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Sexual Situations in Spanish Long-Term Care Facilities: Which Ones Cause the Most Discomfort to Staff?

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Abstract

This study aimed to explore which kinds of residents' sexual expressions cause the most discomfort to staff and to determine the situational circumstances that might be related to this perception of discomfort. The sample was made up of 1895 front-line care staff employed at 152 Spanish long-term care facilities. Participants' answers to an open-ended question regarding the sexual situation that caused them the most discomfort were content-analyzed. Results showed that most participants were able to mention at least one sexual situation that had caused them discomfort. Moreover, the range of sexual situations mentioned by our participants clearly goes beyond the typical behaviors associated with inappropriate sexual behaviors in dementia. Situational circumstances were related to participants' perception of discomfort. Our results suggest the importance of including sexual issues on the formal training of staff and developing explicit guidelines and institutional policies regarding sexual expression in long-term care facilities.

Keywords Sexuality · Long-term care facilities · Inappropriate sexual behaviors · Staff development · Institutional policies

Introduction

In recent years, an increasing number of studies have focused on the sexual expression of older people living in long-term care facilities (LTCF). Although the percentage of sexually active residents seems to be low (Spector & Fremeth, 1996), this does not mean that their sexual interests and needs are non-existent. In fact, Bauer et al. (2013) found that most residents still experience sexual needs and that sexual situations seem to be quite common in LTCF. In another study, Lester, Kohen, Stefanacci, and Feuerman (2016) interviewed 366 LTCF directors and found that more than 70% reported issues regarding residents' sexual expression at their facilities.

Most of the research on sexuality in LTCF has addressed the barriers that residents encounter with regard to the expression of their sexual needs (Villar, Celdrán, Fabà, & Serrat, 2014a). Among these barriers, the attitudes of staff seem to be particularly important because the way they deal with sexual situations (i.e., by supporting them, concealing them, or repressing them) has a key influence on what is and what is not allowed within a LTCF (Bentrott & Margrett, 2017; Mahieu, van Elssen, & Gastmans, 2011). The pressures of limited provision and development of front-line care staff may reinforce a bed-and-body model of care, which squeezes out consideration of holistic support, neglecting issues such as sexuality and leaving under-prepared care staff to deal with complex moral dilemmas in this area (Simpson et al., 2017). It should also be borne in mind that LTCF residents and staff share the same physical space and spend a great deal of time together, thus compromising privacy (Bauer, 1999a); furthermore, the care tasks carried out by staff often involve intimate activities such as washing, bathing, or dressing, which may

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well increase their exposure to residents' expressions of their sexual needs (Taylor & Gosney, 2011). The staff's management of sexual situations depends, at least in part, on the extent to which they consider these situations to be embarrassing, distressing, or difficult to deal with.

Therefore, exploring the kinds of situations which cause the most discomfort to LTCF staff is essential in order to identify specific difficulties and to design and implement institutional policies that optimize and homogenize staff's responses to sexual issues and at the same time guarantee residents' sexual rights (Lester et al., 2016; Villar, Celdrán, Serrat, Fabà, & Martínez, 2018). The main objective of this study was to determine the kinds of situations that cause discomfort by administering a questionnaire to a wide and diverse sample of staff members employed at Spanish LTCF.

To our knowledge, this issue has not been specifically assessed in previous work, although several useful studies have focused on staff's attitudes and management of residents' sexual expressions and can provide us with clues regarding the various situations might cause discomfort. Roughly, these studies can be divided into two main groups: (1) those that assess attitudes towards situations derived from universal sexual needs that do not disappear with age and whose expression in institutional settings might be problematic and (2) those focused on sexual expressions derived from pathological conditions and labeled as "inappropriate" because they are unsafe, disruptive, and damaging to the care of the resident and, in consequence, might cause difficulties to the staff who have to deal with them.

With regard to the first type of study, staff attitudes seem to vary depending on the specific sexual behavior in question. Thus, kissing, hugging, or holding hands are typical expressions of affection that are well accepted in LTCF, and staff tend to adopt a condescending or paternalistic stance towards them (Bauer, 1999b), regarding them as "cute" or even "amusing" (Ehrenfeld, Bronner, Tabak, Alpert, & Bergman, 1999). Such permissive (yet infantilizing) attitudes are less likely when demonstrations of sexual arousal and desire are more explicit, such as sexual intercourse, which might provoke anger, disapproval, or embarrassment among staff (Taylor & Gosney, 2011; Villar, Fabà, Serrat, & Celdrán 2015a). Masturbation, perhaps the most frequent and readily available form of sexual release in LTCF, may also considered as a problematic behavior by some staff members. Villar, Serrat, Celdrán, & Fabà (2016) found that masturbation was deemed acceptable by staff members, but that when asked about the reactions of their colleagues, they were far more likely to report gossiping or joking or suggestions that the resident should be reprimanded. This indicates the existence of widespread negative reactions towards this kind of sexual activity in LTCF.

Other less common sexual expressions might cause even more discomfort to staff. For instance, with regard to same-sex sexual orientation, it has been found that homophobia and heterosexism are strongly present in the health-care environment (e.g., Addis, Davies, Greene, McBride-Stewart, & Shepherd, 2009) and that even when staff in LTCF openly express acceptance of same-sex sexual orientation, they tend to consider it as a potential problem that requires action to avoid feelings of discomfort or complaints from family, other residents, or other staff members (Villar, Serrat, Fabà, & Celdrán, 2015b).

This consideration of sexual activities as a source of discomfort increases when a person with dementia (PwD) is involved. In this case, staff members may tend to consider sexual behavior as a symptom of the disease rather than as a normal expression of a need that does not disappear in PwD (Ward, Vaas, Aggarwal, Garfield, & Cybyk, 2005). In addition, issues concerning abuse and lack of consent, particularly in partnered sexual relationships when just one partner is a PwD, may exacerbate the staff's difficulty in managing this kind of situation and may increase their feelings of discomfort (e.g., Tarzia, Fetherstonhaugh, & Bauer, 2012; Villar, Celdrán, Fabà, & Serrat, 2014b).

Sexuality in PwD opens the door to the second type of sexual situation that staff regard as difficult to manage: what are known as "inappropriate sexual behaviors in dementia" (ISBD; Higgins, Barker, & Begley, 2004; Wiskerke & Manthorpe, 2018; Onishi et al., 2006), a kind of behavior observed across the spectrum from mild cognitive impairment to severe dementia. They are not at all uncommon in LTCF, with a prevalence estimated to range from 2 to 25% of residents (Alagiakrishnan et al., 2005; de Medeiros, Rosenberg, Baker, & Onyike, 2008).

The boundary between sexual expressions deemed "appropriate" or "inappropriate," or between what is "normal" or "abnormal" in sexual behavior, is subjective and is susceptible to individual, institutional, and cultural differences. Some authors choose to define ISBD specifically on the basis of the distress or concern that the behavior causes to others (e.g., Benbow & Beeston, 2012) or on the degree of impairment of care provision caused by the behavior (Wilkins, 2015). In both cases, emphasis is placed on the importance of knowing which sexual expressions are considered as distressing, embarrassing, or difficult to manage by others, and specifically by care providers.

However, the nature of ISBD, and the degree or discomfort they are likely to cause, may be very diverse. For instance, de Medeiros et al. (2008) differentiate between disinhibited behavior (impulsive, indiscriminate, or invasive sexual actions, e.g., touching a nurse's breast in a bathing routine or showing one's genitals in public), intimacy-seeking behaviors (courtship or affective behaviors addressed to the wrong person, e.g., misidentifying him/her as a significant other), and nonsexual behaviors (behaviors without sexual intention that are mistakenly regarded as sexual by others). De Medeiros et al.

(2008) order these behaviors according the degree of disruption they cause, with disinhibited behaviors being the most troublesome.

In contrast, other authors (e.g., Benbow & Beeston, 2012; Tzeng, Lin, Shyr, & Wen, 2009) followed the pioneering classification proposed by Szasz (1983), who divided ISBD into sexual talk (including the use of "foul" language, the unrequested description of past or present sexual experiences or asking staff members to engage in sexual activities), sexual acts (including exposing genitalia, public masturbation, or touching or grabbing staff's breasts or other body parts) and implied sexual behavior (referring to viewing pornographic material or making sexual compliments to staff members or other residents). Sexual acts are the ISBD that cause the most problems to staff.

However, these potentially problematic ISBD (sexual acts in Sasz's classification or disinhibited sexual behaviors in De Madeiros et al.'s terminology) seem to group a very wide range of behaviors under one heading. Therefore, Tzeng et al. (2009) or Markimoto, Kang, Yamakawa, & Konno (2015) proposed to divide them into those involving physical contact with others (e.g., sexual intercourse, cuddling, or touching) and those that do not (e.g., masturbating, exposing breasts, or genitals). Probably, the level of concern raised among care providers by one or other category is notably different, as the former case involves issues of consent and abuse. However, in the case of ISBD, no empirical studies have sought to identify the situations that cause the most discomfort, even though (as we noted above) this is a key element in its definition.

To sum up, when sexual behaviors appear at LTCF, staff may find them difficult to manage. They may be treated as a potentially disruptive issue both by staff members and by the organization as a whole, and as something that may endanger relationships between residents and between the LTCF and residents' families (Hajjar & Kamel 2003). However, to date, no studies using a wide and diverse sample of staff members have been carried out to identify the sexual behaviors in LTCF that cause the most discomfort among staff; neither have studies explored whether there are specific circumstances that might induce a staff member to consider a sexual situation as discomforting. For instance, factors such as gender, the place where the behavior takes place, the direct involvement of staff members or relatives in the situation or, obviously, issues related to consent (Mahieu & Gastmans, 2012) may well influence staff's reactions to residents' expressions of their sexual needs.

In the light of the above, this study aimed to explore which kinds of residents' sexual expressions cause the most discomfort to staff and to determine the situational circumstances (gender of the protagonist, where the event takes place, who participates in the situation, and issues regarding consent and abuse) that might be related to this perception of discomfort.

Methods

Participants

Participants in the study comprised 1895 front-line care staff (staff directly involved in or responsible for care, including directors, technical staff, and auxiliary carers) employed at 152 LTCF from Spain's 17 autonomous regions. The sample was gathered by non-probabilistic procedures. LTCF included nursing homes and assisted living facilities since in Spain both types of care are usually provided by the same institution ("residencia de personas mayores").

Participants' mean age was 39.45, with a standard deviation (SD) of 10.84. Ages ranged between 18 and 70, and 86.6% of the participants were women, a percentage that is similar to the national profile of professional carers, which is highly feminized (Tobaruela, 2003). Table 1 provides some descriptive characteristics of the participants.

To participate in the study, LTCF had to appear in the official register of Spanish residential centers and be long-term facilities for care-dependent older people. Centers catering only for people with a high level of independence and autonomy were excluded, as were palliative care units. Since we wanted to explore sexuality issues in centers where older people actually live, acute care or convalescence centers, or day-care or short-stay units were also excluded from the study.

Measures

Data were gathered by means of a self-administered two-section questionnaire designed by the researchers. The first

Table 1 Description of the sample

	Total ($N = 1895$)
Age (*M*, SD)	39.45 (10.84)
% Females	86.6
Education (%)	
Primary studies	9.7
Secondary studies	50.9
University studies	39.3
Religiosity (%)	
Very	8.2
Quite	28.4
Little	41.3
No religious	22.3
Work position (%)	
Managers/directors	9.1
Technical staff	30.0
Care assistants	61.8
Years of experience (*M*, *SD*)	9.91 (7.15)

section included sociodemographic questions such as gender, education (primary, secondary, and university), religiosity (very religious, quite, a little, and not at all), employment status within the organization (managerial, including directors, deputy directors, and coordinators; technical, including doctors, nurses, physiotherapists, psychologists, social workers, and occupational therapists; and care assistants), and years of experience in the care field.

The second section included both an open-ended question about discomforting experienced sexual situations and some multiple-choice questions aimed at exploring how staff reacted towards different sexual expressions of older people living at LTCF. Since presenting the whole data set we gathered would not be possible in a single paper, and multiple-choice questions were not related to the narrated situation, in this paper, we limited our analysis to participants' answers to the first open-ended question, which was "Please explain briefly a sexual situation which, in your experience as a member of the staff of a LTCF, has caused you discomfort."

Procedure

The first author sent e-mails to 200 LCTF from different regions in Spain that met the inclusion criteria and outlined the objectives of the study and the general procedure for data collection. One hundred and fifty-two LTCF (76%) agreed to participate in the study.

Researchers proposed that each center should appoint a member of staff to coordinate the administration of the instruments. Staff coordinators received an envelope containing questionnaires and a written protocol including the following information: (a) which professionals should be invited to complete the instruments (care assistants, members of technical teams, and directors/managers); (b) advice about how to facilitate participation, maintain confidentiality, and ensure that each questionnaire was completed individually; and (c) instructions regarding the receipt, storage, and return of the questionnaires. Researchers contacted each staff coordinator regularly and individually in order to resolve any issues they might have.

The first page of the questionnaire included detailed information on the purpose of the study and how the information would be managed in order to ensure anonymity and confidentiality. Participants answered the questionnaires at home and then handed them in to the staff coordinator. Each participant had to sign an informed consent form. Participation in the study was voluntary, and no compensation was offered of any kind.

Researchers sent out 3627 questionnaires by post, of which 2261 were returned (a response rate of 63.3%). Among the questionnaires returned, 366 had left the question analyzed in this paper in blank. Thus, the final sample entered in the analysis comprised 1895 questionnaires (52.2% of the questionnaires initially sent).

The entire process was approved and supervised by the Ethics Committee of the Faculty of Psychology of the University of Barcelona.

Analytic Strategy

Participants' responses were transcribed, entered into a database, and content-analyzed by authors 1 and 2.

Researchers first read all the responses to gain familiarity with the data. They then tried to group situations based on repetitions or similarities between them (Krippendorff, 2013). These categories (or types of situation) were inductively differentiated according to the sexual behavior they included. To increase the reliability of the results, the process of categorization was conducted independently by two researchers. Categories obtained by each researcher were compared, and differences were discussed until a consensus on the category system was reached.

Once the categories had been obtained and defined, the researchers independently read the situations again and tried to assign them to a category. Disagreements were identified and used to refine categories, define their limits, and adjust their definition until researchers agreed on a final version of the categorization.

The last step involved an independent rater (researcher 3) who had not participated in the previous process. This rater was given a randomly selected 20% of the answers and the final version of the category system (including category definitions when needed) so that he could assign situations into categories. This independent categorization was compared to the one agreed upon by the researchers by means of the kappa reliability index, an estimation of the extent to which two independent observers agree in their categorizations. The kappa index was .93, which indicates a very good inter-observer reliability (Landis & Koch, 1977).

Additionally, to examine the circumstances in which the sexual situations occurred, each one was coded according to five criteria: location (private space, including resident's room or bathroom; public space, including corridors, dining room, patios, and other common areas in the facility; and location not specified), protagonist/s (one resident involved, two residents involved, more than two residents involved, staff member/s playing a role other than witnessing the situation, visitor/s or relative/s playing a role other than witnessing the situation, other or not specified), protagonists' gender (at least one man involved, at least one woman involved, not reported), explicit mention of disability or cognitive impairment (yes or no), and explicit mention of abuse or consent issues (yes or no).

Results

Out of the 1895 participants who answered the question about the situation that caused the most discomfort, 411 (21.6%) said that they have never experienced a situation of this kind (see Table 2). Most responses were brief, composed by just one or two sentences, but they usually included information to identify the nature of the sexual behavior at stake, as well as the number (see Table 2) of people involved and their gender (see Table 3).

The most frequent sexual situation mentioned by our participants was masturbation, which accounted for almost one third of all the situations. Sexual intercourse was the second most frequent category, included in 17% of situations. After these two categories, there were six others with percentages between roughly 5 and 10%: unidirectional stimulation, sexual talk, mutual stimulation, shared intimate situations, harassment, and oral sex.

We found four additional types of situations showing percentages below 5%: sexual arousal, exhibitionism, explaining to others, and use of pornography, which was mentioned just by 11 participants. Finally, 26 responses did not fit in any category because they reported an extremely rare situation or because they did not offer enough clues to be categorized in any of them. We created a single category "others" for these answers.

Table 3 shows the circumstances that characterized the different kind of sexual situations identified by our participants.

Table 2 Definitions (including examples), frequency, and percentage of categories grouping different discomforting sexual situations

Category	Frequency (%)
Masturbation: situations where residents stimulate their own genitals by manual or instrumental manipulation (e.g., "I saw a resident jerking off in his room").	469 (33.5)
Sexual relationship: situations in which a couple of residents are having a sexual relationship, including coitus (e.g., "Two residents were surprised having sexual relationships in her room").	238 (17.0)
Unidirectional stimulation: situations in which one resident hugs, caresses, fondles, touches, or grabs parts, generally breasts or genitalia, of the body of another resident (or member of staff), who does not collaborate or participate actively (e.g., "one man tried to kiss a female resident, and then tried to caress her genitals").	147 (10.5)
Sexual talk: situations in which the protagonist makes sexual propositions, talks about past sex life or sexual preferences, or uses foul language (e.g., "one resident could not stop telling obscene stories to female residents and even to me and my colleagues").	124 (8.9)
Mutual stimulation: situations in which two residents are involved in mutual masturbation, hugging, fondling, or caressing, both of them participating actively in the situation (e.g., "a couple touching and fondling each other in the corridors").	100 (7.1)
Shared intimate situation: situations in which the type of sexual behavior at stake is not clear. There are no explicit mention of a sexual relationship, but residents are in a situation of intimacy (e.g., "Two residents, a man and a woman, were found sharing the same bed").	100 (7.1)
Harassment: situations describing how one person threatens or uses violence to achieve sexual goals, or when one or more of the protagonists do not consent to the situation (e.g., "one resident waited for a colleague with a condom on his penis and tried to force her to have sexual intercourse").	92 (6.6)
Oral sex: situations describing one person sucking other person's genitals (e.g., "We found a woman sucking a resident's penis, in his room")	82 (5.9)
Sexual arousal: situations in which erection or other explicit signs of sexual arousal are mentioned (e.g., "once I was bathing a resident and I noticed that he had a full erection").	40 (2.7)
Exhibitionism: situations in which a resident shows her/his genitals or other intimate body parts in public or common spaces (e.g., "when a resident pulled up her skirt in the dining room and showed her genitalia to everybody present")	34 (2.5)
Explaining to others: situations in which a staff member hasta to report on sexual issues with relatives or to talk about such issues with a resident (e.g., "I had to tell a relative that her father was having an affair with another resident").	21 (1.5)
Use of pornography: situations in which residents use sexual material or watch pornographic movies or pictures, without any explicit reference to masturbation or sexual intercourse (e.g., "I went to make a bed and found the resident watching a porn movie").	11 (0.8)
Other: responses did not fit or offer enough clues to be included in the categories above (e.g., "We found remains of a sausage in a resident's vagina").	26 (1.8)
Total	1484 (100)

Table 3 Frequency and percentage (among brackets) of different circumstances appearing in the situations mentioned by participants

	Total *N* = 1484
Location	
Private	285 (19.2)
Public	525 (36.4)
Other/not specified	674 (45.4)
Participants	
One resident	482 (32.5)
Two residents	610 (41.1)
Diverse residents	37 (2.5)
Resident + staff	226 (15.2)
Relative/visitant	45 (3.0)
Other/Not specified	84 (5.7)
Protagonists' gender	
Man involved	1099 (74.1)
Woman involved	558 (37.6)
Not explicitly reported	246 (16.6)
Explicit mention to disability or cognitive impairment	132 (8.9)
Explicit mention to abuse or not consentment	81 (5.5)

There were more sexual situations causing discomfort in public spaces, although almost 20% of situations were located in private spaces.

As for the protagonists, situations involving a couple were the most usual ones, but situations with just one resident or involving staff members were not at all infrequent. As for gender, far more situations involved men than women. Some categories that involved a single protagonist, such as sexual arousal (category in which no woman was depicted as protagonist), harassment (only in 3 out of the 90 mentioned cases was the harasser a woman), or masturbation (where just 1 out of 10 references was to a woman), were almost entirely dominated by men.

Finally, explicit references to disabilities/cognitive impairments or to abuse/lack of consent were relatively uncommon, being present in less than 10% of the situations.

There were not statistically significant differences in the stories told (and in their characteristics) according to gender or work position (managerial staff vs technical staff vs care assistants).

Discussion

The objective of this study was to identify the sexual situations that cause discomfort among staff working at Spanish LTCF and to determine the situational circumstances involving these perceptions of discomfort.

Most participants were able to mention at least one sexual situation that had caused them discomfort, which suggests that sexual situations represent a challenge for staff members. We also found that, although ISBD have been defined in the literature in terms of the discomfort that these situations cause to care providers (e.g., Benbow & Beeston, 2012), the range of sexual situations mentioned by our participants clearly goes beyond the typical behaviors associated with ISBD. For instance, participants mentioned residents' cognitive impairment or disability in less than 10% of the situations. Obviously, this does not mean that ISBD were not important, but it obliges us to take at least two issues into consideration.

Firstly, many of the sexual behaviors (and among them, the most frequent ones) reported as causing discomfort were the ones also identified as the most common among older people living in the community, such as masturbation, sexual intercourse, or hugging/kissing (e.g., Lindau et al., 2007, Palacios-Ceña et al., 2012). So certain sexual behaviors in which older people normally engage cause discomfort to staff when performed in a LTCF, a place where the privacy usually associated with sexual expressions is difficult to attain.

In this respect, masturbation is the scenario most mentioned by our participants. Some authors see masturbation as a way of compensating for the lack of other forms of sexual expression, particularly partnered sex (Das, 2007); therefore, in institutional contexts, in which the availability of partners and private space for partnered sex is very limited, masturbation may become a more accessible sexual behavior. The fact that this behavior causes discomfort may interfere with its acceptance and suggests that LTCF should implement practices and spaces to allow its practice (Villar et al., 2016). The same could be said of other sexual behaviors that are common among older people living in the community and also appeared frequently in our participants' responses, such as sexual intercourse, mutual stimulation, or shared intimate situations.

Secondly, our results suggest that the classifications used to identify sexual situations in LTCF based on ISBD (de Medeiros et al., 2008, Szasz, 1983) are not helpful when trying to describe the range of situations that appear in our study. Some categories differentiated by these classifications, such as verbal talk or indirect sexual behaviors, do cause discomfort, but they appeared relatively rarely in our study. In contrast, a single category—sexual acts—includes most of the behaviors mentioned by our participants, regardless of the difference in their nature and implications. Recognizing the diversity and differences between sexual situations occurring in LTC facilities is a first step on the way to giving a tailored response to these situations and to alleviate the degree of discomfort they may cause to staff. It would also help to avoid considering residents' sexual behaviors as symptoms of an underlying illness, but very often as expressions of a need and a right that do not disappear once the person enters the institution.

To understand staff discomfort regarding sexual situations, it is also essential to take into account not only the kind of behavior but also the circumstances in which it occurs. Our results suggest that most of the situations that cause discomfort occur in public spaces: this indicates that it may be the public manifestation of the behavior, rather than the behavior per se, that makes the situation embarrassing or uncomfortable. However, when the location is specified, at least one third of these situations causing discomfort occurred in private spaces (see Table 3), that is, the only spaces residents have to express their sexuality with the level of intimacy required by most expressions of sexual needs.

Our results also indicate that men are more involved than women in situations that cause discomfort. In situations involving just one person (e.g., masturbation), the tendency to mention men is very clear, thus corroborating previous research suggesting that masturbation is far more frequent among older men than among older women (e.g., Palacios-Ceña et al., 2012). In other situations, such as unidirectional sexual stimulation or harassment, women tend to appear as passive objects of sexually active men. The preponderance of men involved in sexual expressions in LTCF, even though they represent a minority of the residents (Tobaruela, 2003), has also been found in other studies focused on ISBD (e.g., Alagiakrishnan et al., 2005, Ward & Manchip, 2013). Although biological differences might be involved, cultural gender narratives may also play their part: sexual initiative may be deemed natural and desirable among men, and something that does not wane with age, whereas women are considered to be more passive and uninterested in sex as they grow older (Sandberg, 2016).

Our results also suggest that sexual situations involving staff members are not uncommon and in fact account for one out of every six situations that cause discomfort. Most of them involve some kind of harassment or being the object of unwelcome sexual advances (fondling or touching, or verbal propositions) by residents. Since the staff at Spanish LTCF are predominantly female, gender issues are also important to understand these interactions, mostly initiated by older men. Exposure to situations of this kind is likely to increase work-related distress and burnout among staff, particularly if they do not receive personal or institutional support to handle the situation.

This lack of resources and staff development is also particularly notable among members of staff who described situations in which they have to talk about sexual issues to residents or relatives as discomforting.

Finally, issues related to sexual diversity hardly appeared at all in the situations reported by our participants. Only 53 out of 1484 situations involved two men, suggesting a gay relationship. Lesbian relationships were even rarer, being mentioned in just six cases out of 1484. Although this cannot be deduced from our results, perhaps the fact that many older lesbians and gay men had to hide their sexual orientation and "go back into the closet" (e.g., Willis, Maegusuku-Hewett, Raithby, & Miles, 2016) explains these extremely low percentages of situations involving same-sex sexual activity.

This study has several limitations that must be considered in any interpretation of the results. Firstly, the sample, though very large, was obtained by a non-probabilistic procedure, which limits the extent to which the results can be generalized. Secondly, participants were prompted to select just one sexual situation, even though they may have reported more than one. There is no way of knowing why participants selected a particular situation. Several different criteria may have been used: they may have chosen the event that caused the most discomfort, or the most frequent one, but also the most shocking one or the most awkward one. In any case, the situations recorded in the study cannot be taken as a wholly reliable representation (in terms of frequency or intensity) of sexual situations causing discomfort in LTCF. Finally, cultural factors may also have played a role. For example, Spain is mainly a Catholic country, and this may have influenced both the kinds of sexual expression of older people living in LTCF and the perception of discomfort towards sexual situations of the staff working there. Therefore, although literature discussed in this paper suggests that stories told by our participants may be transferable to elsewhere in Europe, Australia, or the US, we need more research on this issue.

Despite those limitations, our study highlights how sexual situations causing discomfort are frequent, diverse, and not restricted to ISBD. Common behaviors in healthy people living in community (e.g., masturbation, sexual intercourse, shared intimate situations, mutual sexual stimulation) and sexual expressions appearing in private spaces may also cause discomfort in staff when enacted in LTC facilities.

Our results have at least two practical implications. Firstly, sexual issues must be included in the formal staff development, from the directors to auxiliary carers. This training should include how to manage the diverse range of sexual situations that occur in LTCF, and discuss how to preserve the balance between two contradictory principles that sometimes come into conflict (Tarzia et al., 2012): guaranteeing residents' sexual rights in a context in which sexual expression is not easy and protecting residents (and staff too) from abuse and non-consensual relationships. Training should be addressed and adapted to all staff levels, so that all staff members are able to give a consistent response to these issues.

Second, our results suggest the importance of developing explicit guidelines and institutional policies regarding sexual expression in LTCF. These policies should help to establish a joint approach to this issue and thus contribute to reducing the degree of discomfort and embarrassment that sexual situations may cause to staff (Cook, Schouten, Henrickson, & McDonald, 2017). In addition, these policies should consider ways of allowing residents to express and channel their sexual needs while at the same time safeguarding the rights of other people.

Compliance with Ethical Standards

Conflict of Interest The authors declare that they have no conflict of interest.

Ethical Approval All procedures performed in studies involving human participants were in accordance with the ethical standards of the ethical committees of the institutions participating in the study and with the 1964 Helsinki declaration and its later amendments or comparable ethical standards.

Informed Consent Informed consent was obtained from all individual participants included in the study.

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