

# Directors' leadership styles and operational policies on intimacy and sexuality in Christian-inspired nursing homes: a qualitative study

Ilse Cornu

[ilse.cornu@kuleuven.be](mailto:ilse.cornu@kuleuven.be)

KU Leuven

Wim Vandewiele

KU Leuven

Chris Gastmans

KU Leuven

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## Research Article

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# Abstract

## Background

As nursing homes shift toward person-centred care, addressing residents' affective and sexual well-being has become a social and ethical imperative. However, translating ethical viewpoints on residents' intimacy and sexuality into daily practice remains a challenge. Nursing home directors may substantially influence both the formulation and operational implementation of ethical frameworks and institutional guidelines and policies regarding resident intimacy and sexuality.

## Methods

This qualitative study aims to examine nursing home directors as operational gatekeepers and to analyse how their distinct leadership styles translate guidelines on residents' intimacy and sexuality into institutional policies.

Therefore, we conducted individual, semi-structured in-depth interviews with 21 directors of Christian-inspired nursing homes in Flanders, Belgium. Data collection and analysis occurred concurrently, guided by a Constructivist Grounded Theory approach and the Qualitative Analysis Guide of Leuven (QUAGOL).

## Results

The findings introduce a conceptual continuum of three distinct leadership orientations that shape policy operationalisation: participatory, proactive, and reactive-avoidant. Participatory and proactive directors actively engage in relational governance through multi-stakeholder dialogue (the triad) and architectural accommodation to safeguard residents' affective and sexual needs. Conversely, reactive-avoidant directors experience professional paralysis driven by absent, rigid, or ambiguous institutional guidelines and policies.

## Conclusion

These leadership styles shape how directors align the presence or absence of an institutional vision statement on residents' intimacy and sexuality with the lived, embodied realities of residents' affective and sexual needs. Furthermore, leadership style influences the mechanisms through which dialogue and shared decision-making are implemented, as well as the delivery and format of staff training, and the allocation, type, and specific utilisation of facilities.

## Introduction

According to the World Health Organization [1], sexuality is an essential and inseparable component of human life that should be addressed in patient care. As nursing homes transition toward contemporary paradigms of holistic and person-centred care, addressing residents' affective and sexual well-being has emerged as a compelling ethical and social imperative [2–10]. Historically characterised by institutional

taboos, ageist biases, and systemic silence, nursing homes increasingly face the challenge of normalising residents' intimacy and sexuality as a fundamental human right and need [2, 4–6, 10]. Although studies mainly address the responsibility of individual caregivers [11–16], there is a growing awareness that nursing homes bear significant responsibility in providing optimal care for residents' intimacy and sexuality [17–23]. However, how nursing home directors' leadership styles and operational decisions influence the institutional culture of intimacy and sexuality remains a notable gap in current empirical research.

Understanding directors' leadership styles is imperative for two reasons. First, they possess the agency to dismantle structural barriers to residents' affective and sexual expression through their influence over ethical frameworks, staff training, and the provision of facilities [17, 18, 21, 22]. Consequently, they play a pivotal role in establishing ethical standards and translating them into high-quality care. Second, caregivers also need adequate support from nursing home management in dealing responsibly with residents' intimacy and sexuality [20, 23].

Therefore, this qualitative study aims to explore the pivotal role of nursing home directors as ethical and operational gatekeepers. Our research question was: How do directors perceive their leadership styles and operational policies regarding residents' intimacy and sexuality in Christian-inspired nursing homes in Flanders, Belgium? Historically, the Catholic Church, particularly its religious orders and congregations, laid the foundations for Belgium's contemporary network of high-quality elder care, extending its reach into the most remote corners of Flanders. Over the past seven decades, however, the direct operational and managerial presence of religious personnel has systematically waned. Mirroring this institutional shift, Flanders has undergone a profound secularisation process: transitioning from a homogeneous Roman Catholic society, through a period of intense ideological polarisation between Catholicism and secular humanism, into a secularised landscape. Today, the region operates as a post-secular, religiously pluralistic society, within which the traditional social utility and institutional influence of the Church have substantially diminished [24, 25]. Still, far from representing a negligible minority, Christian-inspired nursing homes constitute nearly one-fifth ( $n = 160$ ) of the total number of nursing homes in Flanders, Belgium ( $n = 820$ ). Investigating this setting, therefore, provides vital insights into how deeply embedded religious and historical traditions interact with contemporary, secular sexual rights [26].

## Methods

### Study Design

To capture a rich, contextualised understanding of how nursing home directors perceive their leadership style and institutional policies regarding residents' intimacy and sexuality, we chose a qualitative design using individual, semi-structured in-depth interviews [see Additional file 1 for the interview design]. We were inspired by a Constructivist Grounded Theory approach [27,28] to systematically derive the motivations, values, and core principles underlying the leadership perspectives directly from empirical data, rather than relying on a priori conceptual frameworks. Methodological transparency and reporting

rigour were guided by the Consolidated Criteria for Reporting Qualitative Research (COREQ) guidelines [29].

## **Recruitment and Participants**

In this study, directors are defined as general managers or executive directors holding primary institutional leadership roles within Christian-inspired nursing homes. To map our target population, we secured a comprehensive register of all Flemish nursing homes (n = 820) from the Flemish Government's Department of Care. From this database, we selected facilities with non-profit status and that were members of Zorgnet Icuuro, the umbrella network for social-profit healthcare institutions in Flanders, Belgium, yielding 316 facilities. Subsequent evaluation of institutional websites and legal statutes identified 160 nursing homes with a clear, active affiliation to a Christian religious congregation.

Participants from these facilities were selected based on five inclusion criteria: 1) Currently serving as an executive director or general manager of a nursing home; 2) Managing a facility historically and contemporarily tied to a Christian religious congregation; 3) Operating within Flanders, Belgium; 4) Being Dutch-speaking; 5) Providing informed consent to participate in an in-depth interview concerning residents' intimacy and sexuality.

We used purposive sampling [30] to select and contact 40 directors across diverse geographic regions between October 2024 and January 2025. Initial outreach was conducted via email, with an invitation letter and a study brochure enclosed. Interested candidates completed a brief questionnaire detailing their sociodemographic backgrounds (for example, gender, age, education), nursing home characteristics (for example, bed capacity), and the presence of any written vision statements on residents' intimacy and sexuality. A single follow-up reminder was sent to non-respondents after two weeks.

Following the transcription and initial analysis of the first ten interviews, we transitioned from purposive to theoretical sampling to refine emerging conceptual boundaries. Early analysis revealed that directors with strong explicit Christian profiles exhibited divergent views regarding residents' intimacy and sexuality. Guided by these emerging concepts, we intentionally sought out additional directors with strong theological or faith-based backgrounds, contacting 34 further potential candidates in March 2025. Recruitment ceased when we judged the sample to have sufficient information power [31]; no new dimensions or conceptual variations emerged after the inclusion of 21 directors.

## **Data Collection**

Between November 2024 and June 2025, the first author, a female PhD researcher in bioethics with a background in theology and sexual ethics, conducted the in-person interviews at the participants' nursing homes. The interviews lasted 57-106 minutes, ensuring a private environment with no third parties present. With explicit consent, all interviews were audio-recorded and transcribed verbatim.

Although no field notes were taken, a contextual profile report for each participant was compiled before the interview to ground the conversation in their specific organisational context.

The semi-structured interview guide [see Additional file 1] was rooted in a systematic review of the argument-based ethics literature [32] and was refined through a pilot interview. It was further adapted abductively during the fieldwork phase to accommodate insights from concurrent data analysis. During the interviews, directors recalled concrete, challenging clinical cases involving residents' intimacy and sexuality. The interviewer used open-ended probing questions to explore the participants' views, decisions, and strategic actions, as well as the underlying ethical reasoning that guided their management strategies.

## **Data Analysis**

Data analysis was conducted entirely in Dutch by the first author. Verbatim quotations were translated into English only during the drafting phase of the manuscript. Data collection and analysis occurred concurrently, inspired by Constructivist Grounded Theory principles. We structured the iterative analytical process using the Qualitative Analysis Guide of Leuven (QUAGOL), moving constantly between raw data and conceptual abstraction [33,34].

QUAGOL's Stage 1 (preparation for coding) comprised five distinct steps: 1) The first author prepared and read the transcripts closely to become familiar with the narratives; 2) A narrative summary was produced for each interview to capture the holistic storyline; 3) These narrative reports were transformed into conceptual schemes [see Additional file 2 as an example], clustering concrete perceptions into broader themes; 4) To minimise analytical bias and establish investigator triangulation, transcripts and summary reports were independently read and scrutinised by two research team members [ANONYMOUS and ANONYMOUS]. Using an inductive approach, they isolated meaningful text segments and verified whether the emerging interpretations accurately captured the participants' accounts and experiences; 5) Dominant concepts were identified into an initial general scheme. Through constant comparative analysis, the research team repeatedly juxtaposed this evolving framework with the raw data to refine similarities, differences, and connections across interviews. Discrepancies in interpretation were addressed through rigorous team dialogue and constant comparison until consensus was reached.

Stage 2, the coding process, was executed by the first author using NVIVO qualitative analysis software (Version 15; Lumivero, 2024). The coding framework was collaboratively refined through ongoing discussions between [ANONYMOUS and ANONYMOUS]. Once all relevant fragments were systematically categorised, we examined the quotes to define the unique dimensions, ranges of meanings, and specific characteristics of each theme. To further enhance trustworthiness, an external qualitative researcher and an expert in the sociology of religion [ANONYMOUS] performed an independent check of the finalised framework, providing an extra layer of analytical verification.

Throughout the research process, reflexivity was maintained via extensive memo writing and recurrent team discussions, allowing the researchers to critically evaluate their own positioning and its potential

impact on data interpretation. This finalised synthesis yielded a broader conceptual framework, the validity of which was continuously cross-checked against individual interview schemes and validated through team debriefings on saturation. Finally, our findings were translated into a coherent narrative account and illustrated with relevant participant quotes, which the first author translated from Dutch into English, ensuring semantic equivalence.

**Ethical Approval and Consent to Participate**

The study was approved by the Social and Societal Ethics Committee (SMEC) of [ANONYMOUS] (approval G-2024-8518-R2 (MIN)), which complied with the General Data Protection Regulation 2016/679. In accordance with the principle of data minimisation, we only collected data relevant to the research, and it was coded and stored on the [ANONYMOUS] institutional server. We stored the codes in a separate protected file, which only the team could access with a password.

Participants received a brochure with detailed information on the research project, both in writing (via email) and verbally (before the interview began). The informed consent form was explained, and participants were encouraged to ask any questions before giving their written informed consent.

Participation was voluntary. All participants received written and verbal information about their rights as research participants, for example, the option to end the interview at any time or to refuse to answer a particular question for any reason. All participants agreed to have their interview audio-recorded. To protect participants’ privacy, access to the recordings and interview transcripts was restricted to the research team. In addition, all identifiable information about the participants and nursing homes was treated confidentially and anonymised in the manuscript. All interviews were performed in accordance with the Declaration of Helsinki. Informed consent was obtained from all participants in this study.

Beyond fulfilling formal procedural requirements, such as securing institutional review board approval and obtaining written informed consent, the interviewer cultivated a safe, private space conducive to open dialogue on this highly sensitive topic, which frequently evokes personal experiences and emotions. Recognising the sensitivity of the subject matter, the researcher consciously adopted a stance of ‘empathic neutrality’ [30], combining professionalism with interpersonal warmth to avoid a cold or detached demeanour. To support this micro-ethical approach, the researcher maintained inclusive, deliberate, and nuanced language throughout the encounters. Additionally, directors were explicitly offered the opportunity for post-interview debriefing or follow-up contact should any discussion point cause lingering distress.

**Results**

Twenty-one directors from 21 nursing homes spanning all provinces in Flanders, Belgium, participated in this study (see Table 1: Characteristics of Study Participants and Nursing Homes).

**Table 1 – Characteristics of Study Participants (n = 21) and Nursing Homes**

| <b>Participants' characteristics</b>                      |                       |    |
|-----------------------------------------------------------|-----------------------|----|
| Gender                                                    | male                  | 8  |
|                                                           | female                | 13 |
| Age range                                                 | 30-40                 | 1  |
|                                                           | 41-50                 | 11 |
|                                                           | 51-60                 | 9  |
| Religious affiliation                                     | Roman Catholic        | 20 |
|                                                           | None                  | 1  |
| Years of experience                                       | 1-4                   | 3  |
|                                                           | 5-9                   | 5  |
|                                                           | 10-19                 | 8  |
|                                                           | 20-29                 | 5  |
| Professional background<br>(multiple answers are allowed) | Nursing               | 13 |
|                                                           | Gerontology           | 3  |
|                                                           | Other Health Sciences | 6  |
|                                                           | Business studies      | 5  |
|                                                           | Social Sciences       | 6  |
|                                                           | Theology              | 1  |
|                                                           | Psychology            | 1  |
| <b>Nursing home characteristics</b>                       |                       |    |
| Flemish province                                          | West Flanders         | 5  |
|                                                           | East Flanders         | 2  |
|                                                           | Antwerp               | 5  |
|                                                           | Flemish Brabant       | 6  |
|                                                           | Limburg               | 3  |
| Number of beds                                            | 61-120                | 9  |
|                                                           | 121+                  | 12 |

The data analysis reveals that directors' leadership styles shape a multilayered operationalisation process. This process unfolds first through relational governance (trialogue), which encompasses

structured dialogue with residents, families, and care professionals, alongside targeted staff training to dismantle deeply ingrained awkwardness toward late-life intimacy and sexuality. Subsequently, this relational stance underpins the provision of facilities, ranging from architectural modifications to the integration of external sexual assistance services. Ultimately, the data highlight the complex operational and ideological balances that directors must navigate in frontline practice. Figure 1 represents the conceptual framework of the directors' leadership styles and the multi-operationalisation processes, derived from the data analysis.

## **Leadership Profiles**

The data analysis reveals a conceptual continuum consisting of three distinct but overlapping leadership orientations regarding residents' intimacy and sexuality: a reactive-avoidant approach, a participatory bottom-up model, and a proactive stance. Because these profiles exist on a continuum, individual directors may exhibit overlapping characteristics across styles.

Within this sample, the vast majority of respondents adopt a participatory orientation, frequently demonstrating a strong inclination toward proactivity. Conversely, the reactive-avoidant style characterises only a small minority of directors. This orientation typically reflects either personal beliefs regarding late-life sexuality or restrictions imposed by the governing board.

### ***The Participatory Orientation***

Directors with a participatory leadership style reported that they were actively moving away from institutional silence and restraint toward an open approach to residents' intimacy and sexuality, and the deliberate involvement of all stakeholders: *"And so, when it comes to sexuality and intimacy, I assume that it's something good. And that I have to do everything in my power to make it possible, as long as I feel that integrity is not at stake."* (D17)

Based on the data analysis, we identified two main aspects of the participatory orientation.

#### **Aspect 1: Dialogue and the Capacity for Open Discussion**

Participatory directors systematically embed a triologue among residents, families, and staff into admission assessments and subsequent evaluations, mediating between resident desires, family perspectives, and professional care ethics. The goal is a shared agreement that keeps the resident central while addressing systemic concerns, as one director explains:

*"And we always try to achieve that triologue: okay, the resident is the most important person here, because we are only here because the resident is here. But the family is often the most important third party for our resident. And yes, the care professional... You can't say 'yes' to everything, but you can't say 'no' to everything either. So, what do we think about it? Where do we stand on this? And why?"* (D16)

This participatory orientation, whether tentative or highly effective, demonstrates a transition toward shared, bottom-up responsibility. More than half of the directors (12/21) prioritise open dialogue on residents' intimacy and sexuality with their care teams: *"It's definitely something we can talk about; no, it's no taboo at all. In our staff meetings, we always set aside the final thirty minutes for discussing residents, and that's when these topics are brought up too."* (D11)

This decentralised approach correlates with a shift in leadership philosophy, moving from the director as an 'all-knowing' communicator toward a receptive stance that values the staff's collective wisdom as the primary source for solutions: *"In the past, I used to think: 'I have to explain it all here.' And I've learned that I should let people explain it themselves and that so much wisdom and knowledge come from that. (...) I've learned to let the solutions come from the people."* (D14)

Because residents' intimacy and sexuality can be challenging for staff, a participatory approach also entails ensuring they feel heard and supported. This support ranges from peer or managerial dialogue to professional psychological assistance.

## **Aspect 2: A Pragmatic Approach**

In nearly one-third of the cases (6/21), directors couple a participatory orientation with a pragmatic approach, treating resident affective and sexual needs like any other practical challenge: *"For me, it's just the same as: if a resident can't drink from a cup, we find a solution. We just look for a different cup to drink from."* (D10)

Under this pragmatic lens, facilities are not offered proactively but are provided only at residents' request or staff prompting. Consequently, support remains contingent on personal initiative or individual staff alertness. Rather than normalising the provision of support for intimacy as a standard component of care, the nursing home's role is primarily to validate and facilitate reactive requests, as one director illustrates:

*"We have a resident for whom we buy oil because they ask for it (...) to be able to pleasure themselves. So without a partner, just for themselves, right. So all those things can and may be asked by staff and can be offered."* (D21)

In the absence of a structural protocol, care is heavily shaped by the individual caregiver's professional boundaries, expertise, and comfort level. This pragmatic reliance on intuition often emerges when the facility's vision statement and guidelines on residents' intimacy and sexuality are insufficiently clear or poorly disseminated. While directors acknowledge the topic is on the agenda, they note it lacks organisational anchoring: *"We've already been working on it a bit. But it's not really alive yet, and it's not enough, well, anchored in the organisation. So that's really a pillar we still want to work on."* (D9)

Consequently, staff must navigate these policy gaps on an *ad hoc* basis. However, prioritising intuition over structure can cause professional uncertainty about potential blind spots in care: *"We might think*

*we're doing a good job because we look at so many things individually and in such a tailored way. But I do think we're missing things as well." (D21)*

Conversely, this lack of strict policy is also viewed as an asset that fosters professional agency and situational flexibility, allowing teams to balance frameworks with the realities of frontline practice:

*"You can have a procedure that tightens things up so much that you don't have any room left, right? But it should be a procedure that defines the criteria and, well, yeah, takes into account sensitivities and the practical side. (...) I think an ethics committee, it can, well, it has to be there, right? There must be, there can be an ethical framework regarding sexuality and intimacy thought out, as far as I'm concerned. But that can never happen without the work floor being involved." (D10)*

### **The Proactive Orientation**

A proactive orientation is characterised by a well-defined organisational vision, open dialogue, and the institutionalisation of intimacy resources. In this study, over half of the directors (11/21) exhibit characteristics of this stance, reflecting an institutional view that intimacy and sexuality are normalised, integral aspects of late life. Proactive directors expect all staff to maintain a consistently positive attitude in daily practice. Rather than waiting for residents' demands or staff alerts, these directors take the initiative by systematically providing facilities and conversations on intimacy and sexuality, often as early as the intake interview or the subsequent weeks.

Proactive directors view their role as crucial in disseminating this orientation to all stakeholders. Rather than remaining distant policymakers, they act as accessible points of contact, signalling that sensitive, affective, and sexual concerns are met with openness and collaborative problem-solving. This personal visibility fosters a safe climate for disclosure:

*"But I'm also, for instance, the person - everyone knows that they can simply come to me - to whom residents sometimes come up and say: 'I've got a problem. I've got this or that on a sexual level. How are we gonna solve that?' Because they do feel... (...) that it can be discussed." (D7)*

However, this proactive approach occasionally encounters resistance from families. To mitigate this, directors prioritise early support to anticipate friction, while countering active resistance through ongoing dialogue and mediation. A significant hurdle is the formal and informal power families hold, particularly as legal signatories of residency agreements. This creates a complex tension where a resident's desire for intimacy clashes with a family's veto power, forcing directors to carefully balance residents' autonomy with familial consent, as one participant explains:

*"If a couple is formed here and (...) since they're always together anyway: an opportunity for a double room or a couple's room is opening up now (...) then you already see the children rearing up, right? (...) Often, those children are the ones signing those residency agreements, right? (...) So you can't just sideline them,*

*right? So yeah, those residents might say: 'Oh yeah, we'd like a double room', but then you're gonna have to bring that family along too." (D15)*

This proactive stance also extends to the staff, who are responsible for implementing and communicating the nursing home's vision to colleagues, residents, and families. To facilitate this, directors support their teams through psychological referrals, collective discussions, and educational initiatives. One participant highlighted the use of interactive methods to align perspectives on resident intimacy and sexuality, while gathering initial input to develop a strategic vision.:

*"Then we also did statement-based exercises with the staff, like: 'How do you stand on that, right? What do you think about it? What do you feel about it?' And that was already an initial stage in developing the vision. The first phases were a bit of preparatory work to align everyone's perspectives, like: 'This is what we're working on.'" (D13)*

### **The Reactive-Avoidant Orientation**

A subset of directors maintains a reactive-avoidant orientation within which two main aspects were identified, based on the data analysis: a rigid institutional context enforces a culture of silence and restraint, which tends to lead to professional paralysis and a cycle of *post hoc* reactions.

#### **Aspect 1: A Culture of Silence and Avoidance**

One-third of the directors (7/21) report grappling with embarrassment and hesitation regarding residents' affective and sexual needs. They perceive their leadership as a constant negotiation with the governing board's rigid boundaries or ambiguous vision on residents' intimacy and sexuality. Feeling their autonomy curtailed, these leaders are silenced in fostering the very dialogue they value, turning daily practice into a frustrating exercise in restraint. While a small minority also personally experiences unease, most adopt a restrictive approach without being restrictively minded by conviction, openly reflecting on this gap between their intentions and actions:

*"I would sometimes like to find the courage within myself to fully follow through on what I say. Because several things are coming up (...) where I think: I'm going to dare now, next time, I say: 'People, take a look at that for once, and, and, and you have to take the courage and the time for it!'" (D17)*

Data analysis shows how this institutional rigidity can foster a culture of trivializing mockery. Several directors note with concern that staff resorts to derisive comments about residents' sexuality, such as: *"Yeah, oooh, what might be going on in there!" (D12)*. Directors reported that this climate impedes care quality by relegating intimacy to the sphere of the vulgar, rather than respecting it as a fundamental human right. Confronted with this environment, directors and staff adopt avoidance as a survival strategy, a collective retreat that ultimately silences residents' needs.

#### **Aspect 2: Professional Paralysis**

Directors perceive that the governing board's restrictive framework creates a trickle-down effect of embarrassment, resulting in a collective reluctance to intervene. The perceived risk of repercussions drives self-censorship, causing staff and management to withdraw from these situations. Within this 'chilling effect,' silence and avoidance become the default response, as one director describes:

*"In the end, everyone washes their hands of it (...) out of fear [of the governing board]. And that is something that is discussed far too little. (...) They know they're in a Christian institution. So: older adults and sexuality, yeah, they do have their questions about that: 'Is that still necessary?' (...) But you get that sometimes: if one is tight and strict about a certain thing, then the entourage becomes a bit scared, and it's not touched anymore. Not even what is actually allowed!" (D18)*

Directors explain how this rigid environment or ambiguous policy on sexuality culminates in professional paralysis, filtering down to the directors' own sense of ownership and agency: *"I'm not the one who's going to, well, let's say, fire that up or drive it. (...) The question is whether it's up to the director at that moment to decide on that. I don't know..." (D8)*

This hesitation leaves residents' intimate needs unaddressed, as neither staff nor management feels empowered to initiate dialogue. Such individual reluctance mirrors a systemic lack of professional confidence across institutional levels: *"And then I do see that we're a bit clumsy in that, right. Yeah, there's still some embarrassment around it, just to talk about it openly. (...) Also at the policy level, you know, those are themes we feel a bit less comfortable with and such, yeah." (D14)* Alternatively, this paralysis can stem from a total absence of guidelines and policies, leaving directors uncertain about the governing board's position.

Without a clear mandate, directors lack the tools to align daily practice with the overarching institutional vision on residents' intimacy and sexuality. Ultimately, this reactive-avoidant orientation is rooted in the institutional culture, resulting in a systemic lack of progress regarding dialogue about intimacy and the provision of facilities: *"Gosh, often it's taboo, uh, fear, uh, or yeah, just not knowing it, or not knowing how to deal with it. And then actually, yeah, preferring to keep it at a bit of a distance and not having to think about it, I think, well, yeah." (D9)*

Despite these barriers, this restrictive state is not entirely fixed. Nearly all reactive-avoidant directors evolved toward a more participatory stance during the interview, expressing a clear desire to break the silence and adopt an open, dialogical approach toward residents' affective and sexual needs.

## **Policy Operationalisation**

In terms of operationalisation, leadership styles govern how directors translate formal vision statements, or the lack thereof, into daily practices that accommodate the lived, embodied dimensions of residents' intimate and sexual desires. This transition relies on three pillars: stakeholder dialogue, staff training, and facility provision. By fostering collaborative dialogue and targeted training, directors establish a collaborative engine that ensures intimacy guidelines and policies are genuinely co-created rather than

imposed from above. Ultimately, this relational and educational foundation influences how effectively directors translate the vision statement into concrete care provision.

### **Vision Statement**

When developing an operational approach to resident intimacy and sexuality, directors noted an ideal reliance on a dedicated vision statement. However, this process remains complex, characterised not only by the inconsistent availability of such documents but also by substantial variations in authorship, thematic scope, and practical applicability.

Nearly half of the directors (9/21) report having a written vision document. However, these texts vary significantly: some address person-centred care generally, whereas others focus explicitly on intimacy and sexuality. Their scope ranges from protocols restricted to residents with dementia to comprehensive frameworks for the entire resident population. In some instances, organisations operate solely on an overarching vision, completely lacking either the concrete guidelines needed to assist staff in daily decision-making or the mandatory policies that govern institutional boundaries. Furthermore, internal accessibility varies, as documents are either restricted to management or integrated into multidisciplinary consultations. Only one nursing home achieved full transparency, disseminating the statement across all staff levels and publishing it online.

Among those with a vision statement, some use documents drafted by the directors themselves, a governing board, or an ethics committee. In some cases, directors establish a dedicated working group, recruiting staff members who either share a specific interest in residents' intimacy and sexuality or encounter these issues daily. Directors frequently collaborate with governing boards to ratify these documents.

Almost all directors with a written vision statement on residents' intimacy and sexuality indicated that an ethics committee had played a central role in drafting the text. Rather than operating in isolation, these committees often develop general policy directly from concrete, real-life cases. Working either as a structurally integrated body or on an *ad hoc* basis, the ethics committee ensures that the development of vision statements, guidelines and policies is a process of continuous ethical deliberation rather than a mere administrative task, which directors highlight as an organisational strength:

*"We have an ethics reference group where thematic texts are written that I always find very good; I have to be honest. That's one of the strengths of [group name], I think. Yesterday, we did some exercises and were asked: 'What do you find unique?' In itself, nothing is unique, because there are so many care professionals. But the ethical reflection in certain processes or in the drafting of certain documents, I find that very strong."* (D21)

Conversely, some nursing homes lack a written policy on the topic entirely, as one director states: *"But to dig up a text now – either I don't know where it is, or it doesn't exist – on how we view intimacy and sexuality within a nursing home, I haven't found one."* (D17). Furthermore, over half of the directors with a

written document (5/9) noted that their text lacks the practical detail required to guide daily care. Some struggle with the complexity of drafting an all-encompassing framework. Consequently, they express a distinct need for operational support: *“As a guide, I already find it very nice to work with. Could there be a bit more? For me, that would mainly be about concrete tips and tricks, and tools, especially.”* (D20)

In contrast, participatory and proactive directors view unclear policy as an asset. They argue that a vague or absent framework invites dynamic engagement, enabling highly responsive, person-centred solutions for residents’ intimate needs:

*“I’m sometimes scared of guides and guidelines and procedures, as they might crush the conversation, the openness, and the diversity (...) with a ‘yes, but we have a policy about that’ and so on. While maybe some people say things that aren’t in that policy, making you think: hey, that’s a great way of looking at it!”* (D3)

### ***Dialogue with and Participation of All Stakeholders***

Reflecting the predominance of participatory leadership, the data analysis demonstrates that dialogue is a cornerstone of operational practice. This commitment to stakeholder involvement decentralizes decision-making through collective deliberation. While the director remains the final arbiter, guidelines and policies on residents’ intimacy and sexuality are implemented in response to the lived experiences of residents, families, and staff, as one participant illustrates:

*“The final decision rests with me, but obviously, you don’t make that decision on your own; you enter into a dialogue with all the actors involved. First and foremost, again, with the residents themselves. What is their desire, what are their things? You consult with the family; if they’re there, you consult with the team that’s there, with the GP. Yes, you consult with all those actors; if necessary, you get together in a kind of care consultation around that theme, around that issue.”* (D1)

### **Residents**

Centred on residents’ intimate well-being, this participatory approach involves active listening and easily accessible, informal initiatives where residents are directly invited to share their perspectives: *“We also have ‘Over Coffee,’ which involves our ‘living and life’ coaches talking with a whole group of residents about all sorts of things. And that theme [intimacy and sexuality] is being discussed there now too, including with people with, well, with dementia.”* (D2)

To facilitate these sensitive conversations, directors look beyond nursing staff and mobilize a range of multidisciplinary experts. They actively involve psychologists, ortho pedagogues, and physicians for clinical support; chaplains and pastoral workers for spiritual care; and ethics staff, dementia care specialists, reference persons for intimacy and sexuality, or other trusted confidants to engage directly with residents.

### **Family Members**

Because partners and families remain central figures in residents' lives, directors devote considerable attention to maintaining strong relationships with them, as one participant reported: *"Yes, the [partner] living at home, right. We really need to know: 'What does that mean for her? How does she assess it? What's positive? What's negative? What are the concerns?'"* (D15).

In certain cases, directors personally participate in discussions with family members and care staff. This occurs primarily during challenging cases where the family disagrees with the nursing home's position regarding the management of a resident's intimate and sexual needs. In such cases, the director seeks to clarify the nursing home's institutional position and the core values upon which this stance is founded. In these high-stakes interactions, the director's presence serves to formalise the institution's commitment to its ethical framework. By personally joining the dialogue, the director provides a clear mandate for the staff's actions, ensuring that the burden of defending a controversial stance does not rest solely on the individual caregiver, as one director illustrates: *"And of course, those are conversations I'll join. Those are care consultations I'll sit in on anyway, just to say for a moment: 'Look, daughter, you can say whatever you want here. This is the organisation's position, and I stand behind it.'"* (D15)

Conversely, some directors deliberately choose not to attend such challenging discussions. They argue that their presence might intimidate family members and give the issue undue formality: *"Well, without meaning it negatively, but if you have a director in the conversation... That adds a certain weight, you know. While we actually mostly want to be caring."* (D13)

Directors indicate that, from time to time, family members are invited, along with the resident, to take part in multidisciplinary meetings held by the care team. These multidisciplinary consultations incorporate the perspectives and concerns of residents' family members. To ensure that stakeholder involvement remains genuine rather than based on assumptions, directors emphasize the necessity of direct inquiry. This approach shifts the focus from professional assumptions to active listening, ensuring that the subjective experiences of both the resident and their family are the starting point for any policy or care-related decision, as one director explains:

*"And we shouldn't start from: 'I think the resident likes this' or 'I think the family feels this way about it.' We always have to ask (...): 'Okay, what does our resident think? What does the family say about it?'"* (D16)

## Care Professionals

At times, directors establish working groups to brainstorm with healthcare professionals about the specific guidelines and policies they wish to implement regarding intimacy and sexuality. To ensure a holistic policy that resonates across all operational levels, these groups are intentionally composed of a highly diverse array of disciplines, as one director illustrates: *"It's really diverse: nurses, nursing assistants, physios, ergos, even logistics was part of it, the staff members, [Name] the ethicist, the care coordinator, the quality coordinator, and a few department heads."* (D4)

Building on this transition from directive to facilitative leadership, directors emphasize that sustainable policy is not merely a top-down mandate but must be grounded in a shared ethical understanding that permeates the entire care team.

*"I try to decide and intervene very little from the top down right now, but rather to start thinking in a solution-oriented way through that conversation and that consultation with each other, based on an ethics. But that ethics – of course, the director has to have it – but it also has to be there with the staff and with the team coaches and such." (D3)*

While the director retains the final decision-making authority on matters concerning intimacy and sexuality among residents, these choices are not based solely on their own ideas; instead, they synthesize the perspectives of all stakeholders. Consequently, even when staff members disagree with the final decision, they can accept it because it emerged from a process of active listening and mutual respect. Central to this consensus-building is the director's recognition of staff members as reflective practitioners rather than passive implementers of policy, as one participant explains: *"The care worker isn't seen merely as an executor, but truly as someone with their own set of values and norms, and their own personal experience." (D13)*

This ongoing dialogue becomes particularly vital in cases of internal disagreement among staff concerning the ethically appropriate response to residents' sexual behaviour or affective needs. During these multidisciplinary consultations, healthcare providers discuss challenging cases and exchange diverse perspectives and best practices. These discussions are often preceded by systematic observation and monitoring of the resident's sexual behaviour, enabling care professionals to provide detailed and accurate reports on the situation. Within this framework, care staff who feel less comfortable can receive peer support from colleagues with greater expertise. More than half of the directors (14/21) indicate that an ethicist occasionally or regularly participates in these multidisciplinary consultations, or that they can draw upon the ethicist's expertise when needed.

## **Training**

Half of the directors (12/21) indicate that care staff occasionally or frequently experience a sense of awkwardness or discomfort regarding residents' intimacy and sexuality. Therefore, directors argue that education is vital to challenge the deeply ingrained bias that strips older adults of their sexuality, as one director explained:

*"The younger staff themselves usually don't have that many problems talking about sexuality. But in the perception of: 'They are our residents, they are so much older,' they don't always have a picture of 'What does that even still mean?' you know. That abnormal image of what is normal. And then entering into a conversation about that, that's a barrier they also have to cross, and not everyone can just do that." (D13)*

To ensure that the nursing home's general view on intimacy and sexuality is effectively translated into practice and that ongoing dialogue and participation are fostered, directors in approximately half of the nursing homes (10/21) provide professional training for both management and care staff. In the majority of these cases (7/10), directors report that such training has been structurally embedded. These educational initiatives are often designed to reach beyond the frontline care staff, aiming to establish a shared ethical vocabulary across the entire institution. By involving every department, directors seek to normalise the topic and ensure that a consistent, vision-led approach to residents' intimacy and sexuality is adopted by all employees, regardless of their role:

*"We've all done training on sexually transgressive behaviour. Those are really cool exercises with statements and such to help the staff reflect. (...) And everyone follows that training, from top to bottom. So that includes logistics, kitchen staff, and technical services. (...) It was really a bit of a top-down story. First, we as management received training and the step-by-step plan on how they would approach it in [Organisation Name]. And then an internal reporting point was requested for each nursing home that could also provide training." (D21)*

Directors emphasize the importance of discussing the theme of residents' intimacy and sexuality within the nursing home itself, involving those who deal with these issues in daily care. In their view, local engagement is superior to external, large-scale initiatives: *"If you have a psychologist, right here in-house, then you can give your training, right? (...) I feel it makes absolutely no sense to have a conference on intimacy and sexuality at group or national level. You gotta discuss that right here." (D15)*

To complement formal educational programmes, some directors implement more subtle, environmental interventions designed to disrupt ingrained biases and spark spontaneous dialogue. These creative strategies aim to lower the threshold for discussing residents' intimacy and sexuality by integrating provocative imagery into the everyday professional workspace, as one director illustrates:

*"Then we started with a massive awareness campaign among the staff. Without them knowing we were working on it, we suddenly started with the desktop backgrounds: actually images of older adults and sexuality, just a new image every time, but every week it got more and more risqué. Just, in your face. (...) And there were like and dislike buttons on there, you know: Do we like this? Do we not like this?" (D13)*

Training is also offered to individual staff members who may feel uncomfortable discussing these topics in a larger setting due to personal vulnerabilities or cultural and religious sensitivities. This individual approach is often chosen to prevent social pressure or judgment within peer groups: *"For example, when people of the same religion are together, and a Moroccan woman asks a question about it, it might be perceived by someone as: 'You are not as good a Muslim as I am.'" (D7)*

## **Facilities**

As a logical consequence of their leadership orientation, which is itself closely intertwined with the presence or absence of a clear vision from the governing board, directors provide these facilities to markedly different extents. While participatory and proactive directors invest in provisioning, their reactive-avoidant counterparts offer few, if any, interventions. Based on the data analysis, five distinct categories of facilities were identified: privacy promotion, support for sexual expression, architectural modifications, relationship cultivation, and the provision of sexual services.

### **Category 1: Privacy Promotion**

When addressing the topic of residents' intimacy and sexuality, nearly all directors emphasize the paramount importance of facilitating privacy, viewing it as a fundamental prerequisite for protecting and promoting residents' intimate and sexual expression. However, they frequently note that care staff still enter rooms without knocking and waiting for permission. To counteract this infringement, nearly two-thirds of the directors (13/21) refer to the active or tentative implementation of 'Do Not Disturb' door hangers. By shifting from a strict 'knock-and-wait' protocol to physical indicators, this policy enables residents to safeguard their privacy proactively. This 'Do Not Disturb' message can encompass a broad spectrum of reasons, ranging from sensory de-escalation due to overstimulation to private visits from a granddaughter, or confidential consultations with the nursing home's psychologist.

Conversely, some directors express hesitation regarding these door hangers, noting that residents or staff members may interpret them strictly through a sexual lens, assuming that the occupants are actively engaged in intimate behaviour: *"The moment a door closes and it's said not to disturb because a partner is visiting, then basically that whole entourage knows what's happening in there."* (D17) To safeguard resident privacy against this unintended hyper-visibility, these directors eschew explicit 'Do Not Disturb' text. Instead, they prefer interchangeable physical objects placed on the doorknob. These subtle markers are correctly understood by the care team as a request for non-intrusion, while conveying no specific meaning to outsiders.

### **Category 2: Support of Sexual Expression**

The policy regarding the provision or permitted use of sexual aids illustrates the directors' perspective that a resident's room constitutes a completely private sphere, where the nursing home should refrain from interfering. By maintaining this boundary, participatory and proactive directors fundamentally conceptualize residents' room as extensions of their own homes, wherein resident autonomy takes precedence over institutional control: *"If people want a porn channel on their TV in their private room, who am I to say they're not allowed to have that? (...) They're going to have to purchase that themselves. But they can install it."* (D17)

The majority of directors are unaware of the institutional procurement of sexual aids, such as toys, lubricants, and Viagra, via the nursing home's pharmacy or via care staff. However, they assume that such requests would not pose any issues should they be initiated by the residents themselves.

### **Category 3: Architectural Modifications**

One-third of the directors (7/21) note the availability of couples' rooms in their nursing home. The majority of directors prefer single beds for couples, as these configurations facilitate more efficient and ergonomically sound professional care delivery. The majority of nursing homes permit couples to occupy two separate rooms, converting one into a living area and the other into a bedroom. Where space permits, beds can be positioned side by side and, if necessary, linked via a 'love bridge' mattress connector. While participatory and proactive directors are more open to such solutions, it remains far from standard practice for them as well. Reactive-avoidant directors, in particular, have often never considered this option due to a lack of awareness. Consequently, the device is typically supplied only when a healthcare professional is aware of its existence or a family member explicitly requests it.

### **Category 4: Relationship Cultivation**

A third of the directors (7/21) indicate that they prioritise celebrating significant milestones in the lives of resident couples, such as wedding or relationship anniversaries, and Valentine's Day. In many instances, these milestones are celebrated throughout the nursing home or across the entire ward, featuring festive decorations, curated music, and special catering. Furthermore, families are frequently invited to participate in these collective celebrations, reinforcing the integration of the residents' informal networks.

*"Anniversaries are celebrated. But for instance, on Valentine's Day, we had a couple's afternoon. So in the local community restaurant, everything was beautifully decorated with hearts. And then the couples who wanted to sign up could come and eat there, like a real restaurant. Well, yeah, beautiful decorations and a bit romantic, yeah, yeah..." (D10)*

Just under half of the directors indicate that, in cases where a partner still resides at home, the nursing home resident is permitted to return home for regular weekend visits, or the community-dwelling partner is occasionally accommodated for an overnight stay at the nursing home.

Two directors indicated that residents' partners are permitted to shower together, either to assist with care-related washing tasks or because the resident experiences pleasure from it, allowing them to share an intimate and meaningful moment as a couple.

### **Category 5: Provision of Sexual Assistance Services**

Whether a nursing home provides sexual assistance services for its residents depends significantly on the governing board's vision and guidelines regarding residents' intimacy and sexuality. While all directors indicate they are, in principle, open to such services, they frequently must navigate a complex tension in operational practice, balancing their own participatory or even proactive approach against the restrictive orientation of their governing board. In environments where the governing board enforces an explicit or implicit prohibition, for example, on religious grounds, directors often adopt a strategic, pragmatic middle ground: refraining from openly promoting the availability of sexual assistance, they

consciously choose not to intervene or obstruct the actual use of the service when initiated by staff and residents.

Where such operational openness exists, whether formally sanctioned or pragmatically tolerated, nearly two-thirds of the directors, all exhibiting a participatory or proactive orientation, report established collaborations with external sexual services. These directors predominantly establish partnerships with specialised organisations that offer tailored sexual assistance; however, they also occasionally facilitate contact with commercial sex workers to accommodate specific residents' demands. Rather than treating these arrangements as covert, they ensure the deployment is integrated into a structured, multi-stakeholder consultation. This collaborative approach prioritises a delicate matching process to align the sexual service directly with the resident's unique needs, as one director illustrates:

*"And then, very often, at the beginning of that process, we also sit down together for a moment with the people from [Name of Sexual Services Organisation], including the sexual service provider, the resident, and the psychologist or the resident's confidant, just to see: 'How do we match this up now?'" (...) "Yes, the commercial sex workers, so there too, if people need information or if they say: 'Ah, we'd like to talk to someone like that to see: does that fit [our needs]'" And they need mediation or something, that's always possible too." (D7)*

Rather than being governed by a fixed protocol, the deployment of sexual services is highly contingent upon a resident explicitly articulating a need or staff identifying one. Several directors indicate that the implementation of these services represents a broader institutional evolution: initial procedural resistance has gradually given way to the structured integration of these interventions, driven by their demonstrated positive impact on residents' overall well-being, as one director testifies:

*"The first time someone asks a question like that, you say, 'Oh no, we're not going to do that. And we're certainly not going to start down that road.' But then you start thinking about it, and you go, 'Okay, why not, actually?' And you evolve in your way of thinking. When you get that question a second time, you're already not going to immediately say, 'No, we're not doing that.' Instead, you say: 'Okay, we have this request, how can we handle this, how should we approach it?' In that way, you actually evolve along with certain mindsets." (D1)*

To ensure the quality and safety of the provision of sexual services, proactive directors provide staff with targeted information, professional education and training. This educational support respects caregivers' freedom of conscience, ensuring staff retain the professional autonomy to decide whether to assist a resident with a sexual service trajectory.

## Discussion

### Discussion of the Main Findings

The findings introduce a conceptual continuum of three distinct leadership orientations that shape the operationalisation of residents' intimacy and sexuality: participatory, proactive, and reactive-avoidant. While participatory and proactive directors actively engage in relational governance through multi-stakeholder dialogue (the triad) and the provision of facilities, reactive-avoidant directors experience professional paralysis driven by absent, rigid, or ambiguous frameworks, provided - or not provided - by the governing board. Ultimately, policy efficacy depends on the director's capacity to align governing boards' vision statements, or the lack thereof, with residents' lived, embodied realities.

This process uncovers a dichotomy between theoretical tolerance and structural implementation. Our analysis reveals that navigating operational barriers forces directors into a complex positioning when managing highly sensitive practices. Specifically, they sometimes experience divided loyalties between the strategic demands of their governing board and the intimate needs of their residents. This underscores that operationalising policies on resident intimacy and sexuality is an ethically contested domain where directors must continuously balance organisational compliance with residents' sexual rights and bodily autonomy.

### ***Leadership Styles***

Leadership styles influence how guidelines and policies are formulated and operationally shaped [35]. In the present study, the identified leadership orientations serve as the primary driver of subsequent policy implementation.

Although the process can be described sequentially - from the governing board's vision, through triad and staff training, and culminating in the provision of facilities - it is not linear. Instead, it functions as a circular, iterative process in which each stage continuously influences the others. Within healthcare management, this non-linear dynamic is conceptualized through double-loop learning, situational leadership adaptation, or models of bottom-up organisational learning [36,37]. The core tenet of these theories is that leadership is not a unidirectional process. For instance, when tangible results and frontline realities of resident intimacy and sexuality emerge, bottom-up feedback from staff during training prompts the director to recalibrate their original vision and leadership approach. Consequently, these elements form a dynamic framework in which institutional guidelines, policies, and daily practices are constantly in dialogue (see also Figure 1).

A notable finding of this interview study is the progressive conceptual evolution observed among the nursing home directors regarding resident intimacy and sexuality. Rather than maintaining static viewpoints, many participants experienced a shift in their professional views as they navigated the complex ethical dilemmas discussed during the interview. The data analysis reveals an overarching interpretive shift toward a more open vision across the entire sample. Specifically, directors initially categorized under the reactive-avoidant profile demonstrated a transition toward a more participatory stance as the conversation progressed. Simultaneously, those operating from an already participatory viewpoint evolved toward a distinctly proactive orientation. Even the directors within the proactive cohort expressed a clear desire to deepen and broaden their future policy implementation. This movement

across categories highlights that leadership orientations regarding residents' intimacy and sexuality are not immutable traits, but fluid frameworks susceptible to reflexive professional growth. This fluidity suggests that targeted dialogic encounters may facilitate managerial reflection and development, transitioning leaders from a stance of reactive avoidance to proactive advocacy.

### ***Policy Operationalisation***

The data analysis underscores that collaboration with the governing board appears to be a pivotal factor in the operationalisation of policy, either as a constraint or a catalyst. The importance of close and transparent collaboration across different organisational levels is corroborated by prior research [39-40]. On the one hand, a restrictive governing board tends to create institutional barriers that can contribute to managerial hesitation, potentially restricting the development of daily care practices. On the other hand, an openly supportive governing board appears to foster a more responsive, person-centred approach to residents' intimacy and sexuality, often by providing a clear, formal vision statement. This institutional backing can serve as a valuable mandate, encouraging directors to align daily care with residents' fundamental sexual rights more confidently.

Furthermore, the data analysis reveals a form of hypothetical tolerance towards residents' sexual expression: directors widely assume that requests for low-threshold facilities, such as sexual aids, door hangers, or a 'love bridge' between two single beds, would not pose any issues, yet they remain rather blind to whether accessible pathways actually exist. Only a small minority of directors proactively integrate these provisions into the standard package of care, leaving such resources available mostly upon request. This dynamic aligns with converging evidence from other qualitative studies [6]. This organisational inertia might suggest a form of implicit sexual ageism, wherein a lack of proactive planning risks leaving the intimate and sexual dimensions of residents' lives largely unaddressed within the broader institutional framework [3].

This asexual framework is also evident in the nursing home's architecture, where the standard prioritisation of single beds for care efficiency can inadvertently embody a non-sexual design logic for incoming couples. Unless residents or families explicitly challenge this default arrangement through deliberate resistance, the spatial design silently overrides the continuity of intimate relational life. Other studies have arrived at similar conclusions [13,14,41-44]. This restriction helps explain why even a simple, low-cost intervention like the 'love bridge' often remains an exceptional, reactive measure. It suggests a persistent tendency within routine care management to view intimacy primarily as an optional 'extra' rather than a foundational component of the care infrastructure. Consequently, while directors may be ideologically open to facilitating residents' sexuality, a gap often remains regarding structural normalisation. By consistently placing the initiative on vulnerable residents, leadership faces challenges in fully safeguarding the sleeping area as a genuine private domain where intimate relational continuity can be preserved.

### **Methodological Discussion**

The credibility, structural rigour, and interpretative depth of this qualitative study are underpinned by several distinct methodological achievements. In terms of analysis, the use of the QUAGOL framework [33] supported a transparent, non-linear, and systematic transition from original-language interview transcripts to high-level conceptual frameworks. Furthermore, to counteract individual interpretative bias, investigator triangulation was structurally embedded in the research lifecycle. Two investigators [ANONYMOUS and ANONYMOUS] independently executed the textual coding, while an external expert specialising in qualitative designs and sociology of religion [ANONYMOUS] audited the finalised analytical architecture. Additionally, the methodological transition to theoretical sampling following the initial ten interviews proved highly effective. By intentionally recruiting directors with prominent faith-based or theological identities, the research team was able to robustly test and redefine the boundaries of the emerging leadership continuum until conceptual saturation was achieved.

Conversely, the conceptual transformation observed among the directors demands a deeper examination of how the data were co-constructed. This fluid movement across leadership profiles challenges the traditional epistemological assumption that qualitative interviews function as passive, neutral data-collection tools. Instead, in this qualitative study, the reflective narrative dialogue of the interview acted as both a mirror and a professional intervention. When an interview functions as a catalyst for participant change, this phenomenon is recognised within qualitative methodology through concepts such as 'participant reflexivity', 'transformative interviewing', or the interview as an 'interventionist space' [45-47]. This dynamic typically occurs when in-depth, critical, or socially sensitive inquiries - such as those concerning late-life intimacy and sexuality - prompt interviewees to interrogate assumptions they previously took for granted. Consequently, the narratives gathered in this qualitative study cannot be viewed as static, pre-existing organisational facts; rather, they are the products of a dynamic, co-constructive encounter that inherently triggered a reflexive process within the directors' professional practice and ethical reflection.

Several methodological limitations emerge from the study's design. First, because nursing home directors are experienced in strategic and institutional communication, the study necessarily relies on self-reports. Consequently, this study risks capturing directors' idealised ethical frameworks and professional identities instead of an objective account of daily practice, a vulnerability potentially compounded by social desirability bias when engaging with an interviewer specialised in sexual ethics.

Furthermore, the sample is vulnerable to self-selection bias, as the participating directors likely possess a higher baseline of openness toward resident intimacy and sexuality than their peers who declined participation. This structural constraint is compounded because the informant cohort is geographically and socioculturally restricted to Flemish, Dutch-speaking, non-profit nursing homes with a Christian heritage. This segment constitutes nearly one-fifth of the regional landscape. Consequently, their specific perceptions and institutional policies may not be universally applicable to secular contexts or private, for-profit facilities. Together, these limitations underscore the critical need for future ethnographic or observational research to triangulate these managerial narratives with the direct, lived, bottom-up experiences of frontline caregivers and residents.

Nevertheless, evaluating this specific sample profile through a purely statistical lens misinterprets the primary objective of this qualitative inquiry. As Smith [48] argued, qualitative studies should not label a lack of statistical generalisability as an inherent limitation or weakness. Unlike quantitative research, which relies on large numbers to calculate statistical probabilities, qualitative inquiry is built on different core assumptions about how knowledge is created. Instead of finding universal laws, it aims to co-construct rich, deeply detailed knowledge from small, purposively selected samples. We contend that the present study offers 'representational' and 'analytical' generalisability. Consequently, other directors of Christian-inspired nursing homes can recognise their own experiences within this analysis and transfer these practical concepts to their unique nursing home settings. This alignment with evocative storytelling allows the empirical findings to resonate meaningfully with the directors.

Finally, the nature of the raw, emotionally charged narratives, ranging from staff mockery to nursing homes' collaboration with sex workers, required the first author to continually practise what is termed 'uncomfortable reflexivity' [49,50]. Methodologically, acknowledging the researcher as an active, embodied participant in knowledge production ensures that the vulnerability of both the participants and the topic is met with strict analytical integrity rather than normative judgment. Given the first author's academic background in theology and sexual ethics, deliberate team debriefings were vital to prevent the unconscious ethical sanitization of data during the QUAGOL coding process.

Beyond these reflexive challenges, the data analysis introduced distinct linguistic considerations. While analysing the data in its original Dutch language safeguarded the narratives' conceptual depth, translating illustrative participant testimonies into English presented minor hurdles. Specifically, achieving full linguistic and idiomatic equivalence remains challenging for localised, sociocultural expressions.

## **Implications for Practice, Education, and Further Research**

### ***Implications for Practice***

The observed diversity in the implementation of intimacy and sexuality guidelines suggests several implications for their design. First, our findings indicate that policy flexibility shapes directors' capacity to navigate the daily realities of late-life intimacy. Rather than relying on rigid, prescriptive manuals, both the transition toward proactive leadership and the operationalisation of intimacy care appear to benefit significantly from clear vision statements and flexible guidelines. The data seem to underscore that directors perceive vision statements and guidelines as most effective when they establish core ethical principles while safeguarding ample discretionary space and collegial leadership. This structural autonomy can support frontline staff in delivering responsive, tailored care that sensitively adapts to contextual, personal, and relational complexities.

Furthermore, such collegial, collaborative, or shared leadership, clear vision statements, and flexible guidelines appear to constitute a facilitative precondition for leaders' ability to both establish and

successfully conduct a trialogue [51-54]. These empirical findings suggest the value of establishing a multidisciplinary trialogue as a structural foundation. This approach assists directors in balancing the competing perspectives of diverse stakeholders regarding resident sexuality. Consequently, it may carry vital implications for daily practice, particularly during admission procedures and ongoing well-being evaluations.

By actively anchoring the collaborative perspectives of residents, families, and professionals —such as psychologists and ethics committees — nursing home directors appear better positioned to transition from defensive risk prevention to models of benefit promotion and relational autonomy [18,55-58]. Embedding this collaborative dynamic can empower multidisciplinary teams, even those with minimal formal ethics training, to formulate solutions tailored to the resident's personal affective and sexual needs.

### ***Implications for Education***

The observed gap between directors' ideological openness toward resident sexuality and reluctant operationalisation suggests important implications for professional development and continuous education. Data analysis points toward the value of case-driven peer consultation and collaborative ethical deliberation for frontline healthcare staff. Supporting directors and caregivers in developing as reflective practitioners may help them better navigate the moral discomfort triggered by complex sexual scenarios. Within this context, successfully engaging in a trialogue appears to require not only clear vision statements to provide an ethical foundation, but also concrete and flexible tools to guide its methodological execution. Specifically, providing staff with practical instruments, such as frameworks for ethical deliberation or structured topic guides for peer consultation, might facilitate the translation of theoretical concepts into daily practice within the nursing home environment. Training directors and staff in these structured trialogue methodologies enables them to balance resident desires, family perspectives, and professional care ethics. This appears crucial for enabling frontline staff to support residents' intimate well-being with confidence.

Mirroring frontline development, the leadership shifts observed in this study suggest important implications for healthcare leadership programmes. Educational programmes could emphasize transformational leadership styles specifically adapted to residential care settings. The findings point toward the relevance of preparing future executives to manage ideological friction with governing boards. Nurturing these competencies could prove highly valuable in helping directors navigate board-enforced silences and implement intimacy-supportive care practices within daily frontline operationalisation.

Finally, while professional development is highly relevant for directors and upper management, the insights from this study suggest that these development opportunities are equally vital for middle management and, by extension, for all staff members involved in any capacity in the care of residents. Furthermore, the fluid nature of leadership orientations discovered in this study also highlights a potentially foundational need within standard nursing, medical, and social care programs. These

academic curricula would benefit from further integrating specialised modules that explicitly address the intimate and sexual dimensions of ageing, which frequently remain underrepresented in traditional geriatric education. Such frameworks appear most effective when designed to alleviate the deeply ingrained awkwardness care professionals often experience, thereby preparing graduates for a culture that recognises intimacy as a core right rather than an optional 'extra'.

### ***Implications for Research***

The regional homogeneity of this sample (Flanders, Belgium) points toward the potential value of expanding future gerontological research into comparative, cross-sectoral designs. The data indicate that systematically exploring how intimacy guidelines and policies are operationalised across faith-based, secular, non-profit, and commercial for-profit settings emerges as an important avenue for further inquiry. Such comparative efforts may help clarify how divergent institutional funding models and ideologies tend to interact with residents' sexual and relational autonomy [26].

Furthermore, the methodological observation that the qualitative interview appeared to catalyse conceptual evolution carries notable implications for future research frameworks. Because these fluid shifts suggest that managerial styles can respond dynamically to reflective stimuli, researchers are encouraged to consider longitudinal or interventionist methodologies. Utilising participatory action research could help investigate how structured, ongoing reflection might minimise managerial hesitation toward resident sexuality. Moving beyond static data extraction might allow future studies to more actively track and support long-term reflexive growth on the subject of resident sexuality within healthcare institutions.

## **Conclusion**

This qualitative study offers nuanced insights into how nursing home directors navigate the sensitive and often complex domain of resident intimacy and sexuality within Christian-inspired nursing homes in Flanders, Belgium. The findings suggest a conceptual continuum of three distinct leadership orientations - participatory, proactive, and reactive-avoidant - which appear to shape how institutional policies are operationalised. Directors who tend towards participatory or proactive styles seem to more actively bridge the gap between institutional vision statements and the lived, embodied realities of residents. They often achieve this by facilitating relational governance through multi-stakeholder dialogue (the triad) and considering architectural accommodations to help safeguard residents' affective and sexual relational autonomy. Conversely, a reactive-avoidant orientation is frequently associated with forms of professional paralysis, a state that appears to be reinforced by absent, rigid, or ambiguous institutional guidelines.

Ultimately, a director's leadership approach seems to play an important role in shaping nursing homes' broader framework on resident intimacy and sexuality. This orientation potentially influences how shared decision-making is operationalised, how staff training is designed and delivered, and how resources are strategically deployed to foster residents' intimate and sexual well-being. To mitigate institutional

barriers and professional hesitation, future policy initiatives might benefit from cultivating proactive leadership frameworks. Providing nursing homes with clearer, more supportive guidelines could offer directors the necessary agency to transcend risk-averse patterns, thereby fostering environments that honour the holistic dignity and intimate and sexual rights of older adults in nursing homes.

## **Declarations**

### **Ethical Approval and Consent to Participate**

The study was approved by the Social and Societal Ethics Committee (SMEC) of KU Leuven (approval G-2024-8518-R2 (MIN), 4 November 2024), which complied with the General Data Protection Regulation 2016/679. In accordance with the principle of data minimisation, we only collected data relevant to the research, and it was coded and stored on the KUL institutional server. We stored the codes in a separate protected file, which only the team could access with a password.

Participants received a brochure with detailed information on the research project, both in writing (via email) and verbally (before the interview began). The informed consent form was explained, and participants were encouraged to ask any questions before giving their written informed consent.

Participation was voluntary. All participants received written and verbal information about their rights as research participants, for example, the option to end the interview at any time or to refuse to answer a particular question for any reason. All participants agreed to have their interview audio-recorded. To protect participants' privacy, access to the recordings and interview transcripts was restricted to the research team. In addition, all identifiable information about the participants and nursing homes was treated confidentially and anonymised in the manuscript. All interviews were performed in accordance with the Declaration of Helsinki. Informed consent was obtained from all participants in this study.

Beyond fulfilling formal procedural requirements, such as securing institutional review board approval and obtaining written informed consent, the interviewer cultivated a safe, private space conducive to open dialogue on this highly sensitive topic, which frequently evokes personal experiences and emotions. Recognising the sensitivity of the subject matter, the researcher consciously adopted a stance of 'empathic neutrality' [30], combining professionalism with interpersonal warmth to avoid a cold or detached demeanour. To support this micro-ethical approach, the researcher maintained inclusive, deliberate, and nuanced language throughout the encounters. Additionally, directors were explicitly offered the opportunity for post-interview debriefing or follow-up contact should any discussion point cause lingering distress.

### **Consent for Publication**

Not applicable.

### **Availability of Data**

Due to the sensitive nature of the qualitative data and ethical approval requirements, the interview transcripts and related materials are not publicly available. Pseudonymised data are securely stored in accordance with the approved ethics protocol and the General Data Protection Regulation. Additional information may be requested from the corresponding author.

### **Clinical Trial Number**

Not applicable

### **Competing Interests**

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

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### **Authors' Contributions**

All authors contributed to the conception and design of the study. (ANONYMOUS) carried out all qualitative data collection. [ANONYMOUS] and [ANONYMOUS] performed data analysis and interpretation, and they drafted the manuscript. All authors critically revised the article. All authors approved the final version of the manuscript. [ANONYMOUS] is the guarantor of the study.

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## **References**

1. World Health Organization. Sexual and Reproductive Health and Research (SRH). 2025. <https://who.int/teams/sexual-and-reproductive-health-and-research/key-areas-of-work/sexual-health/defining-sexual-health>. Accessed 17 March 2026.
2. Schantz Laursen B, Rasmussen P, Voldbjerg SL, Gronkjaer M, Laugesen B. Sexuality, a Fundamental Care Need – Theoretical and Clinical Considerations, a Discursive Paper. Scand J Caring Sci. 2026;40:e7020. doi:10.1111/scs.70207.

3. Yıldız Karaahmet A, Shafaati Laleh S. How sexual health becomes marginalized in long-term care: a scoping review of multi-level barriers. *Sex Med Rev.* 2026;14(2):qeag022. doi:10.1093/sxmrev/qeag022.
4. Castaldo A, Garcia JFJL, D'Amico A, Perrotta G, Eleuteri S. Barriers related to the identification and satisfaction of the sexual needs of nursing homes' residents: a narrative review. *Int J Environ Res Public Health.* 2025;22:1163. doi:10.3390/ijerph22081163.
5. Cheng HY, Liu LY. From Gatekeeper to Facilitator: Balancing Between Sexual Rights and Protection From Harm in Dementia Adults. *Am J of Geriatric Psychiatry.* 2025;33(5):558–571. doi:10.1016/j.jagp.2024.09.014.
6. Giroux D, Fullerton N, Marin A, Auger LP, Pageau F, Beauchamp J, Godin SE, Latulippe K. Sexual Quality of Life of Seniors Living in Long-Term Care Facilities: A Scoping Review. *Int J Sex Health.* 2025;37(2):263–283. doi:10.1080/19317611.2025.2466637.
7. Spencer LH, Carney M, Yang S, Lynch M. Human rights of residents in the nursing home sector: a rapid review of the evidence. *Int J Nurs Health Care Res.* 2025; 8:1616. doi:10.29011/2688-9501.101616.
8. Le K, Bennich M, Strandberg T. A Scoping Review on Attitudes towards Sexuality in Residential Aged Care. *Health Soc Care Community.* 2024; Article ID 1478395: 8 p. doi:10.1155/2024/1478395.
9. Sinkovič M, Towler L. Sexual aging: a systematic review of qualitative research on the sexuality and sexual health of older adults. *Qual Health Res.* 2019;29(9):1239–1254. doi:10.1177/1049732318819834.
10. Simpson P, Horne M, Brown LJE, Brown Wilson C, Dickinson T, Torkington K. Old(er) care home residents and sexual/intimate citizenship. *Aging Soc* 37. 2017;243-465. doi:10.1017/S0144686X15001105.
11. McAuliffe L, Fetherstonhaugh D, Syme M. From 'support' to 'separate': residential aged care staff responses to an intimate relationship involving a resident with cognitive impairment. *BMC Geriatr.* 2025;25:211. doi:10.1186/s12877-025-05865-1.
12. Villar F, Serrat R, Celdrán M, Fabà J, Martínez T, Twisk J. 'I do it my way': long-term care staff's perceptions of residents' sexual needs and suggestions for improvement in their management. *Eur J Ageing.* 2020;17:197–205. doi:10.1007/s10433-019-00546-6.
13. Ho PJ, Goh YS. Health care professionals and care staff challenges and experiences of managing sexual expression among older adults ≥60 years in long-term care facilities: a qualitative review and meta-synthesis. *Age Ageing.* 2022;51(1): January 2022, afab230. doi:10.1093/ageing/afab230.
14. Rodríguez-Mora A, Barrilaro L, García-Rojas A. Attitudes, knowledge and perceptions of care staff in long-term care homes about residents' sexual expressions: systematic review. *Rev Int Androl.* 2023;21(4):4100368. doi:10.1016/j.androl.2023.100368.
15. Mahieu L, Van Elssen K, Gastmans C. Nurses' perceptions of sexuality in institutionalized elderly: a literature review. *Int J Nurs Stud.* 2011;48:1140–1154. doi:10.1016/j.ijnurstud.2011.05.004.

16. Mahieu L, Dierckx de Casterlé B, Acke J, Vandermarliere H, Van Elssen K, Fieuws S, Gastmans C. Nurses' knowledge and attitudes toward aged sexuality in Flemish nursing homes. *Nurs Ethics*. 2016;23(6):605–623. doi:10.1177/0969733015580813.
17. Priede A, Reissing ED. Sexual Expression in Long-Term Care Institutions: Are We Ready for the Baby Boomer Generation? *Can J Aging*. 2024;43(4):559-570. doi:10.1017/S0714980824000163.
18. Howard L, Brassolotto J, Manduca-Barone A. Navigating Tensions About Resident Sexual Expression in Alberta's Continuing Care Homes: a Qualitative Study of Leaders' Experiences. *Sex Res Soc Policy*. 2020;17:632–642. doi:10.1007/s13178-019-00421-0.
19. Messelis E, Bauer M. Sex and Intimacy Policy in Residential Aged Care Facilities in Flanders, Belgium. *Sex Disabil*. 2020;38:85–93. doi:10.1007/s11195-019-09607-1.
20. Roelofs TS, Luijkx KG, Cloin MCM, Embregts PJCM. The influence of organizational factors on the attitudes of residential care staff toward the sexuality of residents with dementia. *BMC Geriatr*. 2019;19:8. doi:10.1186/s12877-018-1023-9.
21. Bauer M, Haesler E, Fetherstonhaugh D. Organisational enablers and barriers to the recognition of sexuality in aged care: A systematic review. *J Nurs Manag*. 2018; 27(4):858-868. doi:10.1111/jonm.12743.
22. Lester PE, Kohen I, Stefanacci RG, Feuerman M. Sex in Nursing Homes: A Survey of Nursing Home Policies Governing Resident Sexual Activity. *JAMDA*. 2016;17:71e74. doi:10.1016/j.jamda.2015.08.013.
23. Syme ML, Lichtenberg P, Moyer J. Recommendations for sexual expression management in long-term care: a qualitative needs assessment. *J Adv Nurs*. 2016; Oct.72(10):2457-67. doi:10.1111/jan.13005.
24. Lingier A, Vandewiele W. The Decline of Religious Life in the Twentieth Century. *Religions*. 2021;12(6):1–25. doi:10.3390/rel12060388.
25. Vandewiele W. The Post-Secular Society. Desert or Oasis for Social Entrepreneurship in Religious Communities and Organizations? *Louv Stud*. 2021;44:131-151. doi:10.2143/LS.44.2.3289493.
26. Miller V, Miller S, Stevens B. Elder Sexual Abuse and Sexual Freedom in Faith-based Residential Care Facilities: Ethical Dilemmas, and Institutional Integrity. *International Journal of Public Theology*. 2021;5:253-273. doi:10.1163/15697320-12341657.
27. Corbin J, Strauss A. *Basics of qualitative research: Techniques and procedures for developing grounded theory*. 4th ed. London: Sage, 2014.
28. Charmaz K. *Constructing Grounded Theory*. 2<sup>nd</sup> ed. London: Sage, 2014.
29. Tong A, Sainsbury P, Craig J. Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups. *Int J Qual Health Care*. 2007;19(6) 349-357. doi:10.1093/intqhc/mzm042.
30. Patton MQ. *Qualitative research & evaluation methods: Integrating theory and practice*, 4th ed. London: Sage; 2015.

31. Malterud K, Siersma VD, Guassora AD. Sample Size in Qualitative Interview Studies: Guided by Information Power. *Qual Health Res.* 2016;26(13):1753-1760. doi:10.1177/1049732315617444.
32. ANONYMOUS Cornu I, Vandewiele W, Gastmans C. The ethics of intimacy and sexuality of older adults living in nursing homes: A systematic review of argument-based literature. *Nurs Ethics.* 2025; (32)4:1013-1034. doi:10.1177/09697330251324301.
33. Dierckx de Casterlé B, Gastmans C, Bryon E, Denier Y. QUAGOL: A guide for qualitative data analysis. *Int J Nurs Stud.* 2012;49(3),360-371. doi:10.1016/j.ijnurstu.2011.09.012.
34. Dierckx de Casterlé B, De Vlieghe K, Gastmans C, Mertens E. Complex qualitative data analysis: lessons learned from the experiences with the qualitative analysis guide of Leuven. *Qual Health Res.* 2021;31(6):1083–1093. doi:10.1177/104973232096698.
35. Denier Y, Dhaene L, Gastmans C. ‘You can give them wings to fly’: a qualitative study on values-based leadership in health care. *BMC Med Ethics.* 2019;20:35. doi:10.1186/s12910-019-0374-x.
36. Argyris C. Single-Loop and Double-Loop Models in Research on Decision Making. *Adm Sci Q.* 1976;21(3):363–375. doi:10.2307/2391848.
37. Van Graas R, Gobbens RJ. Learning and Developing Together for Improving the Quality of Care in a Nursing Home: Is Appreciative Inquiry the Key? *Healthcare.* 2023;11:1840. doi:10.3390/healthcare11131840.
38. Chambers N, Smith J, Proudlove N, Thorlby R, Kendrick H, Mannion R. Roles and behaviours of diligent and dynamic healthcare boards. *Health Serv Manage Res.* 2020;33(2):96–108. doi:10.1177/0951484819887507.
39. Poh L, Tan SY, Lim J. Governance of Assisted Living in Long-Term Care: A Systematic Literature Review. *Int J Environ Res Public Health.* 2021;18(21),11352. doi:10.3390/ijerph182111352.
40. Van Puyvelde S, Caers R, Du Bois C, Jegers M. The Governance of Nonprofit Organizations: Integrating Agency Theory With Stakeholder and Stewardship Theories. *Nonprofit Volunt Sect Q.* 2012;41:431-451. doi:10.1177/0899764011409757.
41. Bentrött MD, Margrett JA. Adopting a multilevel approach to protecting residents’ rights to sexuality in the long-term care environment: policies, staff training, and response strategies. *Sex Res Soc Pol.* 2017;14(4):359–369. doi:10.1007/s13178-016-0260-y.
42. Jen S, Jeong M, Lafountain O, Doll G, Cornelison L. Sexual Expression, Policies, and Practices in Skilled Nursing Settings Serving Older Adults: An Updated Assessment in the State of Kansas. *Gerontol Geriatr Med.* 2022;Jul 19;8:23337214221113137. doi:10.1177/23337214221113137.
43. Syme ML. Supporting safe sexual and intimate expression among older people in care homes. *Nurs Stand.* 2017;31(52):52–63. doi:10.7748/ns.2017.e10906.
44. Monteiro A, von Humboldt S, Leal I. How do formal caregivers experience the sexuality of older adults? Beliefs and attitudes towards older adults’ sexuality. *Psycholog Community Health.* 2017;6(1):77–92. doi:10.5964/pch.v6i1.216.
45. Gomes Pessoa AS, Harper E, Samogim Santos I, Carvalho da Silva Gracino M. Using Reflexive Interviewing to Foster Deep Understanding of Research Participants’ Perspectives. *Int J Qual*

- Methods. 2019;18:1–9. doi:10.1177/1609406918825026.
46. Marcucci O, Elmesky R. Caring in qualitative interviews: A working model for interviews in the transformative paradigm. *Qual Res.* 2026;26. doi:10.1177/14687941261420115.
  47. Perera K. The interview as an opportunity for participant reflexivity. *Qual Res.* 2020;20:143-159. doi:10.1177/1468794119830539.
  48. Smith B. Generalizability in qualitative research: misunderstandings, opportunities and recommendations for the sport and exercise sciences. *Qual Res Sport Exerc Health.* 2018;10(1):137-149. doi:10.1080/2159676X.2017.1393221.
  49. Carr M. Moments of Discomfort: Rethinking Reflexivity and Researcher Subjectivities Through Affect and Poststructuralism, *Gend Work Organ.* 2026;33(2):483-494. doi:10.1111/gwao.70057.
  50. Pillow WS. Confession, catharsis, or cure? Rethinking the uses of reflexivity as methodological power in qualitative research. *Int J Qual Stud Educ.* 2010;16(2),175-196. doi:10.1080/0951839032000060635.
  51. Lynch B, Ryan A, McIlpatrick S, Penney S, Bradley R, O'Neill M, McCauley C, Beck ER, Curran A, Hume U, Muldrew D, Slater P. The Impact of a Leadership Support Programme on Care Home Residents and Their Families: A Qualitative Study From the Perspective of Participating Care Home Leaders. *Int J Older People Nurs.* 2025; Nov 20(6):e70054. doi: 10.1111/opn.70054.
  52. Jönsson M, Edberg AK, Wallin AO, Sundström M, Backman A. Person-centred leadership in residential care for older people as described by first-line managers. *BMC Nurs.* 2025 Jun 23;24(1):666. doi:10.1186/s12912-025-03354-9.
  53. Nachtergaele S, De Roo N, Allart J, De Vriendt P, Embo M, Cornelis. Clinical leadership in nursing homes: A qualitative study of healthcare professionals' perspectives on concept and characteristics. *Nursing open.* 2024;11(6): Article e2166. doi:10.1002/nop2.2166.
  54. Curşeu PL, van Rijswijk J, Schruijer SGL. Collaborative and Shared Leadership Dynamics in Healthcare Action Teams: A Systematic Literature Review. *J Healthc Leadersh.* 2025;(17): 877–899. doi:10.2147/JHL.S520534.
  55. Gómez-Vírseda C, De Maeseneer Y, Gastmans C. Relational autonomy: what does it mean and how is it used in end-of-life care? A systematic review of argument-based ethics literature. *BMC Med Ethics.* 2019;20:76. doi:10.1186/s12910-019-0417-3.
  56. Kontos P, Miller KL, Kontos AP. Relational citizenship: supporting embodied selfhood and relationality in dementia care. *Sociol Health & Illn.* 2017; 39(2): 182-198. doi:10.1111/1467-9566.12453.
  57. Kontos P, Grigorovich A, Kontos AP, Miller KL. Citizenship, human rights and dementia: towards a new embodied relational ethic of sexuality. *Dementia.* 2016;5 (3): 315-329. doi: 10.1177/1471301216636258.
  58. Victor E, Guidry-Grimes L. Relational autonomy in action: rethinking dementia and sexuality in care facilities. *Nurs Ethics.* 2019; 26(6):1654-1664. doi:10.1177/0969733018780527.

## Figures

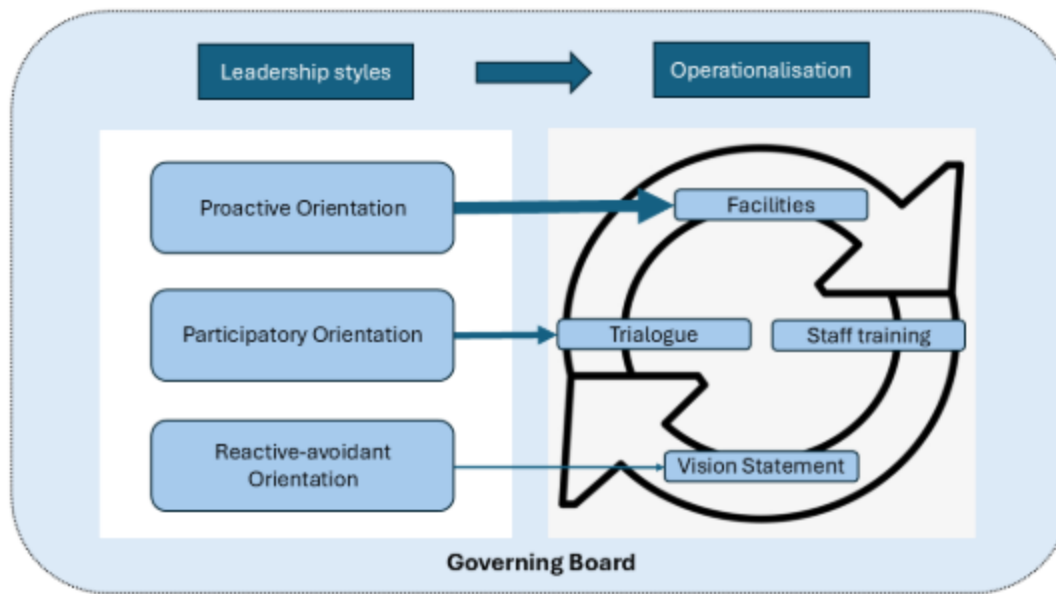


Figure 1

*Visual model of the dynamic feedback loop between leadership styles and institutional policy operationalisation.*

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