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Staff Responses to Sexual Self-Stimulation by Residents with Dementia Living in Residential Aged Care Facilities: A Qualitative Systematic Review

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Abstract

This review synthesizes qualitative evidence about staff members' responses to sexual self-stimulation by residents with dementia living in residential aged care facilities, in an effort to understand the kinds of attitudes their responses convey to residents. A three-step search strategy was created by a librarian and used to identify English language qualitative primary research studies. The search was conducted across four academic databases (Medline, Cumulative Index to Nursing and Allied Health Literature, Embase, Education Resources Information Centre). Grey literature searches were conducted in Google and ProQuest Dissertations and Theses. The reference lists of included studies were also searched for additional resources. Two papers met the inclusion criteria. Two researchers independently appraised the quality of the studies and both were of sufficient quality to merit inclusion. Data extraction was performed by two independent researchers and revealed 24 findings. From these findings, all researchers agreed upon two overarching synthesized findings: 1) staff responses (including normalizing, avoiding interference, assisting) convey positive attitudes toward self-stimulation by residents with dementia in residential aged care and 2) staff responses (including reprimanding, pathologizing, and reporting to superiors) convey negative attitudes toward self-stimulation in this context. From these findings, the researchers highlight a particular need for research that explores residents' experiences of these encounters, along with research about variations between staff members' hypothetical responses and their actual responses in practice. The researchers also highlight a need for increased conversation about the nature of public/private space in residential aged care facilities, which influence understandings of sexual propriety in these environments.

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1. Introduction

Many older adults express themselves sexually well into their advanced years [1]. Research has shown that rates of sexual intercourse often decrease as people age, but alternative sexual expressions (e.g., kissing, petting, flirting) remain important to many older adults well into advanced years [2][3]. Indeed, the need for sexual expression does not naturally decrease with age [2]. The misconception that older adults are primarily asexual is aptly called "ageist erotophobia" in the literature [4]. Ageist erotophobia is fear or revulsion toward the sexual activity of older adults, rooted in the misperception that older adults do not (and ought not) engage in sexual expression. This phenomenon can lead staff in residential aged care facilities (RACFs) to overlook or even discourage residents' sexual expressions [5]. This erotophobia is often amplified in the care of older adults with dementia, who may experience disinhibited sexual behaviors and hypersexuality because of their disease processes [6]. Challenges arise for staff when residents with dementia seem to lack the ability to make reasoned decisions around where, when, and with whom to engage in sexual expression [6][7]. Changes resulting from neurodegeneration can lead staff to dismiss all sexual expressions of people with dementia as inappropriate and to ignore their very real and enduring sexual needs [8]. Increasing dependency on care staff [9] and declining cognitive reasoning skills contribute to the impression that residents with dementia ought to be "post-sexual beings" [10]; people who are too far advanced in disease for appropriate sexual expression. Despite the misperception, many older adults with dementia experience very real sexual needs and continue to express themselves sexually regularly [11].

Staff in RACFs may also struggle to support older adults' rights to sexual expressions in the context of dementia because they must negotiate them alongside concerns about privacy, sexually transmitted infections, consent, and cognitive capacity [12]. Sexual self-stimulation is generally perceived as a safer form of sexual expression for people with dementia because it carries limited risk for disease transmission and is subject to less stringent standards of consent than sexual expression between two or more humans [13]. Sexual self-stimulation takes on a particular significance in the lives of people with dementia because it is often the only expression available to them when current partners do not share the cognitive deficit and/or potential partners (those near the resident) lack the capacity to consent to sexual interaction [7][14][16]. Self-stimulation includes any repetitive, self-focused behaviors that produce sexual pleasure. This can include stimulating one's own genitals, regarding pornographic materials, sensual self-talk, sexual reminiscences, and fantasizing [17]. Despite its importance as a means of sexual expression for older adults with dementia, little is known about staff attitudes toward sexual self-stimulation in the context of residential dementia care.

This systematic review explores existing literature on staff responses to sexual self-stimulation by people with dementia living in RACFs, to uncover what attitudes those responses might convey toward self-stimulation. This review considered the following questions to support this overall aim:

1. What are staff responses to actual encounters with residents engaged in sexual self-stimulation?

2. What responses do staff members imagine having upon encountering residents' sexual self-stimulation?

2. Related works

The focus in dementia and sexuality research has traditionally been on partnered sex. Ethical and legal issues of capacity and consent to partnered sex have been explored in-depth in the literature [7][13][14][15][16][18][19][20][21]. For example, researchers have explored changes to sexual expression and intimacy in couples where one partner is diagnosed with dementia and the other is not [22][23][24][25]. These sexual encounters often raise questions about consent, assault, and sexual abuse [26]. They have been the subject of recent legal cases that strive to differentiate sexual abuse from voluntary sexual activity between couples with mixed cognitive abilities [15]. People with dementia and their supporters are increasingly speaking out about the misperception that a dementia diagnosis signals global incapacity for decision-making [27]. This advocacy has prompted questions about the threshold at which sexual decision-making is no longer possible [26][28]. It also raises concerns about who is best able to make sexual decisions for the person with dementia [4][7][15]. Can a partner who is also a designated decision-maker provide consent to sexual activity on behalf of their partner? Is it ever appropriate to provide consent to sexual activity on behalf of someone else? Similar questions arise when partnerships form between two residents with dementia in a RACF. This phenomenon is relatively common in RACFs, where access to partners and common features of the dementia process (e.g., hypersexuality, disinhibition) increase the likelihood of sexual activity [6][26]. Residents may already be married and engaging in sexual relations with someone other than their partner. This can raise strong emotions for the partner and family members[16][19]. Staff may also experience moral concerns about adultery [26], and they may question their role in supporting residents' expressions if they appear to harm the family or seem inconsistent with the resident's previously held values [7].

Additional literature on sexual expression in dementia focuses on inappropriate sexual behaviors (ISBs) of dementia [8][29]. There is no universally accepted definition of ISBs [8], but definitions typically emphasize hypersexuality and sexual behaviors that interfere with daily functioning [29]. Some authors understand ISBs as a subdimension of aggressive and agitated behaviors [30]. The distinction between appropriate and inappropriate sexual behaviors is often unclear to staff, and understandings of appropriateness "may derive from observers' disapproving attitudes and judgements (e.g., clinicians, nurses and other staff, family, other residents) rather than the behaviours per se" [6]. A basic tenant of person-centered care is that all behavior has meaning, and some researchers encourage exploration of the needs that drive hypersexual and disinhibited behaviors in dementia [31]. Unmet needs for intimacy, stimulation, non-medicalized physical touch, partnership, and belonging may drive ostensibly inappropriate sexual behavior [31]. Focusing on unmet needs might also prompt staff to consider how they might facilitate healthier and more socially appropriate forms of expression.

Self-stimulation is often considered a healthier and more appropriate form of sexual expression because it does not pose the same ethical and legal risks, nor the same risk for sexual transmission of infection. At times, though, self-stimulation can become challenging if it occurs in the wrong context (e.g., communal spaces, during personal care), is done in ways that cause injury to sexual organs, or when it occurs so frequently that it interferes with regular activities [17]. Regardless of its 'appropriateness', self-stimulation remains a complex and challenging activity for care home staff. It is currently managed in largely ad hoc ways, and management often depends upon staff's personal values and assessments rather than evidence-based policies [32][33]. While individual studies have explored staff's perceptions of sexual behaviors in dementia more generally, there has never been a systematic exploration of staff responses to self-stimulation specifically. A systematic review of staff responses to sexual self-stimulation

is warranted at this time, given the prevalence of self-stimulatory behaviors in residential dementia care and the possibility that self-stimulation may be an appropriate way to meet unmet physiological and sensory needs. Management of self-stimulation—whether expressed 'appropriately' by residents or not—troubles care staff in unique ways and a systematic review of available evidence will aid in developing evidence-based policies related to the phenomenon.

3. Methods

The authors considered qualitative studies that addressed staff members imagined or actual responses to sexual self-stimulation by residents with dementia living in RACFs. There were no date limits imposed on the search. The authors considered studies that focused on any staff members, including nurses, physicians, social workers, allied health professionals, and administrators of all ages, education levels, experience, genders, and ethnicities. Studies focusing on self-stimulation included, but were not limited to, studies that explored genital stimulation, reviewing pornographic materials, exposure of sexual organs, and sensual self-talk. Studies were considered for inclusion if they were conducted in any setting that provided residential care for older adults. RACFs included long-term care facilities, special care homes, hostels for the aged, geropsychiatric facilities, and in-patient geriatric units.

The three-step search strategy for this review was developed by the fourth author, a librarian, and aimed to locate published and unpublished studies. An initial limited search of MEDLINE (Ovid) and the Cumulative Index to Nursing and Allied Health Literature (CINAHL, EBSCO) was undertaken using the following keywords: masturbation, self-stimulation, self-pleasure, onanism, staff perception, staff attitude, staff response, dementia, cognitive impairment, residential aged care, long-term care, and nursing home. This was followed by an analysis of the index terms of relevant studies, as well as the key terms used in the titles and abstracts. A second search using all identified keywords and index terms was performed across the following academic databases: CINAHL with Full-Text (EBSCO), Medline (Ovid), Embase (Elsevier), and Education Resources Information Centre (ERIC, EBSCO). A search for unpublished and grey literature was undertaken in ProQuest Dissertations and Theses and Google. Lastly, the reference lists of all identified studies were searched for additional resources. Despite this thorough approach, it is still possible that some studies were missed by the search strategy.

Following the search, all identified citations were collated and uploaded into reference management software called Endnote V8.2 (Clarivate Analytics, PA, USA). This software allows all references from database searches to be downloaded as a single file and stored in a central location. References were then uploaded from Endnote into Covidence (Covidence, Melbourne, Australia). Covidence is an online screening tool that streamlines the systematic review process. Titles and abstracts of all references were screened in Covidence by two independent reviewers for assessment against the inclusion criteria. Potentially relevant studies were retrieved in full. Studies that did not meet the inclusion criteria were excluded. Any disagreements that arose between the reviewers were resolved through discussion. Two studies [34][35] met the criteria for inclusion. Both studies were independently appraised by two authors for methodological quality and dependability using the standard *Joanna Briggs Institute Critical Appraisal Checklist for Qualitative Research* [36]. Possible levels of article dependability were high, moderate, and low.

Data were extracted using the *Joanna Briggs System for Unified Management of the Assessment and Review of Information* (JBI SUMARI). Two authors extracted the primary findings from each article, along with directly reported evidence of those findings. This

evidence took the form of verbatim quotations from the studies' participants that illustrated the study findings. Each finding was then assigned an individual level of credibility (unequivocal, credible, unsupported) based on the congruence between the study authors' stated findings and the evidence provided. The findings were grouped into categories based on similarities in meaning and then examined to generate a comprehensive set of synthesized findings that best represented the body of evidence on the topic. The authors produced a pair of synthesized findings for this review. Any disagreements during this process were resolved through discussion. The final synthesized findings were then graded using the ConQual approach, which combines the dependability and credibility ratings described above to generate an overall grade for the quality of the synthesized evidence [37].

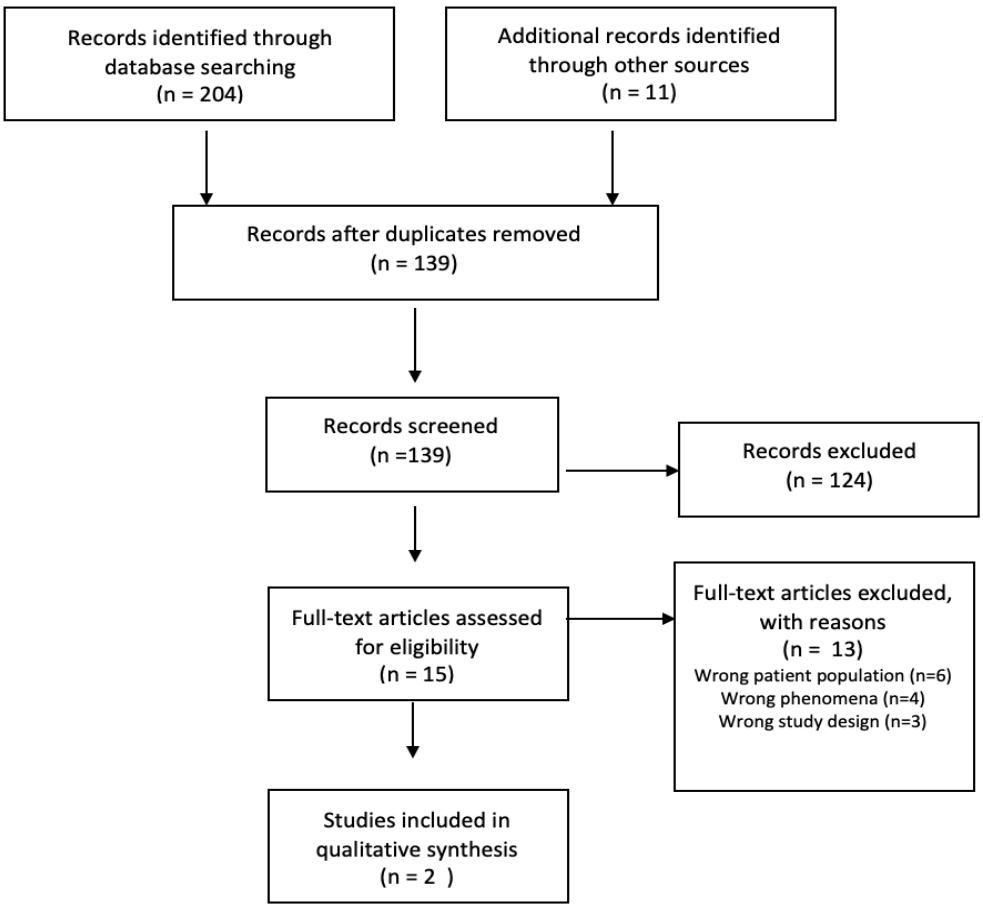

Figure 1. PRISMA flow diagram

Table 1. Characteristics of included studies

Study	Methods for data collection/ analysis	Country	Phenomena of interest	Setting/ context/ culture	Participant characteristics and sample size
Villar F. et al. (2019)	Survey with closed and open-ended questions	Spain	Residents' sexual expressions and staff discomfort	152 long-term care facilities across Spain	Front-line care staff (n=1895). Approximately 62% were care assistants and remaining staff were managers/directors and 'technical staff' such as doctors, nurses, physiotherapists, psychologists, social workers, occupational therapists
Villar F. et al. 2016.	Semi-structured interviews, including open-ended questions about attitudes toward sexuality in later life and responses to a vignette about interrupting a resident while they masturbated in their room	Spain	Masturbation and staff responses	5 long-term care facilities in Spain	Staff members (n=53) with at least one year of long-term care experience, at least 6 months of experience in the facility, and direct care experience with residents; nursing assistants (n=23) and professional/managerial staff (n=30) including managers, education specialists, nurses, physiotherapists, psychologists, and social workers)

4. Results

After duplicates were removed, the initial search revealed 139 studies. Of these, 124 did not meet the study criteria. Fifteen studies were reviewed in full, and 13 were excluded with reasons. The reasons for exclusion included: wrong patient population (n=6), wrong phenomena (n=4), and wrong study design (n=3). The final number of studies documenting staff responses toward self-stimulation by residents with dementia was small, with only two studies included in the final set [34][35] see [Figure 1]. Included studies were published in 2016 and 2019, and both studies were completed by the same primary investigator. Both studies were completed in RACFs across Spain. Both studies focused on a broad mix of staff and paid explicit attention to residents with dementia. Individual characteristics of the two studies are presented below in Table 1. While the final number of studies was only two and the primary investigator was the same for both studies, the authors chose to continue with the systematic review. This decision was reached through discussion and was made because both studies were of moderate quality and the authors felt that synthesized findings from the review would further the understanding of staff responses to self-stimulation in the context of residential dementia care.

There were 24 findings overall. Findings were drawn directly from the two studies [34][35] and illustrated by verbatim illustrations from their study participants. The credibility of 18 findings was graded as unequivocal and the credibility of the remaining six was graded as credible. Findings were grouped into five categories based on similarity in meaning. These categories were analysed and aggregated further to produce two synthesized findings: 1) staff responses convey positive attitudes toward self-stimulation and 2) staff responses convey negative or neutral attitudes toward self-stimulation. The overall ConQual score [37] for both findings, taking together the credibility scores of individual findings and overall article dependability scores, was moderate [Table 2].

Table 2. ConQual summary of findings

Synthesized Finding	Type of Research	Dependability	Credibility	ConQual Score	Comments
Positive attitudes [35]	Qualitative	Moderate (downgraded one level)	Moderate (downgraded one level)	Moderate	Dependability: Moderate. Study scored 4/5 (lacking statement locating authors theoretically/culturally) Credibility: Moderate. Downgraded one level due to mixture of unequivocal (U) and credible (C) findings. U=11; C=1
Negative attitudes [34, 35]	Qualitative	Moderate (downgraded one level)	Moderate (downgraded one level)	Moderate	Dependability: Moderate. One study scores 4/5, as noted above, and the other scored 3/5 (lacking statement locating authors theoretically/culturally and authors' influence on research) Credibility: Moderate. Downgraded one level due to mixture of unequivocal (U) and credible (C) findings; U=6; C=5

4.1 Synthesized finding one: Responses convey positive attitudes

Positive attitudes toward residents' self-stimulation were found to be communicated via staff members' normalizing, supportive, and neutral responses to residents' self-stimulation [34][35]. While neutral responses were not demonstrative of overtly positive attitudes, they did communicate staff members' respect for the residents' right to privacy and self-expression. This synthesized finding includes two categories: i) normalizing responses and ii) neutral responses, for a total of twelve findings see [Table 3].

Table 3. Results of meta-synthesis 1: Responses convey positive attitudes

Findings	Categories	Synthesized findings
Masturbation as a human need. U	Normalizing responses	Positive attitudes
Informing workmates. U		
Helping. U		
Other staff would react by avoiding interference like me. U		
Other staff would react by normalizing/accepting like me. U		
Recognizing embarrassment. U	Neutral responses	
Avoiding interference. U		
Apologizing. U		
Talk to the resident to understand their point of view. U		
Not saying anything. U		
Masturbating is a normal behavior among residents. C		
Masturbation is part of a resident's private world. U		

(1) Category 1.1 Normalizing responses.

Positive attitudes toward residents' sexual self-stimulation were communicated through actions that normalized the behaviors as natural human behaviors [35]. Staff who characterized self-stimulation as a normal part of sexual expression also tended to perceive that other staff member would normalize the experience and avoid interfering in the activity [35]. Normalizing responses were noted about self-stimulation that occurred in private [35]. Study participants tended to describe the responses they felt would be ideal, rather than the responses they have actually taken when confronted with self-stimulation in practice [35].

Finding 1: Helping.

"I'd ask her if she needed anything... I mean, if she needed some kind of cream to make stimulation easier, for instance" [35].

Finding 2: Informing workmates.

"I'd tell my workmates… just to warn them of what's going on with that resident so that they'd be careful about entering his room without knocking" [35].

Finding 3: Masturbation as a human need.

"I'd see it as something natural, something completely normal in everybody's life, a biological need" [35].

Finding 4: Other staff would also avoid interference.

"They [other staff] would react the same as me: closing the door and respecting their privacy and rights" [35].

Finding 5: Other staff would normalize/accept.

"They'd [other staff] act naturally. It's the resident's body and he can do as he pleases. Times change, and people of my generation don't see it as a sin, or as something shameful that must be kept hidden" [35].

(2) Category 1.2: Neutral responses

Positive attitudes toward self-stimulation were also communicated, albeit less explicitly, through staff members' neutral responses [35]. In these cases, staff described themselves as respecting the resident's privacy, recognizing the resident's potential embarrassment, reacting dispassionately, and talking to the resident to understand their perspective [35]. There were seven findings within this category.

Finding 1: Apologizing.
"I'd apologize. And I'd explain to the resident that, because he or she didn't answer when I knocked, I thought something might be wrong" [35].

Finding 2: Avoiding interference.
"I'd say: 'I'll be back later' and I'd leave quickly, so that he could finish the job without any interference, ha!" [35].

Finding 3: Masturbating is a normal behavior among residents.
"I don't see it as something to make a fuss about, and even if I did… well, provided they do it in their own private space. This is their home now, after all" [35].

Finding 4: Not saying anything.
"I wouldn't say anything. It's not something that should be talked about because it's private to the resident, we have no right to meddle" [35]

Finding 5: Masturbation is part of a resident's private world.
"I'd really regret it [interrupting a resident masturbating]. I'd feel that I'd invaded his privacy... and that I'd cut short his pleasure" [35].

Finding 6: Recognizing embarrassment.
"I'd say: 'Poor guy, I've interrupted him with the job half done'. And probably he's the one who feels really embarrassed, maybe not for doing it but for having been discovered" [35].

Finding 7: Talk to the resident to understand their point of view.
"If he or she is well enough to talk about it, I'd try to get some kind of explanation" [35].

4.2 Synthesized finding two: Responses convey negative attitudes

Negative attitudes toward residents' self-stimulation activities were communicated via staff members' actual and imagined reprimanding or denigrating responses toward residents' expressions of self-stimulation [34][35]. This synthesized finding included two categories: i) pathologizing/reprimanding responses and ii) uncomfortable responses see [Table 4].

Table 4. Results of meta-synthesis 2: Responses convey negative attitudes

Findings	Categories	Synthesized findings
Request help/advice from people who are better informed. U	Pathologizing/ reprimanding responses	Negative attitudes
Make the resident aware that masturbating might cause conflict. U		
Others would react based on traditional stereotypes of sexuality and aging. U		
Others would react by reprimanding. U		
Others would react by informing superiors. U		
Discomfort with exhibitionism. C	Uncomfortable responses	
Discomfort with masturbation. C		
Discomfort with sexual arousal. C		
Discomfort with sexual talk. C		
Discomfort with use of pornography. C		
Surprise. C		

(a) Category 2.1. Pathologizing/reprimanding responses

In some cases, staff responded that they would react to a residents' sexual self-stimulation by seeking out treatment options for the ostensibly aberrant behavior or by warning the resident against further self-stimulation [35]. There were five findings within this category.

Finding 1: Other staff would react by informing superiors.

"I don't know… I suppose they'd [other staff] avoid gossiping, but they'd inform the nurse or the psychologist" [35]

Finding 2: Request for help or advice from other people who were better informed.

"I would inform someone… Yes, I'd tell my supervisor or the psychologist about it. Maybe they could do something to deal with the situation if it happened again" [35].

Finding 3: Make the resident aware that masturbating might cause a conflict.

"Afterwards I'd talk to the resident. I'd say: 'Look, that was an embarrassing situation, you share the room with another resident and someone might easily open the door… things here are not like they were in your home!" [35].

Finding 4: Other staff would react with traditional stereotypes concerning sexuality in older age.

"Some of them [other staff] would make a fuss about it… some of them certainly would, joking about dirty old men and things like that" [35].

Finding 5: Other staff would react by reprimanding.

"It depends… but I'm sure that someone would react by saying 'Oh my God! What are you doing? How dare you do that filthy thing here! At least due to the bathroom so that nobody can catch you at it!" [35].

(b) Category 2.2: Uncomfortable responses

Many staff reported that they have experienced or would experience discomfort or surprise if they encountered a resident who was sexually aroused or engaged in a self-stimulation [34][35]. One study asked staff members to describe a situation in which they felt "the most discomfort" [34]. The other study elicited uncomfortable responses by asking participants how they would respond to a vignette read by the interviewer involving a resident who was masturbating [35]. There were seven findings within this category. In some cases, these responses occurred in response to public self-stimulation and others occurred in the resident's private room or during personal care [34][35]. In some instances, the activities involved others (e.g., self-stimulation during personal care) but were not ostensibly intended to elicit a sexual response from others [34][35]. There were seven findings in this category.

Finding 1: Discomfort with exhibitionism.

"[I felt the most discomfort] when a resident pulled up her skirt in the dining room and showed her genitalia to everybody present" [34].

Finding 2: Discomfort with masturbation.

"[I felt the most discomfort when] I saw a resident jerking off in his room" [34].

Finding 3: Discomfort with sexual arousal.

"[I felt the most discomfort when] once I was bathing a resident and I noticed that he had a full erection" [34].

Finding 4: Discomfort with sexual talk.

"[I felt the most discomfort when] one resident could not stop telling obscene stories to female residents and even to me and my colleagues" [34].

Finding 5: Discomfort with use of pornography.

"[I felt the most discomfort when] I went to make a bed and found the resident watching a porn movie" [34].

Finding 6: Surprise.

"I'd be taken aback… because it seems that at that age you can't do it any more, I mean, it's hard to imagine that you'd still feel like that" [35].

This review revealed 24 findings related to staff responses to sexual self-stimulation in RACFs. From these findings, two overarching synthesized findings were generated: 1) staff responses (including normalizing, avoiding interference, assisting) convey positive attitudes toward self-stimulation by residents with dementia in residential aged care and 2) staff responses (including reprimanding, pathologizing, and reporting to superiors) convey negative attitudes toward self-stimulation in this context. These findings imply that staff responses to self-stimulation convey their attitudes about solitary sexual expression, and they highlight a particular need for research that explores residents' experiences and perceptions of these attitudes.

5. Discussion

Self-stimulation is a common means of sexual expression in older age and is a particularly important outlet for older adults with dementia [5][12][38], and yet there is limited qualitative research into staff's responses toward these expressions in RACFs. Only two studies explored staff responses toward self-stimulation by residents with dementia living in a RACF [34, 35]. The synthesized findings from this review provide some much-needed insight into staff responses toward a relatively common but extremely under-researched phenomenon.

The findings of this review highlight significant variations in how sexual self-stimulation is conceptualized by staff members. The first synthesized finding indicated that staff members' normalizing and neutral responses (be they actual or perceived) conveyed their positive attitudes toward older adults' self-stimulation in RACFs. While neutral responses were not always indicative of overtly positive attitudes, this analysis revealed that these neutral responses were often directed by values of respect for privacy and bodily autonomy. Neutral attitudes could also represent staffs' acceptance that sexual desires are part of the human experience and by extension, should not be unexpected in people with dementia. It is, however, notable that none of the findings in this category addressed public displays of self-stimulation. The second synthesized finding indicated that staff members' reprimanding, pathologizing, and uncomfortable responses communicated negative attitudes toward self-stimulation in older adulthood. These findings addressed private and public displays of self-stimulation. In many instances, staff members viewed self-stimulation as a pathological behavior that required intervention and treatment regardless of where it occurred.

The contrast elucidated by this review is between staff members' views of RACFs as public or private spaces. Some staff described self-stimulation as appropriate because RACFs are the residents' home now, and the home is the idealized location for sexual behaviors. On the other hand, staff also described these behaviors as inappropriate because the resident is living in a communal facility that is emphatically not like their private home. This speaks to the larger challenge of RACFs' dual roles as institutions of clinical care and homes for residents. When

self-stimulation is viewed exclusively as a private activity, it will inevitably become embroiled in the larger debate about whether or not RACFs are truly 'homes' [39][40][41][42]. While this full debate is beyond the scope of this paper, it does provide an interesting insight into sexual expression in residential care: residents with cognitive impairments are expected to understand the difference between private and public spaces in residential care (e.g. between hallways and their own bedrooms), and yet staff, institutions, and the larger public actively debate and disagree about whether or not a RACF is a home or an institution [43]. Common social rules of propriety dictate that sexual activities ought to occur in private, and yet many common social rules are flouted in long-term care environments [44]. Activities that were once private, such as toileting, may now require a great deal of assistance and intervention. Indeed, areas that are typically considered private have become locations where staff regularly intervene and assist residents with personal care. There is, then, little wonder that some residents are uncertain about which spaces are public and which are private and about where self-stimulation ought to occur in residential care. While sexual disinhibition is often characterized as a symptom of dementia disease processes [6], it is possible that such disinhibition in residential care may be fuelled by the uncertainty of public versus private spaces in these environments.

This research also raises the possibility of reframing self-stimulation as a necessarily private and solitary activity. This research suggests that staff responses reveal their attitudes toward sexual expression in older adulthood. These attitudes may be rooted in flawed understandings of dementia, sexuality, and aging. Many RACFs are guided by person-centered care philosophies, which hold that all behavior has meaning [31]. Responsive behaviors like wandering, agitation, and aggression can express unmet needs such as pain, toileting requirements, and sensory overload [31]. Similarly, some self-stimulation might be better understood as expressing unmet needs for intimacy, touch, sensory stimulation, or comfort. The human need for non-medicalized, intimate, physical contact does not evaporate with dementia [45][46]. Indeed, this need may even increase as disease progresses and as staff members become more reluctant to engage in non-medicalized touch with residents who can no longer provide consent. Skin hunger—the overwhelming need for non-medicalized touch —is common in institutionalized older adults living with dementia [45]. Rather than framing self-stimulation as always necessarily sexual, perhaps it might be better reframed as a resident's attempts to meet needs for touch, comfort, physical closeness, and sensory stimulation. This reframing may influence staff responses toward self-stimulation in positive ways. This reframing does need to be undertaken cautiously, though, as there are drawbacks to reframing self-stimulation as distinctly asexual. As noted in Villar [34], staff often hold ageist stereotypes about sexuality and aging that can stand in the way of safe sexual self-expression of older adults. In ongoing discussions of self-stimulation, staff must also be reminded not to stand in the way of sexually gratifying expressions of people living with dementia. The healthy satisfaction of sexual needs is increasingly recognized as an important right and pathway to overall wellness in person-centered philosophies of care in RACFs [9]. All individuals across the lifespan ought to be entitled to opportunities for safe sexual expression [47].

Every attempt was made to include all relevant studies, but it is always possible that some studies were missed by our search strategy. For example, only studies published in English were included due to the authors' language restrictions. The final number of studies included in this review was just two, and both were conducted by research teams in Spain that were headed by the same primary investigator. This limitation means that the generalizability of the findings and their reflectiveness of global trends is uncertain. Both identified studies were published within the last five years, which does indicate relevancy to residential care at this time. This review was unique in its singular focus on self-stimulation. There is a tendency in

the literature to cluster self-stimulation alongside other sexual expressions. More research about self-stimulation, in particular, is needed due to its' unique presentation and staff members' unique attitudes toward the behaviors.

6. Conclusion

This review captured staff members' responses toward residents' self-stimulation in RACFs. Self-stimulation is an integral part of healthy sexual expression for many people. The singular focus on partnered sex in the literature elides the importance of supporting and encouraging healthy sexual self-expression. The findings from this review provide valuable insights into staff responses to self-stimulation and the day-to-day realities of negotiating a sexual life for older adults with a dementia diagnosis living in a RACF. They raise important questions for future research about residents' perceptions and lived experiences. These findings may also prove useful for educators who are designing programming around sexuality and dementia, and for staff who are struggling to balance privacy and safety concerns with empowerment and autonomy. The findings from this review highlight the importance of supportive and neutral responses to self-stimulation. Staff who help and convey their respect for privacy and bodily autonomy by quietly exiting the residents' rooms were more likely to provide residents the space they need to touch, talk, and fantasize as they would like. Equally important, the findings indicate that uncomfortable responses and ones that pathologize or stigmatize self-stimulation can convey staff members' negative attitudes toward residents' sexual expression

Dedicated research on self-stimulation is needed to elucidate its meanings and functions for residents with dementia. Retrospective reflective research is particularly needed, with purposeful sampling of staff who have been in a situation where a resident is engaging in self-stimulation. Staff's self-reported responses also need to be accompanied and corroborated by in vivo observations of these responses. While Villar et al. [34][35] made concerted efforts to reduce social desirability biases in their work, attitudinal questionnaires, and interviews toward residents' self-stimulation need to be accompanied by observational research. Attitudinal surveys and interview responses based on fictional vignettes elicit descriptions of hypothetical responses and may not correlate with what happens in day-to-day practice. Additionally, while Villar et al. [34] found no statistically significant differences in responses based on work position, additional research is needed to explore potential differences across professional groups.

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