflect these understandings of the relationship between wellbeing and sexuality.

4.1.3 Older Adults' Sexuality

Reports on older adults' sexuality often reference the widely held assumption of the sexless older person, (for example, Drench & Losee, 1996; Walz, 2002). To consider the reported sexuality changes which occur across the lifespan, three theoretical accounts have been considered: bioneurological perspectives; a psychological perspective, and a social constructionist approach.

Bioneurological perspectives suggest that the physical deterioration and hormonal changes associated with age impact on sexual practice. For example, older women experience a decrease in oestrogen levels which contributes to vaginal dryness; older men experience a decline in the circulation of testosterone which contributes to reduced sexual desire, and overall responses to sexual stimulation reduce with age (Sander, 2007). Historically, the majority of research into older adults' sexuality had focused on behavioural practices and physical health[26]. Therefore, it is perhaps unsurprising that theories of ageing and sexuality are often positioned from a biological or evolutionary perspective which comments on fertility and draws associations between ageing and the hormones which regulate reproduction. Bowen and Atwood (2004) propose a theory of ageing related to the hormones that regulate reproduction, which they suggest act in an antagonistic pleiotrophic

[26] The history of sexuality research has been commented on within section 4.1.1.

manner to control ageing via cell cycle signalling. Their theory describes that it is this signalling that promotes growth and development early in life to achieve reproduction. However, in a futile attempt to maintain reproduction in later life, they suggest these signals become dysregulated and drive senescence. In another account, Galinsky et al. (2014) suggest that the behavioural and motivational changes in relation to sexuality which occur with age are driven by neurological and hormonal mechanisms. They describe that these processes become tightly co-ordinated with reproductive maturity but due to these components ageing at different rates they become uncoupled again later in life. This neuroendocrine perspective likens sexuality in older age to that of those in the late juvenile period, providing a neurological account of the reduced levels of sexual activity of those later in life. Both of these bioneurological accounts of older adults' sexuality link sexuality expression with the purpose of reproducing. On this basis, elderly people are no longer to be viewed as sexual beings because they are not within the fertile period (Kenny, 2013). Bioneurological perspectives on ageing sexuality are limited in that they fail to account for the wealth of literature which reports on the maintained importance of sex and sexuality into later life. Adopting a purely physiological perspective from which to understand ageing sexuality reveals a discord between theoretical accounts of the non-sexual older person based on physiology and reports which suggest that sexuality remains an important part of the identity of older adults.

There are a number of psychological factors which have been cited to account for the reduced levels of sexual activity reported amongst older adults. Amongst these are experiences such as stress, a lack of adjustment to physiological changes, and marital conflict (Garrett, 2014; Huang et al., 2014; Lindau et al., 2010). Retired older adults are often less engaged in their communities and are

more isolated, thus opportunities to meet a new partner are reduced (Kenny, 2013). Furthermore, as people age the likelihood of them having a partner decreases due to increased rates of people who are single, divorced or widowed (Garrett, 2014). The psychological construct of 'widower's syndrome' has been proposed to account for some of the reduced sexual activity amongst older adults who have experienced the death of a spouse or partner (Rheaume & Mitty, 2008). According to the literature, widowers may harbour guilt about pursing a new sexual relationship when they have lost a previous sexual partner. The guilt experienced can be related to internal processes relating to the individual's own beliefs (for example, the belief that sexual intercourse outside of marriage is inappropriate) and contributed to by external factors. For example, the negative attitudes of adult children towards their older parents' sexual relationships can increase the guilt experienced by the person when considering forming a new relationship after a spousal bereavement (Rheaume & Mitty, 2008; Travis, 1987). The guilt experienced then impacts on the individual's ability to achieve sexual arousal, which in turn creates anxiety regarding potential future sexual performance. As a result of this newfound performance anxiety, the likelihood that the person will continue to seek out sexual contact or experiences is reduced, thus providing an explanation regarding the asexual role which can be ascribed to this population.

Social constructionist understandings of changing sexuality across the lifespan also offer some account of the sexless older person. Social constructionists understand sexuality as something which is socially constructed and therefore individual perceptions and experiences of sexuality will be constantly reviewed and modified on the basis of social discourses about sexuality (Foucault, 1978); a distinct shift in the understanding of the term when considered against medical-model approaches to human sexuality which

dominated early sexuality research. Goettsche (1989) suggested that social norms and culture provide the social parameters for sexual enactment, informing how sexuality can be considered, expressed, and experienced. From a constructionist perspective, the interaction between external processes (e.g. social norms and discourse) and internal processes (e.g. one's capacity to respond to physical experiences related to sexual practices) shapes an individual's sexuality. The impact of the external forces on the construct of sexuality has been described as relating to scripts, which are conceptualised as the mental representations that a person constructs and uses to make sense of their experiences, including their own and others' behaviour (Wiederman, 2015). Laws and Schwartz (1977) define scripts as a "repertoire of acts and statuses that are recognized by a social group, together with the rules, expectations, and sanctions governing these acts" (p.18). Expanding upon this, Gagnon and Simon (1973) proposed the notion of 'sexual scripts', a concept which provides some theoretical account of the changing construct of sexuality with age from a social constructionist perspective (Villanueva, 1997). According to theorists, sexual scripts inform how an individual may engage with their sexuality based upon a series of scripted behaviours which are linked with the individual's context (Laws & Schwartz, 1977). Sexual scripts arise from social discourse, and cultural ageism has been well documented across the literature, particularly across Western societies where commonly held beliefs include that sex and sexual behaviour is only for the young (Garrett, 2014). The sexual scripts relating to older adults' sexual identities have been described as mirroring those in the pre-pubescent phase, where sexually significant events occurring at either extreme end of the lifecycle are rarely anticipated (Wiederman, 2015). By this account, it is the lack of acknowledgement of older

adults as sexual beings that prompts and maintains the widely held assumption of the sexless older person.

4.2 Extended Methods

4.2.1 Epistemology

The epistemological position of the researcher underpins their practice, providing a philosophical grounding for deciding what kinds of knowledge are possible (James & Busher, 2009). The various epistemological positions are usually depicted along a continuum, where a highly constructionist view of knowledge sits at one end, opposite the unproblematized 'direct window onto the world' view proposed by positivists (Barnett-Page & Thomas, 2009). These supposed polar opposites, constructionist versus realist, are most commonly cited choices when determining epistemological positions (Darlaston-Jones, 2007). A constructionist perspective of sexuality might suppose the individual and the social environment are connected and developed through social interactions and societal structures, and that beliefs about ageing and sexuality are constructed through social processes (Bauer et al., 2012). Therefore, the constructionist paradigm usually indicates the endorsement of qualitative approaches to research which recognise the supposition of 'truth' as a human and social construction. In contrast, positivists strive for objective knowledge, seeking the assumed measurable constructs which relate to the truth of the subject matter being researched (Ward, Furber, Tierney, & Swallow, 2013). A positivist approach to sexuality research may advocate for quantitative measures in order to uncover the 'truth' in the natural world.

This research was conducted from a pragmatic approach. Pragmatists do not view any particular epistemological paradigm as superior to other modes of inquiry (Rorty, 1982), and Cameron

described pragmatism as a "practical approach to a problem" (2011, p.101). Pragmatists evaluate outcome by the extent to which the goal has been met; a 'what works' approach, (Tashakkori & Teddlie, 1998). The pragmatist paradigm is placed outside of the typical epistemological continuum, challenging the notion that varying epistemologies seek different forms of 'truth' and the nature of truth as necessarily representing reality (Rorty, 1982). The pragmatic researcher acknowledges merits with both quantitative and qualitative approaches, viewing them as tools to conduct meaningful research, rather than being anchored to a specific understanding of what is 'truth'. Researching sexuality is problematic given its position as a poorly defined term across the literature. The absence of a clear understanding about the sexuality term also demonstrates the lack of consensus amongst researchers regarding which properties of sexuality pertain to 'truth' (e.g. observable, measurable behaviours versus individual constructions). With these tensions in mind, the pragmatic approach was deemed to be compatible with this research study. The pragmatist is outcome orientated and evaluates research on the basis of clinical utility and usefulness rather than on the notion of 'truth'. The pragmatist paradigm argues that the most important determinant of how to approach research is the research questions themselves, as choosing between one position (epistemology, ontology, or axiology) and the other is said to be unrealistic in practice (Creswell & Plano Clark, 2011; Saunders, Lewis, & Thornhill, 2009). This is particularly relevant where the research question does not suggest clearly that either a positivist or interpretive philosophy should be adopted in an inquiry (Ihuah & Eaton, 2013). As previous sexuality research has been conducted using both quantitative and qualitative research methods, from both constructionist and positivist positions, there is no clear indication about which approach is most suitable for understanding this topic. Furthermore, due to the

different understandings of sexuality, research on older adults' sexuality in care homes has focused on exploring the topic of sexuality by examining different areas, from sexual behaviour (for example Elias & Ryan, 2011) to understanding sexuality as a construct (for example, Lemieux et al., 2004). As a researcher, I understood sexuality as having the potential to be an individually understood concept and that pre-defined definitions of sexuality may have different applicability across populations depending on the relevance to individual experience. With this in mind, my subscription to the notion that the definition of sexuality encapsulates multiple individual realities driven by both internal and external factors based on 'what works' for each person was congruent with the philosophy of pragmatism.

From a pragmatic perspective, adopting a qualitative approach which was interview-based and using thematic analysis (rather than a quantitative approach or a mixed-methods design) was considered to be a workable approach for this research question. The first research aim was to establish context by exploring participants' definitions of sexuality, a construct which has previously been poorly defined across the history of the literature. Previous sexuality research alludes to the concept of sexuality as containing both overt and covert elements, which may hold consensus or individual relevancy. Adopting an interview-based qualitative approach to data collection was identified as being the most appropriate method to allow the collation of data with the potential to capture both reports on observational accounts of sexuality and participants' individual representations of the internal constructs of sexuality. Further rationale for using thematic analysis within this approach has been expanded upon in section 4.2.5.

4.2.2 The Semi-Structured Interview Schedule

Semi-structured interviews were used to explore individual experiences of sexuality. Interviews have been described as a useful tool to collect data pertaining to 'experience' (Saunders et al., 2009), thus from a pragmatic approach this data collection method appeared to best respond to the research question. As sexuality has been noted as an area that not many people openly discuss (Bouman, Arcelus, & Benbow, 2006), semi-structured interviews were selected to facilitate an informal conversational style aimed at maximising participant engagement and disclosure. By following leads of respondents, participant responses and individual experiences were able to be explored with breadth and depth whilst being sensitive to the needs of respondents and remaining topic focussed. Furthermore, the predetermined order of the interview schedule questions (i.e. establishing a definition before exploring views about the perceived impact of the care home environment on sexuality experiences) necessitated a semi-structured approach to interviewing (versus structured or unstructured interview structures). The implementation of a semi-structured schedule also provides a template for study replicability, a quality deemed to be integral to demonstrating rigor for qualitative research (Elliot, Fischer & Rennie, 1999).

Semi-structured interview techniques were viewed as the most appropriate method of data collection compared to some qualitative alternatives. For example, focus groups could have been used to explore sexuality. Frith (2000) suggests focus groups as a method for sex and sexuality research have a number of benefits when exploring under-researched topics as they facilitate the conditions under which participants feel more comfortable to discuss the topic and enable insights into the language commonly used by respondents to describe sexual activities. However, our research intended to

explore individual prognostications about how transitioning to a care home might impact upon sexuality experiences rather than capture group discussions, and it is noted that participants of focus groups may refine their own views in light of being exposed to the responses of others (Merriam & Tisdell, 2015). Alternative methods such as questionnaires only offer a one-way process of data collection which would have prevented the 'live' exploration of concepts and terms provided by participants. The inability to further clarify participants' use of language would have risked the output of data which replicated the vague and uncertain definitions of sexuality prevalent across the existing literature. Providing participants with full access to the deductive framework (as would have been required if using questionnaire based data collection methods) may have also influenced the data obtained. Furthermore, our first interview question sought to establish a definition of sexuality against a deductive framework based upon the WHO's working definition of sexuality whilst also allowing ideas to emerge which may have gone beyond the WHO's conceptualisation of the term (further description regarding the use of the deductive framework has been outlined below). With this in mind, interview techniques for data collection were identified as the most appropriate method to suit the dual deductive-inductive intentions of our interview questions.

The semi-structured interview schedule included three broad research questions to respond to the study aim (a copy of the semi-structured interview schedule has been presented within Appendix F). The lead author drafted the construction of the interview schedule, which was then discussed within research supervision for suitability where the acceptability of terms and the questions' ability to respond to the research aims were considered. As a number of accounts detailing the definition of sexuality can be located across the literature, the first question was explored flexibly against a deductive

framework based on the WHO's working definition of sexuality. The inclusion of a deductive framework functioned to facilitate conversation around sexuality in an exhaustive manner to fully explore participant views whilst minimising the potential impact of researcher preconceptions or assumptions on participant responses. Participants were asked open questions regarding their interpretation of the term 'sexuality'. Follow-up questions were then asked to explore responses, and where discussion did not address all aspects of the terms included within the WHO's definition, specific questions regarding these neglected areas were posed to participants. An excerpt from a transcript has been provided to demonstrate how the semi-structured interview schedule and questioning technique was applied during participant interviews:

> Interviewer: And now we're pondering over it a little bit longer does anything else come to mind about what [sexuality] might mean?
> F4: Not really, because to me sexuality is about how you present from a sexual point of view, as I say, and I really don't go beyond that just with that word to be perfectly honest. I would have been looking for other words if I was to go beyond how people present and how they, how they, what their orientation is and how they behave in private. You know, and that is all it means to me at this point in time.
> Interviewer: OK. Within the literature it has been said that within the sexuality definition you get things like masculinity, femininity. Do you think that has a place within this definition?

The initial question sought to establish the parameters of understanding and position the participant's awareness of the topic in relation to the literature. Interview questions intended to encourage

participants to consider of the subject of sexuality without introducing any bias from the interviewer.

When conducting semi-structured interviews in qualitative research, the interviewer is allowed the opportunity to clarify interviewee's responses in search of establishing mutual understanding. Some position the dynamic nature of the semi-structured approach as being a strength, suggesting that it reduces the risk of data being misinterpreted by the interviewer and therefore misrepresented across the data findings (Alshenqeeti, 2014). However, the qualitative interview technique has also been criticised for its inability to obtain impartial data on the basis of the co-construction of meaning which occurs between the interviewer and interviewee (Potter & Hepburn, 2005). With the criticisms of qualitative interviews in mind, the researchers acknowledged that by using a deductive element within the semi-structured interview the WHO's perspectives may have had the potential to influence participant responses. To mitigate these risks as much as possible and to try to capture the views of older adults (rather than replicate the views of the WHO), it was intentional that the interviewer first asked broad open questions regarding participants' views on the definition of the term 'sexuality' and exhaustively followed-up on participants' responses before introducing the suggested topics of relevancy as cited by the WHO. Where participants were unable to respond to broad initial questions which asked them to define 'sexuality', participants' views around the concept of sexuality were explored by asking questions from the semi-structured interview schedule which offered a context for discussion, for example:

> Interviewer: People describe sexuality as being lots of different things such as relationships, sex, and intimacy. I wonder what sexuality means to you?

Whilst the later introduction of themes as identified by the WHO as being relevant to sexuality may have potentially introduced biases into participant responses, it was noted that participants both offered agreement and disagreement with these suggestions (please refer to section 4.3.3. and Table 7), suggesting that the data obtained did not simply represent a forced understanding based on the use of a deductive framework within the interview schedule during the interview process. Fereday and Muir-Cochrane (2006) suggest that offering participants summaries of their responses as a means to validate the accuracy of the researcher's understanding of the discussion is a helpful way to remain data-driven during the interviewing processes. To remain faithful to participants' views as much as possible (as opposed to solely replicating the content of the deductive framework and thus capturing the views of the WHO and not the participant), summaries were regularly provided to participants to clarify their responses. An example has been provided below:

> Interviewer: OK. So when thinking about the word 'sexuality' and trying to get a definition on that, what I've heard, you first said that, to you, it is about sexual orientation, and within that umbrella there are things like that sexual identity, how people see you and how you present yourself as a sexual person. And then coming under that there is something about masculinity/femininity as being important. And then you said for you actually that femininity side, presenting yourself as a woman, going out with lipstick on, having a particular way that you present, is important to you. Is that right?
> F4: Yes, yes.

To further ensure that the data obtained was based closely on the responses from participants (versus the views of the interviewer or the WHO), rigorous quality checks were taken when obtaining and analysing the data (further discussion regarding quality assurance has been provided within section 4.2.9).

4.2.3 Participant Recruitment

Older adults' sexuality and the impact of the care home environment on experiences is a starkly under-researched area. Consequently, we wanted to obtain varied views and perspectives to provide an initial broad understanding of this topic. To promote heterogeneity, participants were recruited using both snowball sampling and purposive sampling (Biernacki & Waldorf, 1981; Tongco, 2007). Initially snowball sampling techniques were employed to recruit participants. Snowball sampling is an approach which has been deemed to be particularly applicable when the focus of the study is on a sensitive issue (Biernacki & Waldorf, 1981). The snowball sampling technique involved communicating with both known associates and organisations that have contact with older adults and encouraging these contacts to disseminate the study information to appropriate potential participants, who in turn would be requested to circulate this information amongst their known associates and peers. Using this recruitment technique, a number of national and local services and online platforms were contacted regarding the study, including: Age UK; Street Life (a community network website); Local retirement age groups listed on social networking sites; University of the Third Age; Pensioners Forum; Gransnet; Buzz50 (a website which hosts online senior chat rooms); Call For Participants (an online study advertisement website); and local groups targeted towards those of retirement age (e.g. Lichfield's Science and Engineering Society and

Staffordshire book groups identified via online social networking websites).

During the initial phase of recruitment, it was identified that the emerging participant sample held a number of shared characteristics (i.e., they were all White British heterosexuals) which did not represent the intended heterogeneous participant group. The initial emerging participant homogeneity in terms of ethnicity may have been related to the social marginalisation of racial minority groups and therefore the lack of representativeness of these individuals across the local services that were contacted about the study (Mehra, Kilduff & Brass, 1998). However, as recent census data suggests 86% of the UK population classify themselves as White British (Office for National Statistics, 2011), the recruitment of White British participants may be more simply understood in terms of probability. The initial lack of variance in terms of participants' sexual orientation may have been related to research findings which suggest that the majority of older LGBT individuals have experienced victimisation at some point during their life as a direct result of their sexual orientation (D'Augelli & Grossman, 2001). The experience of having been discriminated against or victimised as a direct result of having disclosed information about sexual orientation draws the association between openly discussing sexuality and increased vulnerability to victimisation. This explanation provides one hypothesis regarding the under-representativeness of LGBT participants during the early recruitment phases. However, as no direct responses from non-White British heterosexual populations were received to offer a rationale for their lack of participation, we can only hypothesise about the reasons for these groups having been under-represented within our sample.

As the emerging homogeneity of participants was identified, purposive sampling was used to target specific characteristics to increase the opportunity for non-White British heterosexual

individuals to participate with the research. For example, to promote the inclusion of LGBT participants the advertisement of the study was tailored towards organisations and individuals with the potential to maximise recruitment from these populations. These included the non-for-profit organisations Safe Ageing No Discrimination (SAND) and Opening Doors, services which provide support to older LGBT people in the UK. To promote the inclusion of non-White British participants the study description on Call For Participants was amended to emphasise our interest in participants from minority ethnic backgrounds, those involved with the snowball sampling process were requested to specifically target non-White British older adults where possible or appropriate, and attempts were made to identify local and national services for older non-White British populations. Only one local group had been identified (Tamworth African Caribbean Association) before data sufficiency had been achieved and participant recruitment was closed.

The final data set included responses from a gay man and a lesbian woman, one of whom was recruited as a result of the targeted sampling as described above. As recent data on the population demographics of the UK suggests 1.7% identify themselves as lesbian, gay, or bisexual (Office for National Statistics, 2016), the recruitment of two gay and lesbian participants out of ten was deemed to be representative of the UK population. Unfortunately, no non-White British older adults expressed an interest in participating with the study despite intentions to target these populations. The underrepresentation of ethnic minority groups has been described as characteristic of sex and sexuality research due to difficulties in the recruitment and retention of participants from these populations (Crooks & Baur, 2010; Sullivan et al., 2011). The lack of ethnic diversity across our sample is consistent with the marked trend in literature regarding demographic biases. However, as we intended to

obtain a varied participant group to establish a broad understanding of the topic, the effectiveness of our participant recruitment strategy can be questioned. The homogeneity of participants recruited is a noted limitation of the research as the extent to which study findings can be generalised to wider ethnic groups is unclear. On this basis, implications for future research include replicating the study amongst older adults from non-White British ethnic minority groups.

4.2.4 Ethical Considerations

Initially the scope of the study was to explore the views of care home residents, a proposal which was approved by the Research Ethics Committee of the Faculty of Medicine and Health Studies, University of Nottingham on 17th October 2014 (see Appendix A). The ethics application was then amended to reflect the intentions of the current project, which was approved on 11th September 2015 (see Appendix B). Further minor amendments were made to some of the supporting documentation for the study (e.g. the Participant Information Sheet), alterations which were approved on 1st October 2016 (see Appendix C).

Ethical considerations were attended to throughout the study process. Participants were required to have read the participant information sheet (see Appendix D) and signed a consent form before completing the interview. All consent forms were signed, dated, and countersigned by the interviewer and participants were offered a copy of this agreement (the consent form is presented within Appendix E). In accordance with guidelines published by The British Psychological Society (2013) it was explained to participants that participation was voluntary. They were advised they would be able to stop the interview at any point, an instruction which was shared both verbally and written within the participant information sheet. At the end of each interview, participants were asked whether they had any

concerns or questions following their participation. Participants were then issued with a debrief form (contained within Appendix G) thanking them for their participation, reiterating the aims of the study, and providing details regarding how to withdraw their data. Debrief forms were issued either electronically or in paper copy depending on the preferences of the participant. All participants completed the full interview and gave permission for their information to be used within the study.

Transcription services were employed to support with the transcription of interviews. Prior to any data being shared, the transcriber was required to sign a confidentiality agreement. A copy of this signed agreement has been presented within Appendix H.

To protect the identity of the participants, pseudonyms were assigned during the data analysis phase. The list of corresponding pseudonyms to participants was only accessible to the lead author within a password protected document. Once each participant's withdrawal period had elapsed (one week post-interview), names were deleted from this document and the participant's demographic information and pseudonym was transferred to a separate secure document. To preserve participant anonymity, prior to any data being discussed within research supervision, the lead author reviewed the transcripts and removed any information which had the potential to identify the participant (e.g. names of places and people).

4.2.5 Thematic Analysis

Qualitative approaches share the commonality of seeking to explore the perspectives of those experiencing a particular phenomenon in order to arrive at an understanding, and there is noted overlap between the methods, procedures, and techniques across the different qualitative approaches (Vaismoradi, Turunen, & Bondas,

2013). With this in mind, it could be hypothesised that our findings may be equivalent regardless of the approach taken to analysis. In this instance, thematic analysis was selected to analyse the data. The approach taken to data analysis has been described in further detail within Table 3. A rationale for the decision to apply thematic analysis to the data has been considered below.

Thematic analysis was deemed an appropriate approach as it has utility across a range of epistemological and theoretical approaches as a method to analyse data for themes. On a continuum indicating the extent to which the data is transformed during interpretation, thematic analysis has been positioned towards the descriptive end where findings remain relatively representative of the data set (Vaismoradi et al., 2013). As the topic of older adults' sexuality is an under researched area, it was considered that approaches which emphasise the role of interpretation may draw away from understandings gained by directly attending to participant perspectives as much as is possible within the limitations of qualitative methods.

An additional consideration for selecting thematic analysis was the previous experiences of the research team. Braun and Clarke position thematic analysis as "a comparatively easy to learn qualitative analytic approach, without deep theoretical commitments" which "works well for research teams where some are more and some are less qualitatively experienced." (2014, p.2). This project represented the lead author's first qualitative research endeavour in terms of interpreting primary data. With consideration to the research team's skill set, the well-defined and systematic approach to data analysis provided by thematic analysis appeared a suitable fit.

Table 3. The six-phase process of thematic analysis as described by Braun and Clarke (2006) as it was applied for this research.

Phase	Actions	Output
Phase 1 Data familiarisation	Read/re-read transcripts and notice emerging themes	List of ideas and potential coding schemes
Phase 2 Generating initial codes	Produce initial codes from data, being as inclusive/exhaustive as possible	Ideas sorted into meaningful groups with a collection of data relevant to each code
Phase 3 Searching for themes	Sort codes into themes, considering relationships between codes, main themes and sub-themes	Thematic map with extracts of data coded in relation to them
Phase 4 Reviewing themes	Level 1 analysis – assess coded data for coherency, omitting anything not supported by data or where data is too diverse, and merging similar themes Level 2 analysis – consider validity of themes in relation to data set and if map accurately reflects meaning in data set as whole	Refined set of themes which are internally consistent, unique, and which capture the whole data-set.
Phase 5 Defining and naming themes	- Further refine themes, identify what the theme captures and ensure a coherent and internally consistent account of the data - Themes and subthemes to demonstrate hierarchy and add structure to the data	Detailed analysis of themes and the overall story about the data
Phase 6 Producing the report	- Refer to set of themes and select extract examples to include which are related to the analysis of the research question and existing literature - Generate succinct summary of findings to disseminate back to participants	- A concise and coherent account of the story the data tells - Summary sent to participants

This research was aimed at exploring a topic which has direct implications for clinical practice. Thematic analysis has been described as a useful method when analysing health research, as the approach enables information to be presented in an accessible format for non-academics (Braun & Clarke, 2014). One of the key strengths of thematic analysis is its ability to be applied flexibly. The flexibility inherent to thematic analysis allows researchers to construct a model that best suits the scope of their research questions and their data (Trahan & Stewart, 2013). We considered that the flexibility of the approach increased its appropriateness for use in this study as we were able to apply it in a way which responded to the aims of the project, an approach which was congruent with the stated epistemological position. However, the flexible property of thematic analysis has also been criticised for its potential to result in research which cannot be replicated and due to a lack of transparency regarding the data analysis processes (Javadi & Zarea, 2016). By utilising the structured approach to thematic analysis as described by Braun and Clarke (2006), we aimed to compensate for these criticisms. However, it may be considered that as an under-researched area, the replicability of this research will be inherently compromised; as the subject of older adults' sexuality in care homes becomes more widely recognised and explored, understandings of the topic will develop and therefore participant responses to the same questions about sexuality and residential care may be more considered. On this premise, the ability to replicate our research findings may be compromised as the topic under investigation becomes more widely researched and understood.

Some alternative approaches to data analysis were considered, however they were concluded as being less robust in terms of appropriately responding to the research question. Discourse analysis was considered, however discourse analytic studies usually

begin from a broad or general problem area and develop more focused research questions as the research progresses so that researchers can remain genuinely open to new insights (Shaw & Bailey, 2009). However, due to our semi-structured interview schedule and deductive aspect to the data collection, this method of analysis would not have been suitable. Content analysis was also considered, as similarly to thematic analysis it enables the researcher to establish patterns within narratives to explore meaning. However, when compared with thematic analysis, content analysis has been described as being more vulnerable to frequency and the potential for themes identified to be related to how often they occur across the data (Vaismoradi et al., 2013). Our research was completed against a step-wise semi-structured interview schedule, where the answers to the first set of questions provided context to subsequent responses. Therefore, it was likely for participants' views about the potential impact of the care home on sexuality experiences to be unique to their previously considered position on what 'sexuality' meant to them. With this in mind, where participants had differing views about the construct of positive sexuality experiences, adopting an approach which was sensitive to frequency may have resulted in the misinterpretation or misrepresentation of participant accounts when analysing data. Furthermore, as a unique research study, any data skew occurring as a result of analysis processes which are sensitive to frequency would not be able to be detected due to the absence of baseline understandings from which to position the data.

The initial phase of thematic analysis involved transcribing and reviewing the transcripts. The lead author transcribed the first three interviews; professional transcription services transcribed the remaining interviews to ensure the timely completion of the project. The lead author then checked the scripts for accuracy and removed any personal identifiable information before reading and re-reading

the transcripts to increase familiarity of the data. During this process notes were made by the lead author regarding initial responses to the data and possible emerging themes.

The remaining data analysis phases were completed using a computer assisted qualitative analysis data program called NVivo Pro (version 11). While this software offers the capability to search across the data for emergent themes based on frequency, this option was not utilized for reasons discussed above and the identified codes and themes from the data were recorded manually by the lead author and then reviewed amongst the research team.

Phases 3 and 4 were the most interchangeable processes; themes were considered and identified, checked against the codes for consistency and coherence, further refined, and then checked back with codes. Whilst Braun and Clarke (2006) present their phase-model in a step-wise and linear format, they note that the researcher is able to move through the phases flexibly. The constant checking and re-checking which occurred during the progression through these phases allowed for the refinement of themes which were deemed to most accurately depict the key aspects of the data.

Eight out of the ten participants requested a summary of the findings from the research either via email or postal address. These contact details were stored in a separate secure electronic file. Once the summary of findings was disseminated (see Appendix O), this electronic record was deleted so that no personal contact information for participants remained post-analysis.

4.2.6 Manifest/Latent Analysis

Within thematic analysis, a theme represents, "some level of patterned response or meaning" within the data (Braun & Clarke, 2006, p.10) and can be from explicit or implicit content (Joffe, 2012).

As sexuality is a complex and abstract concept which is not often openly discussed, it was considered that participants may be unable to offer an unambiguous account of their experiences and the language used by participants may require interpretation. On this basis, data analysis was conducted from a mixed latent and manifest level. This included identifying codes which were evidenced semantically and explicitly cited within the data (manifest level coding) as well as coding by applying some interpretation to establish the meaning of what was being said (latent level coding). To ensure that analysis processes were data-driven, both manifest and latent level codes were supported using exerts from raw data. When using latent level coding, the researcher is able to draw meaning from the data which may not be explicit. This method increases the potential that data may be misrepresented or misinterpreted by the researcher. To mitigate this risk and promote our ability to gain a credible account of participant views when using latent coding, a number of quality assurance checks were taken during the data analysis phase, including accessing regular supervision to ensure latent level interpretations were representative of the data (see section 4.2.9 and Table 5 for information on quality assurance checks related to coding processes). Whilst some themes represented either a majority of latent or manifest codes, most themes were constructed using mixed-level coding. An illustrative example has been provided to demonstrate data which was coded against the sub-theme of 'heteronormative' at both manifest and latent levels, where the sub-theme was represented both directly from within the text and concluded from making an interpretation about the meaning of what was being said.

Examples of 'heteronormative' latent level codes:

> *"But what I think is that, it's kindness that matters. Kindness between men and women." (F2)*

> *"If they are sexually active I don't see any problem with that, but I don't know if it's allowed. If there is such a thing as it being allowed. You know, because I don't know if all care homes are set up for male and female, you know, couples. (F5)*

> *"Sex and sexuality are two different words and two different meanings and they're nothing to do, well I suppose they are to do with each other, but not, they're related I suppose but it's not the main. I don't think of sexuality alongside sex between male and female, you know, sex relationships." (F7)*

Examples of 'heteronormative' manifest level codes:

> *"I can't separate myself out from being a gay man within a straight society." (M2)*

> *"Because I've been married, got a couple of kids, probably look a bit more feminine, people don't make any assumptions about me at all … but it also means that sometimes you do have to actually tell people [about sexual orientation] because they're making assumptions." (F4)*

> *"And that kind of pressure of knowing in every situation to some extent although most people will not be prejudiced of pejorative in any way there is this sense to be assumed to be heterosexual unless you say otherwise." (M2)*

"A man and a woman, yes, I mean that's the normal." (F2)

"But then you think, well, if you're a person of our age living in a small town or large village, we're never quite sure what it's called where they live, you perhaps wouldn't even consider doing anything other than marrying a person of the opposite sex when we did, we got married. It was so much more unusual." (F6)

"But I think that is still the group of people that are arriving in the care homes. I think they have always, the vast, vast majority of them will have conformed to a straight male or female orientation. I know that hasn't been going on inside them but society has forced that upon them." (F8)

In contrast, the sub-theme 'displacement' was predominantly constructed from latent level codes, where the data was interpreted as representing the ways in which participants were not directly able or willing to speak about their own sexuality. Some examples of data which was interpreted as being a parallel example described by the participant to talk about an aspect of sexuality indirectly have been provided below:

"I think being able to sit on a sofa beside someone you've got that physical contact much more. And erm. I mean like for example, well the dog comes and sits on the sofa beside me and I like that." (F1)

"I think it may have been in the States about a little boy who was raised as a girl by his mother and the courts have stepped in and said he isn't a little girl, he's a little boy. He's never

shown any interest in being a girl. You're dressing him as a girl and the father has stepped in and said 'This is ridiculous'. It's a separated couple. 'This is ridiculous. He is a little boy'. He is now in the father's care because the courts took him away from the mother and he's now a perfectly happy little boy doing boy things, and she would, you know, wanting to dress him as a fairy and in plaits and with jewels and pink and whatnot, and that seems to me what people are talking about when they're talking about sexuality." (F3)

4.2.7 Mixed Inductive/Deductive Analysis

A mixed inductive and deductive approach to analysis was taken. Pragmatists believe that "in order to fully analyse a phenomenon, it is vital and necessary to support an inductive approach with deductive thinking to enable it to tackle a real-world problem." (Ihuah & Eaton, 2014, p.940). The deductive approach of applying an a priori coding template as described by Crabtree and Miller (1999) was taken in order to establish an understanding of the definition of sexuality. Coding templates should be defined before an in-depth analysis of the data has taken place (Crabtree & Miller, 1999). The coding template developed for the deductive analysis was informed by the domains cited by the WHO as being pertinent to the definition of sexuality (an overview of this has been provided within Table 7). The judicious use of coding templates in qualitative research can allow researchers to capture important theoretical concepts or perspectives that have informed the design and aims of their study (Brooks, McCluskey, Turley & King, 2015). The use of a mixed inductive/deductive approach to analysis complimented the mixed inductive/deductive approach taken during the data collection phase to respond to the research aim of clarifying the use of the term 'sexuality' (see section

4.2.2 for further information regarding the approach to data collection).

Deductive analysis techniques have been criticised for their potential to misrepresent the data, as important information which does not match the pre-determined characteristics of the coding template may be filtered out (Blair, 2015). Using the WHO's definition to form the basis of the deductive coding template increased the risk that findings regarding participants' definitions of sexuality would echo the WHO's pre-specified domains. A number of strategies were used to minimise the risks of the deductive coding template restricting data analysis or misrepresenting participant views. The deductive coding template was only applied when considering participants' responses to the first research question regarding establishing a definition of sexuality. Once the coding template had been applied to evaluate the relevancy of the WHO's sexuality definition for participants, transcripts were subsequently re-coded in a data-driven inductive format, where emergent codes and themes were identified through a bottom-up process based upon transcript content. This dual inductive/deductive approach allowed for the consideration of the utility of the WHO's sexuality definition from an older adults' perspective, as well as the consideration of other emergent themes and perspectives which went beyond the WHO's position on the definition of sexuality. During analysis, equal attention was given to the content of each transcript to capture data relevant to the deductive coding template, as well as respect the breadth and depth of participant responses by using inductive analysis techniques. Deductive coding templates are intended to be tentative and any specified a priori themes may be redefined or removed if they prove ineffective at characterising the data (Brooks et al, 2015). By allowing the integration of inductively and deductively identified codes and themes, the emergent understanding

of the data was able to both evaluate the relevancy of the WHO's sexuality definition as well as capture the broader understanding of what the term 'sexuality' meant to participants. This approach reduced the risk that data would be misrepresented, as the identified a priori themes related to the WHO's sexuality definition could be redeveloped, recoded, and removed in light of the inductively obtained codes. To ensure analysis was data-driven, emergent codes and themes identified during analysis were supported by exerts from the raw data which increased rigor by directly linking interpretations with the words of the participants (Fereday & Muir-Cochrane, 2006). Whilst the deductive coding template may have introduced the potential for data to be interpreted in a restrictive manner and therefore solely reflect the views of the WHO (as opposed to enabling a credible account of participants' views), the semi-structured nature of the interview and the mixed inductive/deductive approach to analysis minimised the extent to which an understanding could be forced upon the data. Furthermore, the data obtained suggested that participants offered both areas of agreement and disagreement with the WHO's sexuality definition (see Table 7 for a summary). On this basis, it was concluded that the final thematic map and data obtained post-analysis went beyond replicating the deductive coding template and as accurately as possible depicted participants' views to represent the data set as a whole.

4.2.8 Developing Codes and Themes

A theme represents "some level of patterned response or meaning" within the data." (Braun & Clarke, 2006, p.10). Beyond this description, no formal guidance exists regarding what level of codes are needed to represent a theme (Javadi & Zarea, 2016). Whilst some may view this as a criticism of thematic analysis, Braun and

Clarke (2006) advise against using pre-determined rigid rules regarding what constitutes a theme and emphasise the role of judgement. To consider the emergent codes and themes, regular supervision was accessed to consider both the salience and prevalence of codes and themes across the data set as well as within each transcript. Good practice for thematic analysis suggests that the researcher should involve an outside reviewer during the initial stages of data analysis to evaluate any identified themes and assess their compatibility with the data set as a whole to ensure the reliability and validity of codes and themes (Alhojailan & Ibrahim, 2012). Involving the whole research team in the data analysis phase contributed to a more refined process of making sense of the data and it was these group reflections and discussions which determined the salience and relevance of codes and the constituents of each theme. This was in part achieved by reviewing themes for internal homogeneity and external heterogeneity. Internal homogeneity refers to codes having been amalgamated to represent themes in a meaningful way; external heterogeneity refers to the demonstration of clear and identifiable differences across individual themes (Trahan & Stewart, 2013). This process resulted in the streamlining of themes and sub-themes and the merging of data to prevent repetition or duplication of ideas. Evidencing the emergent codes and themes with extracts from across the transcripts was also a helpful way to minimise researcher bias and demonstrate the link between the original data and the interpretations made. An example of the coding process and its connection with emergent themes has been provided within Appendix I. While the information has been presented to demonstrate a linear process (e.g. codes development and then theme identification), as described in section 4.2.5, the analysis phases were undertaken interchangeably.

As the codes and themes were reviewed and refined, a number of reorganisations took place across the data. A summary of the ways in which some of the sub-themes were merged with other sub-themes or disbanded has been described in Appendix J. To demonstrate these changes visually, the final thematic maps each depicting participants' views on the definition of sexuality and the perceived impact of the care home on sexuality experiences have been presented against earlier versions (see Appendices K-O).

4.2.9 Quality Assurance

A number of considerations towards quality assurance were made during the course of the research process. There are no set guidelines regarding data quality for qualitative research (O'Reilly & Parker, 2012). However, Mays and Pope (1995) suggest there are two goals that should be achieved in ensure rigour in qualitative research: to create an account of method and data which can be replicated; and to produce a plausible and coherent explanation of the phenomenon under scrutiny. To respond to these goals, the 15-point checklist for 'good' thematic analysis (as described by Braun & Clarke, 2006) and Yardley's Evaluative Criteria for qualitative research (Yardley, 2000) were considered (see Table 4 and Table 5). Whilst it is considered good practice to invite participants to validate the data (Finlay, 2006), the adoption of a latent coding approach may have made it difficult for participants to recognise or agree with interpretations made, therefore it was decided not to involve them with data validation. In the absence of participant perspectives on the data analysis processes, regular research supervision with the co-authors was accessed to minimise the risk of potential biases or assumptions being applied to the data and facilitate the development of interpretations of the data which were outside of my subjective viewpoint.

Table 4. Yardley's (2000) Evaluative Criteria for qualitative research.

Essential characteristics	**Evidence**
Sensitivity to context	Relevant literature and empirical data was acknowledged. Participant demographics were reported on to acknowledge context. Ethical issues were considered.
Commitment and rigor	The process of thematic analysis was conducted using well-regarded guidelines which were clearly defined and replicable. Research supervision was accessed to reflect upon breadth/depth of analysis.
Transparency and coherence	Quotes were provided to illustrate themes and sub-themes. A reflexive approach was taken during the research process.
Impact and important	The findings represented an enriched understanding of the topic. A number of practical clinical implications for care services were identified.

Table 5. Braun and Clarke's (2006) 15-point checklist for 'good' thematic analysis.

Process	Criteria	Evidence
Transcription	Data transcribed appropriately and checked for accuracy	Data transcribed by a professional service; scripts checked for accuracy by the lead author
Coding	Data given equal attention in the coding process	The lead author reviewed the distribution of codes across each transcript
	Thorough, inclusive, and comprehensive coding process	Themes reviewed as the data developed and those generated from an anecdotal approach were excluded
	All relevant extracts for each theme collated	Computer software used to ensure inclusion of all codes within themes
	Themes checked against each other and with the original data set	Codes and themes developed through a reiterative process of checking and re-checking
	Themes internally coherent, consistent, and distinctive	Research supervision accessed to reflect upon coherency and consistency of themes
Analysis	Data analysed beyond paraphrase	Results and discussion combined to provide a balanced account of the data beyond description with illustrative quotes
	Analysis tells a convincing story	
	Balance between analytic narrative and illustrative extracts	
	Extracts illustrate the analytic claims	Quotes provided throughout
Overall	Time allocated equally to phases of the analysis	Timescale regularly reviewed during supervision
Written report	Approach to thematic analysis clearly explicated	The approach to thematic analysis has been expanded upon within section 4.2.5
	Method and analysis are consistent	
	The language of the report is consistent with epistemology	Report reviewed by co-authors for consistency
	The researcher positioned as active	The impact of the researcher was considered (see section 4.2.10)

4.2.10 Impact of the Researcher

Within thematic analysis the researcher is positioned as 'active' within the research process, as researchers acknowledge their inherent biases will unavoidably influence the interpretation of data (Braun & Clarke, 2006). The pragmatist approach also acknowledges that the values of the researcher can play a vital role when interpreting results using subjective and objective reasoning (Creswell & Plano Clark, 2011). To facilitate the identification of interpretational biases, the lead researcher maintained a reflective journal throughout the recruitment and analysis phases and accessed regular supervision. Transparency with processes enables others to challenge findings and to trace progression (Joffe, 2012); some examples of the content of the reflective journal which were noted to have informed the research process have been outlined below.

The first reflexive exercise undertaken was to consider my position with regards to understanding the concept of sexuality and identify underlying assumptions and beliefs. As a qualitative researcher interested in exploring views and experiences, rather than quantitative measures of behaviour, it was important to recognise my initial understanding of sexuality as a collection of concepts and ideas holding meaning which goes beyond behavioural accounts or observable behaviours. Furthermore, as a pragmatist, the explanation of sexuality as a broad yet individual construct was more persuasive in terms of interpreting the clinical utility of previous research. For example, previous findings have suggested links between mental and physical wellbeing and older adults' positive sexuality experiences. I found these conclusions difficult to make sense of against reports of the reduced levels of sexual activity amongst older adults unless the predefined categories of what constitutes 'sexual behaviour' could be challenged and sexuality

recognised as a much broader concept. It was important to identify my position regarding my personal definition of sexuality before pursuing interviews with participants in order to recognise the potential for participants to be influenced by my perspectives on how sexuality could or should be defined. The recognition of my expectations and values served to minimise the potential impact this may have had on the data interpretation as it enabled me to remain faithful to the voices of the participants and take a critical position against my own expectations of the data. The utilisation of a mixed inductive/deductive approach also restricted the potential impact of myself as the researcher. Using a framework from which to explore participant views helped maintain the focus of the interview, rather than the inadvertent perusal of questions which would seek to affirm my preconceptions about the definition of sexuality for older adults.

It is also recognised that emotional responses to participants can shape interpretations about their accounts (Mauthner & Doucet, 2003). One participant commented on their views about sexual orientation which were in direct opposition with my own beliefs. It was important to recognise this incompatibility to ensure the participant's viewpoint was fairly integrated with the data findings and maintain a balanced position in terms of representing the views of the participants regardless of the congruence of these with my position as a researcher.

4.3 Extended Results and Discussion

4.3.1 The Merging of Results and Discussion – A Rationale

Although it has been argued that is it not usually appropriate to present qualitative research in the conventional format of the scientific paper, with a rigid distinction between the results and discussion sections of the account (Mays & Pope, 1995), this

conventional layout has been used as a framework for the majority of published qualitative research. Our research findings resulted in the presentation of a range of themes which were separated across two related broad topics: defining sexuality; and the perceived impact of the care home on experiences. In order to provide a coherent account of the data and its position within current literature, the findings and discussion were integrated as it was deemed that this structure enabled the most accessible narrative to be provided.

4.3.2 Data Sufficiency Versus Saturation

Adequate sample sizes in qualitative research often relate to the concept of saturation, where data is sufficient so all themes are fully accounted for and no new themes emerge (Marshall, Cardon, Poddar, & Fortenot, 2013). However, critics argue that whilst data saturation is useful at a conceptualisation level, it is a guideline which is difficult to operationalise (Guest, 2006). There are no pragmatic guidelines regarding when data saturation has been achieved (Fusch & Ness, 2015). Furthermore, the concept of data saturation is often conflated with data completeness, where claims are made that no new data can be obtained (Nelson, 2016). This understanding of the term is problematic as it alludes to the potential requirement of an unending cyclic pattern of data collection and analysis to affirm whether any new understandings of the concept under investigation arise. With the limitations of data saturation in mind, the concept 'data sufficiency' (Dey, 1999) was applied in this research. Suri describes that "the logic of data sufficiency is guided by the synthesist's perception of what constitutes sufficient evidence for achieving the synthesis purpose." (2011, p.73). The notion of data sufficiency, rather than data saturation, was also congruent with the pragmatist position adopted for this research.

Thematic sufficiency was considered throughout the data analysis process and was concluded as having been achieved when agreed by the research team. This occurred after the initial seven transcripts had been coded. At this point the themes were no longer being revised on the basis of new information and a plausible and coherent understanding of the data had been developed. This is consistent with previous research that suggests meta-themes may be present as early as six interviews and a complete understanding of the data may be achieved by twelve interviews (Guest, 2006). A more detailed account of the prevalence of themes and sub-themes across the individual participant accounts has been provided within Table 6 and Table 8.

4.3.3 Defining Sexuality

Whilst codes were identified from both an inductive and deductive approach, the themes depicted to represent participants' definitions of sexuality were reflective of the data set as a whole. The frequency of the themes and sub-themes across individual participant accounts relating to the definition of sexuality has been outlined within Table 6. In this section, a more careful consideration of the utility of the WHO's working definition of sexuality has been provided.

The WHO state that "sexuality is a central aspect of being human throughout life and encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction." (2015, p.5). Comparing the themes identified from the data with the deductive framework constructed to represent the WHO's sexuality definition reveals a number of areas of agreement from participants. A summary of the areas where consensus was achieved and how this was represented across the themes described has been provided within Table 7.

Table 6. Defining sexuality - The prevalence of sub-themes coded across participant accounts.

		Participants									
Theme	**Sub-theme**	**M 1**	**M 2**	**F 1**	**F 2**	**F 3**	**F 4**	**F 5**	**F 6**	**F 7**	**F 8**
Exists in a society			x			x	x		x		x
Changeable	Relationship status	x	x	x	x	x	x	x	x	x	x
	Sexuality over time	x	x	x	x	x	x	x	x	x	x
	Individual	x	x	x	x	x	x	x	x		x
	Circumstantial		x			x		x	x	x	
Integral to self	Important		x	x	x	x	x	x	x	x	x
	Identity		x	x	x		x	x	x	x	x
	Being human		x	x	x			x			
Constructed with words	Displacement	x		x		x			x	x	
	Not sure	x		x		x		x			x
	Not a recognised word		x	x		x		x	x		x
	Not discussed or thought about	x		x			x	x	x	x	
Could be harmful		x	x		x	x	x	x	x		x
Sexual relationships	Sexual orientation	x	x	x	x	x	x	x	x	x	x
	Heteronormative		x	x	x		x	x	x	x	x
	Sex	x	x	x	x	x	x	x	x	x	x
	Attraction and desire	x	x	x	x		x		x		
Positive feelings	Love	x	x	x	x				x		
	Comfort and support	x	x	x	x	x	x	x	x	x	x
Demonstrating sexuality	Gender	x	x	x	x	x	x	x	x	x	x
	Touch	x	x	x	x	x	x	x	x	x	x
	Not sexual		x	x	x	x	x	x	x	x	x
	Appearance					x	x	x	x	x	x
	Being recognised		x	x			x	x	x	x	x
	Gender identity	x	x	x	x		x	x	x	x	x
	Intimacy	x	x	x	x	x	x	x	x	x	x

'x' indicates the sub-theme was coded in the participant's transcript.

Table 7. Comparing the WHO's working definition of 'sexuality' with participant responses.

The WHO's sexuality definition (2015, p.5)	Participant agreement?	Thematic representation
"Sexuality is a central aspect of being human throughout life;	✓	Integral to self
it encompasses sex, gender identities,	✓	Sexual relationships, Demonstrating sexuality
And [gender] roles,	X	
sexual orientation,	✓	Sexual relationships
eroticism, pleasure,	X	
intimacy,	✓	Demonstrating sexuality
and reproduction."	X	

A significant area of disagreement with the WHO was the concept of sexuality and gender roles:

> *"I don't know if [gender roles is] really on the subject of sexuality."* (F5)

This debate also exists across the literature, where some authors describe gender, gender-roles, and gender-identity as being separate from sexuality (for example, Burke, 1996); whereas other portrayals of sexuality include gender (for example, Herek, 1986). As one participant aptly describes:

> *"When you think of the abbreviation LGBT. LG and B are about sexuality. T is about gender."* (M2)

Participants generally agreed that gender roles had the potential to inform sexuality expression, but they were not viewed as being an

integral or important part of sexuality experience or described as a distinct concept. Indeed, in many accounts the topic of gender roles was introduced in line with the deductive framework and did not naturally occur within participants' descriptions of their definitions. Some examples have been presented below:

> *"Q: Do you think gender roles are relevant to a definition of sexuality?*
> *F7: No, no. Gender roles. What a man does, what a lady does. No, I can't see that it is, no."* (F7)

> *"Q: How about the concept of gender roles. Is that relevant to sexuality?*
> *F8: Well it shouldn't be, no. I think in a lot of households it is but I would rebel against that."* (F8)

One participant provided a different account, where they described the importance of gender roles within sexuality:

> *"I love it when I've got, a lovely charming young man stands up and offers me the tube, a seat on the tube, on the underground, because I just think that's how it should be … I love that kind of old-fashioned acknowledgement of gender, that is important to me, yes."* (F6)

The distancing of the concept of gender roles from the definition of sexuality may have been related to participants' interpretations of the term as relating to negative experiences. For example, a gay male participant associated gender roles with stereotypes and discrimination:

"So I think there is a difference between gender and sexuality but I think gender is, gender norms are the root of a lot of the stereotypes and the prejudices that we face." (M2)

Other participants viewed gender roles as being restrictive and leading to the assumed inability to be able to complete certain activities or the experience of being provided with fewer opportunities:

"My husband's mother thinks it's really quite strange that I would go to her house and change a plug and help her put the curtains up. She thinks that that's something that her son should be doing and not me, but if he's busy why shouldn't I do it? I can, so why wouldn't I?" (F3)

"She's more butch than I am, let's put it that way. Doesn't wear make-up and whatever, but she still likes to dress smartly … I've known her to be, not recently but in years gone by, to have been stopped by people when trying to go into the ladies loo saying you're going into the wrong loo." (F4)

"As I grew up I always believed in equality. That women and men should be treated equal, but that's slightly different from femininity isn't it? But there are certain things that, well, as I say, I've had to do like little repairs about the house and things like that that perhaps is not a thing that some women would want to do or enjoy doing but it's necessity sometimes." (F5)

The negative associations held against the nature of gender-roles by many participants may have been one explanation as to why this was not considered relevant when developing the construct of sexuality.

The topics of eroticism, pleasure, and reproduction as cited by the WHO as being components of sexuality were other areas of contention. As previously acknowledged, older adults are not within the range considered to be of reproductive age. However, research suggests that many older adults remain either interested in sex or are sexually active (Age UK, 2014). Interestingly, masturbation was not discussed by participants and only one participant spoke about sexual desire. The lack of salience of concepts such as eroticism and fantasy and the absence of masturbation amongst participant accounts may be congruent with earlier stipulations regarding ageing sexuality and the changed importance away from sexual intercourse and genital stimulation towards concepts such as intimacy. This hypothesis is consistent with our findings that whilst pleasure did not feature, participants did talk about a more general affective component to sexuality, represented by the theme 'positive feelings'. There were mixed accounts of the concept of reproduction across the data. For interpretation purposes, reproduction was referenced against the notion of family, a term which was more frequently used by participants. Many participants spoke about their relatives in the context of other aspects deemed to be part of sexuality experiences, such as giving a loved one a hug. However, uncertainty arose when considering whether family in itself was within participant's sexuality definition:

> *"I mean, it's not a sexual relationship with your family. So is it part of your sexuality, I don't really know."* (F1)

> *"Q: That contact that you have with family, do you see that as being relevant to sexuality?*
> *F2: Well it's all grown out of it hasn't it.*

Q: Okay. So is there something about family relationships that's relevant when you think about what sexuality means?
F2: Not really I suppose. Not really." (F2)

"Q: You're talking about family there. Does family fit in that definition of sexuality for you?
F5: I don't know the answer to that one. I don't really know where that would come in." (F5)

Due to the lack of agreement regarding whether family was a salient enough concept to be within the definition of sexuality, it was not included within the final thematic map.

4.3.4 The Perceived Impact of the Care Home on Sexuality

A number of associations between definitional and prognostic themes were identified across the cases by comparing the prevalence of sub-themes across individual participant accounts (see Table 6 and Table 8). Nine of the ten participants depicted sexuality as something which was important. In contrast, all participants anticipated that when becoming a resident of a care home their sexuality would no longer be as integral to themselves as represented within the sub-theme 'get over it and get on with it'. All ten participants also reported on the opportunities for expressing sexuality being different as a resident (sub-theme 'possibilities change') and the notion of becoming a patient instead of a person was identified across the data set. These observations are seemingly in conflict, as despite sexuality being important to individuals they predicted not being able to engage with their sexuality in the same way and this change being something which could be accommodated. The high prevalence of the sub-theme 'patients instead of people' suggests some association

Table 8. The perceived impact of the care home on sexuality - The prevalence of sub-themes across individual participant accounts.

		Participants									
Theme	**Sub-theme**	**M 1**	**M 2**	**F 1**	**F 2**	**F 3**	**F 4**	**F 5**	**F 6**	**F 7**	**F 8**
Negative feelings towards care homes		x	x	x	x	x	x	x	x	x	x
Changed relationships	Compromises			x	x	x	x	x			x
	You become 'one'	x	x	x	x	x	x	x	x		x
	Can't initiate	x	x	x		x	x	x			x
	Care home community	x	x	x	x	x	x	x	x	x	x
	Moderated by others	x	x	x	x	x	x	x	x	x	x
	I don't know what to do, I've got an audience		x	x	x	x	x	x	x	x	x
Impeding culture	Boundaries and rules		x	x		x	x	x		x	x
	Not part of the job	x		x	x			x	x		
	Environmental barriers		x	x	x	x	x	x	x	x	x
Loss of the sexual self	Necessary intimacy		x	x	x			x	x	x	
	Get over it and get on with it	x	x	x	x	x	x	x	x	x	x
	Patients instead of people	x	x	x	x	x	x	x	x	x	x
	Everything becomes past		x		x	x		x	x	x	x
	Possibilities change	x	x	x	x	x	x	x	x	x	x
	It's too private	x	x	x	x	x	x	x	x		
The sexual resident	Touch		x	x	x	x	x	x	x		x
	Sexuality still relevant	x	x	x	x	x	x	x	x	x	x
	Need it more	x	x	x				x	x		x
	Sex		x	x			x	x	x		x
	Togetherness	x	x	x	x	x	x	x	x		
Sexuality and care provision	Facilitate sexuality	x	x	x			x	x	x	x	x
	Ask questions	x	x	x	x	x	x	x	x	x	x
	Should be like home		x	x	x	x	x	x		x	x
	Can't prospective plan	x		x		x	x	x	x		
	Looking like me			x		x	x	x	x	x	x
	Agents of sexuality	x	x	x	x	x	x	x	x	x	x

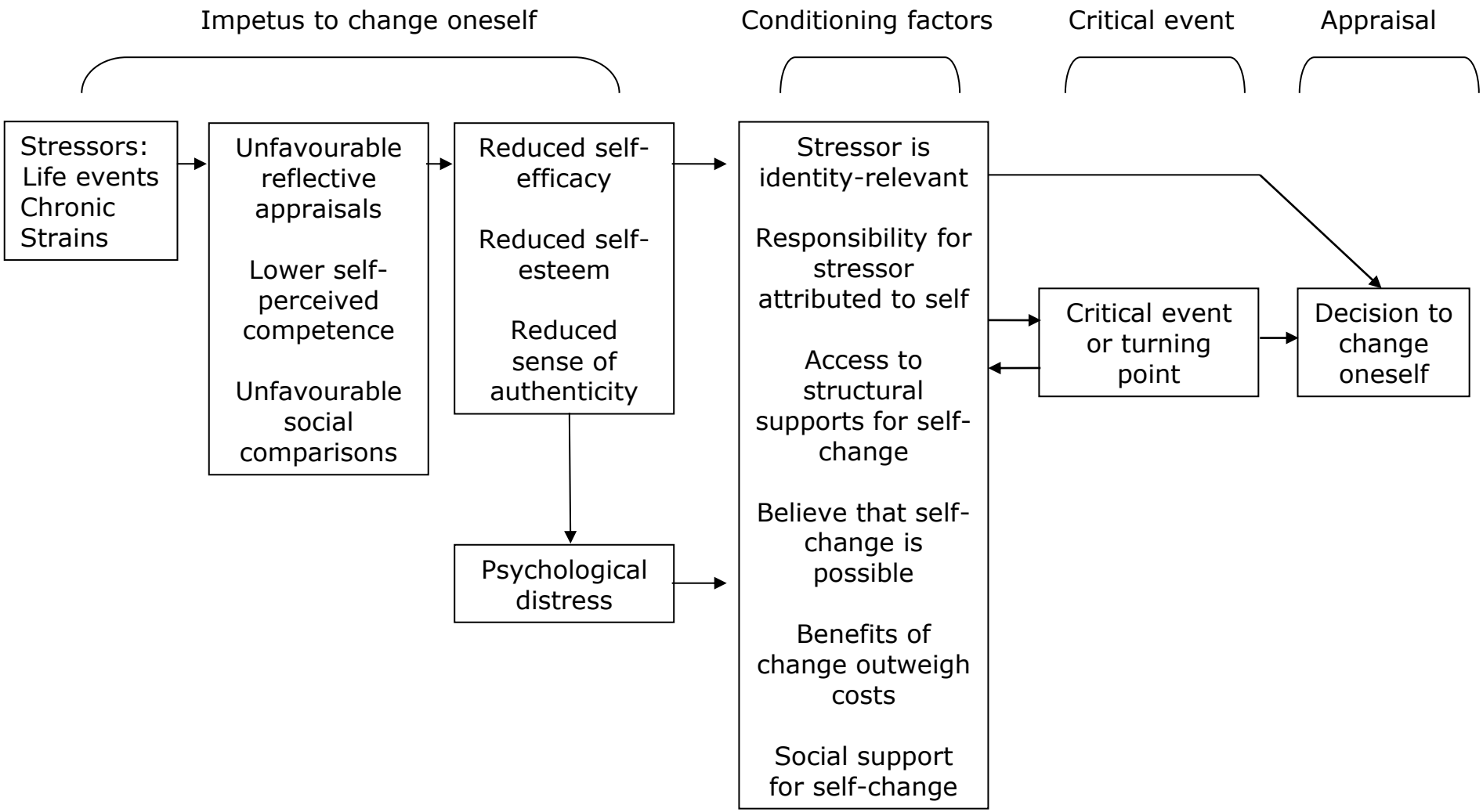
with roles and identity; a hypothesis which founded the consideration of self-identity theories when theoretically understanding the data (see section 4.3.5).

4.3.5 Kiecolt's Theory of Self-Identity and Stress

Whilst Kiecolt's theory of self-identity is arguably dated, it provides a useful theoretical account of self-identity with the specific consideration of stress. Participants consistently described that being a resident of a care home was an undesirable experience. They also reported that becoming a resident of a care home would prompt a number of negative changes with regards to how they felt they would be able to experience and express their sexuality. Roles were described as being an integral contributor to these changes, for example, by adopting the role of the patient (the following sub-themes are some examples where this belief was prevalent across the thematic map: patients instead of people; everything becomes past; and get over it and get on with it). In line with participants' reports of being in a care home as being a stressful change and the predicted change of self-identity and sexual identity associated with becoming a care home resident, it was deemed that Kiecolt's theory provided an appropriate framework from which to consider the findings of this research.

Kiecolt's (1994) theory of stress and self-identity supposes that the impetus to change oneself begins with a stressor. A diagrammatic representation of Kiecolt's theory has been provided within Figure 1. According to the model, change may occur depending on an individual's appraisal of the experienced stressor. Participants reported strongly wanting to avoid becoming a care home resident (represented by the theme 'negative feelings towards care homes'), demonstrating participants' negative appraisal of

Figure 1. Model illustrating the decision to change oneself (Kiecolt, 1994)



becoming a resident of a care home. The identified sub-themes 'possibilities change' and the 'care home community' represent the ways in which participants felt they would become less competent and may compare themselves unfavourably with the other residents. Kiecolt theorises that the combination of the stressor and the associated appraisals results in the individual experiencing reduced self-efficacy, reduced self-esteem and a reduced sense of authenticity. The inclusion of authenticity in Kiecolt's model refers to the extent to which an individual believes they are fulfilling their commitments to their core sense of self (Kiecolt, 1994).

According to the theory, the impetus to change oneself is not sufficient, and conditioning factors mediate whether the decision is made to alter self-identity or not. Within these conditioning factors, Kiecolt describes that the responsibility for the stressor must be attributed to the self. Our results indicated that for many participants, they anticipated having made an advance decision to have been in a care home to either receive necessary health care support or to alleviate the care burden for their home carers and loved ones, for example:

> *"I would hope that by the time I went into a care home [maintaining sexuality expression through a feminine appearance] didn't matter so much, or, as I said before, I had taken that decision and therefore the decision means that I have to care about [sexuality] less … So you would hope that you were able to reconcile the bits that you didn't like and weren't comfortable with because they didn't fit with you as a person with the validity of the decision you'd made to [be in a care home] in the first place."* (F3)

"I suppose it's all the different reasons people are going into a care home. You know, the, as I say, if it's their choice that they feel they are at the time of life that perhaps they'd be cared for better there than being in their own environment. They've made a conscious choice." (F5)

"I don't want to be a burden to my kids so if they were worried about me at home I might say, well I'll go into a home just so that they're not worried." (F7)

These accounts suggest that participants as residents would adopt responsibility for the decision to have subjected themselves to the stressor, which in this instance has been depicted as the transition into the care home. Other conditioning factors include the belief that self-change is possible and whether the benefits of change outweigh the costs. In participants' earlier definitions, sexuality was described as being individual and changeable, suggesting that sexuality could be seen as an aspect of self-identity that was fluid. The costs of maintaining the identity of the sexual self were reported on, for example:

"I think it's a good thing that you become institutionalised because I think it means you, you get used to what there is. Um, and if you're forever sad about what you're not having for a long time then that doesn't help. It doesn't help you settle, it doesn't help you be, you know, be content. If you're forever looking for your previous life." (F3)

Research suggests that individuals engage in relationships and maintain them as long as is profitable in terms of reward and cost balance (Sabatelli & Shehan, 1993). With consideration to sexuality,

participants described the expectation of being a single occupant as a care home resident, and the anticipation of relationships breakdowns, both with intimate relationships as well as with family and friends:

> *"I would miss the.. obviously being with my wife and seeing my children and grandchildren less regularly, which would almost certainly be the case."* (M1)

> *"It's unfortunate that most people going into care homes are going to be single. You get a few married couples I think go in, but mostly people go in as a single person, either having no partner, or having left a partner at home because they're not at a point in their lives where they need that kind of care."* (F4)

One participant described the losses associated with becoming a resident of a care home as being:

> *"A sort of living bereavement"* (F2)

Participants clearly predicted the benefits from becoming asexual as outweighing the costs, and likewise maintaining a sexual identity was associated with more costs than benefits. According to Kiecolt's model, this position increases an individual's vulnerability to take the decision to change an aspect of self-identity.

The final ingredient prior to the decision to change oneself has been described by Kiecolt as being the presence of a critical event or turning point. This event may be a minor event which follows a number of prior incidents or events, or a significant point where the person can no longer maintain their previous sense of self (Kiecolt, 1994). As our results were based upon predicted experiences, we can only speculate regarding how the critical event may present itself

for older adults transitioning into care homes. Through exploring the thematic map, there are a number of scenarios providing evidence of how the sexual self may be further nullified when becoming a care home resident. For example, the predicted necessity of requiring support for washing or dressing oneself was conflicted with the person being able or willing to view themselves as a sexual being. In this example, it may be the being intimately washed by a care staff member which represents the critical event whereby the resident is no longer able to acknowledge themselves as a sexual person. It may be the environmental barriers to expressing sexuality which prompt the resident to re-evaluate the usefulness of their sexual identity. Another critical incident may be the lack of opportunity to express sexuality which marks the turning point from sexual to non-sexual (e.g., due to a lack of privacy for masturbation, not having an available sexual partner, not being able to dress or apply make-up in the way that one might want, or not being able to display pornography in the room etc.)

Kiecolt's theory of self-identity and change offered an acceptable theoretical account from which to understand older adults' predicted change in self-identity from sexual to non-sexual when transitioning into a care home. However, the model is not without its limitations. One limitation of the model is that the empirical evidence cited by Kiecolt as underpinning the model was based on individuals with substance abuse or gambling problems. The basic premise of the model is that under stress, an individual can choose to change an aspect of their self-identity which is no longer beneficial, such as moving from 'drug-addict' to 'sober'. Participants described sexuality as being an integral and important aspect of their self-identity, and this was maintained when considering transitioning into a care home environment, evidenced by the theme 'the sexual resident'. This suggests that for participants, sexuality is a desired aspect of self-

identity but one which becomes neglected as a direct result of becoming a care home resident. The influence of the environment was a significant aspect of our findings, where participants predicted that the care home environment would significantly contribute to the loss of the sexual-self in multiple ways (evidenced through the themes 'impeding culture' and 'loss of the sexual self'). However, Kiecolt's model describes processes which are largely internal cognitive processes, rather than those which relate to external pressures. The de-emphasis on the role of environmental factors within the model limits the extent to which Kiecolt's theory fully accounts for the predicted change in sexual identity when becoming a care home resident. A final noted limitation of the model is the lack of clarity regarding a number of Kiecolt's model components. For example, the 'critical event' can represent both a significant or minor occurrence, which questions the integrity of the discrete components of the model. Furthermore, the inclusion of constructs which could arguably be interpreted to represent any aspect of human experience subjects Kiecolt's model to the criticisms that a theory which attempts to account for everything, accounts for nothing.

While Kiecolt's model of self-identity and stress offers some theoretical understanding regarding the self-identity change of older adults when becoming a resident of a care home, Kiecolt (1994) positions this change as being active, or intentional. However, it is not clear from our results whether participants predicted to want or need to change themselves, or whether this was an indirect consequence of the impact of the environment. For example, some participants described the process of institutionalisation and conforming to the expectations of the care home and this contributing to the loss of the sexual self:

> *"As I get older if I'm in a home there is that institutionalisation that happens as you are in there"* (M2)

> *"I think you also become institutionalised in a care home. You become used to whatever is there fairly quickly*." (F3)

For other participants, the predicted lack of control and choice which they thought would result from becoming a care home resident was a contributing factor to not being able to engage with their sexuality in the same way that they may have been able to before:

> *"Somebody else is running my life rather than me. I'm not in charge. I'm not doing what I want to do. I'm fitting in with the ethos of the home which is obviously from a management point of view is much better, but from my point of view it would be fitting in rather than perhaps what I would like to do."* (F7)

Kiecolt attempts to distinguish between deliberately sought self-change and self-change which is later rationalised by differentiating between prospective and retrospective accounts of self-change (Kiecolt, 1994). Participants were asked to consider prospective planning and consider situations that were potentially outside of their lived experiences. Therefore, we could hypothesise that the change in self-identity anticipated by participants could be deemed to represent intentional change, however the question of whether the predicted self-change is prompted from within the individual (internally driven) or as a result of the environment (externally driven) remains unanswered. This lack of clarity regarding the change agent limits the extent to which Kiecolt's theory can fully account for the research findings.

4.3.6 Clinical Implications

In this study participants were asked to consider future experiences. The association between a person's expectations and their interpretation of reality has been well documented across the literature. This link is often referred to as the 'placebo effect' (Sabatelli & Shehan, 1993). Therefore, participants' expectations for the future will likely inform or influence lived experiences. With this in mind, it will be important to consider how the perceived negative impact on sexuality experiences from becoming a resident of a care home can be addressed. The Social Care Institute for Excellence (2009) advocate implementing person- and relationship-centred care in care homes, promoting individual identity and independence as a key to wellbeing. Our findings acknowledged some of the anticipated threats posed to older adults' self-identity and sexuality by care home environments, and these understandings have the potential to practically inform how to provide person-centred care.

Across the data there were a number of implicit and explicit recommendations made regarding how services could acknowledge and facilitate residents' sexuality in care homes. A summary of these implications for practice has been provided within Table 9. Whilst these recommendations have been collated on the basis of participant responses and the developed thematic maps, they have also been considered theoretically in light of Kiecolt's (1994) model of stress and self-identity. This model was previously cited to provide an account of how older adults may adopt the identity of the sexless resident when transitioning into a care home (see section 4.3.5).

Kiecolt's (1994) model describes a number of mediating factors said to influence whether someone will change their self-identity. Participants anticipated experiencing a shift in sexual self-identity when transitioning into a care home, from a sexual person to that of the sexless older resident. Therefore, we might hypothesise that to

Table 9. A summary of recommendations for care home services.

Care aspect	Recommendations
Care home policies and protocols	- Include sexuality in service information, e.g. ask about sexuality during information gathering procedures with residents - Develop sexuality specific care plans for residents - Ensure sexuality is cited within the policies and guidelines which underpin clinical practice
Staff and care provision	- Ask residents questions about sexuality - Establish what is appropriate touch for residents - Acknowledge residents' losses - Consider residents' partners and how they would like to maintain these relationships - Appropriately facilitate contact between residents - Ask about problems with sexuality/sexual function - Explore which aspects of sexuality are important for each resident - Be mindful of assumptions made about sexuality based on age or relationship status - Provide activities which enable residents and their visitors to spend time together - Provide resources for positive sexuality experiences, e.g. lipstick, pornography etc. - Keep the person as the person, e.g. call them by their preferred name, dress them in their clothes - Facilitate contact between the resident and their loved ones, e.g internet access, video calls etc. - Enable residents' visitors to share in vehicles that facilitate intimacy, such as sharing a meal
Environmental factors	- Allow privacy (e.g. close bedroom doors) - Allow opportunities for residents to either be included or separate from others - Consider the furniture and space; provide a mix of communal and private spaces, single armchairs and larger sofas, single and double beds etc. - Present the care home as a non-clinical space - Present material which acknowledges non-heterosexual orientations (e.g. LGBT posters/leaflets, LGBT film nights, representatives from LGBT communities coming into the care home for events etc)

protect and preserve older adults' sexual identities as care home residents, the mediating factors as outlined by Kiecolt (1994) ought to be addressed, and a number of the recommendations specified attempt to target these. For example, a significant component of the theoretical understanding of the anticipated changes in sexuality experiences for older residents was what Kiecolt (1994) labelled as the unfavourable reflective appraisals in relation to a stressor. All participants described the prospect of moving to a care home as aversive and the care home environment as being inconducive to positive sexuality experiences. The above recommendations which involve care homes publicising that sexuality is on their agenda (for example, by sexuality being referred to in care homes' service information, LGBT posters being on display, and double occupancy rooms being available) will be helpful to initiate positive change as the expectation that care homes will fail to acknowledge residents' sexuality can begin to be challenged. Kiecolt (1994) also described factors including reduced self-efficacy, reduced self-esteem, and reduced sense of authenticity as increasing the likelihood of self-identity being altered. Participants to this study anticipated that as a care home resident they would be less able to initiate or maintain intimate relationships and would lose their individual identities in place of becoming a 'patient' or 'resident'. Therefore, to minimise the impact of these factors, care home services should seek to continue to uphold the sexual identities of their residents by promoting positive self-esteem, self-efficacy, and the sense of authenticity in relation to resident's individual sexualities. The cited recommendations which correlate with these suggestions include the instruction for care staff to explore which aspects of sexuality are important for each resident, provide resources for positive sexuality experiences, e.g. lipstick, pornography etc, and keeping the person

as the person, e.g. call them by their preferred name, dress them in their clothes.

The relationship between potential residents' expectations of care homes, and subsequent care experiences could also be understood in relation to the Pygmalion effect; the cyclic pattern of how our expectations of others informs their beliefs and subsequent expectations of us, which in turn shapes our beliefs about ourselves and in turn our expectations of how others will treat us (Jussim & Harber, 2005). Therefore, to allow for positive change in terms of providing care to residents which acknowledges sexuality, there may need to be targeted change towards both services and potential service-users to build a culture where residents expect to be recognised as sexual beings, and care home services expect residents to present with sexuality needs. Whilst a number of the practical recommendations described in Table 9 help target some of the anticipated ways that new residents to care homes might shut down in relation to their sexuality, Clinical Psychologists may be able to offer additional support to enable positive change to become embedded within the culture of care services themselves.

The standards of proficiency for psychologists emphasise the need for professionals to understand the impact of sexuality on psychological wellbeing and behaviour (Health and Care Professions Council, 2012). The role of the Clinical Psychologist within care homes is often to work indirectly, contributing to individualised service planning and providing consultation and training to care teams to share psychological knowledge, principles, and interventions (The British Psychological Society, 2007; 2009). Knowledge gained from this study can contribute towards the psychologists' ability to develop an enriched understanding of sexuality in later life and the impact of the care home environment on sexuality experiences to provide informed consultation regarding psychological aspects of care

drawing upon evidence from a first-person perspective. The possible role of the Clinical Psychologist may involve providing support with training and supervision for care staff to increase their confidence in talking to residents about sexuality, or evaluating care-planning tools and advance decision making documentation to ensure relevant aspects pertaining to older adults' sexuality are appropriately considered. However, as our findings were based upon anticipated experiences, caution should be given before making assumptions or generalisations regarding the current practices of residential care services in relation to residents' sexuality. Therefore, consideration would need to be given to each care service on an individual basis before specific recommendations could be detailed in terms of what role the Clinical Psychologist might be able to take to support with the promotion of positive sexuality experiences for older care home residents.

4.4 Critical Reflections

4.4.1 Project Development

During the early stages of the project development, this research intended to explore the experiences of residents rather than those of a community based sample from a prospective planning approach. However, there were a number of noted challenges and limitations with this original study concept, including difficulties with participant recruitment and the questionable utility of the study findings. The problems associated with this earlier design were reviewed and discussed within research supervision and the study was amended and developed in response to these challenges to both increase the research impact and enable the project to be completed within the confines of doctoral level research. Adapting the project design was

challenging as it required the reconsideration of what was achievable and the requirement to reconceptualise the project in a way which was consistent with my values and beliefs as a researcher. However, I believe overcoming the challenges associated with earlier versions of this project fundamentally resulted in a more robust research study with the potential to meaningfully contribute to understandings of older adults' sexuality and care home services in a way which went beyond the scope of previous versions of the project. I believe my experiences of adopting a critical stance in relation to evaluating the progress of the research and considering its utility as a project also furthered my skills as a scientist-practitioner.

4.4.2 Theoretical Accounts of Older Adults' Sexuality

Sexuality is a poorly defined concept and across the literature there is much uncertainty regarding the parameters of the topic. Even less is understood about older adults' sexuality and the impact of the environment on experiences. As a consequence, existing research on sexuality either fails to provide any theoretical account or researchers modify disciplinary theories to include sexuality (Goettsch, 1989). Our research was not immune from this theoretical uncertainty, as it was difficult to develop a theoretical account of the study findings in a manner which felt fully applicable to the topic. The majority of theoretical accounts on sexuality understand the concept as relating to physical sexuality and coital relationships, resulting in a saturation of neurological, biological, and evolutionary perspectives on older adults' sexuality which conclude that older adults represent a non-sexual population. Whilst these theoretical accounts offer some useful understandings, they are limited in their application when understanding sexuality as a construct which cannot be reduced to observable or biological processes. These theories are also

incongruent with qualitative literature (and our research findings) which indicate sexuality remains an integral and influential component of older adults' self-identity regardless of sexual practices. Whilst our findings clearly inform practice from a clinical perspective, theoretical understandings of older adults' sexuality and the environmental impact on sexual experiences remain anecdotal and under developed, and this remains a significant weakness of modern sexuality research.

4.5 References

Age UK. (2014). *Later life in the United Kingdom.* Retrieved from http://www.ageuk.org.uk/Documents/EN-GB/Factsheets/Later_Life_UK_factsheet.pdf?dtrk=true

Alhojailan, M. I., & Ibrahim, M. (2012). Thematic analysis: A critical review of its process and evaluation. *West East Journal of Social Sciences*, *1*(1), 39–47. http://doi.org/10.1177/1525822X02239569

Alshenqeeti, H. (2014). Interviewing as a data collection method: A critical review. *English Linguistics Research, 3*(1), 39-45.

Ayaz, S. (2012). Sexuality and nursing process: A literature review. *Sexuality and Disability*, *31*(1), 3–12.

Barnard, A. (2009). Lesbians' constructions of depression. *Health Care for Women International*, *30*(5), 373–389.

Barnett-Page, E., & Thomas, J. (2009). Methods for the synthesis of qualitative research: a critical review. *ESRC National Centre for Research Methods*, *9*, 1–26. http://doi.org/10.1186/1471-2288-9-59

Bauer, M., Fetherstonhaugh, D., Tarzia, L., Nay, R., & Beattie, E. (2014). Supporting residents' expression of sexuality: the initial construction of a sexuality assessment tool for residential aged care facilities. *BMC Geriatrics*, *14*(1), 82. http://doi.org/10.1186/1471-2318-14-82

Bauer, M., Fetherstonhaugh, D., Tarzia, L., Nay, R., Wellman, D., & Beattie, E. (2012). "I always look under the bed for a man".

Needs and barriers to the expression of sexuality in residential aged care: the views of residents with and without dementia. *Psychology and Sexuality*, *4*(3), 1–14. http://doi.org/10.1080/19419899.2012.713869

Biernacki, P., & Waldorf, D. (1981). Sampling: Problems and techniques of chain referral sampling. *Sociological Methods & Research*, *10*(2), 141–163.

Blair, E. (2015). A reflexive exploration of two qualitative data coding techniques. *Journal of Methods and Measurement in the Social Sciences, 6*(1), 14-29.

Bouman, W. P., Arcelus, J., & Benbow, S. M. (2006). Nottingham study of sexuality & ageing (NoSSA I). Attitudes regarding sexuality and older people: a review of the literature. *Sexual and Relationship Therapy*, *21*(2), 149–161.

Bowen, R. L., & Atwood, C. S. (2004). Living and dying for sex. A theory of aging based on the modulation of cell cycle signaling by reproductive hormones. *Gerontology*, *50*(5), 265–290.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*(2), 77–101.

Braun, V., & Clarke, V. (2014). What can "thematic analysis" offer health and wellbeing researchers? *International Journal of Qualitative Studies on Health and Well-Being*, *9*(26152). http://doi.org/10.3402/qhw.v9.26152

Briddock, A. (2014). The recognition of refugees based on sexual orientation and gender identity in the UK: An overview of law and procedure. *Birkbeck Law Review*, *4*(1), 123–157.

http://doi.org/10.1525/sp.2007.54.1.23.

British Geriatrics Society. (2011). *Quest for Quality. An Inquiry into the Quality of Healthcare Support for Older People in Care Homes: A Call for Leadership, Partnership and Improvement.* London: Author.

Brooks, J., McCluskey, S., Turley, E. & King, N. (2015). The utility of template analysis in qualitative psychology research. *Qualitative Research in Psychology, 12*(2), 202-222.

Buffington, R. M., Luibhéid, E., & Guy, D. J. (2013). *A global history of sexuality: The modern era*. Oxford: Wiley-Blackwell.

Burke, P. (1996). Gender shock: Exploding the myths of male and female. New York, NY: Anchor Books/Doubleday.

Bullough, V. L. (1998). Alfred Kinsey and the Kinsey Report: Historical overview and lasting contributions. *The Journal of Sex Research*, *35*(2), 127–131.

Burri, A., Spector, T., & Rahman, Q. (2012). The etiological relationship between anxiety sensitivity, sexual distress, and female sexual dysfunction is partly genetically moderated. *The Journal of Sexual Medicine*, *9*(7), 1887–1896.

Crabtree, B., & Miller, W. (1999). A template approach to text analysis: Developing and using codebooks. In B. Crabtree & W. Miller (Eds.), *Doing qualitative research* (pp. 163–177). Newbury Park, CA: Sage.

Creswell, J. W., & Plano Clark, V. L. (2011). *Designing and conducting mixed methods research* (2nd ed.). California, CA: Sage

Publications.

Crooks, R. L. & Baur, K. (2010). Our Sexuality. Belmont, CA: Wadsworth, Cengage Learning.

D'Augelli, A. R. & Grossman, A. H. (2001). Disclosure of sexual orientation, victimization, and mental health amongst lesbian, gay, and bisexual older adults. *Journal of Interpersonal Violence, 16*(10), 1008-1027.

Darlaston-Jones, D. (2007). Making connections : The relationship between epistemology and research methods. *The Australian Community Psychologist*, *19*(1), 19–27.

Dey, I. (1999). *Grounding grounded theory*. San Diego, CA: Academic Press.

Drench, M. E., & Losee, R. H. (1996). Sexuality and sexual capacities of elderly people. *Rehabilitation Nursing*, *21*(3), 118–123.

Elias, J. & Ryan, A. (2011). A review and commentary on the factors that influence expressions of sexuality by older people in care homes. *Journal of Clinical Nursing, 20*(11-12), 1668-1676.

Elliot, R., Fischer, C. T. & Rennie, D. L. (1999). Evolving guidelines for publication of qualitative research studies in psychology and related fields. *British Journal of Clinical Psychology*, *38*, 215-229.

Fereday, J., & Muir-Cochrane, E. (2006). Demonstrating rigor using thematic analysis: A hybrid approach of inductive and deductive coding and theme development. *International Journal of Qualitative Methods*, *5*(1), 80–92. http://doi.org/10.1063/1.2011295

Finlay, L. (2006). "Rigour", "ethical integrity" or "artistry"? Reflexively reviewing criteria for evaluating qualitative research. *British Journal of Occupational Therapy*, *69*(7), 319–326.

Foucault, M. (1978). *The History of Sexuality, Volume 1: An Introduction*. New York, NY: Pantheon. http://doi.org/10.2307/1904618

Frith, H. (2000). Focusing on sex: Using focus groups in sex research. *Sexualities, 3*(3), 275-297.

Fusch, P. I., & Ness, L. R. (2015). Are we there yet? Data saturation in qualitative research. *The Qualitative Report*, *20*(9), 1408–1416. http://doi.org/1, 1408-1416

Gagnon, J. H., & Simon, W. (1973). *Sexual Conduct: The Social Sources of Human Sexuality*. London: Transaction Publishers.

Galinsky, A. M., McClintock, M. K., & Waite, L. J. (2014). Sexuality and physical contact in national social life, health, and aging project wave 2. *Journals of Gerontology - Series B: Psychological Sciences and Social Sciences*, *69*(8), S83–S98. http://doi.org/10.1093/geronb/gbu072

Garrett, D. (2014). Intimacy for older people. *British Journal of Nursing*, *23*(6), 327–332.

Goettsch, S. (1989). Clarifying basic concepts: Conceptualising sexuality. *The Journal of Sex Research, 26*(2). 249-255.

Guest, G. (2006). How Many Interviews Are Enough?: An Experiment with Data Saturation and Variability. *Field Methods*, *18*(1), 59–82.

Health and Care Professions Council. (2012). *Practitioner*

psychologists - Standards of proficiency. Retrieved from http://www.hpc-uk.org/assets/documents/10002963SOP_Practitioner_psychologists.pdf

Heath, H., & White, I. (2002). *The challenge of sexuality in health care*. London: Blackwell Science Ltd.

Herek, G. M. (1986). On heterosexual masculinity. Some psychical consequences of the social construction of gender and sexuality. *American Behavioral Scientist, 29*(5), 563-577.

Hogan, R. (1982). Influences of culture on sexuality. *The Nursing Clinics of North America, 17*(3), 365-376.

Huang, Y.-P., Chen, B., Ping, P., Wang, H.-X., Hu, K., Yang, H., … Huang, Y.-R. (2014). Asexuality development among middle aged and older men. *PloS One*, *9*(3), e92794. http://doi.org/10.1371/journal.pone.0092794

Ihuah, P. W., & Eaton, D. (2013). The pragmatic approach: A framework for sustainable management of public housing estates in Nigeria. *Journal of US-China Public Administration*, *10*(10), 933–944.

Institute for Public Policy Research (2008). *Older people and wellbeing*. Retrieved from http://www.ippr.org/files/images/media/files/publication/2011/05/older_people_and_wellbeing_1651.pdf?noredirect=1

James, N., & Busher, H. (2009). *Online Interviewing*. London: Sage Publications.

Javadi, M., & Zarea, K. (2016). Understanding thematic analysis and its pitfall. *Journal of Client Care*, *1*(1), 34–40. http://doi.org/10.15412/J.JCC.02010107

Joffe, H. (2012). Thematic Analysis. In D. Harper & A. R. Thompson (Eds.), *Qualitative Research Methods in Mental Health and Psychotherapy*. Chichester: John Wiley & Sons, Ltd.

Jootun, D., McGhee, G., Marland, G. (2009). Reflexivity: promoting rigour in qualitative research. *Nursing Standard, 23*(23), 42-46.

Jussim, L. & Harber, K. D. (2005). Teacher expectations and self-fulfilling prophecies: Knowns and unknowns, resolved and unresolved controversies. Personality and Social Psychology Review*, 9*(2), 131–155.

Kane, R.A., Kling, K.C., Bershadsky, B., Kane, R.L., Giles, K., Degenholtz, H.B., Liu, J., & Cutler, L.J. (2003). Quality of life measures for nursing home residents. *The Journals of Gerontology. Series A, Biological Science and Medical Sciences, 58*(3), 240-248.

Kenny, R. T. (2013). A review of the literature on sexual development of older adults in relation to the asexual sterotype of older adults. *Canadian Journal of Family and Youth*, *5*(1), 91–106.

Kiecolt, K. J. (1994). Stress and the decision to change oneself: A theoretical model. *Social Psychology Quarterly*, *57*(1), 49–63.

Kinsey, A. C., Pomeroy, W. B., & Martin, C. E. (1948). *Sexual Behavior in the Human Male*. London: W.B. Saunders Company.

Kinsey, A. C., Pomeroy, W. B., Martin, C. E., & Gebhard, P. H.

(1953). *Sexual Behavior in the Human Female*. London: W.B. Saunders Company.

Langer, N. (2009). Late Life Love and Intimacy. *Educational Gerontology*, *35*(8), 752–764.

Laws, J. L., & Schwartz, P. (1977). *Sexual Scripts: The social construction of female sexuality*. Hinsdale, IL: Dryden.

Lemieux, L., Kaiser, S., Pereira, J., & Meadows, L. M. (2004). Sexuality in palliative care: patient perspectives. Palliative Medicine, 18(7), 630–637.

Lindau, S. T., Tang, H., Gomero, A., Vable, A., Huang, E. S., Drum, M. L., … Chin, M. H. (2010). Sexuality among middle-aged and older adults with diagnosed and undiagnosed diabetes: a national, population-based study. *Diabetes Care*, *33*(10), 2202–2210. http://doi.org/dc10-0524 [pii]\r10.2337/dc10-0524

Marshall, B., Cardon, P., Poddar, A., & Fortenot, R. (2013). Does sample size matter in qualitative research?: A review of qualitative interviews in IS research. *Journal of Computer Information Systems*, *54*(1), 11–22.

Mauthner, N. S., & Doucet, A. (2003). Reflexive accounts and accounts of reflexivity in qualitative data analysis. *Sociology*, *37*(3), 413–431. http://doi.org/10.1177/00380385030373002

Mayers, K. S., Heller, D. K., & Heller, J. A. (2003). Damaged sexual self-esteem: A kind of disability. *Sexuality and Disability*, *21*(4), 269–282.

Mays, N., & Pope, C. (1995). Rigour and qualitative research. *British*

Medical Journal, *311*(6998), 182–184. http://doi.org/http://dx.doi.org/10.1136/bmj.311.6997.109

Mehra, A., Kilduff, M. & Brass, D. J. (1998). At the margins: A distinctiveness approach to the social identity and social networks of underrepresented groups. *Academy of Management, 41*(4), 441-452.

Merriam, S. B., Tisdell, E. J. (2015). *Qualitative Research (Fourth Edition)*. San Francisco, CA; Jossey-Bass.

Nelson, J. (2016). Using conceptual depth criteria: addressing the challenge of reaching saturation in qualitative research. *Qualitative Research*. http://doi.org/10.1177/1468794116679873

National Institute for Health and Care Excellence. (2013). *Mental wellbeing of older people in care homes.* Retrieved from http://publications.nice.org.uk/mental-wellbeing-of-older-people-in-care-homes-qs50#close

National Institute for Health and Care Excellence. (2015). *Older people in care homes.* Retrieved from https://www.nice.org.uk/advice/lgb25/chapter/Introduction

Office for National Statistics. (2011). *2011 Census analysis: Ethnicity and religion of the non-UK born population in England and Wales.* Retrieved from https://www.ons.gov.uk/peoplepopulationandcommunity/culturalidentity/ethnicity/articles/2011censusanalysisethnicityandreligionofthenonukbornpopulationinenglandandwales/2015-06-18

Office for National Statistics. (2016). *Sexual identity, UK: 2015.* Retrieved from

https://www.ons.gov.uk/peoplepopulationandcommunity/culturalidentity/sexuality/bulletins/sexualidentityuk/2015

O'Reilly, M., & Parker, N. (2012). "Unsatisfactory saturation": a critical exploration of the notion of saturated sample sizes in qualitative research. *Qualitative Research*, *13*(2), 190–197.

Pasko, L. (2010). Damaged daughters: The history of girls' sexuality and the juvenile justice system. *The Journal of Criminal Law and Criminology*, *100*(3), 1099–1131.

Potter, J. & Hepburn, A. (2005). Qualitative interviews in psychology: problems and possibilities. *Qualitative Research in Psychology, 2*, 281-307.

Redelman, M. J. (2008). Is there a place for sexuality in the holistic care of patients in the palliative care phase of life? *The American Journal of Hospice & Palliative Care*, *25*(5), 366–371. http://doi.org/10.1177/1049909108318569

Rheaume, C., & Mitty, E. (2008). Sexuality and intimacy in older adults. *Geriatric Nursing*, *29*(5), 342–349.

Rorty, R. (1982). *Consequences of pragmatism: Essays, 1972-1980*. Minneapolis, MN: University of Minnesota Press.

Sabatelli, R. M., & Shehan, S. L. (1993). Exchange and resource theories. In P. G. Boss, W. J. Doherty, R. LaRossa, W. R. Shumm, & S. K. Steinmetz (Eds.), *Sourcebook of Famiy Theories and Methods: A Contextual Approach*. New York, NY: Plenum Press.

Sander, R. (2007). Sex in the golden years. *Nursing Older People*, *19*(2), 38.

Saunders, M., Lewis, P., & Thornhill, A. (2009). *Research methods for business students (4th Edition)*. Essex: Person Education Limited.

Scocco, P., Rapattoni, M., & Fantoni, G. (2006). Nursing home institutionalization: a source of eustress or distress for the elderly. *International Journal of Geriatric Psychiatry, 21*(3), 281-287.

Shaw, S., & Bailey, J. (2009). Discourse analysis: What is it and why is it relevant to family practice? *Family Practice*, *26*(5), 413–419. http://doi.org/10.1093/fampra/cmp038

Sit, V., & Ricciardelli, R. (2013). Constructing and performing sexualities in the penitentiaries: Attitudes and behaviors among male rrisoners. *Criminal Justice Review*, *38*(3), 335–353. http://doi.org/10.1177/0734016813491965

Social Care Institute for Excellence. (2009). *Personalisation briefing: Implications for residential care homes.* Retrieved from http://www.scie.org.uk/publications/ataglance/ataglance17.asp

Spitzer, R. L. (1981). The diagnostic status of homosexuality in DSM-III: a reformulation of the issues. *The American Journal of Psychiatry, 138*(2), 210-215.

Stevenson, C. (2010). Talking about sex. In C. Butler, A. O'Donovan, & E. Shaw (Eds.), *Sex, Sexuality and Therapeutic Practice* (pp. 31–54). Hove: Routledge.

Sullivan, P. S., Khosropour, C. M., Luisi, N., Amsden, M., Coggia, T., Wingood, G. M. & DiClemente, R. J. (2011). Bias in online recruitment and retention of racial and ethnic minority men who have sex with men. *Journal of Medical Internet Research*,

13(2):e38. doi:10.2196/jmir.1797.

Suri, H. (2011). Purposeful sampling in qualitative research synthesis. *Qualitative Research Journal*, *11*(2), 63–75. http://doi.org/10.3316/QRJ1102063

Tashakkori, A., & Teddlie, C. (1998). *Mixed methodology: Combining qualitative and quantative approaches*. London: Sage Publications.

The British Psychological Society. (2007). *New ways of working for applied psychologists in health and social care.* Retrieved from http://web.archive.org/web/20081203202853/http://www.nimhe.csip.org.uk/silo/files/progressreportpdfapril2007.pdf

The British Psychological Society. (2009). *Psychological health and well-being: A new ethos for mental health.* Retrieved from http://www.bps.org.uk/sites/default/files/images/psychological_health_and_well-being_-_a_new_ethos_for_mental_health.pdf

The British Psychological Society. (2013). Ethics Guidelines for Internet-mediated Research. Leicester: Author.

The My Home Life. (2012). *Promoting Quality of Life in Care Homes.* York: Joseph Rowntree Foundation.

Tongco, M. D. C. (2007). Purposive sampling as a tool for informant selection. *Ethnobotany Research and Applications*, *5*, 147–158. http://doi.org/http://hdl.handle.net/10125/227

Trahan, A., & Stewart, D. M. (2013). Toward a pragmatic framework for mixed-methods research in criminal justice and criminology. *Applied Psychology in Criminal Justice*, *9*(1), 59–74. Retrieved

from http://dev.cjcenter.org/_files/apcj/apcjspring2013trahan.pdf_1368481261.pdf

Travis, S. S. (1987). Older adults' sexuality and remarriage. Journal of Gerontological Nursing, 13(6), 8–9.

Vaismoradi, M., Turunen, H., & Bondas, T. (2013). Content analysis and thematic analysis: Implications for conducting a qualitative descriptive study. *Nursing and Health Sciences*, *15*(3), 398–405. http://doi.org/10.1111/nhs.12048

Villanueva, M. I. M. (1997). *The Social Construction of Sexuality: Personal Meanings, Perceptions of Sexual Experience, and Females' Sexuality in Puerto Rico*. Virginia, VA: Virginia Polytechnic Institute and State University.

Walz, T. (2002). Crones, dirty old men, sexy seniors: Representations of the sexuality of older persons. *Journal of Aging and Identity*, *7*(2), 99–112.

Ward, D. J., Furber, C., Tierney, S., & Swallow, V. (2013). Using Framework Analysis in nursing research: A worked example. *Journal of Advanced Nursing*, *69*(2000), 2423–2431. http://doi.org/10.1111/jan.12127

Wiederman, M. W. (2015). Sexual Script Theory: Past, Present, and Future. In J. DeLamater & R. F. Plante (Eds.), *Handbook of the Sociology of Sexualities* (pp. 7–22). http://doi.org/10.1007/978-94-017-9912-6

Yardley, L. (2000). Dilemmas in qualitative health research. *Psychology and Health*, *15*, 215–228.

5. Appendices

5.1 Appendix A. Evidence of Ethical Approval from the University of Nottingham (17/10/14)

Direct line/e-mail
+44 (0) 115 8232561
Louise.Sabir@nottingham.ac.uk

The University of Nottingham

Faculty of Medicine and Health Sciences

Research Ethics Committee
School of Medicine Education Centre
B Floor, Medical School
Queen's Medical Centre Campus
Nottingham University Hospitals
Nottingham
NG7 2UH

17th October 2014

Anna Hooper
Trainee Clinical Psychologist
Division of Psychiatry & Applied Psychology
University of Nottingham
YAN Fujia Building, B Floor
Jubilee Campus
Wollaton Road
Nottingham
NG8 1BB

Dear Anna

Ethics Reference No: J09102014 SoM PAPsych – please always quote
Study Title: The impact of care home settings on sexuality; an exploration of the experiences of older adults.
Chief Investigator/Academic Supervisor/s: Danielle De Boos, Lecturer, Division of Psychiatry and Applied Psychology, Dr Roshan das Nair, Consultant Clinical Psychologist & Honorary Associate Professor Division of Rehabilitation & Ageing, School of Medicine, Dr Nima Moghaddam, Research Tutor Clinical Psychology, School of Psychology, University of Lincoln
Lead Investigator/Student: Anna Hooper, Trainee Clinical Psychologist, School of Medicine
Duration of Study: 11/2014-11/2015 12 mths **No of Subjects:** 15-25

Thank you for your recent application which was considered by the Committee at its meeting on 9th October 2014 and the following documents were received:

Care Homes and Sexuality:
- Ethics Application form, final version 1.0, date: 03/09/14
- Research Protocol version 1.1 date: 10/09/14
- Recruitment Advert version 1.0
- Participant Information Sheet version 2.0, Date: 03/08/14
- Consent Form Final version 2.0, Date: 03/08/14
- Semi- Structured Interview Schedule

These have been reviewed and are satisfactory and the study is approved.

Approval is given on the understanding that the Conditions of Approval set out below are followed.

1. A copy of the Debrief Sheet that you will use is submitted for approval.

2. Letters of permission from the Residential Care Home Managers are submitted when these are available for approval.

3. You must follow the protocol agreed and inform the Committee of any changes using a notification of amendment form (please request a form).

4. You must notify the Chair of any serious or unexpected event.

5. This study is approved for the period of active recruitment requested. The Committee also provides a further 5 year approval for any necessary work to be performed on the study which may arise in the process of publication and peer review.

6. An End of Project Progress Report is completed and returned when the study has finished (Please request a form).

Yours sincerely

Dr Clodagh Dugdale
Chair, Faculty of Medicine & Health Sciences Research Ethics Committee

5.2 Appendix B. Ethics Amendment Approval Letter (11/09/15)

Direct line/e-mail
+44 (0) 115 8232561
Louise.Sabir@nottingham.ac.uk

Faculty of Medicine and Health Sciences

Research Ethics Committee
School of Medicine Education Centre
B Floor, Medical School
Queen's Medical Centre Campus
Nottingham University Hospitals
Nottingham
NG7 2UH

11th September 2015

Anna Hooper
Trainee Clinical Psychologist
Division of Psychiatry & Applied Psychology
University of Nottingham
YAN Fujia Building, B Floor
Jubilee Campus
Wollaton Road
Nottingham
NG8 1BB

Dear Anna

Ethics Reference No: J09102014 SoM PAPsych **–** please always quote
Study Title: The impact of care home settings on sexuality; an exploration of the experiences of older adults.
Chief Investigator/Academic Supervisor/s: Danielle De Boos, Lecturer, Division of Psychiatry and Applied Psychology, Dr Roshan das Nair, Consultant Clinical Psychologist & Honorary Associate Professor Division of Rehabilitation & Ageing, School of Medicine, Dr Nima Moghaddam, Research Tutor Clinical Psychology, School of Psychology, University of Lincoln
Lead Investigator/Student: Anna Hooper, Trainee Clinical Psychologist, School of Medicine
Duration of Study: 11/2014-11/2015 24 mths **No of Subjects:** 15-35 (18+ and 65+ yrs)

Thank you for notifying the Committee of amendment no 1: 31/07/2015 as follows:

- Extend the duration of the study due to the student interrupting her studies with a new end date of 30/11/2016.
- Extend recruitment to gain additional perspectives on the research topic. In addition to care home residents, to invite participation from: adults aged 65+years, who are currently living in the community and care staff who work in residential care homes.
- Extend recruitment via the internet and use online chat forums to gather data in addition to individual audio recorded interviews.
- Research protocol, information sheets and semi-structured interviews have been revised for these additional groups.

and the following documents were received:

Care Homes and Sexuality:

- Research Protocol version 2.0 date: 31/07/2015
- Participant Information Sheet – Residents version 2.0, Date: 03/08/14
- Participant Information Sheet – Non Residents version 1.0, Date: 31/07/2015
- Participant Information Sheet – Staff version 1.0, Date: 31/07/2015
- Semi- Structured Interview Schedule – Residents, version 1.0: 12/09/14
- Semi-Structured Interview Schedule – Non Residents version 1.0 31/07/15
- Semi-Structured Interview Schedule – Staff version 1.0 31/07/15

The University of Nottingham

- Debrief version 2.0, Date: 31/07/2015

These have been reviewed and are satisfactory and the study is approved.

Approval is given on the understanding that the conditions set out below are followed:

1. You must follow the protocol agreed and inform the Committee of any changes using a notification of amendment form (please request a form).

2. You must notify the Chair of any serious or unexpected event.

3. This study is approved for the period of active recruitment requested. The Committee also provides a further 5 year approval for any necessary work to be performed on the study which may arise in the process of publication and peer review.

4. An End of Project Progress Report is completed and returned when the study has finished (Please request a form).

Yours sincerely

pp Lamagrani

Professor Ravi Mahajan
Chair, Faculty of Medicine & Health Sciences Research Ethics Committee

5.3 Appendix C. Ethics Amendment Approval Letter (01/10/16)

Direct line/e-mail
+44 (0) 115 8232561
Louise.Sabir@nottingham.ac.uk

Faculty of Medicine and Health Sciences

Research Ethics Committee
School of Medicine Education Centre
B Floor, Medical School
Queen's Medical Centre Campus
Nottingham University Hospitals
Nottingham
NG7 2UH

1st October 2016

Anna Hooper
Trainee Clinical Psychologist
Division of Psychiatry & Applied Psychology
University of Nottingham
YAN Fujia Building, B Floor
Jubilee Campus
Wollaton Road
Nottingham
NG8 1BB

Dear Anna

Ethics Reference No: J09102014 SoM PAPsych – please always quote
Study Title: The impact of care home settings on sexuality; an exploration of the experiences of older adults.
Chief Investigator/Academic Supervisor/s: Danielle De Boos, Lecturer, Division of Psychiatry and Applied Psychology, Dr Roshan das Nair, Consultant Clinical Psychologist & Honorary Associate Professor Division of Rehabilitation & Ageing, School of Medicine, Dr Nima Moghaddam, Research Tutor Clinical Psychology, School of Psychology, University of Lincoln
Lead Investigator/Student: Anna Hooper, Trainee Clinical Psychologist, School of Medicine
Duration of Study: 11/2014-11/2016 24mths **No of Subjects:** 15-35 (18+ and 65+ yrs)

Thank you for notifying the Committee of amendment no 2: 15/09/2016 as follows:

- Minor amendments to, information sheet, consent form and debrief.

and the following documents were received:

Care Homes and Sexuality:

- Participant Information Sheet – Non Residents version 2.0, Date: 19/08/2016
- Consent Form 3.0, Date: 19/08/2016
- Debrief version 3.0, Date: 19/08/2016

These have been reviewed and are satisfactory and the minor amendments no 2: 15/09/2016 is noted and approved.

Approval is given on the understanding that the conditions set out below are followed:

1. You must follow the protocol agreed and inform the Committee of any changes using a notification of amendment form (please request a form).

2. You must notify the Chair of any serious or unexpected event.

3. This study is approved for the period of active recruitment requested. The Committee also provides a further 5 year approval for any necessary work to be performed on the study which may arise in the process of publication and peer review.

The University of Nottingham

4. An End of Project Progress Report is completed and returned when the study has finished (Please request a form).

Yours sincerely

pp Lamiggadini

Professor Ravi Mahajan
Chair, Faculty of Medicine & Health Sciences Research Ethics Committee

5.4 Appendix D. Participant Information Sheet

Participant Information Sheet
Version 2.0 – 19th August 2016

Title of the study: The impact of care home settings on sexuality; an exploration of the experiences of older adults
Name of researcher: Anna Hooper
Research supervisors: Danielle De Boos, Roshan das Nair, Nima Moghaddam

We would like to invite you to take part in our research study. Before you decide, please take some time to read the following information which should explain what we are doing and what it would involve for you. One of our team can be available to answer any questions you might have and go through it with you.

What is the purpose of the study?
The purpose of the study is to explore how adults aged 65+ think being a resident of a care home might impact on their experience of their sexuality. More specifically, we are interested in what the word 'sexuality' means and we would like to understand what older adults see as being important in their relationships. We would like to talk about what hopes and fears people have about their sexuality when thinking about transitioning into a care home environment and understand how they would like care staff to acknowledge their sexuality should they ever reside in a care home in the future.

Why have I been invited?
You have been invited as you are aged 65 years or above.

Do I have to take part?
No, your participation is completely voluntary.

What will happen to me if I take part?
Firstly you will be asked to sign a consent form. You will be requested to share with us information about your age, gender, sexual orientation, ethnicity, and marital status. You will then be asked to take part in an interview with the lead researcher. They will interview you, which will be like a conversation. They will ask you what the word 'sexuality' means to you, what's important for you now and what you anticipate being important in the future if you were to move into a care home. You do not have to answer every question and there are no right or wrong answers. The interview will be audio recorded so the conversation can be listened to again. You can stop the interview at any time. The interview can be held in a quiet and

private space at your home, at an alternative venue such as a community space (as long as it can be private), or over the telephone.

Will my taking part in the study be kept confidential?
The members of the research team and authorised persons from the University of Nottingham who are involved in organising the research may have access to the information that you share. We will follow ethical and legal practice and we will treat your information as strictly confidential. All information will be either stored electronically on password protected devices, or locked in a filing cabinet at the University of Nottingham.

Anonymised quotes may be included in the findings; your name or information about where you live or who you are will not be included anywhere in any published findings. You will be given a pseudonym to protect your identity. Some interviews will be passed to professional transcription services to help type out the interviews, before they have access to any of your information they will sign a confidentiality agreement which will state that they are not to share any of your information. We will not pass on your recorded interview to anyone else.

The only exception to confidentiality will be if you disclose something to the researchers that cause them to have concerns about your safety, or the safety of anybody else. We will make every effort to let you know if this is the case.

What will happen to the information?
The interviews will be typed out word for word as a script and then the researchers will look across the scripts to see if there are any common themes in the things that people are saying. The information will help researchers to think about and understand what it might be like for older adults being in a care home setting and what impact this might have on how they think about things such as love, intimacy and sex.

In accordance with the Data Protection Act (1998), any information you provide us with will be securely archived for at least 7 years from the end of the study.

What are the possible disadvantages for me taking part?
The interview will take up your time and you will be asked about sexuality and the prospect of being a resident of a care home, areas that some people may find personal and sensitive to talk about. You

are free to stop the interview at any point and you do not have to answer every question.

What are the possible advantages for me taking part?
We cannot say if there will be any advantages for you personally, however your information shared may help improve guidance and care practices in the future.

How long will it take?
It is likely the interview will last between 25-45 minutes depending on how much you would like to say. The researcher will leave up to an hour free to make sure there is enough time for you to ask questions.

Will I get paid?
No, unfortunately we are not able to pay you for your time. Reasonable travel expenses will be paid back to you if you need to travel to get to the interview.

Who has reviewed the study?
The research has been reviewed by the University of Nottingham Research Ethics Committee who has given the study a favourable opinion and permission to carry out the research.

Who is organising and funding the research?
The research is being organised and funded by the University of Nottingham as part of the lead researcher's thesis for the Trent Doctorate in Clinical Psychology.

What happens to the results?
The results will be included in the lead researcher's thesis. It is likely the findings will also be prepared for publication for a scientific journal. It may be that some of the things you say during the interview are used as quotes. Your name will not appear anywhere in any published findings and any identifiable material will be changed.

You can request to have a summary of the main findings of the study if you are interested. For this you will need to provide us with an appropriate way of contacting you. By providing this information you are agreeing for us to keep your details on record until the completion of the study, after which point this information will be destroyed.

Can I change my mind?
You can stop the interview at any point. You do not have to answer every question. Once the interview has finished, you will be able to request to have your data removed up to one week afterwards. After this point it is likely that your information will have already been analysed and we may not be able to delete it from the findings.

What if there is a problem?
If there is a problem during the interview please let the researcher know and the interview can be stopped. If you have any more questions or anything else that you would like to know about the research, please contact the lead researcher Anna Hooper or any other member of the research team. Feel free to talk to others about this study if you would like.

Contact details
Lead researcher -

Anna Hooper (Trainee Clinical Psychologist)
E-mail: lwxaj5@nottingham.ac.uk
Telephone: 07980987032

Research supervisors –

Dr. Danielle De Boos
E-mail: danielle.deboos@nottingham.ac.uk
Telephone: 0115 846 6646

Dr. Roshan das Nair
E-mail: roshan.nair@nottingham.ac.uk
Telephone: 0115 846 8314

Dr. Nima Moghaddam
E-mail: nmoghaddam@lincoln.ac.uk
Telephone: 01522 837 733

All members can be contacted at the following address:

Division of Psychiatry & Applied Psychology
University of Nottingham
YANG Fujia Building, B Floor
Jubilee Campus
Wollaton Road
Nottingham, NG8 1BB

Concerns and complaints

If you have any concerns about this project and do not wish to contact the lead researcher but would like to speak to another member of the research team, you may contact:

Dr. Thomas Schröder
(Associate Professor in Clinical Psychology)
Address: as above
E-mail: thomas.schroder@nottingham.ac.uk
Telephone: 0115 846 8181

If you would like to raise a complaint and do not wish to contact a member of the research team, you may prefer to contact:

Dr. Richard Masterman
(Director of Research and Graduate Services)
Room B50 (1st Floor) Financial & Business Services
King's Meadow Campus, Lenton Lane
Nottingham, NG7 2NR
E-mail: richard.masterman@nottingham.ac.uk
Telephone: 0115 84 66418

5.5 Appendix E. Consent Form

Consent Form
Version 3.0 – 19th August 2016

Title of the study: The impact of care home settings on sexuality; an exploration of the experiences of older adults
Ethics Reference Number: J09102014 SoM PAPsych
Name of researcher: Anna Hooper
Research supervisors: Danielle De Boos, Roshan das Nair, Nima Moghaddam

Please initial box

I confirm that I have read/understood the information sheet (Version 3.0, dated 19/08/16) for the above study and have had the opportunity to ask questions.	☐
I understand that my participation is voluntary and that I am free to withdraw at any time during the interview or up to one week after the interview, without giving any reason or having my legal rights being affected.	☐
I understand that the data collected in the study may be looked at by authorised individuals from the University of Nottingham, the research group and regulatory authorities where it is relevant to my taking part in this study. I give permission for these individuals to have access to these and to collect, store, analyse and publish information obtained from my participation in this study. I understand that my personal details will be kept confidential.	☐
I understand that the interview will be recorded and that anonymous direct quotes from the interview may be used in the study reports.	☐
I agree to take part in the above study.	☐
I would like a summary sheet of the findings from this study when it is complete.	☐

If you have indicated that you would like a copy of the findings please choose from one of the following two methods for the summary sheet to be sent to you:

I would like the summary sheet to be emailed to me.
My email address is:

_____

I would like the summary sheet to be posted out to me.
My postal address is:

_____

_____

_____

_____

_____

_____ _____ _____
Name of Participant Date Signature

_____ _____ _____
Name of person taking consent Date Signature

2 copies: 1 for participant and 1 for the project notes

5.6 Appendix F. Semi-Structured Interview Schedule

Introduction: Name, role, purpose of interview, recording, confidentiality, stop at any time, information withdrawal.

General topic: Sexuality experience[27]
Aim: Introduction to the topic to understand how the respondent describes their sexuality and what factors are important for them

- People describe sexuality as being lots of different things such as relationships, sex, and intimacy. I wonder what sexuality means to you?
- Do you see yourself as a sexual person?
- What is important for you in how you express your sexuality?

General topic: Changes in views around sexuality as a care home resident
Aim: To explore whether the respondent's view of their sexuality changes when thinking about becoming a resident of a care home and what factors the respondent thinks might impact on this.

- If you were to move into a care home, do you think your view of sexuality would change?
- How do you think you would see yourself as being different/the same?
- Is there anything that you think might influence how you meet your sexual needs and express your sexuality?

General topic: How the care home setting supports/inhibits sexuality
Aim: To explore the respondent's expectations of how their sexuality would be recognised/responded to if residing in a care home

- How do you anticipate care staff acknowledging your sexuality?
- What is important for you when thinking about sexuality and the care you might receive as a resident?
- How would you like to be recognised as a sexual person in a care home?

Prompts – Can you say more about that? How have you made sense of that? What did this mean to you? Do you have any examples that you can share? Minimal encouragers

[27] Due to the sensitive nature of discussing sexuality, this schedule is intended as a guide to facilitate discussion and may be amended depending on how the respondent engages with the interview. The interviewer will use the respondent's language wherever possible and follow leads offered by the respondent in their answers to explore these topics further.

5.7 Appendix G. Debrief Form

Thank you for participating with this study.

The questions you were asked were aimed at understanding how you think about sexuality and what impact you think becoming a resident of a care home might have regarding this.

If you have any more questions about this research you can contact the lead researcher (Anna Hooper) using any of the contact details below:

Telephone: 07980987032
E-mail: lwxaj5@nottingham.ac.uk
Address: Division of Psychiatry & Applied Psychology
University of Nottingham
YANG Fujia Building, B Floor
Jubilee Campus
Wollaton Road
Nottingham, NG8 1BB

If you have any concerns about having participated in this study or you would like to raise a complaint and do not wish to contact Anna, you can speak to Dr Nima Moghaddam, via nmoghaddam@lincoln.ac.uk, on 01522 837 733 or by using the address provided above.

If you change your mind about this research and you no longer want your information to be included in the research findings, please let us know by [*Personalised date*] (one week from your interview). If we do not hear from you by this date, we will assume that you are happy for us to use the information you have shared.

If you have requested a plain English summary of the research findings, this will be sent to you via your preferred method once the research has been completed.

Thank you again for your time.
With best wishes,
The Research Team

5.8 Appendix H. A Signed Copy of the Transcriber Agreement

UNIVERSITY OF LINCOLN

Data Protection Act 1998 Confidentiality Agreement for Transcribers

This Agreement is made as of 16/12/16 (Date), by and between the University of Lincoln, with principal offices at Brayford Pool Lincoln LN6 7TS (the University) and J A Jones with principal offices at Jones Transcription Services Rochus Rd, Kent (the Transcriber).

The Transcriber has been appointed by the University of Lincoln to transcribe audiotapes/audio files and documentation ~~resulting from research~~ undertaken by Anna Hooper ~~which will involve the disclosure to the~~ Transcriber of personal data held by the University. Accordingly the Transcriber is required to deal with any such information in accordance with the terms of this Agreement and the Data Protection Act 1998.

The Transcriber undertakes to respect and preserve the confidentiality of personal data. Accordingly, for an indefinite period after the date of this Agreement the Contractor shall:

- maintain the personal data in strict confidence and shall not disclose any of the personal data to any third party;
- restrict access to employees, agents or sub-contractors who need such access for the purposes of the contract (and then only if the employee, agent or subcontractor is bound by conditions of confidentiality no less strict than those set out in this agreement, which the Transcriber shall enforce at the University's request);
- ensure that its employees, agents or sub-contractors are aware of and comply with the Data Protection Act 1998; and
- not authorise any sub-contractor to have access to the personal data without obtaining the University's prior written consent to the appointment of such sub-contractor and entering into a written agreement with the subcontractor including conditions of confidentiality no less strict than those set out in this agreement, which the Transcriber shall enforce at the University's request.

The Transcriber agrees to indemnify and keep indemnified and defend at its own expense the University against all costs, claims, damages or expenses incurred by the University or for which the University may become liable due to any failure by the Transcriber, its employees, agents or sub-contractors to comply with any of its obligations under this Agreement.

For the avoidance of doubt, the confidentiality imposed on the Transcriber by this Agreement shall continue in full force and effect after the expiry or termination of any contract to supply services.

The restrictions contained in this Agreement shall cease to apply to any information which may come into the public domain otherwise than through unauthorised disclosure by the Transcriber.

This Agreement shall be governed by and construed in accordance with the laws of England and the parties hereby submit to the exclusive jurisdiction of the English courts.

Signed for and on behalf of JONES TRANSCRIPTION SERVICES

Signed: J A Jones Name: J. A. JONES

Title: Ms Date: 16/12/16

5.9 Appendix I. Extracts From Transcripts to Demonstrate the Coding Process and Emerging Themes

Extract	Codes	Emerging Themes
"Well I think for me that sexuality is a word that. It's really more about identity for me in the sense that I think the word sexuality, because it contains the word sex, immediately makes people think of having sex with people, and presumably with yourself as well. But it involves around, for me the problem with the word is that it tends to revolve around sex, the idea of sex acts, rather than a whole person. So for me personally the word sexuality is a word which, which envelops the whole of me. It isn't, I can't separate myself out from being a gay man within a straight society." (M2)	Identity Sex Society Heteronormative Non-sexual Individual	Integral to self Sexual relationships Changeable
"Well I, I think, you immediately think it's about sex because that's what it seems to be in, in, on the media. If people talk about their sexuality it usually means how they perceive their, their sexuality to be. Whether they are attracted to men or women. That kind of thing. But I think being an older person it also means how you feel as a woman. How you, what that's, how that's different now from how it was when I was younger, and it might, maybe, change. Looking at my mother and my aunt, how that has changed." (F3)	Sex Sexuality over time Gender Sexual orientation Changes across generations Ageing sexuality	Sexual relationships Demonstrating sexuality Changeable

Extract	Codes	Emerging Themes
"On different levels intimacy, obviously in a sexual relationship role. Well I'm not in a relationship at the moment so I don't really think of that at the moment. You know, well between, it doesn't have to be between a man and a woman these days, but, but there can be intimacy with friends or family. I mean, closeness can be quite intimate. I mean I feel I've got a close relationship with my two daughters, and there is a certain amount of intimacy there. It's not a sexual thing, it's, you know, can be tactile, you know, hugs and things like that" (F5)	Intimacy Relationship status Generational change Sexuality over time Family Touch Not sexual	Demonstrating sexuality Changeable
"Well, um, I would have said initially very, very quickly it was about, I think of it meaning common usage, your sexuality is who you would enter a sexual relationship, whether it were with another man or another woman, but obviously it's more than that isn't it? And the other problem I had when I thought a little bit about it, I was trying to think back and I thought, you know, sexuality isn't a word that was used throughout my life. It's sort of that kind of word that's always in modern parlance, its in the newspaper very, very frequently and in the media and everywhere but through most of my life it just wasn't something that you even considered. So I found that quite a difficult question when you, when you first said it." (F6)	Sexual orientation Sex Changes across generations Sexuality over time Society Not a recognised word Not sure	Sexual relationships Changeable Constructed with words

5.10 Appendix J. Summary of Code Merges and Disbandment During Coding Process

Sexuality definition code merges

Original code	Merged into…
Community Society	Exists in a society
Feeling happy	Positive feelings
In the past Ageing sexuality Changes across generations	Sexuality over time
It's personal Individual/Internal	Internal private
Multiple relationships Between people	Changeable
Using people I know for reference Metaphors and parallels	Displacement
Comfort and support for me Comfort and support for them	Comfort and support
Flirting	(Not considered a salient theme)
Family	(Not consistent agreement on whether it related to sexuality)
Language Not a word people use	Not a recognised word
Metaphors and parallels	Displacement
Important Deficit approach	Important
Needs	Not supported enough, fulfilled by 'being human and instincts'
Sharing Interpersonal	Intimacy
Intimacy	
As a tool	(Not considered a salient theme)
Positive feelings Showing emotions	Positive feelings
Touch and physical contact	Touch
On a scale	Individual
Internal private	Identity

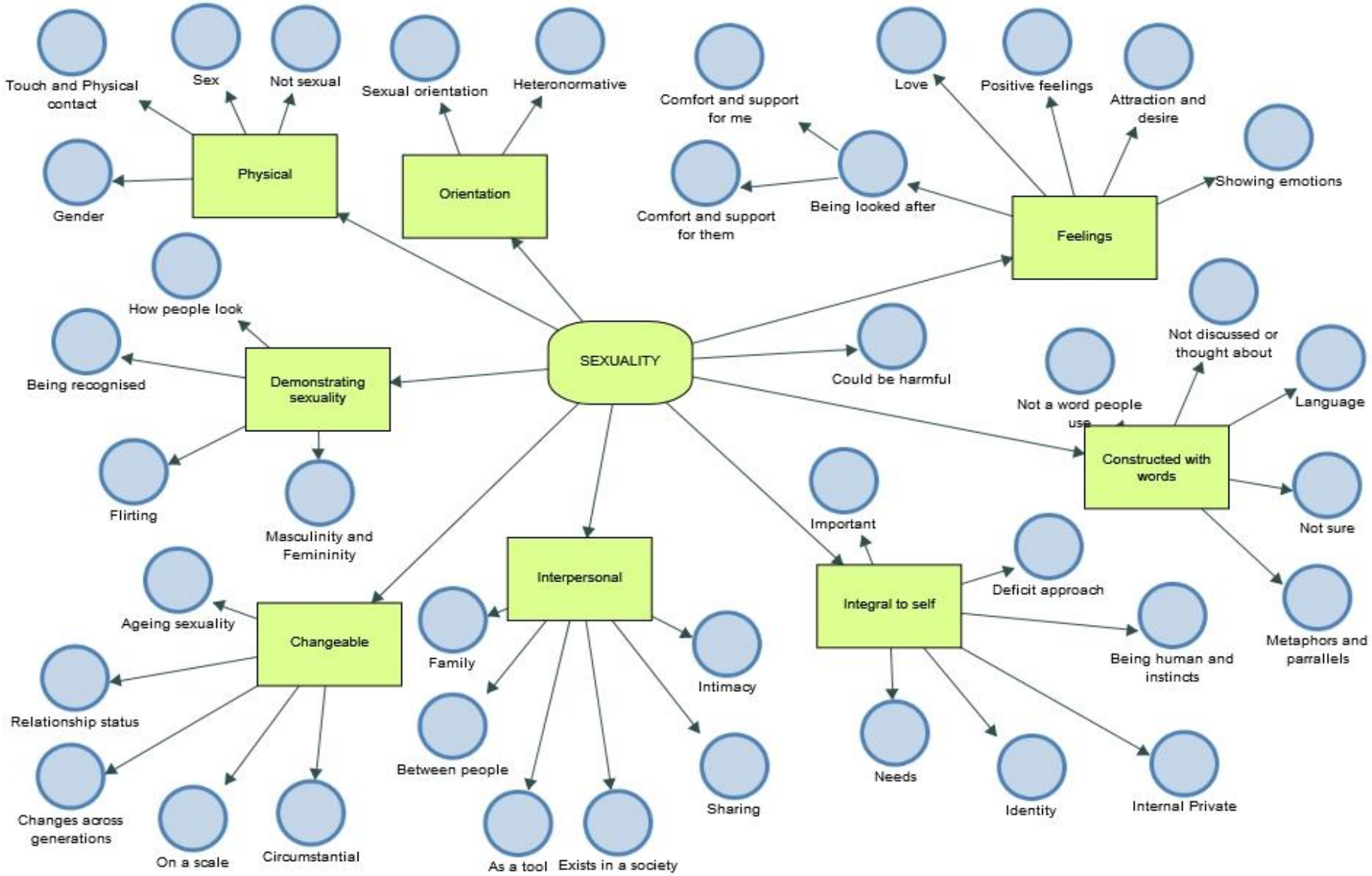
Sexuality and care homes code merges

Original code	Merged into…
Being alone Stuck On your own X does y doesn't	You become 'one'
Stuck	Can't initiate
Physical state (deterioration) Physical trumps sexual Old things to be abused	Patients instead of people
Recognised as a person The 'inside' me Recognise sexuality Sexuality is part of you Power	Sexuality still relevant
Sexuality is private	It's too private
Maybe you won't know Just get on with it	Get over it and get on with it
Limited possibilities If you can't walk the walk, you can't talk the talk	Possibilities change
New community positive New community negative	Care home community
Life giving Need it more	Need it more
Recognise needs Facilitate sexuality	Facilitate sexuality
Choice Ask questions	Ask questions
I don't know what to do I've got an audience Privacy	I don't know what to do I've got an audience
Isolating environment Environmental barriers	Environmental barriers
Staff attitudes Feel as if I'm more than a job	Not part of the job

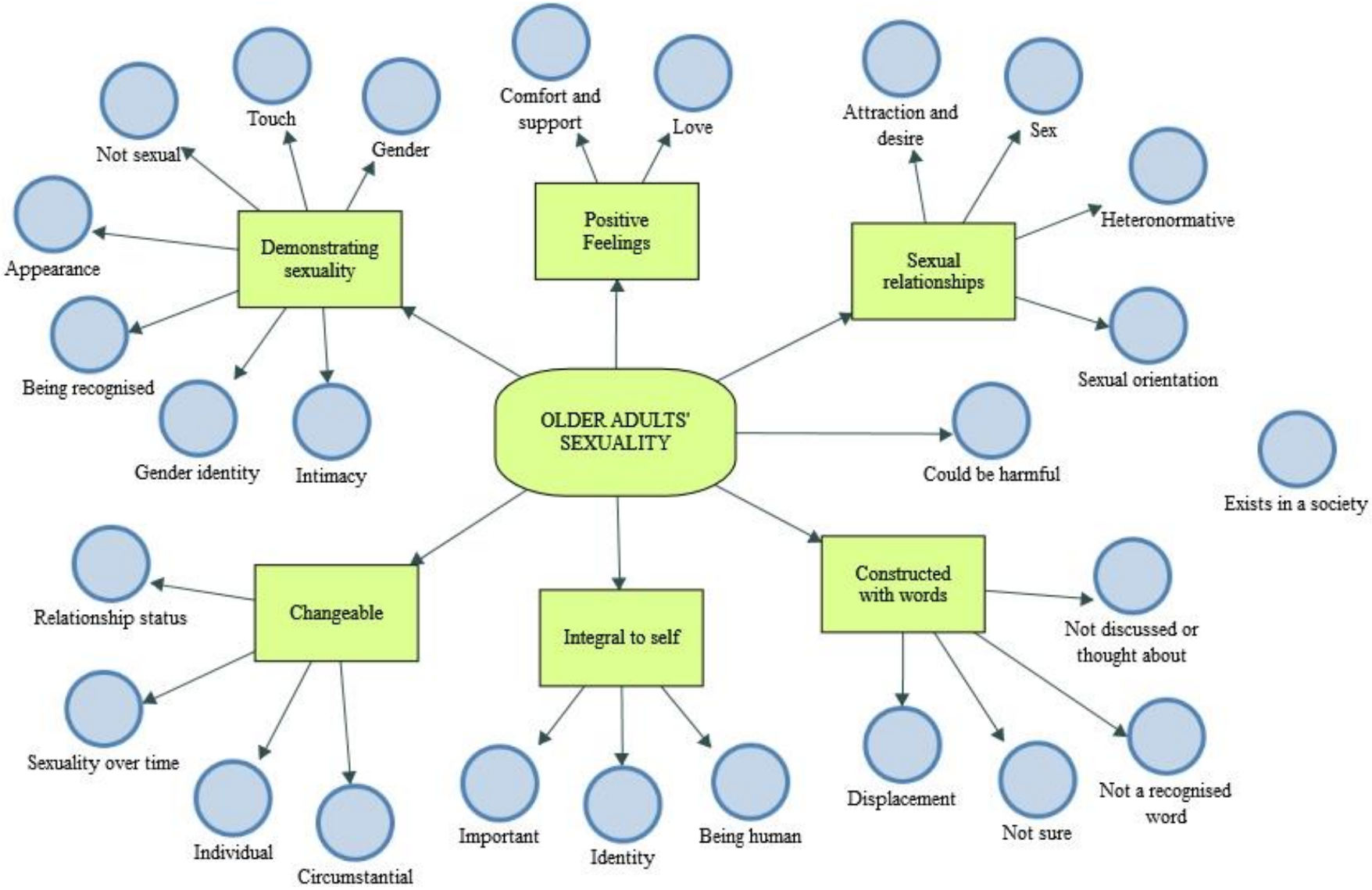
Disbanded codes

Code name	Disbanded across…
Environment	Should be like home Privacy Isolating environment
Staff	Practical care Necessary intimacy Can't initiate
Choices to pacify others	Moderated by others Get over it and get on with it
Need permission	Moderated by others
Language	Patients instead of people Ask questions Facilitate sexuality Necessary intimacy Agents of sexuality
Fear	Negative feelings towards care homes
Dignity and respect	Not part of the job
Staffing	Not part of the job Agents of sexuality
Taking time	Moderated by others Agents of sexuality Not part of the job Facilitate sexuality

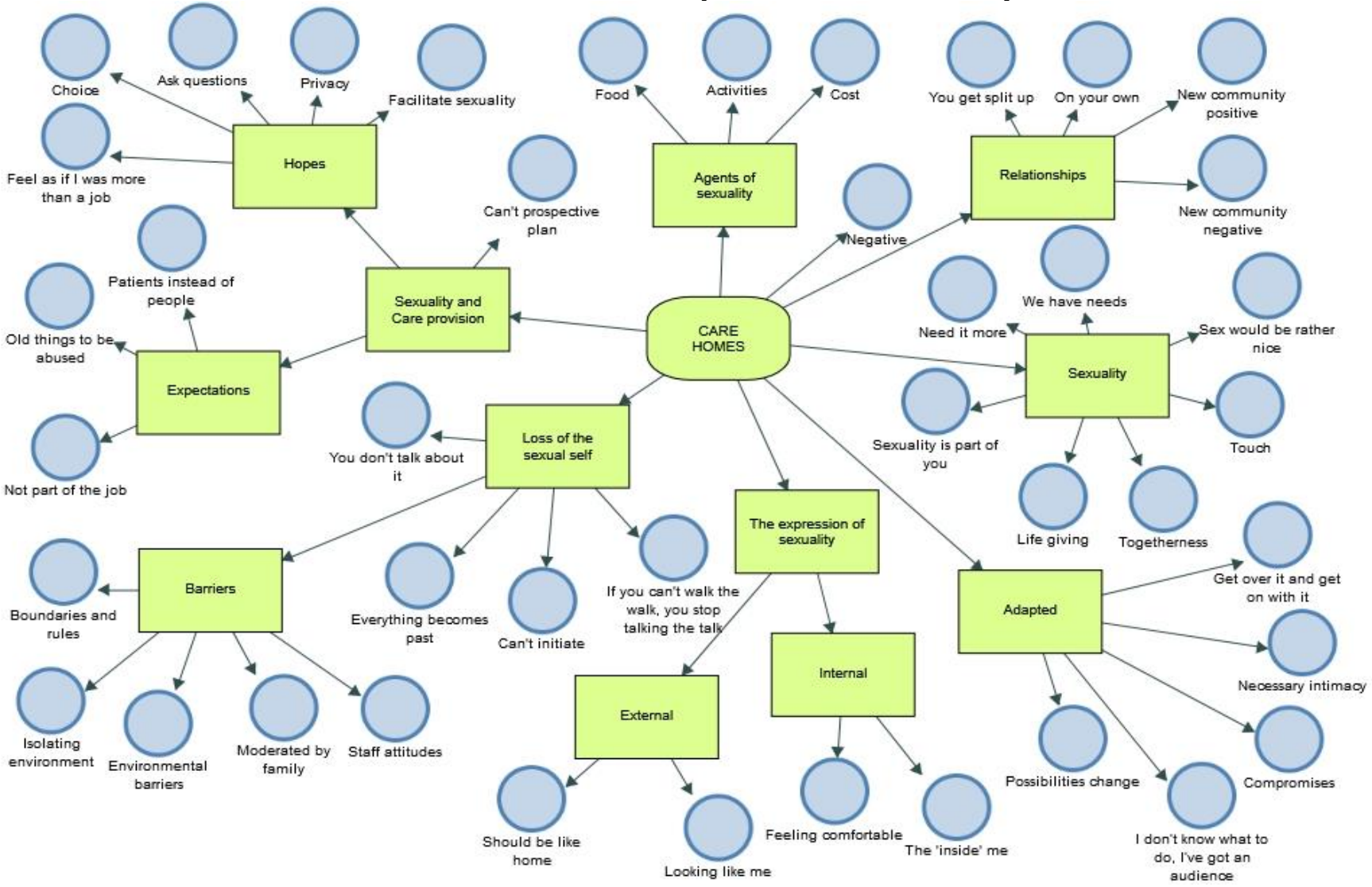
5.11 Appendix K. Initial Thematic Map to Represent Older Adults' Definition of 'Sexuality'



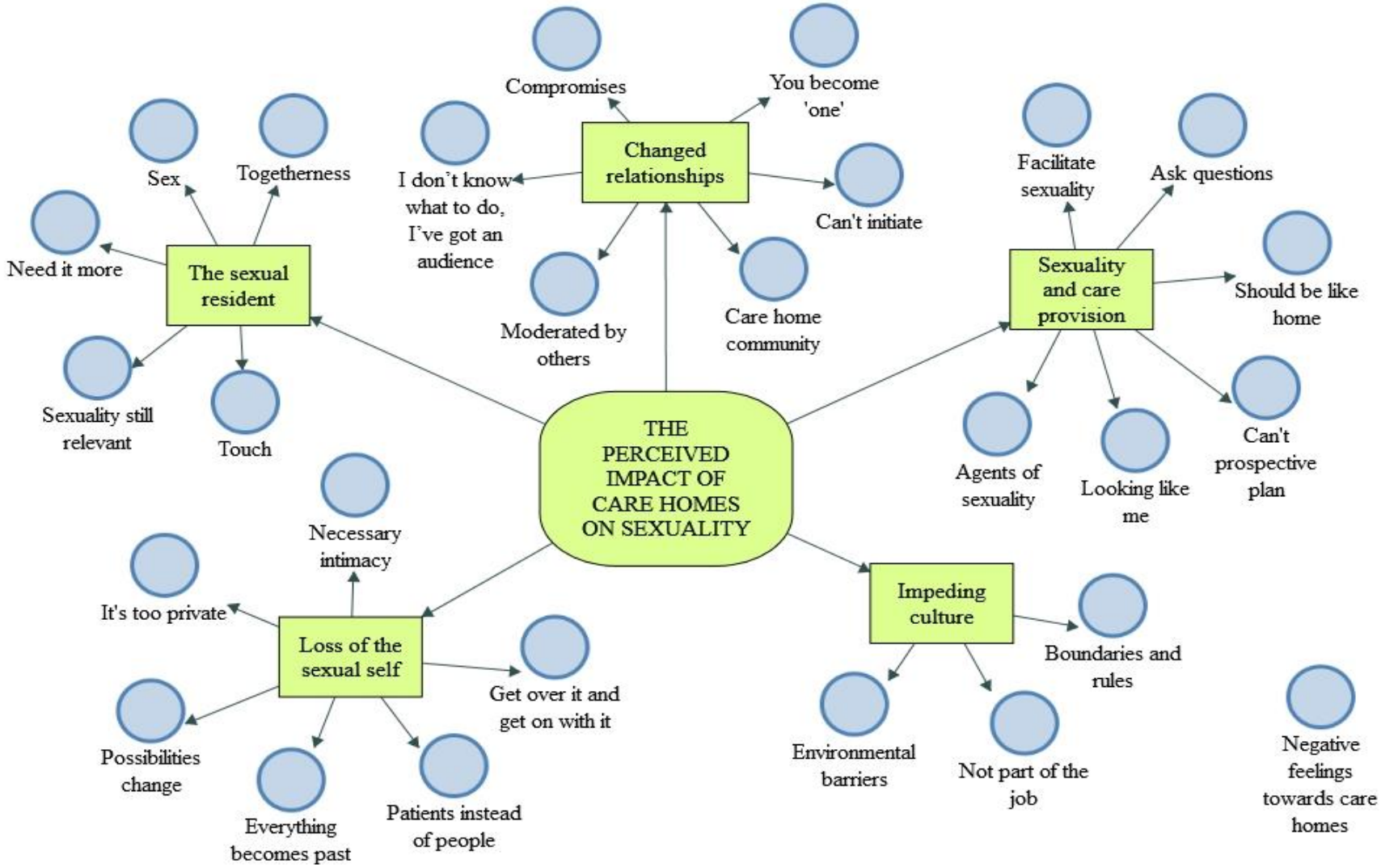
5.12 Appendix L. Amended Thematic Map to Represent Older Adults' Definition of 'Sexuality'



5.13 Appendix M. Initial Thematic Map to Represent Older Adults' Views on the Impact of Care Home Environments on Experiences of Sexuality



5.14 Appendix N. Amended Thematic Map to Represent Older Adults' Views on the Impact of Care Home Environments on Experiences of Sexuality



5.15 Appendix O. Summary of Findings Disseminated to Participants

Title of the study: The impact of care home settings on sexuality; an exploration of the experiences of older adults
Ethics Reference Number: J09102014 SoM PAPsych
Name of researcher: Anna Hooper
Research supervisors: Danielle De Boos, Roshan das Nair, Nima Moghaddam

17th July 2017

Thank you for taking part in our research. We wanted to ask people over the age of 65 what the word 'sexuality' meant to them, how becoming a resident of a care home might impact on sexuality experiences, and explore their hopes and fears regarding care provision. You indicated that you would be interested in our results so we are writing to provide a summary of findings from this research.

In total we spoke with 10 people between the ages of 65-75 from across the UK. Two men and eight women took part. Five people reported being in a relationship at the time of the interview. We stopped interviewing at 10 people because we had enough information at this point to answer our research question. All conversations were recorded and then typed out in full. The research team then analysed all the data to find important themes which represented what you were saying. We divided our findings into 'defining sexuality' and 'the perceived impact of the care home on sexuality'. Here is what we found:

A total of eight themes were identified to describe what participants thought sexuality meant. Within some of the themes are 'sub-themes'. Overall, sexuality was seen as being many things, and something which was unique to each individual and changeable with age.

A total of six themes were identified to describe how participants thought becoming a resident of a care home might impact on their sexuality experiences, and their hopes and fears for care provision. These answers were based upon participants' individual definitions of sexuality.

The themes and sub-themes we found have been described in the following tables.

Defining sexuality

Themes	Sub-themes	Comments
Exists in a society		Sexuality was seen as being related to societal and cultural norms.
Changeable	Relationship status	This made sexuality changeable, as areas thought to be important were related to whether someone was in a relationship or not.
	Sexuality over time	Participants thought the meaning of sexuality had changed from generation to generation. Sexuality was also described as being important in different ways as you age.
	Individual	Sexuality was thought to mean different things to different people.
	Circumstantial	Participants described their sexuality as being different depending on where they were and who they were with.
Integral to self	Important	All participants spoke about sexuality being important to them.
	Identity	Sexuality was seen as a part of self-identity, affecting how people think and feel about themselves.
	Being human	Sexuality was viewed as a fundamental part of being a person.
Constructed with words	Displacement	Sometimes participants used other examples to talk about sexuality. This was interpreted as being related to sexuality being a difficult topic to talk about, made easier by using third-party examples (e.g. about something from the news or a story about a friend).
	Not sure	Lots of participants were not sure what the word meant when they first thought about it.
	Not a recognised word	Some participants said 'sexuality' was not a word that people used when they were growing up, so it was tricky for them to have a clear picture of what the word meant.
	Not discussed or thought about	Some participants said they did not often talk about or think about sexuality, either when on their own or with others.

Themes	Sub-themes	Comments
Could be harmful		A few participants noted that sexuality could be related to negative or harmful experiences (e.g. negative consequences to expressing sexuality, and unmet sexuality needs being linked with painful emotions)
Sexual relationships	Sexual orientation	Participants thought sexual orientation related to sexuality, describing the types of sexual relationships a person might want to have.
	Sex	Participants agreed sex was part of sexuality, however lots of participants said sex was not as important as an older person.
	Heteronormative	Society's assumption that sexual relationships would be between men and women was either indirectly or directly recognised by participants.
	Attraction and desire	This was spoken about as being part of sexual relationships and of sexuality.
Positive feelings	Love	Interestingly, lots of current definitions of sexuality don't include 'love'.
	Comfort and support	
Demonstrating sexuality	Gender	
	Gender identity	Gender identity (masculine/feminine etc.) was described as an important part of sexuality.
	Touch	Participants spoke about touch communicating sexuality.
	Intimacy	Intimacy did not necessarily need to be physical intimacy; emotional intimacy was seen as being important too.
	Appearance	This was particularly important for female participants, who spoke about showing sexuality through e.g. dress, make-up.
	Being recognised	For some participants, having sexuality recognised was important. For example, having other people see their femininity, or acknowledge their sexual orientation.
	Not sexual	Sexuality was described as something that did not necessary need to be about sex or sexual relationships.

The perceived impact of the care home on sexuality

Themes	Sub-themes	Comments
Negative feelings towards care homes		All participants thought care homes should be feared or avoided.
Changed relationships	You become 'one'	Many participants spoke about expecting to be a single occupant in a care home.
	Compromises	Residents were assumed to need to compromise to meet their sexuality needs. E.g., touch from loved ones was predicted to happen less often, so massages or pedicures/manicures from staff were viewed as other ways to experience touch.
	Can't initiate	Being in a care home was associated with being poorly, so participants predicted that relationships might be different because they wouldn't be able to initiate (e.g. not being able to stand to hug someone).
	Care home community	Sharing a home with other residents was viewed both positively and negatively; participants were not sure whether they would be open to new relationships or if they would get on with other residents.
	Moderated by others	Participants expected either family members or staff to make decisions for them.
	I don't know what to do, I've got an audience	The care home was expected to be a public place which would change how residents and their visitors interacted.
Impeding culture	Boundaries and rules	Participants were not sure if care homes allowed sexual relationships. Safety rules were also predicted to impact on sexuality experiences, e.g. not being able to bath alone.
	Not part of the job	Participants thought staff wouldn't see resident's sexuality as part of their job.
	Environmental factors	Participants spoke about the care home environment and the ways they predicted this might inhibit sexuality experiences, e.g., the expectation for single armchairs, single beds, and being in a clinical environment (no carpets/soft furnishings).
Loss of the sexual self	Necessary intimacy	Participants thought the help needed to wash/ dress might change how they felt about their bodies.

Themes	Sub-themes	Comments
Loss of the sexual self	Get over it and get on with it	Some participants spoke about needing to forget about sexuality because of there being no other option.
	Patients instead of people	Because residents were assumed to have lots of physical health needs, participants expected staff to see them as patients.
	Everything becomes past	Participants spoke about residents as the person that "was" rather than the person that "is".
	Possibilities change	Participants thought they would be unable to maintain sexual relationships or make choices about their sexuality expression as a resident.
	It's too private	Some participants said they might not want to talk to staff about their sexuality needs.
The sexual resident	Sexuality still relevant	All participants thought sexuality would be important to them as a care home resident.
	Touch	Participants wanted to be touched as a resident.
	Sex	Participants wanted care homes to allow sex.
	Togetherness	Sharing and being with loved ones was seen as an important part of sexuality as a resident.
	Need it more	Some thought the stress associated with being a resident would make sexuality more important.
Sexuality and care provision	Facilitate sexuality	All participants wanted care homes to recognise and facilitate their sexuality.
	Ask questions	Participants wanted staff to ask what was important to them.
	Should be like home	The environment being like home both physically (showing photographs/pictures, having a comfortable bed) and emotionally (feeling safe) was seen as helping to maintain resident's sexuality.
	Can't prospective plan	Some participants said it was difficult to think about future planning. Despite this, everyone made some predictions about being a resident.
	Looking like me	Appearance was particularly important for female participants, who wanted to 'look like themselves' as a care home resident.
	Agents of sexuality	Factors which could impact on sexuality experiences in care homes were described. Money was associated with quality of care. Activities (bingo, dominoes etc) were seen as being ways to bring people together. Sharing a meal was linked with intimacy, so being able to have private dining with loved ones was identified as being important.

Overall, we think our findings are important because they helped us to think about the ways in which becoming a resident of a care home might impact on sexuality experiences for people over the age of 65. Our results suggested that participants viewed sexuality as an important part of their identity, and that as potential residents of a care home they wanted their sexuality to be recognised by care providers. Based on our results we can hypothesise that becoming a resident changes a person's self-identity from a sexual person to a non-sexual person because of being in an environment that neither acknowledges or facilitates sexuality and the stressors associated with becoming a resident. Previous research tells us that sexuality is related to physical health and mental wellbeing, so it was important to hear about the ways participants would want their sexuality acknowledged in order to minimise the potential negative impact that becoming a resident might have on their sexuality experiences. It was also important to note how the meaning of sexuality and sexuality expression can change with age. We therefore advise against making assumptions about what this term means for individuals and what aspects of their sexuality might be important to them as they grow older.

I hope you have enjoyed reading about the results. We would be happy to hear from you if you have any questions about this research.

Thank you again for your participation.

Anna Hooper
Lead Researcher

E-mail: lwxaj5@nottingham.ac.uk
Telephone: 07980987032
Address:
Division of Psychiatry & Applied Psychology
University of Nottingham
YANG Fujia Building, B Floor
Jubilee Campus
Wollaton Road
Nottingham, NG8 1BB

6. Poster

Great Sexpectations: Older adults' perceptions about how transitioning to a care home might impact on experiences of sexuality

Anna Hooper, Danielle De Boos, Roshan das Nair, Nima G Moghaddam
Trent Doctorate in Clinical Psychology

Introduction

Older adults' sexuality has been linked with a number of factors associated with wellbeing, including positive mental health, physical health, and quality of life [1-3]. Despite changing sexual practices across the lifespan, sexuality continues to be an important part of the identity of older adults [4,5]. The UK's ageing population is placing more demands on care services, yet despite the acknowledged benefits of sexuality across the life span, our understanding of the impact of the care home environment on older adults' sexuality is limited.

A prospective planning approach

We adopted a prospective planning approach as the Care Act (2014) encourages service providers to liaise with local populations about their needs and aspirations to inform care. Furthermore, our previous meta-ethnography found residents of healthcare settings experienced 'adapted sexuality' [6], suggesting residents themselves may not be best positioned to construct positive sexuality experiences in care settings due to experiences having already changed.

Research aims

To explore views of older adults' regarding how transitioning to a care home might impact on sexuality experiences and hopes and fears regarding care delivery.

Method

Semi-structured one-to-one interviews were conducted with people aged >65 to answer three broad questions: How do participants define 'sexuality' and what elements do they consider important?; what impact might becoming a care home resident have on sexuality experiences?; and how do participants want sexuality to be recognised by care home services? Interviews were audio recorded, transcribed, and analysed using thematic analysis. Data analysis was undertaken from a dual inductive and deductive approach. Whilst the first research question adopted a theoretical (deductive) approach in relation to the World Health Organisation's (WHO) sexuality definition [7], transcripts were coded via a data-driven (inductive) process.

"People look at somebody my age and think well he's completely passed it."

"Sexuality to me is more than the outside of a person - it's what's inside."

"It is bound to be an individual thing because there are so many shades of everything."

Results

Two men and eight women aged between 65-75 years from across England were interviewed. One man and one woman identified as gay, the remainder as heterosexual. All participants were White British. Five participants were in long-term relationships; of the single participants, two were widowed. Interviews lasted between 30-80 minutes and were face-to-face (*n=5*) or via telephone (*n=5*). We divided findings into 'defining sexuality' and 'the perceived impact of the care home on sexuality'.

"I could imagine some people would be, 'Oh I don't know what to do here, I've got an audience.'"

"I think the more stressful a situation you're in the more important that intimacy becomes."

"You've got no partner … sexuality is going to be about maintaining your image."

"I think you would just have to shut, to some extent, shut that side of your thoughts down."

"I think I would feel impotent, and I don't mean that physically."

"[Residents are] all too tired to bother. Drugged up to their eyeballs."

"I would think [the care home environment] renders [sexuality] well-nigh impossible really … I mean nearly all these places have just got single beds in a small room. None of these places are conducive really to sitting comfortably beside somebody."

Defining 'sexuality'

Eight themes captured participants' views on what 'sexuality' meant and what elements were important.

They saw sexuality as ***Existing in a society*** and being ***Changeable***. They viewed sexuality as ***Integral to the self***. Sexuality was ***Constructed with words***, but also something which was behavioural - ***Demonstrating sexuality***. For some, sexuality was associated with experiences that ***Could be harmful***. Sexuality was also thought to be about ***Positive feelings*** and ***Sexual relationships.***

The concept of 'ageing sexuality' was identified; where importance shifts away from sexual relationships and sex, and towards aspects such as intimacy and gender identity as people age. Unlike the WHO, participants did not include *reproduction, eroticism and pleasure,* or *gender roles* within their definitions. Participant's sexuality definitions contextualised subsequent answers.

The perceived impact of the care home on sexuality

Six themes captured participants' views on how becoming a resident of a care home might impact on their sexuality experiences, and hopes and fears regarding care provision. Participants expressed ***Negative feelings towards care homes.*** They anticipated to have ***Changed relationships*** as a resident. They described the ***Impeding culture*** of the care home impacting on experiences and contributing to the ***Loss of the sexual self***. Despite this, participants spoke about ***The sexual resident*** and the ways sexuality would be important, and described ***Sexuality and care provision*** and the ways they wanted services to acknowledge their sexuality as a care home resident.

Conclusions and recommendations

Sexuality is a multifaceted term experienced and expressed differently across the lifespan, yet remains an important aspect for older adults. Participants perceived that becoming a resident of a care home would prompt significant (and often negative) changes with regards to how they could experience sexuality. Kiecolt's model of self-identity and stress [7] offers some theoretical explanation regarding these predicted changes; stressors associated with changing roles (from person to resident) and being situated in an environmental context that neither acknowledges nor facilitates sexuality prompts the change in self-identity from sexual to non-sexual, reinforcing the concept of the asexual older resident. Participants wanted services to demonstrate attempts to minimise the environmental impact on sexuality and promote positive experiences in a manner that was responsive to individual need, particularly with respect to the changing meaning of sexuality across the lifespan. However, as a widely neglected area of research, further exploration of this topic is indicated.

References [1] Bach, L. E., Mortimer, J. A., Vandeweerd, C., & Corvin, J. (2013). The association of physical and mental health with sexual activity in older adults in a retirement community. *Journal of Sexual Medicine*, *10*(11), 2671–2678. [2] Lee, D. M., Nazroo, J., O'Connor, D. B., Blake, M., & Pendleton, N. (2016). Sexual health and well-being among older men and women in England: Findings from the English Longitudinal Study of Ageing. *Archives of Sexual Behavior*, *45*(1), 133–144. [3] Robinson, J. G., & Molzahn, A. E. (2007). Sexuality and quality of life. *Journal of Gerontological Nursing*, *33*(3), 19–29. [4] Langer, N. (2009). Late Life Love and Intimacy. *Educational Gerontology*, *35*(8), 752–764. [5] Popeo, D. M., Sewell, D. D., Johnson, K. K., & Abrams, J. M. (2014). Addressing sex and sexuality with older adults: An opportunity to learn and practice effective communication techniques. *The American Journal of Geriatric Psychiatry*, *22*(3), S5–S6. [6] Hooper, A., De Boos, D., das Nair, R., & Moghaddam, N. (2016). First-person narratives around sexuality in residential healthcare settings: a meta-ethnographic synthesis. *Sexual and Relationship Therapy, 31*(2 PG-207-229), 207–229. [7] World Health Organization. (2015). Sexual health, human rights and the law. Retrieved from http://apps.who.int/iris/bitstream/10665/175556/1/9789241564984_eng.pdf [7] Kiecolt, K. J. (1994). Stress and the decision to change oneself: A theoretical model. *Social Psychology Quarterly, 57*(1), 49–63.