TROUBLING SEXUALITY AND WORK IN LONG-TERM RESIDENTIAL CARE

ALISA GRIGOROVICH, PHD
POSTDOCTORAL FELLOW
DALLA LANA SCHOOL OF PUBLIC HEALTH

THE INSTITUTE FOR LIFE COURSE & AGING
APRIL 13, 2017
OVERVIEW

- PhD research
- Dementia and sexuality in the news
- Dementia and sexuality in the empirical professional literature
- Sexual harassment in the healthcare workplace
- Limitations with existing knowledge base
- Postdoctoral research study
- Results of phase 1
- Challenges & next steps
Publicly paid for home care in Canada is considered an “add-on” option to unpaid familial care.

This is problematic for lesbian and bisexual women:
- Less likely to have children
- Have low levels of natal support
- Higher risk for poor mental health and poor physical health at younger ages

‘False neutrality’ of public health and social care policies supports and reinforces sexual- and gender-based health inequities.
Older lesbian and bisexual women have restricted access to home care, and have limited private resources to supplement public care (e.g. children, money to buy care).

- Home care providers can be at best ignorant of sexual diversity, and at worst dismissive and discriminatory.

- The importance of relational and interpersonal competencies, as well as knowledge about sexual diversity, for enabling quality of care.
DEMENTIA AND SEXUALITY IN THE MEDIA

- Primarily appear in the crime sections of news sources
- The sexual expressions of men with dementia: behavioral manifestations or sexual offences
- Women with dementia are represented as asexual and vulnerable to sexual abuse

Boca Nursing Home Abuse Lawyer Says Nursing Homes Can Be Crime Scenes
Sexuality of persons with dementia is often considered to be ‘troubling’ to both informal and formal care providers.

In part, this is because the dominant ethical framework is biomedical ethics (e.g. bioethics).

We propose an alternative ethic of embodied relational sexuality to better support sexual expression.

Development of policies, guidelines, and education for long-term care based on this ethic is complex.

We need to better understand providers’ experiences, and how and why they perceive the sexual expressions of persons with dementia ‘troubling’ or burdensome.
SEXUAL HARASSMENT IN THE HEALTHCARE WORKPLACE

- Addressing sexual harassment in healthcare is a public health priority:
  - Ontario Action Plan to Stop Sexual Violence and Harassment
  - ONA’s campaign ‘Code White’

- Sexual harassment, sometimes also referred to as unwanted sexual attention, can range from verbal sexual comments (e.g. requests for sex) to physical contact and non-contact behaviors (e.g. sexual gestures, touching of breasts)

- Unwanted sexual attention from care receivers has been found to be pervasive or ‘every day’ occurrences in long-term care settings (Burgess et al, 2016; Bannerjee et al, 2011)

- A hazard to the health and well-being of care providers and to quality of care:
  - Can prompt feelings of stress, guilt, and shame that negatively affect mood and overall mental health (Ehrenfeld et al., 1999; Roach, 2004; Tzeng et al., 2009; Archibald, 2002)
  - Linked to job dissatisfaction, burn-out, and long-term sickness absence, as well as increased rates of staff turnover (Evers, Tomic and Brouwers, 2002; Clausen, 2012)
  - May negatively influence care relationships between providers and care receivers (Archibald, 2002; Evers, 2002; Ruchti, 2012)
LIMITATIONS & PROBLEMS WITH EXISTING KNOWLEDGE

- Most studies to date have been quantitative -- describing and counting the number of times care receivers behave in a sexually “inappropriate” manner and identifying antecedents for such behaviors.
- Quantitative measures are expansive and there is a lack of consistent definitions across studies.
- Many studies do not differentiate between residents’ sexual attention towards providers, and towards other ‘targets,’ or lump providers’ exposure to unwanted sexual attention with their exposure to other forms of combative or difficult behavior.
- Exploring unwanted sexual attention quantitatively and only at the micro-level of care is problematic as it ignores context and assumes the following:
  1. That this is an objective and universal phenomenon.
  2. There it has clear and fixed boundaries to it.
  3. All workers will interpret sexual behavior in the same manner.
A critical multi-method study of unwanted sexual attention towards female care providers in one residential long-term care in Ontario

Single case study with multiple embedded units

Purpose: To understand how the organization, as a meso-level structure, mediates between macro-level structural interventions (e.g. legislative and professional regulations that govern workers’ practices) and individual workers’ decision-making and experiences at the micro-level of care

Three types of data:
- Public policy and organizational documents
- Observations (e.g. workers’ interactions with residents, team meetings)
- In-depth interviews with care providers from diverse professions and roles
THEORETICAL FRAMEWORK FOR THE RESEARCH

- Feminist political economy:
  - A materialist perspective: focus on economic and social production and reproduction
  - Gender inequality and lived experience
  - Intersectionality
  - Assumes that social change is possible as “people collectively and individually make their own history, although not under conditions of their own choosing or simply as a result of ideas that spring independently to their minds” (Armstrong et al., 2001: viii).

- This perspective is useful for examining unwanted sexual attention:
  - Considers sexual norms as being mediated by social and historical forces and practices
  - Questions whose interests (e.g. workers, employers, governments) are represented within public policy
  - Uncovers the everyday reality of social relations, and links it to ‘relations of ruling’ (Smith, 2012)
PHASE 1 – PUBLIC POLICY ANALYSIS

- Online sources:
  - Legislation: https://www.ontario.ca/laws
  - Professional documents (e.g. unions, professional colleges):
    - https://www.ona.org/
    - http://www.cno.org/
  - Educational curriculums (course description on websites of educational institutions)
  - Ministry-level documents (e.g. Action plan to stop sexual violence and harassment)

- Drawing on feminist political economy, I examined what these texts said about sexuality, and how they construct or “give shape” (Bacchi, 2009: xi) to the ‘problem of sexual harassment,’ as well as to its potential solutions.
Ontario Human Rights Code

7. (1) Every person who occupies accommodation has a right to freedom from harassment because of sex, sexual orientation, gender identity or gender expression by the landlord or agent of the landlord or by an occupant of the same building. R.S.O. 1990, c. H.19, s. 7 (1); 2012, c. 7, s. 6 (1).

(2) Every person who is an employee has a right to freedom from harassment in the workplace because of sex, sexual orientation, gender identity or gender expression by his or her employer or agent of the employer or by another employee. R.S.O. 1990, c. H.19, s. 7 (2); 2012, c. 7, s. 6 (2).

Occupational Health & Safety Act

“workplace sexual harassment” means,

(a) engaging in a course of vexatious comment or conduct against a worker in a workplace because of sex, sexual orientation, gender identity or gender expression, where the course of comment or conduct is known or ought reasonably to be known to be unwelcome, or

(b) making a sexual solicitation or advance where the person making the solicitation or advance is in a position to confer, grant or deny a benefit or advancement to the worker and the person knows or ought reasonably to know that the solicitation or advance is unwelcome; (“harcèlement sexuel au travail”)

Long-Term Care Homes Act

The fundamental principle [of this] Act is that a long-term care home is primarily the home of its residents.

Every resident has the right to be protected from abuse,

“abuse”, in relation to a resident, means physical, sexual, emotional, verbal or financial abuse, as defined in the regulations in each case; (“mauvais traitement”)

19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).
The right to be free from sexual harassment in the legislation is qualified under the principle of the ‘reasonable person.’

Conduct must not just be offensive to the complainant, but has to be established as conduct that would also be offensive to a ‘reasonable person’ in a similar environment and thus reasonably known as unwelcome.

This burden of proof may be difficult to demonstrate in the context of care work.

- Care work is an intimate and relational form of labor that involves direct touching of bodies.
- Whether a specific interaction is identified as offensive, or as agreeable will depend not only on the intention, but also on interpretation of intent and the interchange.
- Routine normalization of residents’ aggressive and provoking actions as an unavoidable aspect of care work makes it unlikely that providers would interpret unwanted sexual attention as a form of discrimination that they are legally entitled to protection from.
LEGAL DUTY TO PROTECT FROM ABUSE

- Long Term Care Health Act: policy of zero tolerance of abuse, mandatory reporting obligation
- No mention of residents’ duties with respect to collective prevention of abuse
- Legislation is underpinned by the normative assumption that residents are essentially, and permanently, vulnerable to abuse
- Fails to consider how care receivers can be both vulnerable and aggressive
- Renders providers’ experiences of sexual harassment from residents as unrecognisable and irremediable
PROFESSIONAL EDUCATION

- Long-term care providers may not have sufficient training and knowledge of how to respond to unwanted sexual attention.

- Educational programs rarely include a mandatory course focused on sexuality.

- Providers are simultaneously instructed to develop close and caring relationships with care receivers, while also maintaining a professional distance.

- The onus is placed on providers to ensure that they, as well as the care receiver, do not breach intimate or sexual boundaries.
‘Therapeutic Client-Nurse Relationship practice standard’ - CNO

- At the core of nursing is the therapeutic nurse-client relationship. The nurse establishes and maintains this key relationship by using nursing knowledge and skills, as well as applying caring attitudes and behaviours… The nurse-client relationship is one of unequal power… Nurses are responsible for effectively establishing and maintaining the limits or boundaries in the therapeutic nurse-client relationships… [including] Protecting the client from abuse. The nurse meets the standard by … not engaging in behaviours with a client or making remarks that may reasonably be perceived by other nurses and/or others to be romantic, sexually suggestive, exploitive, and/or sexually abusive.

‘Standards for the Prevention of Sexual Abuse’ - COTO

- OTs are responsible for setting and boundaries to ensure that the trust a client has placed in the OT is not betrayed. When setting boundaries, OTs need to work towards treatment goals and ensure their words, actions, and interpersonal relationships are not misinterpreted by the client.
Susan has been treating Jacob for two weeks... Susan provides Jacob with support and encouragement by discussing his progress with him and reminding him of his achievements since treatment was initiated. During treatment, Jacob tells Susan that he is developing feelings for her.

Discussion: Susan has a professional obligation to manage the therapeutic relationship and ensure that appropriate boundaries remain intact. She should objectively review her behaviour over the previous two weeks and reflect on how she may have contributed to Jacob’s misunderstanding. She will also want to recalibrate the boundaries and inform Jacob about what her responsibilities are in the therapeutic relationship. If she feels she is unable to re-establish and maintain the therapeutic relationship, she will have to consider transferring Jacob’s care to another physiotherapist.
I anticipated that I would have some ethical and practical challenges.

But, I did not anticipate how challenging it would be to get ethics approval, or how long this process would take:

- Lack of guidelines and protocols
- Engaging research site
- Institutional concerns
- Establishing an independent advisory committee
Since this study is examining interactions that may be ambiguous until they are discussed with another person, there is a small chance that something could come to light during the course of the study that may lead to identification of a risk for resident abuse or neglect by an individual (either you, a work colleague, a family member, or a co-resident).

If you share any information during the study about a situation that will result in imminent harm to a resident, or any abuse or harm, past or present, actual or suspected, of a resident, the study investigator will be legally obligated to report this information to people not involved in the study (e.g. by seeking advice of the Independent Advisory Committee for the study).
For the staff interviews, “at a time of their convenience” – does this mean within or outside of work hours? And if it is within work hours, is this something that managers are aware of, and have agreed that staff may take an hour to meet with you should they choose to participate?

You comment that staff may not see some situations as sexual attention – but in the course of your interview and upon reflection, they may then see it as sexual attention – but you think this is unlikely to occur? And if so, what ramifications will this have on the resident-caregiver relationship?
THANK YOU! ANY QUESTIONS?

Contacts:

alisa.grigorovich@uhn.ca

@AlisaGrig