A “BURDEN”, A BLESSING, AND WORTHY OF BELONGING: DISCUSSIONS OF DISABILITY AND SEXUAL EXPRESSION IN ALBERTA CONTINUING CARE HOMES.

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DEDICATION

This thesis is dedicated to the prairie skies and wild sunflowers for making Lethbridge my home for my academic journey.

With my whole heart I also dedicate my thesis to the remarkable people who helped support me on my academic journey at the University of Lethbridge, because I could not have imagined this winding adventure of lessons and discovery without you all. My dear parents, Debbie and Ted, for supporting me in chasing my dreams. My fiancé Nick, for his unwavering love and support. My sweet Danni, for growing alongside me through every piece of my Lethbridge journey. My cherished parents-in-law, Trish and Trevor, for your care and support through my studies. My grandparents, Barb and Ted, and my dear late grandma, Ruth, for always cheering me on. My academic mentor, Julia, for meeting 18-year-old Brianna in a Roots sweatsuit and messy bun and believing in me. Lastly, to my sweet pup Theo for his endless kisses and barks on my Zoom calls.

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ETHICS STATEMENT

The co-principal investigators Dr. Julia Brassolotto and Dr. Lisa Howard of the dataset utilized for this thesis received ethics approval (Pro00072539) from the University of Alberta's Health Research Ethics Board. Operational approvals from Alberta Health Services, CapitalCare, Carewest, and Covenant Health were also secured. Use of this dataset for this thesis falls within the approved use of this dataset for analysis by a University of Lethbridge graduate student.

USE OF GENERATIVE AI

The only use of AI-assisted programs was through Grammarly for standard grammar and spelling correction. AI was not used to generate ideas or content in any capacity. All writing is my own.

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CHAPTER 1: INTRODUCTION

Sex, intimacy, connection, and self-expression are important components of the human experience that contribute to a healthy and empowering life (Gianotten et al., 2021). Unfortunately, sexuality is often regarded as taboo in our society, which creates barriers to healthy sexual expression (Tohit & Haque, 2024). For individuals living in continuing care homes, barriers to sexual expression are often exacerbated by policies and care practices that prohibit authentic, fulfilling, or stigma-free experiences (Frankowski & Clark, 2009; Howard et al., 2020). As a queer person who lived in Southern Alberta for most of my adulthood, the rhetoric I always heard was that sexuality should exist behind closed doors – but what if there are no closed doors? For people living in continuing care homes, privacy and autonomy are cited by numerous scholars as everyday struggles (Sun et al, 2024; Roelofs et al., 2021). These barriers are only heightened for individuals living with disabilities due to added societal stigma surrounding sexuality and ableist perspectives (Esmail et al., 2010; Villar et al., 2014). My thesis aims to continue this important discourse through exploring the experiences of residents living in Alberta's continuing care homes and examining how disability is experienced, discussed, and navigated in these settings as it pertains to sexual expression.

Although other scholars have researched sexual expression in continuing care (Howard et al., 2020; Frankowski & Clark, 2009; Villar et al. 2014) and barriers surrounding sexual expression for people living with a disability (Sinclair et al. 2015; Goulden, 2025; Su & Cyr, 2021) there is still a significant gap in research exploring how disability is discussed as it pertains to sexual expression for residents of varying ages and disabilities within the continuing care context (Doll, 2013; Frankowski & Clark, 2009). In other words, this thesis bridges together scholarship on sexual expression in continuing care homes and scholarship on disability and sexuality, which often focuses on younger people.

In this thesis, I used Braun and Clarke's (2022) approach to reflexive thematic analysis (RTA) to understand how disability was discussed as it pertained to sexual expression. I performed a secondary analysis of resident interviews from Dr. Julia Brassolotto and Dr. Lisa Howard's 2018-2019 dataset on sexual expression in Albertan continuing care homes. Their research was a qualitative exploratory design using semi-structured interviews to understand experiences and opinions surrounding sexual expression in continuing care (Brassolotto & Howard, 2019).

This thesis explores how residents in Alberta's continuing care homes discuss and describe disability as it relates to sexual expression. Situated within a context where continuing care environments are historically medically focused and underfunded (Gao et al., 2025), my findings show how structural barriers, ableist attitudes, and societal stigma intersect to shape participants' experiences with disability influencing opportunities for intimacy, connection, and sexual expression. Using Braun and Clarke's (2022) approach to RTA, I identified three main themes: 1) negative descriptions of disability for oneself vs. acceptance of disability for others, 2) the tension between the freedom of sexual expression and the constraints of the care home context, and 3) despite the challenging context, residents still found opportunities for sexual pleasure, emotional intimacy, and enjoying the "tastiness of life." Despite participants sharing an array of experiences and varying interest in sexual expression, it remained clear that they believed sexual expression deserved a space in continuing care. As a public health researcher focused on health promotion, I approached this data with a goal to understand the nuanced ways participants describe disability as it relates to sexual expression to understand what fosters sexual expression in continuing care homes and what makes sexual expression difficult. The purpose of this research was to better understand resident experiences and provide evidence-informed recommendations. These findings can be used to help enhance continuing care home policies and programming to better support the sexual expression of residents with disabilities.

This thesis is comprised of three chapters. In this first introductory chapter, I provide an overview of key concepts associated with the project, some background on the continuing care sector, and situate myself reflexively as a researcher. Chapter 2 is a manuscript-style chapter that describes the study methods and design, focuses on the findings of my RTA, details the three themes that I identified, and provides a preliminary discussion of their implications. In Chapter 3, I discuss some additional implications of my analysis, provide several recommendations for policy and practice change, and discuss potential avenues for future research.

Background

Defining Sexual Expression

"Sexual expression" is a multi-faceted term that describes how an individual experiences sexuality and communicates their sexuality with the world around them (Beckwith & Drake, 2022). Similarly, the World Health Organization defines "sexual health" as a state of autonomy, knowledge, and wellness that is not solely limited to physical sexual relationships. The World Health Organization states that sexual health is:

> "…a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled" (WHO, 2006, p. 5).

Sexual expression can encompass anything from self-presentation and personal grooming to handholding, kissing, bed sharing, and solitary or partnered sexual acts and practices

(Brassolotto, Howard & Manduca-Barone, 2020). The term also describes the thoughts, feelings, fantasies, relationships, behaviours, and values humans have as dynamic and sexual individuals (Gianotten et al., 2021, Syme et al., 2019). Sexual expression is a healthy and normal part of human adulthood that contributes significantly to mental health, physical health, social health, and one's sense of self (Gianotten et al., 2021, Syme et al., 2019). Sexual expression, and access to sexual health overall, are public health concerns that deserve attention within continuing care homes (Mitchell et al., 2021).

Continuing Care in Alberta

With advances in medicine and improved quality of life, Statistics Canada (2024) predicts a steady rise in the number of Albertans aged 65 and above over the next 20 years. There is an increased demand for continuing care homes as Albertans are living longer with complex care needs. As of 2021, Alberta reported over 45,000 beds in continuing care (including supportive living and long-term care homes) with numbers rising since then (Government of Alberta, 2021). Simultaneously, there is also a growing need to support middle-aged adults with more medically complex care needs (Suter et al., 2014). While continuing care homes have historically catered to older adults, Canada is seeing an increase in adults of all ages with complex care needs seeking out these spaces. In 2020, the Canadian Institute of Health Information showed that 6.7% of long-term care residents were below the age of 65 (Canadian Institute of Health, 2020).

Alberta defines "continuing care" homes as publicly-funded licensed facilities that provide residents with medical care, personal support, and enrichment activities to live happy and healthy lives (Alberta Health Services, 2024). Continuing care includes "Type A" long-term care facilities which provide care for people with more complex health needs requiring 24-hour care, and "Type B" supportive living facilities that help meet residents' basic needs while still promoting independent living (Government of Alberta, 2024). Alberta's continuing care home structure also includes "Type C" hospice care (Government of Alberta, 2024), but there were no participants in this study in hospice at the time of data collection. Alberta's new guidelines emphasize continuing care residents have access to a variety of resident services (e.g., meals, housekeeping, physician services, nursing services, and personal care); however, these services significantly overlook social, emotional, and sexual support (Government of Alberta, 2024). In addition to caring for residents' health and care needs, it is the responsibility of continuing care homes to respect the diversity of all residents, focus on enhancing quality of life, and focus on person-centered care that prioritizes everyone's unique needs and actively consults residents regarding their care (Continuing Care Act, 2024). It is important to note that Alberta has since undergone significant changes to the continuing care sector, including the decentralization of care (Alberta Health Services, 2024). This change allegedly provides greater autonomy to care homes to adjust their care approach based on resident needs, but has introduced significant confusion in the sector and leaves room for sexual expression to be under-prioritized.

Despite the desire for person-centered care and enhancing quality of life, continuing care homes often have significant barriers to fostering community and supporting individualized care. Continuing care homes in Canada have historically been designed as medical or "hospital-like" environments that prioritize clinical efficiency and physical care over social and emotional wellbeing (Kane, 2001). These environments are often characterized by strict care routines, shared rooms, limited access to privacy, and a lack of communal spaces conducive to meaningful social gathering (Kane, 2001). The built environment tends to cater to supervision and safety rather than comfort or personalization, and programming frequently focuses on standardized group activities rather than community building, niche interests, or individualized activities (Gao et al., 2025; Howard et al., 2020). In addition to structural and social concerns, continuing care homes are consistently underfunded and understaffed leading to an operational focus on task-based and clinically measurable outcomes (Rowntree & Zufferey, 2015; Doll, 2013). With limited staff and time constraints, continuing care homes must prioritize physical and medical care while leaving sexual expression as an optional component of resident wellbeing (Rowntree & Zufferey, 2015; Doll, 2013).

Context of Sexual Expression in Alberta

This research was conducted in Alberta, which has a distinct political and social context that is worth noting. For instance, this traditionally conservative province has numerous policies aimed at censoring evidence-based sexual health education (Grace, 2018; Maine et al., 2024; Santinele Martino et al., 2024). Sexual health education within Alberta high schools continues to be inconsistent, lacking comprehensive information and universal implementation (Grace, 2018; Santinele Martino et al., 2024). At the time the data for this study were collected, parents could withdraw their child from lessons deemed to focus on sexual health which is alarming due to the link between comprehensive sexual health education and one's understanding of 2SLGBTQ+ identities, healthy relationships, understanding intimate partner violence, and consent (Goldfarb & Lierberman, 2020; Santinele Martino et al., 2024).

In present day, sexual expression and sexual health education continue to be challenged within Alberta (Goldfarb & Lierberman, 2020; Santinele Martino et al., 2024). In 2024, Alberta passed the Education Amendment Act, which mandates schools to notify parents if their child requests to change their preferred name or pronouns (*Education Amendment Act*, 2024). This exposes students to a variety of potential harms such as "outing" them to unsupportive parents and minimizing the student's identity, which can have negative impact on mental health and wellbeing (Degagne, 2015; Grace, 2018). This amendment also allows parents to opt their child in, rather than opt out, of any class material "that deals primarily and explicitly with gender identity, sexual orientation, or human sexuality" (*Education Amendment Act*, 2024). This bill will deprive students of critical information despite decades of research demonstrating comprehensive sexual health education is the foundation for a healthy relationship with oneself and the people around them (Goldfarb & Lieberman, 2020). Although these pieces of legislation apply to the education sector rather than healthcare, they reflect dominant social and political norms in the province that do not operate independent from those living and working in continuing care homes.

Defining Disability

When speaking about "disability" in this research, I am referring to any physical or intellectual impairment, or chronic illness, that leads to limitations and participation restrictions in daily life (Altman, 2014). This aligns with how the World Health Organization describes disability as what results when an individual's health, body, or cognitive function interacts with their environment creating a barrier to their desired action (2002). As a researcher who is attentive to the social determinants of health, I believe that one's lived experiences, identity, health, and social location intersect to inform how one can access their own health and wellness. For instance, distinct barriers or stigmas exist for queer or racialized people with disabilities. This definition frames disability as a part of one's unique identity, rather than viewing disability as a medical constraint that inherently prohibits sexual expression (Dirth & Adams, 2019; Addlakha et al., 2017).

Throughout this thesis, I will be using a combination of person-first language to speak about disability (e.g., "person with a disability") and identity-first language (e.g., "disabled person"). Identity-first language is important to many people living with disabilities to reclaim their disability as an integral part of themselves rather than something to be separated from

(Andrews et al., 2019). It is the choice and preference of many disabled people who argue their disability is an inherent part of who they are and choose identity-first language to represent this (Dunn & Andrews, 2015). Alternatively, person-first language puts emphasis on the person before their disability (Dunn & Andrews, 2015). Person-first language reinforces the idea that disability is simply another aspect of one's lived experiences that does not define who an individual is (Crocker & Smith, 2019). While all 12 participants discuss disability within their interviews, participants of this study were not asked to explicitly self-disclose any disabilities nor share their own language preferences. For this reason, I will use a mix of identity-first language, with an emphasis on person-first language when discussing participants' experiences.

Defining Ableism

Ableism is discussed multiple times throughout my findings and can be summarized as prejudice or discrimination against disabled people on the basis that being able-bodied is considered superior, normal, and desirable (Reber et al., 2022; Addlakha, Price & Heidari, 2017). Ableism can be perpetuated through policies, built environments, communities, and individuals, but can also be internalized by people living with disabilities. A key element of *internalized* ableism is taking these harmful rhetorics and blaming oneself for oppression rather than realizing these beliefs are falsely constructed by oppressive systems (Reber et al., 2022; Sinclair et al., 2015).

Defining Intersectionality

Intersectionality recognizes how an individual's social identities (e.g., race, age, gender, sexuality, etc.) intersect and interact within their daily world to influence their lived experiences, opportunities, forms of oppression, and privileges (Crenshaw, 2017). Rather than understanding identities in isolation, intersectionality emphasizes that social inequities are produced through overlapping experiences that cannot be separated from one's identity (Crenshaw, 2017).

Disability and Sexual Expression

Disabled people continue to face systemic obstacles to autonomy and visibility both outside and within continuing care homes. The 2022 Canadian Survey on Disability shows that over a third of Canadians living with a disability experienced barriers in their daily life as a direct result of behaviours, misconceptions, or assumptions from the people around them (Statistics Canada, 2022). The ability to show up authentically and present oneself in a way congruent to how one feels is highly associated with feelings of belonging and self-fulfillment, especially in the cultural context of North America (Kim & Sherman, 2007). Self-expression and autonomy often act as a bridge to build meaningful connections with others and feel confident in oneself (Kim & Sherman, 2007).

Disabled people are often desexualized (Kafer, 2003), viewed as asexual, and left out of sexual health curricula, which further contributes to internalized ableism and feelings of shame surrounding sexual expression (Goulden, 2025; Su & Cyr, 2021). Sexual expression, sexual pleasure, sexual health, and sexual justice are cited as the four main elements defining sexual wellbeing, yet these pillars to sexual wellness are often deemed by society as ‘optional’ or ‘unnecessary’ for disabled people (Goulden, 2025; Mitchell et al., 2021). Politically and medically, sexual and reproductive rights continue to be heavily critiqued and contested worldwide for over 15% of our global population living with a disability (Addlakha et al., 2017). Disabled people continue to be met by society with rejection from the right to human sexuality despite this ideology being based on misinformed judgment. For example, findings from one study illustrate that physicians often assume disabled patients are asexual and therefore do not discuss methods of contraception or safer sex (Su & Cyr, 2021).

There is a gap in mainstream sex education that leaves disabled people without knowledge or resources to navigate sexuality in an empowered, safe, and informed way (Esmail et al., 2010). Statistics show people living with disabilities are at higher risk to sexual violence due to a lack of comprehensive sexual health education on topics of sexuality, autonomy, and consent (Davies et al., 2023). Everyone should have the right to determine what does or does not happen to their own body and what relationships they engage in. In the rare instances when sexual health curricula exist for disabled people in school, health, or care settings, content often focuses on heterosexual relationships, preventing pregnancy, and self-pleasure as a more welcomed alternative to partner-based sex (Gill, 2015). Without widely accessible disability-informed sexual health education that encompasses all aspects of human sexuality, people living with disabilities cannot receive the tools they need to explore sexual expression in a healthier, safer, and more informed way (Davies et al., 2023; Su & Cyr, 2021; Esmail et al., 2010).

An additional element of this issue is that disabled people may require others to facilitate their sexual expression. In *Loneliness and Its Opposite* (2015), Kulick and Rydström discuss the facilitation of sexuality for people with disabilities. They do a comparison of Danish and Swedish approaches to sexuality and disability, noting that while both nations are generally thought of as progressive, they have very different approaches – with Denmark treating the erotic lives of people with disabilities as not only something that needs to be facilitated, but also as crucial for dignity and broader social justice. This emphasizes that supporting sexual expression for disabled people may require not only supportive attitudes, but also active support from care staff (e.g., provision of materials such as lubrication, adjusting physical placement into a particular position, permitting overnight guests, and more). Similarly, Gill (2015) highlights how the sexuality of people with disabilities (in this case, intellectual disabilities) is often seen as "risky" or "inappropriate" without attention to or concern for the pleasure, joy, and connection that it might provide.

Shame and confusion about sex are common in a society filled with ableism and lack of positive representation for disability and sexuality (Alexander & Gomez, 2017). Sexual advisor Vivi Hollænder (Kulick, 2015) states, "when it comes to sexuality, every handicapped person knows exactly what they're not allowed to do. The problem is that most of them don't know what they *are* allowed to do." This quote is extremely powerful in showcasing the repercussions of a society that does not show what healthy sexuality looks like for people with disabilities– the only ideas that get conveyed are what one cannot or should not do. This lack of understanding of the importance of sexual expression is consistent with findings from continuing care homes, which suggest that resident sexual expression is typically only addressed when it is problematic (Howard et al., 2020; Villar et al., 2014). Sexual expression is treated as something staff must react to when it is non-consensual or disruptive, but rarely as a natural part of human sexuality to be proactively discussed (Simpson et al., 2017; Villar et al., 2017). Care home staff often cite concerns for consent and capacity for residents with cognitive impairments, such as dementia, often scrutinizing sexual expression due to concerns over the lack of one's ability to consent (Grigorovich et al., 2022; Howard et al., 2020). There have seemingly been limited efforts to support the sexual expression of people living with dementia in meaningful ways.

Crip Theory and "Cripping"

Despite discrimination and stigma, disabled people continue to challenge ableist ideologies surrounding sexual expression and center their own bodies and experiences. McRuer (2006) introduces crip theory as a way to confront ableist norms and "compulsory able-bodiedness" and reconstruct these norms with disabled existence, liberation, and joy at the forefront. In brief, crip theory is a theoretical framework that merges queer theory with disability justice to challenge normative expectations about bodies, minds, sexuality, and productivity (McRuer 2006; Schalks, 2013).

While the concept of cripping has its roots in crip theory, this word is often used among disabled communities as a verb that extends beyond academia and into lived experiences of advocacy and celebration. The term "crip" has been reclaimed as a way to celebrate and centre disabled experiences as a form of joy and resistance (Schalks, 2013). Disabled people continue to "crip" sex, sexual expression, and sex education by celebrating and centring their experiences in spaces that have historically excluded them (Schalks, 2013). Cripping sexual expression continues to transform the way society views sex, pleasure, and expression in ways that benefit and are accessible to everyone (Schalks, 2013). This could include reimagining sex outside of penetrative, partner-based, heteronormative acts to validate and include anything that is consensual and feels good. While my research does not use crip theory as a theoretical framework, my research is heavily built upon both research from scholars in crip theory and the revolutionary act of cripping sexual expression being done by disabled communities worldwide.

Defining Health Promotion and Harm Reduction

Health promotion and harm reduction are two complementary, application-based approaches that translate public health knowledge to enhance the overall health and wellbeing of specific populations. Throughout this thesis, I discuss both approaches as meaningful ways my findings can be applied in continuing care home contexts.

Health promotion is defined in the Ottawa Charter for Health Promotion as:

> "the process of enabling people to increase control over, and to improve, their health. To reach a state of complete physical, mental and social well-being, an individual or group must be able to identify and to realize aspirations, to satisfy needs, and to change or cope

> with the environment. Health is therefore, seen as a resource for everyday life, not the objective of living" (World Health Organization, 1986).

In the context of continuing care, health promotion involves ongoing and proactive efforts to support residents in obtaining their highest level of physical, social, mental, and sexual wellbeing. Health promotion recognizes that each resident has different identities, capacities, and histories, and emphasizes environments, policies, and programs that support a pursuit of holistic health and wellness.

Harm reduction seeks to reduce risks, enhance autonomy, and support safer sexual expression (Sansone et al., 2022). Harm reduction focuses on minimizing potential risks associated with sexual expression in continuing care (Sansone et al., 2022). Rather than prohibiting or dismissing sexual expression in continuing care homes, harm reduction aims to minimize potential physical, social, or mental harms that may arise.

Both health promotion and harm reduction share the same understanding that sexual expression does not simply end with age, disability, or in continuing care homes, and should be appropriately addressed to support holistic health. When combined, harm reduction can work to minimize harms such as sexually transmitted infections, coercion, loneliness, shame, or injury during intimacy, and health promotion can provide ways to celebrate, understand, and embrace sexual expression in continuing care homes in ways that are safe and respectful for everyone involved.

Reflexivity

In Braun and Clarke's approach to reflexive thematic analysis, subjectivity is viewed as valuable– fundamentally helping shape the unique process of knowledge production (Braun & Clarke, 2022, p.12). In this sub-section, I outline my personal, professional, and educational experiences that influence how I am situated within my research. Personally, my passion for destigmatizing sexual health and promoting sexual wellness has influenced my belief that everyone deserves to have equitable access to sexual expression in whatever ways feel empowering to them. As such, I approached my research with sex-positivity and a focus on the sexual autonomy of continuing care residents with disabilities. My analysis foregrounds sexual expression as a legitimate and essential component of wellbeing, rather than a peripheral or "controversial" idea. This is further supported through intentionally discussing participant stories of success surrounding connection, resilience, and finding ways to enjoy the tastiness of life, rather than what needs to be improved. My experience as a queer woman (working closely to listen and engage in active allyship to other 2SLGBTQ+ identities and POC experiences), paired with my education in public health, informed an intersectional and empathetic approach to the data. This enhanced my attentiveness to how stigma, marginalization, and internalized beliefs interact within participant experiences. For example, in theme one, I directly identify the stark difference in how participants describe their own disability as a "burden", compared to how they positively discuss the disabilities of others. My outlook on public health is heavily influenced by the social determinants of health and the belief that an individual's experiences, identities, and environments simultaneously interact to inform how they navigate their own health and wellness, or more specifically, sexual expression. My analysis focused on the nuanced experiences, often simultaneously positive and negative, that demonstrate how disability and sexual expression were experienced and discussed. My training in public health, in both my undergraduate and graduate education, has led me to focus on health promotion, harm reduction, and the applied health and policy contexts. As a result, my thesis focuses on the implications of my findings for those settings, rather than aiming to contribute to critical theory or sociological scholarship in this area. My experience working at a continuing care home for adults with disabilities directly informed my passion for advocating for holistic wellness within care homes and destigmatizing sexual expression for adults with disabilities. I believe that humans, sexual expression, and health are nuanced and complex, and my analysis reflects this.

Conclusion

In reflecting on my work, this thesis explores how residents in Alberta's continuing care homes experience and discuss disability as it relates to sexual expression. Grounded in Braun and Clarke's (2022) RTA, this research is shaped by my own commitment to harm reduction, health promotion, and the belief that sexual expression belongs in continuing care homes. I show that while residents often internalized disability as a personal limitation to sexual expression, they simultaneously expressed acceptance toward others, highlighting the deep influence of internalized ableism. Medicalized models of care, understaffing, time constraints, and lack of guiding policies only exacerbated barriers in participant sexual expression. Despite these barriers, participants still found ways to crip sexual expression and demonstrated creativity, connection, and resilience in redefining what sexual expression was in the presence of disability. By bridging conversations from disability studies, healthy aging, continuing care, and public health, my findings show the lived realities of sexual expression and disability in continuing care homes. I hope that my findings can be used to reimagine continuing care homes as a place that honours sexual expression to guide health promotion interventions, education, and resources for residents living with disabilities.

CHAPTER 2: MANUSCRIPT

This chapter includes the manuscript I have prepared outlining the findings of my reflexive thematic analysis.

Introduction

This research explores how residents discuss disability as it relates to sexual expression in Alberta continuing care homes. Guided by my passion as a researcher to centre the experiences of disabled people and approach health holistically, I aimed to share nuanced resident experiences of disability and sexual expression and to generate recommendations for future programs and policies that better support this population.

I used Braun and Clarke's (2022) reflexive thematic analysis (RTA) to analyze participant semi-structured interviews and identified three key themes: 1) negative descriptions of disability for oneself vs. acceptance of disability for others, 2) the tension between the freedom of sexual expression and the constraints of the care home context, and 3) despite the challenging context, residents still found opportunities for sexual pleasure, emotional intimacy, and enjoying the "tastiness of life." Inspired by the notion of "cripping" sexual expression (McRuer, 2006; Schalks, 2013), these findings call for reimagining sexual expression in continuing care through resident programming and staff training that centres disabled joy, sexual expression, and holistic wellness.

Background

Following the more extensive review of related literature in Chapter 1, this section provides a brief overview of the context within which this research is situated. Sexual expression is an often-overlooked component of holistic health in society (Gianotten et al., 2021; Tohit & Haque, 2024) and continues to face stigma and mainstream neglect for people living with a disability (Sinclair et al. 2015; Goulden, 2025; Su & Cyr, 2021). For individuals living in continuing care homes, barriers to sexual expression are often exacerbated by policies and care practices that prohibit authentic, fulfilling, or stigma-free experiences (Frankowski & Clark, 2009; Howard et al., 2020). While other scholars have researched sexual expression in continuing care (Howard et al., 2020; Frankowski & Clark, 2009; Villar et al. 2014) and the experiences surrounding sexual expression for people living with disabilities (Goulden, 2025; Su & Cyr, 2021; Sinclair et al., 2015), there is a gap in connecting these experiences (Doll, 2013; Frankowski & Clark, 2009).

When discussing “continuing care homes”, I refer to Alberta Health Services’ definition of publicly funded licensed facilities that provide 24-hour nursing care, personal support, and enrichment activities to support resident quality of life (Alberta Health Services, 2024). At the time of this study, participants were living in Alberta continuing care homes, including long-term care and supportive living facilities (Alberta Health Services, 2024). In this research, I define “disability” as any physical or intellectual impairment, or chronic illness, that leads to limitations and participation restrictions in daily life (Altman, 2014; World Health Organization, 2002). By “sexual expression” I refer to Dr. Julia Brassolotto and Dr. Lisa Howard’s definition created alongside participants to include a variety of acts, relationships, solitary or partnered practices, and identities through which humans express their sexuality. This includes things such as: self-presentation, personal grooming, handholding, kissing, hugging, masturbation, fantasizing, cuddling, bedsharing, and sexual acts or practices (Brassolotto et al., 2020).

In this thesis, I used Braun and Clarke’s (2022) approach to reflexive thematic analysis (RTA) to understand how disability was described as it pertained to sexual expression in Alberta continuing care homes. I performed a secondary analysis of resident interviews from Dr. Julia

Brassolotto and Dr. Lisa Howard’s 2019 dataset that used semi-structured interviews to understand experiences and opinions surrounding sexual expression in continuing care from residents and family members (Brassolotto & Howard, 2019). I provide insight into the culture surrounding continuing care homes and sexual expression in Alberta, the lack of disabled representation in mainstream sexual health and wellness, and current research surrounding sexual expression in continuing care to frame these participants’ nuanced experiences.

Existing literature consistently demonstrates that sexual expression remains a meaningful component of identity, intimacy, and wellbeing for residents living in continuing care homes, yet it is often overlooked or constrained by structural, cultural, and interpersonal barriers. Institutional policies often focus on risk management and clinical care, with less emphasis on sexual expression as a foundation to wellness (Frankowski & Clark, 2009; Howard et al., 2020). When institutional barriers compound with internalized ableism and societal stigma surrounding ageing and disability, sexual expression is repeatedly neglected in many continuing care homes (Esmail et al. 2010; Villar et al., 2014).

Through these findings, I demonstrate the need to reimagine sexual expression in continuing care and apply them directly to health promotion initiatives, education, and resources that directly benefit residents and the continuing care homes in which they live. In the following section, I outline my research questions, the study design, and my approach to data analysis.

Methods

Research Questions

This research aimed to better understand the experiences and discourse surrounding disability and sexual expression in continuing care. I explored this aim through the following research questions:

1) How do residents in Alberta continuing care homes describe and discuss disability as it pertains to sexual expression?
    a) What do residents identify as barriers to expressing and navigating sexual expression in the context of disability?
    b) What do residents identify as factors that promote expressing and navigating sexual expression in the context of disability?

Dataset Origin

This research is a secondary analysis of Dr. Julia Brassolotto and Dr. Lisa Howard's 2019 dataset on sexual expression in Alberta's continuing care homes. Their research was a qualitative exploratory design using semi-structured interviews to understand experiences and opinions surrounding sexual expression in continuing care from residents and family members (Brassolotto & Howard, 2019). Working with a subset of this dataset was exciting as I had previously worked on this project as a Research Assistant in my undergraduate degree with my supervisor Dr. Julia Brassolotto as the Principal Investigator. Four articles have been published from this dataset, but none have explored disability as the focus of the analysis. I used reflexive thematic analysis to analyze the dataset as it is flexible, adaptable, and seeks to amplify the lived experiences of participants (Braun & Clarke, 2022).

Data Collection

Data collection was conducted between May 2018 and March 2019. Ethics approval for this research was received from the University of Alberta Research Ethics Office and operational approvals were received from Alberta Health Services, CapitalCare, Carewest, and Covenant Health. In this phase of the research, Dr. Julia Brassolotto and Dr. Lisa Howard used a qualitative exploratory design to better understand sexual expression in continuing care from the perspectives of residents and family members. While this dataset includes interviews from residents' family members, only the 12 interviews from residents were used in my analysis. I chose to use this subset of the data because it allowed me to focus on the direct perspectives and experiences of residents themselves, and because this sample size was appropriate and feasible for a beginner researcher conducting a master's level inquiry. Resident participants were recruited through advertising in continuing care homes and connected stakeholders. Recruitment initiatives included posters in continuing care homes, e-mail listservs, and direct e-mails to recreation therapists and care home managers who shared this study at resident council meetings. Semi-structured interviews were conducted in-person and via telephone and were digitally recorded and then transcribed. Residents were asked a variety of questions about their experiences with sexual expression while living in continuing care such as how they defined sexual expression, what conversations or experiences they have had, what conversations they think are needed, and supports that would be useful. Resident participants ranged in age from mid-40s to early 90s and also ranged in their physical and cognitive functional abilities. Seven of the residents were women, and five were men.

Data Analysis

For this thesis I used reflexive thematic analysis as defined and described in *Thematic Analysis: A Practical Guide* (Braun & Clarke, 2022). RTA is an iterative and interpretive qualitative approach used to meaningfully interpret patterns across data. Through extensive cycles of familiarization, coding, interpretation, and theme development, RTA supports a deep and nuanced understanding of shared meanings and experiences within the data (Braun & Clarke, 2022). RTA is best used to explore contextual, experiential, and societally embedded perspectives to generate how participants make sense of their lives and environments (Braun &

Clarke, 2022), which made it a great fit to explore how disability and sexual expression were discussed in continuing care.

Reflexive thematic analysis was chosen for my process because RTA views qualitative analysis as storytelling in which the researcher generates insights by situating themselves as a key part of data analysis (2022). In other words, RTA acknowledges the subjectivity of the research process and the fact that other scholars might draw different conclusions about the data than my own. This is done with rigour, repetition, and in-depth personal reflection to understand what my findings are and any factors that may influence them.

RTA was also selected due to the active and fluid process of generating themes as thinking develops (Braun & Clarke, 2022). The researcher actively constructs themes during an in-depth exploration of the research which lends itself to be beneficial when exploring shared experiences, perceptions, attitudes, and social discourse (Braun & Clarke, 2022; Byrne, 2022). Since my research sought to understand deep experience and nuanced discourse surrounding disability and sexual expression in continuing care, and have findings that could directly be applied to health promotion, RTA was an appropriate fit. In contrast, other traditional methods of coding often prioritize coding before or during the very early stages of analysis. There is emphasis on sorting data into reliable categories and consistency across coders rather than RTA's evolving deep understanding of the data underpinned by depth and transparency (Braun & Clarke, 2022; Byrne, 2022).

Braun and Clarke outline a six-step approach to RTA: 1) data familiarization, 2) coding, 3) generating preliminary themes, 4) developing and reviewing themes, 5) refining, defining, and naming themes, and 6) writing my findings. My analysis occurred over five months, beginning with an in-depth (and ongoing) reflexive exploration into my positionality as a researcher (as outlined in Chapter 1).

Preparing for Analysis

Throughout Braun and Clarke's six-step approach to RTA, I developed a deep understanding of my positionality through reflexivity and used my proximity to the research as a resource when answering the above research questions (Gough & Madill, 2012). Before I began immersing myself in participant interviews, I utilized Braun and Clarke's immersive journalling exercise (2022, pg. 16-18) to understand my personal positionality, public health positionality, and my relationship to ageing and sexual expression. Even after beginning my data analysis journey, I continued to keep a living document on my Google Drive where I would reflect on who I am in relation to my research, where my opinions might come from, and how they impact my work. Reflexivity was an ongoing process I continued even through writing my final findings.

I was fortunate to have previously reviewed this dataset while working as a research assistant in my undergraduate degree, which made revisiting it again a few years later with new perspectives very interesting. Throughout my data familiarization process, I began by reading all the participant interviews in chronological order. After I read through the interviews the first time, I went back and read them again. On my second pass through, I began writing general notes about who the participants were and the experiences they shared. I then printed out copies of the interviews, and on my third review, I began going through each participant's interview and highlighting quotes that stood out to me. I engaged in a combination of inductive and deductive coding. Inductively, I simply began highlighting quotes from participants that were relevant to their overall story or were interesting to read. Deductively, I was looking for quotes that implicitly or explicitly touched on matters related to disability and would enable me to answer my research question(s).

After becoming very familiar with the interviews I began the coding process, where I began exploring key elements and patterns of meaning from the interviews, and applying code labels to each identified quote/experience. My approach to coding was generating a mix of semantic and latent codes. Semantic codes allowed me to capture the explicit and overt meaning of the text to begin understanding patterns in what residents where expressing (Braun & Clarke, 2022). My initial rounds of coding began with semantic codes with identifying emotions and situations that were explicitly stated by participants. I would write one/two-word notes in the margins of the transcripts that directly summarized what was being stated. For example, several times participants describe their own disability as being a fault or flaw that negatively impacted their ability to pursue a sexual partner (e.g., a participant expresses that only way they could find a romantic partner is if someone could "accept" she is in a wheelchair). These excerpts used codes like "inadequacy" or "flaw." As I continued past developing semantic codes, I began to use more latent codes which identify the implicit meaning and context that helps shape the text (Braun & Clarke, 2022). To expand on the example above, I then utilized the code "internalized ableism" to denote when a participant was expressing a negative view about their own disability. This semantic code goes beyond what the participant is directly saying to identify the sub-text and meaning behind the excerpt. Each passage with a corresponding code was highlighted with an assigned colour.

Generating, Revising, and Creating Themes

Generating themes was a cyclical process that I revisited multiple times. I began by using my sticky note codes to group experiences together to try and identify common overarching themes. In the beginning stages, I developed an overarching theme that encompassed the “struggle to be seen”. This theme was later named “self-perception and societal misconception: the tension between disability and sexual expression”, and described how stigma, infantilization, and bias intertwined to influence the struggle for people with disabilities to be seen as sexual and relational beings. Codes encompassed in this theme included: “inadequacy”, “flaw”, “internalized ableism”, “overt ableism”, “stigma”, and “not being seen as whole.”

I would then contrast my tentative themes against one another and ask if it truly captured the story I wanted to tell in a way that remained authentic to the context and tone of experiences participants shared. I used Braun and Clarke’s prompt to check in and ask: “does each theme capture a (different) core point, and some rich diversity and nuance (multiple facets), about the dataset, that *you* want to convey in addressing your question” (2022, pg. 98). I had discussions with my committee members and numerous meetings with my supervisor to discuss my themes.

My supervisor Dr. Julia Brassolotto and literature from Braun and Clarke (2022) reinforced the foundation of RTA that interpretation is a direct result of the subjectivity of myself as the researcher, the current scholarship surrounding this topic, societal context, *and* the data (Braun & Clarke, 2022). At this point I began to understand I did indeed have autonomy over generating my themes and what story I wanted to tell. Since my education is in public health and I have a passion for health promotion, I wanted to ensure the research I shared was relevant to the experiences of continuing care residents living with disabilities and could be applied directly to policies and programming. After multiple revisions, discussions, regrouping of potential themes and quotes, and committee approval I had identified my three main themes. These three themes are discussed in greater detail in the following section.

Findings

The findings from my research show the rich and contextual ways in which residents in Alberta continuing care homes discussed disability and sexual expression. I identified three overarching themes from the resident interviews: 1) negative descriptions of disability for oneself vs. acceptance of disability for others, 2) the tension between the freedom of sexual expression and the constraints of the care home context, and 3) despite the challenging context, residents still found opportunities for sexual pleasure, emotional intimacy, and enjoying the "tastiness of life." Across these themes, residents' accounts reveal the contradictions of sexual expression in continuing care: affirming others while doubting oneself, yearning for intimacy while navigating structural barriers, and finding joy despite pervasive ableism. My findings illustrate how sexual expression persists as a vital aspect of identity and wellbeing within continuing care homes and identifies the multifaceted role disability has in how sexual expression is discussed.

Theme 1: Negative Descriptions of Disability for Oneself vs. Acceptance of Disability for Others

When participants discussed disability, there was a clear difference in how they spoke about their own disability compared to the disabilities of peers or potential partners. When participants spoke about their own disability, it was often described as a burden, barrier, or source of sexual inadequacy. In contrast, when participants spoke about others, they emphasized that disability was simply one of many pieces of one's identity that would not diminish intimacy, attraction, or the right to have meaningful connections.

Acceptance of Other Peoples' Disabilities

When speaking about other people, participants described disability as simply another aspect of a person's identity and as something that should not diminish their experience of intimacy or sexuality. For instance, when discussing potential romantic partners, most participants indicated that disability would not be a limitation for connection or attraction. Resident 3 reflected, "If I met the right one, it wouldn't matter if she's in a wheelchair now or she's got some kind of other disability." Similarly, Resident 2 emphasized valuing inner qualities in a potential partner regardless of disability:

> "Well, you see, for me, I never look at the outside of the package. I've always looked at the inside as I'm talking to somebody. And I don't see outside. I see inside. I see the person, the package. I unwrap a person first, you can say. I look at the inside to see the person, you know, not the packaging".

This demonstrates participants' acceptance of other people's disabilities. Rather than perceiving disability as a barrier to attraction, connection, or healthy relationships, participants emphasized that what truly mattered was what was on the inside.

Even residents who were not in a romantic or sexual relationship themselves expressed support and encouragement towards intimate connections between continuing care residents, and a need for care homes to make opportunities for these connections more accessible. Resident 4 stated that she is not interested in pursuing any new romantic relationships, but reflects on how important it is for other residents to be able to connect with their loved ones in ways that are fulfilling for them. Resident 4 shared how her friend in continuing care had a husband who came to visit and made her friend beam. When asked about how other residents respond to this couple's public displays of intimacy, Resident 4 says, "I guess they say, 'go for it boy, go for it!'" This sentiment challenges the ableist notion that individuals living in continuing care homes and requiring assistance with the activities of daily living should have to give up on sexual expression – and the notion that such public displays would be unwelcome in a care home setting.

Despite never having been in a long-term relationship, Resident 2 spoke about how important it is for continuing care homes to have accommodations in place to allow couples spaces to have physical intimacy despite their care needs. He said:

> "We should be encouraging every facility to have that, you know, where if you want to spend the night with your loved one, but they still need the medical care of the facility, and you cannot bring them home with you, but you can actually spend the night with them, so you can have that intimacy with them."

He further spoke about the need for beds that could accommodate two bodies with mobility supports, as well as visiting hours and privacy that would make such overnight visits possible. Quotes such as these illustrate the overarching acknowledgement that supporting intimacy is important in continuing care, even when participants were not interested in seeking romantic or sexual connection themselves. Their insights show a beautiful community-oriented understanding of the value of sexual expression that extends beyond personal desire to ensure everyone's needs are nurtured in ways that are fulfilling to them.

Participants consistently described disability as ordinary and a non-limiting part of a person's identity, emphasizing that disability does not diminish one's worth. Residents spoke of evaluating potential partners based on inner qualities rather than bodily norms or abilities, rejecting the notion that disability is a barrier to attraction or fulfilling relationships. These participant quotes showed a clear acceptance of others' disabilities and affirmed that sexual expression has a place in continuing care regardless of disability.

One's Own Disability as a Limitation or Potential Burden

Although many participants expressed positive views of attraction, support, or encouragement towards their disabled friends or prospective partners, their views about disability were often more negative when they were speaking about themselves. In this context, participants tended to describe disability as a potential barrier or personal failure. For example, regarding what she would need if she were to get into a romantic relationship, Resident 6 said:

> "Well, it would be a matter of actually meeting up with someone that could accept this type of situation that I'm in a wheelchair and I can't take care of myself and that type of thing."

Participant reflections on sexual expression and desirability were much more self-critical when considering themselves as a potential partner, and reflect dominant ideas about the value and importance of personal independence (and a corresponding shame associated with requiring assistance or support).

Despite saying that he would have no trouble with someone else's disability (as noted above), Resident 3 did not hold himself to the same standard. When he discussed the possibility of getting into a relationship, he reflected on having a disability and said, "I don't want to be a burden, and I don't want someone to feel like, you know, I'm burdening them." This demonstrates the internalization of dominant ableist messaging and may also reflect generational gendered expectations about men being independent providers. Similar to Resident 3, while Resident 2 said he would not judge a person for what they look like, he did not believe others would do the same for him. This participant said that he expected that only someone else with a disability, who understood his experience, would be open to dating him:

> "I've always thought, you know, as I met someone- I'd have to see somebody in a wheelchair because they could see me. The only way they could see me, maybe somebody else that has my story."

Resident 2 further added that he thought his disability prevented him from being seen as a prospective love interest for men he might be attracted to:

> "A lot of people can't get past the wheelchair to see [name], the gay man. They see [name], the man in the wheelchair… This is why I'm not too worried about finding somebody because I guess my thought is that I probably won't ever find somebody because I'm in a wheelchair… There's a double bigotry for me. I would be gay and in a wheelchair. So when you're meeting with gay people, they see the chair, they don't see [me]."

This quote reveals the intersection of ableism and homophobia that informed this participant's experience and self-perception. These quotations show how deeply internalized ableism shapes participants' perceptions of their own desirability and possibilities, even when they express acceptance and inclusivity toward others. This paradox shows how societal stigmas become absorbed into self-perception and shape how one views their own multi-faceted identity. Resident 7 also expressed that, even beyond any potential limitation to private intimacy in the care home, his disability was his greatest barrier because, "I feel inadequate because I'm stuck in my chair." This shows how problematic ableist norms are that centre "able-bodiedness" as the standard for what is deemed desirable or attractive.

Theme Summary

Overall, theme 1 illustrates the striking paradox in how participants understood disability in the context of sexual expression. While participants readily affirmed that disability does not diminish another person's capacity for connection, desire, or healthy relationships, they often struggled to extend the same compassion and acceptance to themselves. When speaking about peers or potential partners, disability was described as an inconsequential aspect of identity, and participants focused on the importance of inner qualities, emotional connection, and the need for support for sexual expression within continuing care homes. Yet, when participants reflected on their own disabilities, they framed them as a burden or limitation to being desirable. These self-perceptions shaped by deeply internalized ableism reveal how ableist stigma surrounding disabled people and sexual expression impacted participants' self-worth and sexual agency.

Theme 2: Tension Between the Freedom of Sexual Expression and the Constraints of the Care Home Context

Participants identified structural and interpersonal challenges to sexual expression in continuing care homes through staff behaviours, policies, and the overall culture. Resident 6 summarized this theme perfectly when she said, "I don't feel that a long-term care facility is a very sexy place to be." This is congruent with current research that shows barriers to sexual expression in continuing care homes are largely attributable to ableism and a lack of preparedness for the sexual expressions of disabled and older people (Grigorovich et al., 2022; Howard at al., 2020), and the clinical focus of continuing care homes (van Hoof et al., 2016). In this theme, I discuss challenges associated with a) policies and staff behaviours in continuing care homes and b) challenges associated with receiving care while pursuing sexual expression.

Policies and Staff Behaviours in Continuing Care Homes

While sexual expression is a normal part of human life and holistic wellness, many residents face challenges to sexual expression that are imposed or upheld by the staff and systems that are intended to support them. In general, participants reported that they did not feel that sexual expression was supported by staff. Resident 2 said, “well, now you’re in long-term care. Well, that ends your life altogether. If the two of you meet or something like that. We discourage them from getting too close. If you see a couple kissing or something like that, “ah, ah, ah,” you got to stop that.” This attitude reflects the notion that once residents are living in a congregate setting focused on medical care, that they are no longer seen as sexual subjects. Staff behaviours can actively constrain residents’ sexual expression by creating environments where intimacy and pleasure are stigmatized rather than supported. These actions not only invalidate resident desires but also reinforce an ageist and ableist environment in which sexual expression is deemed as inappropriate or wrong.

Resident 3 discussed his experience with having a girlfriend who lived outside of the care home and the challenges they faced when being intimate in the care home due to visiting hour policies and strict bedtime routines:

> “She felt kind of nervous, shy kind of. Like, if we decided to be- get a little romantic, you know, because the door doesn’t lock. So of course, you just come up with ways and we did but she still would feel kind of like she’s on the clock, you know. They want me out of here by 11:00. Your times to be romantic are kind of cut in quarters.”

These strict policies were perceived by this participant as patronizing and infantilizing, which is reminiscent of the literature on disability and sexuality for young adults with intellectual disabilities (Goulden, 2025; Gill, 2015). For instance, Resident 3 said that these policies made being intimate in continuing care feel like, “you’re kind of like a junior high or high school kid again. You know, it really does feel that way kind of. Like you’re sneaking.” This language demonstrates the common paternalistic attitude towards the sexual lives of continuing care residents.

Resident experiences and opinions surrounding intimacy and sexual pleasure in continuing care can be summarized well by Resident 2’s observation that “staff need to be taught that we’re still sexual beings. That it does not end because we’re in long-term care.” These experiences show that staff behaviours and policies restrict sexual expression and sense of autonomy for residents in continuing care homes. Quotes from Resident 2, Resident 3, and Resident 11 in this subsection and the following prove small staff behaviours such as intrusive questions, discouraging physical affection, or failing to give residents autonomy in the care provided left a lasting impression that sexual expression was unwelcome or unimportant. Policies further challenged the ability for privacy and intimacy through restricted visiting hours and a lack of locking doors. Staff behaviours and policies often converge to make sexual expression difficult and taboo, reinforcing the idea that this population would or should not be concerned about sexuality and intimacy.

Reliance on Continuing Care Staff as a Barrier to Sexual Expression

Whether residents were looking to fulfill their sexual expression through sexual pleasure or self-expression, participants identified that a reliance upon staff can undermine their sense of self and inhibit sexual expression. For instance, Resident 3 shared how needing assistance to be intimate with a partner can feel extremely discouraging and takes him out of the headspace for intimacy:

> “A part of [me wonders] will I ever get to be like intimate with somebody again because I mean, well, there’s the hospital not wanting your company to stay, but then… I got to go through such a rigamarole. You got to get, you know, lifted into the bed and then you got to get disrobed and then you got to get… I mean I got to wear a brief and, you know, you just, I mean, kind of start feeling like an overstuffed sausage… by the time you get into your bed you kind of lost that loving feeling.”

Resident 3’s above account focused on how needing assistance transformed what should have been an intimate and empowering experience into one that felt clinical and disconnected. This highlights how the policies, procedures, and environment of continuing care homes and the need for care staff assistance can make sexual expression feel unattainable. It also highlights the opportunity for care staff to debunk and challenge the ableist (and perhaps gendered) stigma associated with requiring physical assistance to engage in intimacy.

Many residents require mobility aides, have a limited range of motion, or require assistance retrieving personal items. This became a problem for Resident 11 when she would ask staff for help to retrieve her sex toy from her bedside table and would receive unnecessary comments and hesitation:

> “I also have a personal toy that I like to use at night and sometimes the staff kind of embarrass me because they say they don’t understand why I have to use it and stuff. It just gets to be a little embarrassing and quite uncomfortable.”

This commentary about Resident 11’s masturbatory habits added embarrassment and discomfort to what was otherwise a pleasurable experience and a meaningful opportunity for her to feel good in her body. This scenario exemplifies the difficulty with relying upon assistance from others in order to actualize one's sexual expression, as well as the damaging effects of staff overlooking the sexual agency of disabled residents.

Even participants who did not desire physical intimacy or sexual pleasure still faced challenges to sexual expression. Resident 6 shared that sexual expression requires privacy and modesty. Maintaining her sense of her sexual self was hard because staff did not value the same level of modesty as her: "The thing that I find hardest in here is that there isn't a lot of modesty allowed here because all these people are changing you and seeing you naked and yet, you're supposed to go into the dining room and interact with [other residents] as friends." This demonstrates how challenges to sexual expression in continuing care homes extend beyond intimacy and sexual desire to also include broader senses of bodily autonomy, privacy, and identity.

Theme Summary

Overall, participants' reflections clearly demonstrate that sexual expression in continuing care homes is profoundly shaped, and often constrained, by care home structure, relationships, and culture. Residents described feeling that the clinical atmosphere, restrictive policies, and staff behaviours combined to make continuing care homes "not a very sexy place to be" (Resident 6). Relying on staff for care was often identified as vulnerable or limiting and clashed with the desire for autonomous and fulfilling sexual expression. Staff behaviours reflected ableist, paternalistic, and sometimes infantilizing views about residents living with disabilities. Together, these accounts highlight the tension between the realities of relying on others for bodily care and the desire for liberatory sexual expression. This emphasizes the need for continuing care homes to intentionally work to recognize and affirm sexual expression as an important part of person-centred care and resident wellness.

Theme 3: Despite the Challenging Context, Residents Still Found Opportunities for Sexual Pleasure, Emotional Intimacy, and Enjoying the "Tastiness of Life"

Despite the challenges associated with the continuing care context, participants still found ways to cultivate intimacy, express themselves authentically, seek out pleasure, and forge meaningful connections. In this theme, I describe how disability served as a catalyst for reimagining sexual expression, and how individuals embraced disability and supported sexual expression in continuing care homes when policies and programming fell short.

Disability as a Catalyst for Reimagining Sexual Expression

Some participants described creative approaches to sexual expression, from experimenting with a homemade sex toy to reframing what intimacy means to them. Resident 1 showed innovation and creativity in pursuing sexual pleasure within the continuing care home by sharing his idea to create a sex toy:

> "The two bandages that I've been using in lieu of the compression stockings that I had… I was looking at them and thinking oh, well, what might be interesting and easier to keep clean is using a tube bandage because of the elasticity and taking a condom and using it as the inside, so that sperm can be kept confined and then just discarded, instead of using, say, a fleshlight that has to be cleaned afterwards. But using a condom as kind of the inner skin and with suitable lubricant and all that sort of stuff, making an artificial vagina for myself. So, I've got all the bits now and I just have to do the experiment."

Resident 1 demonstrated his ability to innovate a way to find pleasure that was accessible to him regardless of physical ability, environmental constraints, and material constraints. His desire to adapt everyday supplies into a personalized sexual aid showed how residents continue to create ways to find pleasure. By reframing sexual pleasure as something that can be self-designed and responsive to his needs, Resident 1 perhaps unknowingly challenged ableist norms of how sex and pleasure exist.

After being widowed and having increased health complications from diabetes, Resident 12 moved into a continuing care home. She reflected on how her desire for sexual expression changed and is now fulfilled by reading romance novels:

> "I'll read a good book for a good tingle, you know, like, a good romance novel... If you want love, get it from a book. It's a lot safer and you get a new guy every time, and you're not breaking your heart or anyone else's... I get the glow, the warm, fuzzy glow of love and intimacy through my books that I read. That's kind of my sexual expression these days."

The loss of her spouse and increased care needs transformed the way Resident 12 accessed her desire for intimacy. This aligns with the idea of "cripping" sex in a way that moves past traditional ableist norms of what sex and pleasure should look like, and focuses on expanding the definition of sexual pleasure to include all forms of intimacy (McRuer, 2006; Schalks, 2013).

For Resident 3, disability was a catalyst for reimagining sexual expression in terms of expanding his thinking about romantic prospects. He claimed that he would happily date a woman who had a disability but shared how his opinion was different before his disability progressed:

> "I'm just trying to think of my own self when I wasn't crippled and didn't even know I would be. Like I probably wouldn't – I wouldn't say no to going out with somebody who was in a wheelchair, but it would probably not be like I – you know, I would probably go with the walking people. And kind of now I'm like, Jesus, am I so shallow that I would think that way?"

This reflection showed a deep moment of self-awareness where Resident 3 recognized that his previous preferences were shaped by social norms that positioned disabled people as less desirable or less sexual. His shift in perspective sparked by his own disability revealed how lived experience can challenge ingrained assumptions. This moment of self-reflection became a catalyst for reimagining sexual expression that embraced disability. Resident 7 similarly shared how his disability altered how he viewed desirability and relationships. Before his brain injury, he claimed that he had been a "player" who "always relied on my looks." After his brain injury, Resident 7's perspective on relationships had completely changed, "Before I had no conscience. Now I care. I want to belong to somebody." Rather than framing disability as solely a loss, his experience revealed how his brain injury opened a space for growth, introspection, and more understanding in his relationships.

Exemplary Care Staff Embraced Disability and Supported Sexual Expression When Programs and Policies Fell Short

Despite the challenges identified above, there were several instances where care staff took action on their own accord to support disability and sexual expression in continuing care. Resident 11 shared how the recreational therapist and her practicum student helped her replace her broken vibrator: "They were able to order it online for me and they just used a credit card and then I paid them back for it." This demonstrated how individual action supported Resident 11's sexual expression. In the same environment where other staff had shamed her for using her toy, the recreational therapist and her practicum student normalized Resident 11's masturbatory habits by supporting her in her need to replace her broken vibrator. These care staff further made Resident 11's purchase possible by providing her with logistical support to acquire a new toy despite her disabilities that made it difficult to procure one herself.

Resident 2 told the story of how the gay manager of his continuing care home agreed to sit with him when he (the resident) came out to his mom after vulnerably approaching her. "I said, 'my mother probably knows, but I need to say the words and I want you present, if you could, please, because I'm very nervous about this. I need to say the words to her.'" In the absence of formalized processes or structures that supported his coming out journey, he found support through a staff member who went above and beyond the scope of her role and supported his sexual expression. This manager stepped in and provided emotional safety and affirmation that enabled this resident to live authentically in the care home and actualize his sexual expression. This manager created conditions where he could express an important part of his identity in a system that did not yet fully acknowledge or support residents' queer identities. Resident 2 then took this experience of coming out in the continuing care home after hiding his identity for decades and made a commitment to show fellow residents the importance of living their truth. He shared how he covered his door with rainbow flags and worked to model embracing his identity:

> "I've tried to show people that [though you may be] in the closet when you go into long-term care, it is okay to be yourself. You must be yourself. I've lived a lifetime of not being myself and my God, it feels so good to be yourself!"

He offered a form of peer-led advocacy and affirmation to fellow 2SLQBTQ+ residents that the continuing care home itself did not provide. By sharing his identity and advocating for authenticity and acceptance in long-term care, he created a symbolic and practical invitation for others to feel safer to own their identities too.

Resident 4 shared how important it was to receive love, physical touch, and connection, especially when having a bad day. She lived in the same continuing care home as her husband before he passed, and knew how painful it can be when your loved one is not there. Resident 4 shared how she provided meaningful connection for a fellow resident when she is alone: “I hold hands quite a bit with [fellow resident] because she really needs it.” She shared that when they hold hands she knows it supports her friend because, “she brightens up. She just like, she turns a different colour. Yup.” In the absence of any structured programs or policies that prioritized emotional intimacy, this quotation shows how residents often step in to support one another’s needs.

Resident 2 also emphasized how special receiving physical touch is for feeling loved and connected, but how rare it was to receive it outside of a medical context. He reflected fondly on a rare occasion when a staff member went out of his way to give him the connection he longed for:

> “And [staff member] came into the room one evening and I was crying. He said, ‘What's wrong?’ I said, ‘I miss being touched.’ ‘You get touched all the time,’ he said. I said, ‘Yes, to be washed, to be bathed. Never just to be touched.’… [The staff member then hugged the resident in a long embrace]. And for those two minutes I was in heaven. Because you do that little expression, and at that time it was an expression of sexuality, but also an expression of being human. …Oh my God, it was glorious. I knew he had a partner, but I was crying tears of joy. I told him, ‘you don't know what this means to me’.”

His distinction between being touched *for care* versus being touched *with care* underscores a systemic shortcoming that continuing care homes often prioritize clinical tasks while neglecting the human need for affection and intimacy in all forms. The staff member giving this resident a long, genuine embrace was such a stark contrast to the usual clinical centered care that it moved this resident to tears.

Taken together these participant experiences illustrate how, when formal macro level policies and meso level programs failed to support resident sexual and emotional expression, individuals stepped in to provide intimacy at the micro level in ways that challenged ableist norms to provide intimacy, connection, and fulfillment inside the continuing care home.

Theme Summary

In sum, participants demonstrated that, despite ableist and ageist norms, as well as institutional barriers, continuing care homes can still be a space of joy, expression, and possibility for residents with disabilities: “From my point of view, if you do not find the world tasty and sexy you are out of touch with the most important things in life; the kinds of things that are supremely important about being alive in the world, right? The world is a wonderful place and tastiness and sexiness are just part of what makes the world wonderful” (Resident 1).

Conclusion

These findings reveal the deeply layered ways in which residents in Alberta continuing care homes discuss and experience disability and sexual expression. Across the three themes, participants described support for sexual expression for others with disabilities while struggling to extend the same acceptance to themselves, the struggle of navigating clinical environments where ableism and lack of consideration of sexual expression prevail, and how residents and allies persist through systemic and relational barriers to create, adapt, and reinvent sexual expression in a way that was accessible. This thesis illustrates the need to not only bring sexual expression into continuing care homes, but crip sexual expression—centering the lived experiences, exploration, pleasure, and needs of disabled residents to make policies and programs that support sexual expression for all.

Discussion

In this section, I briefly discuss the implications of my findings and explicitly answer my research question by naming the ways in which disability was discussed in this data set. I also situate my findings in relation to relevant scholarship. Further conclusionary content is provided in Chapter 3.

My findings emphatically confirmed much of what has been identified in the extant scholarship about disability being perceived as burdensome. Participants frequently described their own disabilities as potential barriers to intimacy, which aligns with long-standing narratives that portray people with disabilities as being undesirable or asexual (Goulden, 2025; Esmail et al., 2010). Participants expressed fears of inadequacy, burdening their potential partner, or only being seen as their disability which show how disability was often internalized as a personal deficit. This is unsurprising as scholars cite the dire need for sexual health resources and greater representation for people living with disabilities (Goulden, 2025). In rare instances when curricula does exist for disabled people in school, health, or care settings, content often focuses on heterosexual relationships, preventing pregnancy, and self-pleasure as a more welcomed alternative to partner based sex (Gill, 2015). When society rarely shows disabled bodies in sensual, sexual, and autonomous ways, it is clear why internalized ideas of inadequacy are perpetuated.

The sense of inadequacy and fear of being a burden was particularly pronounced when participants discussed the possibility of having an able-bodied partner. This reinforces how societal views of disabled bodies being undesirable, asexual, or inadequate continue to manifest and have detrimental impacts on self-image for people living with disabilities (Goulden, 2025; Esmail et al., 2010). While preexisting literature and participant stories show barriers to sexual expression at structural and societal levels, these narratives show how many participants experienced internal barriers even before institutional or interpersonal barriers were encountered. These internalized feelings continued to be amplified by participants with intersecting marginalized identities, which shows why intersectionality is important in addressing holistic health (Crenshaw, 2017; Esmail et al., 2010). Crenshaw emphasizes that systems of power overlap and compound to create unique struggles that cannot be addressed independently of one another (e.g., the participant who uses a wheelchair and is openly gay faces distinct challenges to his sexual expression compared to an able-bodied resident or to a heterosexual resident with a disability). This is complementary to the way in which crip theory aligns with queer theory to support interconnected struggles for liberation.

When discussing peers or potential partners, participants unanimously deemed disability to be a non-defining factor that was irrelevant to attraction, connection, and intimacy. This contrast between how residents viewed themselves and how they viewed others shows how truly harmful internalized ableism is. Participants did not speak negatively about others on the basis of disability– only themselves. This aligns with extensive scholarship that demonstrates how disabled people often navigate cultural narratives that frame disability as undesirable or incompatible with sexuality, which often leads to these messages being internalized. Even for people who support other disabled people and their sexual expression, internalized ableism manifests to cause inward blame, feelings of inadequacy, and fear of being a burden (Goulden, 2025; Su & Cyr, 2021).

Regarding one's own disability as a burden to intimate relationships but simultaneously embracing a potential partner's disability as non-defining is an interesting paradox to be explored. Because continuing care homes are environments in which disabilities are commonly visible, residents may experience normalization in how they perceive others with disabilities. Participants discussed disabilities among their peers as irrelevant to attraction, connection, and intimacy, which suggests that the more normalized disability is, the less distinguishing or stigmatizing it becomes.

Participant experiences and discussions aligned directly with existing research that identifies two prevailing barriers to disability-affirming support of sexual expression in continuing care: ableist ideologies informing a lack of need or preparedness for the sexual expression of disabled and older people (Grigorovich et al., 2022; Howard at al., 2020), and the clinical focus of continuing care homes that makes exploring and experiencing authentic sexual expression hard (van Hoof et al., 2016). Research shows disabled people are often regarded as asexual and sexual expression is made to be shameful, optional, or wrong (Goulden, 2025; Su & Cyr, 2021). These incorrect assumptions directly inform the lack of value placed on sexual expression in continuing care, and the ways in which it is paternalistically and sometimes clinically "managed." As U.K. disability rights activist Dennis Queen has said, "landlords don't usually get the right to police our behaviour in the bedroom, but for people in supported living, this is not unusual" (Fae, 2011). It is imperative to note that disability is compatible with sexual expression in continuing care homes as shown through participant stories of resilience—research simply shows we need to provide meaningful care environments that acknowledge, support, and nourish sexual expression in order to allow it to thrive (Sinclair at al., 2015; Rowntree & Zuffrey, 2015; Tohit & Haque, 2024).

While internalized ableism is an apparent barrier to resident sexual expression, it is critical to also discuss the external sources that continue to reinforce and replicate ableism regarding sexual expression. Policies and cultures within continuing care homes such as restricted visiting hours, lack of privacy, and staff judgement surrounding sex created environments that were not conducive to resident sexual expression. Residents share how comments from staff regarding pursuits of pleasure and displays of affection reinforced feelings of shame and discomfort.

When examining my findings, two key factors summarize how we might optimally support sexual expression in continuing care homes. First, sexual expression can be physically supported when participants are able to sexually express themselves in ways that are accessible, without stigma from staff, and in ways that are available within the continuing care home and community. Second, residents can be internally supported through normalizing disability in sexual expression and building a safe space for exploration and belonging. In Chapter 3, I continue this conversation and suggest ways to apply my findings using health promotion tactics to support disability and sexual expression in Alberta's Continuing Care Homes. I discuss a need to crip sexual expression by centering the experiences of disabled people, celebrating disabled sexual expression, and fostering an environment where this is possible through health promotion programs and policies.

Conclusion

It is evident that sexual expression is an important part of identity and wellness that requires attention within continuing care homes. While disability was described in many ways, both 'good' and 'bad', it remained a central aspect of residents' lives in Alberta continuing care homes as they navigated and discussed sexual expression. Sexual expression is important to residents, but is highly influenced by stigma, structural barriers, internalized ableism, and autonomy. These findings show that continuing care homes need to meet resident needs beyond safety and medical care to create an affirming space where sexual expression can be recognized, supported, and celebrated as important pieces of residents’ quality of life.

In the third and final chapter, I will discuss my research journey and discuss implications of my findings, recommendations, reflections on my process, and potential areas for future research.

CHAPTER 3: CONCLUSION

When reflecting on current research and the findings in my thesis, there is a clear need for sexual expression to be normalized, understood, and celebrated for people living with disabilities in continuing care. Participant experiences demonstrated the negative impact of ableist attitudes, internalized judgment, and barriers to living in continuing care homes on sexual expression. However, despite these obstacles, participants also showed a commitment to resiliency, acceptance, innovation, and persisting to find fulfilling sexual expression. When understanding these nuanced experiences and reviewing the existing literature, I propose a push to further crip sexual expression in continuing care. This research has been a long and rewarding journey to deepening the conversation surrounding disability and sexual expression in continuing care, and I am grateful to have been able to bring these participant experiences forward through my thesis.

Implications

One significant implication of this research is understanding how residents have internalized stigma and shame surrounding their own disabilities and sexual expression. Residents validated and supported the right for others to seek out fulfilling sexual expression regardless of disability but perceived themselves as being a “burden” or “unworthy”. This demonstrates the need for programs and resources that give people living with disabilities tools to understand and access sexual expression in accessible and affirming ways. Normalizing sexuality as a part of disabled and aging identities is important, but doing so in ways that meet continuing care home residents where they are at is crucial.

These findings also show that continuing care home policies and staff attitudes can contribute to how residents discuss and navigate sexual expression. Participants shared how factors like restricted visiting hours, lack of privacy, lack of discussions surrounding sexuality, and stigma from staff surrounding sexual expression were limiting barriers to their own sexual expression. Continuing care homes need to address sexual expression as a normal part of daily life that needs to be anticipated and supported.

When looking at the residents' experiences overall, there is a combination of stigma and silence surrounding sexual expression in the context of disability and aging paired with a resiliency to find ways to seek fulfilling sexual expression. Theme 3 demonstrates residents' creativity in adapting intimacy and sexual pleasure despite barriers. Many residents had to "invent" ways to find meaningful sexual expression because there was no accessible information guiding them, and express feelings like inadequacy or uncertainty surrounding disability and sex.

A key insight that surprised me was the profound discrepancy between how residents viewed their own disabilities compared to how they viewed the disabilities of others. This insight not only confirmed the weight of internalized ableism, but demonstrated the possibility for support and normalization of disabled sexual expression in spaces where disabilities were seen as ordinary parts of identity. Another significant takeaway was the extent to which sexual expression in continuing care homes was being redefined. Residents described intimacy and pleasure through emotional closeness, companionship, adaptive masturbation, and literature—all supporting McRuer's push to "crip" sexual expression to include and affirm experiences that are pleasurable and accessible no matter one's ability.

These findings directly engage with both intersectionality (Crenshaw, 2017) and compulsory able-bodiedness (McRuer, 2006). That is, they account for residents' distinct and diverse circumstances, while illustrating the overarching narrative that able-bodied sexual expression is considered most "normal" or "ideal." Participants' self-doubt and fears of being a burden illustrated how compulsory able-bodiedness shapes perceptions of what is ideal, desirable, or attractive. Despite living in a setting where disability is the norm, residents still compared themselves to able-bodied standards, revealing how these ableist ideals persist even in environments that challenge them daily. Despite the pervasive internalized ableism, participants still demonstrated a resounding acceptance for others' disabilities, which shows a subtle but powerful resistance to compulsory able-bodiedness. Their acceptance showed the ability to subconsciously reject society's ableist views about sexual expression and shows hope for policies and programs to help support, destigmatize, and celebrate sexual expression in continuing care homes in the future.

Limitations

One of the most significant limitations to this research is that the data was collected in 2018-2019. Since data collection, Alberta continuing care homes were significantly impacted by the COVID-19 pandemic and structural changes within Alberta's continuing care sector. As a result, these findings may not reflect current conditions or evolving policies or practices as a response to both of these significant shifts. As this is a secondary analysis, I was unable to engage in the data collection process or tailor questions to my area of interest. While many participants in this study spoke about their own disabilities or experiences of their peers, the initial questions did not focus explicitly on disability. Due to the lack of specific focus on disability, the depth and specificity of stories related to disability were somewhat limited for my analysis. Lastly, while I used research related to crip theory and intersectionality to shape my understanding of disability and sexual expression in continuing care homes, my disciplinary training and analytic approach is rooted in applied public health. Therefore, this thesis does not undertake a full theoretical application of critical disability frameworks or offer contributions to theory development.

Recommendations

Participant support of sexual expression in continuing care, internalized ableism, lack of supports for sexual expression inside the care home, and participant persistence to find ways to access sexual pleasure all point to the need to crip sexual expression within the context of continuing care. As discussed in the background literature, “cripping” comes from McRuer’s crip theory that aims to confront ableist norms and reconstruct them with disabled existence, liberation, and joy at the forefront (McRuer, 2006). Cripping sexual expression transforms the way society views sex, pleasure, and expression in adaptable ways that embrace disabled existence and question how society typically centres sexual expression in white, able-bodied, and heteronormative ways (McRuer, 2006; Schalks, 2013).

I suggest a need to centre the experiences and desires of residents with disabilities when addressing sexual expression in continuing care homes in three ways:

1. Provide continuing care staff with engaging, targeted, and informed sexual health resources centered around celebrating, affirming, and working with residents with disabilities.

    Alberta Health Services currently has a webpage of resources directed to continuing care staff, which has an array of information for supporting 2SLGBTQ+ residents (Alberta Health Services, n.d.). However, these resources are not mandatory to review, are all online, and have no interactive components. My recommendation is to utilize health promotion principles to create a workshop for continuing care home staff that is collaborative, engages community stakeholders, has clear and specific key messages, and provides a way to measure effectiveness of implementation in the care home. A priority would be put on elevating the voices of disabled scholars and centring the training around successes, joy, and the importance of sexual expression for resident holistic health. This training would not only focus on supporting sexual expression, but also on fostering feelings of privacy, autonomy, and choice, which have been identified as key desires by many participants. Interactive activities would provide opportunities to have staff practice role playing in a guided environment. This training can be provided by sexual health educators within AHS and recognized as part of ongoing, formal professional development.

2. Advocate to the provincial government for standardized continuing care home policies and procedures that regard sexual expression as an element of resident holistic health to be supported.

   Recommendation 1 focuses on empowering and educating individual staff members, while recommendation 2 focuses on creating policy to ensure everyone is taken care of. Health policy and promotion specialists could work to create information packages directed to care home leadership that explain why sexual expression an integral part of many residents' holistic health to gain advocacy support. With the support of continuing care home staff and family and resident councils, we could demonstrate the need and support from relevant stakeholders to push for an inclusive and supportive care home policies. Such policies would recognize sexual expression as an activity of daily living and require care homes to attend to residents' related needs for privacy, dignity, and bodily autonomy while living in continuing care.

3. Provide opportunities within care homes for residents to comfortably access, learn about, and celebrate sexual expression.

   Continuing care homes could provide optional opportunities for residents to learn and celebrate sexual expression through care home programming. This work could potentially fall under the purview of recreation therapists, whose role focuses on the therapeutic benefits of recreational and pleasurable activities, as well as supporting residents' quality of life. It could also be supported through strategic community partnerships, or built environments that fulfill needs for privacy or autonomy. Some examples include:

   - Work with a local sex educator, sexual wellness shop, or resource centre to give a disability-focused sexual health class. The presenter could educate residents on general sexual health in addition to information that caters to disabilities (e.g., how to give and receive consent in different ways, positioning aids for partner-based sex, ergonomic, adaptive or hands-free sex toys, etc.).
   - Have a local drag queen run a workshop on experimenting with hair and makeup as a form of self-expression, empowerment, and play.
   - Host a date night for residents in relationships and invite their partners along. Plan a fun accessible activity followed by a workshop on how to navigate nurturing your relationship when a partner has moved into a

continuing care home. This kind of event could potentially align with some of the work on sexual intimacy done by the Alzheimer Society.

- Provide private guest rooms that residents can book out to allow for an overnight guest to stay with them in an intentional and intimate space. These rooms would focus on creating a cozy atmosphere that still enables staff to provide care to the resident using the space as needed.

Areas for Future Research

This research shows how important it is to use resident experiences to inform understanding, programming, and policies surrounding sexual expression in continuing care. Future areas to expand related research could potentially include:

1. Design a new, qualitative study looking at sexual expression with an explicit focus on disability and intersectional experiences in Alberta's continuing care homes.

   As previously identified, one limitation to this study was that residents were not asked to explicitly identify their disabilities. Additionally, the initial sample was overwhelmingly heterosexual and caucasian. Future research could build upon existing data and more explicitly address the intersection of diverse social locations to explore how the relationship between disability and sexual expression changes in continuing care homes for older adults, people of colour, or residents in the 2SLGBTQ+ community. This would allow for greater specificity in understanding how participants experienced their own disability and sexual expression and would help identify any patterns among participants' experiences specific to their own disabilities. Revisiting this topic in present day would also capture ways in which continuing care homes, and the residents within them, have changed since 2019. It would add context to enable us to better understand how significant events such as the COVID-19 pandemic and Alberta's decentralization and reorganization of continuing care may have impacted how disability and sexual expression is discussed and experienced.

2. Transgender experiences in continuing care homes.

The number of transgender Canadians continues to rise as changes in policies, legal protection, access to information, and general societal perception allow people to safely come out. The 2021 census reports 59, 460 people living in Canada identifying as transgender or non-binary, with many individuals likely unreported (Statistics Canada, 2021). Research to explore staff preparedness and ability to provide affirming care (e.g., knowledge on pronoun use, gender affirming gear, gender affirming surgery, hormone replacement therapy, etc.), inclusion of transgender residents in continuing care home policies (e.g., room assignments based on gender instead of sex), and transgender residents' ability to access holistic health (e.g., access to gender affirming clothing, sexual expression, mental health supports, 2SLGBTQ+ community activities, etc.) would be extremely valuable as continuing care home demographics shift.

3. Supporting sexual pleasure for adults with disabilities.

This thesis research focused on sexual expression as a wide array of possibilities that support an individual's sexual wellness, sense of self, relationships, or pleasure—but there is an opportunity to focus on physical sexual pleasure and related health promotion. Many people seek out physical sexual pleasure through masturbation, toys, or partner-based sex, but face challenges when requiring assistance throughout this process (e.g., purchasing a toy, undressing, being positioned in bed, cleaning up bodily fluids, a chauffeur to the sex club, etc.). This more narrowly focused research would seek to understand the needs of a wide array of people with different disabilities and different sexual desires in how they physically require support in achieving their desires.

4. Accessing disability affirming sex work.

   While regulated, safe, and legal sex work remains highly contested in Canada, it continues to be an access point for many people living with disabilities to intimacy, pleasure, and sex (Sinclair et al., 2015; Hilberink et al., 2022). An article out of the Netherlands explores the experiences of sex workers and their educational needs to provide safe and affirming experiences to clients with disabilities (Hilberink et al., 2022). Research to explore how people with disabilities in Canadian care homes are accessing sex work, sex workers' experiences with providing services for care home residents with disabilities, and areas of training or regulation for sex workers to provide safe and affirming care are all relevant but significantly under-researched.

Reflections

As I near the end of my master's thesis, I can truly say this process has been transformative and deeply personal. Having always thrived in academic environments, I started my thesis with confidence and enthusiasm but soon learned the open-ended nature of qualitative research challenged me in new ways. I found joy in exploring a topic close to my heart and appreciated the true depth and meaning in qualitative storytelling, but I also felt the weight of representing participants' lived experiences. Unlike my academic career up until this point, which was guided by rubrics and measurable objectives, this process was guided by newness, uncertainty, reflection, and trust in my own voice.

As I reflect on my thesis journey, I now recognize how deeply intertwined my struggles were with my ADHD and the pressure of being a first-generation university student. Many days of research began with self-doubt, the pressure of analyzing qualitative data, and the fear of getting it "wrong." The lightbulb moment occurred when my counsellor guided me to the realization that ADHD brains struggle with starting a task if they have immense pressure on the end goal. The anxiety I placed on my research was less about the work itself and more about its outcome—getting my master's, setting myself up for success, being a first-generation university graduate, and taking care of my loved ones. Despite my internal challenges, I was blessed to be supported by an encouraging supervisor who reinforced resiliency and self-compassion. I feel grateful that I was able to persevere through my thesis journey to not only contribute to an area of research I love, but to learn more about how to work with my ADHD and offer myself grace.

When reflecting on my analysis process, one of my most surprising experiences was learning how fluid and "non-linear" reflexive thematic analysis is. While my supervisor and Braun and Clarke (2022) state that revisiting steps in the six-step process to RTA is normal and encouraged, I did not realize *how many* times I would revisit different steps until I was experiencing it. With reflexive thematic analysis it was my duty as the researcher to extract quotes, identify patterns, and generate themes from the interviews while preserving the tone and nuance behind what participants said. As a result, I found myself moving back and forth between familiarizing myself with the data, generating initial codes, going back to the data, rechecking my codes, and continuing the process as I began to generate themes. I also found myself cycling back to reflexivity throughout the entire analysis and writing process. As someone passionate about using intersectionality to understand people's experiences and health, I always considered myself aware of my social identity and how it impacts my life. Because of this, I initially assumed that engaging in reflexivity would come naturally. However, I quickly discovered the process of reflexivity was far more complex and challenging than expected. With both my undergraduate and graduate degrees in public health, I came to realize just how deeply public health frameworks were embedded in the way I interpret data and understand the world around me. For example, I was quick to consider potential health promotion campaigns or educational initiatives in response to my findings, rather than engage with other disciplinary perspectives on the issue. It was easy for me to understand that my experience as a queer woman influences my passion for 2SLGBTQ+ inclusion in continuing care practices and policies. It took deep reflection to consciously understand that my education in public health has shaped my understanding that health is holistic and requires healthy relationships and a sense of belonging for overall wellness – and that this thinking about health and sexuality is not necessarily the norm for all continuing care staff, residents, and families in Alberta or beyond.

If I were to begin this process again, I would love to restart my research with knowledge of the verb "crip". In the final weeks preparing for my thesis defence, I had the privilege to attend a conference on disability and sexuality. I listened to a dozen scholars share the way they were researching and showing up to the world of disability and sexuality, and the verb "crip" was easily one of the most used concepts throughout this conference. Previous to this conference, my only exposure to the term "crip" was rooted in crip theory, a theoretical framework. However, it soon became clear that *cripping* was the verb used to describe the important work being done to centre disabled experiences of pleasure and joy that extended beyond academia. Literature on sexual expression may discuss risks, concerns, and challenge the need for autonomous pleasure, whereas literature on *cripping* sexual expression puts the experiences of disabled people, needs, and pleasure at the front. While I firmly believe harm reduction should always be considered alongside health promotion, I am curious as to what background literature and perspectives I may have encountered through my initial background research if my focus was on *cripping* sexual expression specifically.

Alternatively, I would love to try conducting this data through the lens of crip theory. Throughout my education in public health, I was taught about different theoretical frameworks that shape the way we understand the world around us. Through my reflexive process, I now realize that despite citing background literature from scholars engaged in feminist theory, queer theory, and critical disability studies, I was still understanding the data through the lens of public health and health equity. Health equity is a core value of mine and subconsciously influenced how I viewed this data, but I recognize that this is one of many ways of potentially viewing this topic.

Additionally, I would seek to address the noted limitations of this study by collecting new data. Although this dataset offers valuable and nuanced insights, it was collected in 2019. Collecting data in present day would help account for how society has transformed since the COVID-19 pandemic, capture new insights from participants who may not have been living in continuing care homes in 2019, and update experiences to align with our everchanging society. When collecting new data, I would also ask participants to identify and describe any disabilities they live with. This would allow for greater specificity in understanding how participants experienced their own disability and sexual expression and would help explicitly identify any patterns related to these experiences and perceptions.

Overall, I feel proud of my research and am reminded of how important, relational, and collaborative RTA is. Despite never meeting these participants, working with their interviews felt like a beautiful (though at times daunting) collaboration between their voices and my writing. I loved the ability to integrate myself into this research through reflexivity and being able to use these participants’ experiences to move the conversation surrounding disability and sexual expression in continuing care forward.

Conclusion

My thesis shows the complex intersections of disability, aging, and sexual expression within continuing care homes to reveal the overarching need to crip sexual expression and embrace it in continuing care homes. Internalized ableism, stigma, lack of resources, and institutional environments heavily influence resident perceptions of self-worth and sexual expression. Through engaging elected officials in policy reform and engaging care staff in education and resident-centred programming, we can begin to dismantle ableist and restrictive assumptions about sex, intimacy, and identity. By reframing sexual expression as a component of holistic health, continuing care homes can create space for residents to feel affirmed in whatever sexual expression means to them.

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Appendix

Evolution of Thesis Themes

Draft 1 - April 30, 2025

Theme 1:
Self-perception and social misconception: The tension between disability and sexual expression

- Tensions/views from within
- Judgements/tension from external sources/society

Theme 2:
Rewritten but never erased: Loss and transition through disability as defining elements of sexual expression

- Evolving emotional needs
- Evolving physical/intimate relationships
- Evolving self-discovery/relationship with oneself

Theme 3:
Resilient desires: How disability informs the pursuit for sexuality and self-expression

- Agency
- Dignity
- Advocacy

Draft 2 - May 2, 2025

Theme 1:
Self-perception and social misconception: Disability as a perceived limitation for sexual expression

- 1.1 Disability as a perceived limitation for sexual expression - from oneself about oneself
    - Numerous participants described their disability as being a burden for another human to navigate or accommodate
        - "I don't want to be a burden and I don't want someone to feel like, you know, I'm burdening them or they're burdening me."
        - "I'm sure we would be fine, but the role is she can walk, I can't. I think that's a drawback. That's a problem because I feel inadequate because I'm stuck in my chair and she can walk. That's the big difference."
    - Participants describe disability as a cloak that hides who they are as a sexual being
        - "But when this ambulatory person actually gave me his phone number and said, "Call me sometime." And I said, "You know I'm in a wheelchair?" And he said, "Yeah so what?" And he said, "You're a person." I'm thinking, "Okay. Maybe he can see me."
        - "A lot of people can't get past the wheelchair to see Sean, the gay man. They see Sean, the man in the wheelchair… This is why I'm not too worried about finding somebody because I guess my thought is that I probably won't ever find somebody because I'm in a wheelchair."

- 1.2 Disability as a perceived limitation for sexual expression - from oneself about other people with disabilities
    - Participants recognize others as being disabled and desirable.
        - "Well you see, for me, I never look at the outside of the package. I've always looked inside when I'm talking to somebody. And I don't see outside. I see inside. I see the person, the package. I unwrap a person first, you can say. I look at the inside of a person, you know, not the packaging."
        - "I've never seen the wheelchair. I've never seen the cerebral palsy." I said, "I've seen you."
        - "If I met the right one it wouldn't matter if she's in a wheelchair now or she's got some kind of other disability."

- 1.3 Disability as a perceived limitation for sexual expression - from society at large
    - Assumed lack of sexual desire
        - "The staff need to be taught that we are still sexual beings. That it does not end because we're in long-term care."

        - "I also have a personal toy that I like to use at night and sometimes the staff kind of embarrass me because they say they don't understand why I have to use it and stuff."
    - Assumed lack of ability to engage in sexual expression
        - "They had dance lessons for us. It's where they taught two people in wheelchairs to dance. You actually had intimacy there for people in the wheelchair. You learned to dance together. Now, they had a couple who were in wheelchairs – I forget their names, but they taught people in wheelchairs to dance together. Now, it is a possibility. Most people think it's not possible, but you can dance together, and you have that intimacy."
    - Inability to see past disability and see a full human
        - "Lots of people think I'm too naive. Lots of people think I'm very naive."
        - "When I was in high school back in the early seventies, I had this nurse, and so he told me, you have to go one step further, because you're in a wheelchair. People will look and they will judge you, so don't give them anything, be normal - with quotes, again - as you can be, because the world will look at you and they will judge you, because you're in a wheelchair."

Theme 2:
Rewritten by never erased: Disability as a defining element of residents' evolving sexual expression

- 2.1 Evolving emotional needs
    - Many residents describe their desire for romantic or sexual partnerships moving into a desire for friendships and emotional intimacy.
        - "Well, I think just connecting with other people is the important thing, not so much the sexual part of life, but just having human connections."
        - "My impression is that most people around here, and especially as we age, really are interested in emotional support…"
    - Residents express the importance of being seen for who you are.
        - "I want to feel like I belong, belong to someone."
        - "When I moved in here I said, "Now, you can tell everybody because I mean within 15 minutes of knowing me, you know that I'm gay." I have flags on my door, the multi-coloured flags of acceptance. I wear a band of the multi-coloured flags of acceptance. And you certainly know that I'm gay with talking to me."

- 2.2 Evolving physical/intimate relationships
    - Residents show the importance of finding physical connection with others outside of romantic partnerships

        - I met a couple of men. And one man in particular, who is a friend, we kiss when we meet. And for me, that's a blessing in itself, to be able to hug a man and to kiss him is such a blessing for me.
        - He said, "Every shift I come on and then I leave, I'll give you a hug and a kiss." I said, "I'll never say anything." And for those two minutes I was in heaven. Because you do that little expression. And at that time, it was an expression of sexuality, but expression of being human. Because just – and I could barely – I could hug with one arm only because I only had the use of one arm at that point. I was just able to use my left arm a little bit, so I could hug him back just a wee bit. But oh my God, it was glorious. I knew he had a partner. But I was crying tears of joy for the first time. Like I told him the other day, "You don't know what this means to me."
        - "I hold hands quite a bit with Judy because she really needs it."

- 2.3 Evolving self-discovery/relationship with oneself
    - Residents identify finding pleasure from masturbation
        - "...I'm looking forward to some more experiments. I'm aware of various tantalizing things, but I did realize is with the two bandages that I've been using in lieu of the compression stockings that I had and that's another thing, I'm supposed to be getting new set, but they haven't measured me yet. But I was looking at them and thinking oh well, what might be interesting and easier to keep clean is using a tube bandage because of the elasticity and taking a condom and using it as the inside so, that sperm can be kept confined and then just discarded instead of using say a flashlight that has to be cleaned afterwards. But using a condom as kind of the inner skin and with suitable lubricant and all that sort of stuff, making an artificial vagina for myself. So, I've got all the bits now and I just have to do the experiment. Once I'm sufficiently rested and feeling up to it. But I certainly have an adequate pornography collection to masturbate to, but I just haven't had the inclination to take that on just yet."
        - "I also have a personal toy I like to use at night…"
    - Finding sexual fulfillment independently outside of physical relationships
        - "I'll read a good book for a good tingle, you know, like a good romance novel, to give you a good, like, to feel good."
        - "Anyway, what I intend to do is get in touch with this club to see about getting to know them. Getting to be around people that I can talk more freely to about sexuality and about the things they do. Not sure if I'm really primed for intimacy in a relationship, but that's the kinds of things I would be exploring is getting out into the community and through the possibly through the artist centres and things."

Theme 3:
Resilient desires: How disability informs the pursuit of sexuality and self-expression in continuing care homes

- 3.1 Living with a disability amplifies the importance of agency
    - The ability to make decisions about oneself is crucial in continuing care homes
        - “...That’s mine, those are my clothes, that’s what I want to wear.”
        - “I’m trying to show residents here who thought this is the last run, “You know, well I’m going to die here.” You’re going to die anyway, dear. The shell is going to go, yes, but you will go on, so you must live every day as a blessing. So, express yourself in every way.”
    - Importance of maintaining desired sense of self and self-expression
        - “Well, some people they don’t give a hoot what they look like or anything. I was always brought up to cleanliness before Godliness.”
        - “And whether or not I’m top of the line or bottom of the heap, I want to be good about me.”
        - “I don’t feel that a long-term care facility is a very sexy place to be. A lot of focus here is just on maintaining and care for the body…”

- 3.2 Living with a disability amplifies the importance of dignity
    - Privacy as a need in continuing care
        - “I’m very vocal… my business is my business, and they’re very good with that, they know me by now, they protect me that way, and I’m very thankful for that. Because when you get new guys, like, when you get a new guy, I have to teach them from scratch how to hide, like, my privacy.”
        - “...The thing that I find hardest in here is that there isn’t a lot of modesty allowed here because all these people are changing you and seeing you naked and yet, you’re supposed to go into the dining room and interact with them as friends and stuff. It’s just that there isn’t a lot of room for modesty in here.”

Draft 3 - May 14, 2025

Theme 1:
"I've never seen the wheelchair. I've never seen the cerebral palsy." I said, "I've seen you.": Resident acceptance and celebration of disability and sexual expression in continuing care homes.

This theme explores the way residents speak about the importance of sexual expression to be supported in continuing care, and how sexual expression is part of overall human health. Residents viewed having a disability as simply another aspect of a person's identity and does not diminish their existence as a sexual or relational person. Residents believe there should be added support for disability and sexual expression within continuing care homes, regardless of their own desires for romantic or sexual relationships.

The following are quotes that demonstrate residents' positive views toward having a romantic or sexual relationship with someone with a disability.

- "Well, you see, for me, I never look at the outside of the package. I've always looked at the inside as I'm talking to somebody. And I don't see outside. I see inside. I see the person, the package. I unwrap a person first, you can say. I look at the inside to see the person, you know, not the packaging." (Resident 2)
- "...If I met the right one it wouldn't matter if she's in a wheelchair now or she's got some kind of other disability." (Resident 3)

Even for residents who personally were not in a romantic or sexual relationship, there was an overall feeling of support and encouragement.

- Interviewer: "But that touch of her husband is still, that still really makes her beam, doesn't it?
  Resident: "It does, yeah."
  Interviewer: "And so Audrey, do they do that in the privacy of their room or is he pretty open?
  Resident: "Oh, he's open about it."
  Interviewer: "And how do people respond when they see that married couple?"
  Resident: "I guess they say go for it boy, go for it."
- "The other thing, that I would like to see, is more places in facilities where couples could be together. This would be especially for older couples that have been together for many years and now have to face being separated because one person needs more care than the other. After all those years with each other, they are now separated and cannot rely on the comfort that they have always received from the other one, be this sexual or not." (Resident 6)
- "We should be encouraging every facility to have that, you know, where if you want to spend the night with your loved one, but they still need the medical care of the facility and you cannot bring them home with you. But you can actually spend the night with them, so you can have that intimacy with them." (Resident 2)

Theme 2:
Self-perception and societal misconception: Disability as a perceived limitation to sexual expression.

Despite residents expressing positive views of attraction, support, or encouragement for their disabled peers or partners navigating sexual expression, these views were often negative toward themselves and their own identities. This theme identifies how residents view their own disability as a limitation to sexual expression. This theme also explores the ableist opinions from staff and society at large that negatively influenced residents' own sense of self and internalized barriers to sexual expression.

Many residents identify their own disability as a burden or barrier to sexual expression.

- Regarding what she would need if she were to get into a romantic relationship: "Well, it would be a matter of actually meeting up with someone that could accept this type of situation that I'm in a wheelchair and I can't take care of myself and that type of thing." (Resident 6)
- "I don't want to be a burden and I don't want someone to feel like, you know, I'm burdening them or they're burdening me." (Resident 3)
- Regarding if a relationship would be supported in the continuing care home: "I'm sure we would be fine, but the role is she can walk, I can't. I think that's a drawback. That's a problem because I feel inadequate because I'm stuck in my chair and she can walk. That's the big difference." (Resident 7)
- Resident expressed interest in another resident: "...He told me once that because we're both in wheelchairs he didn't think we could do anything, so." (Resident 11)
- "I've always thought, you know, as I met someone- I'd have to see somebody in a wheelchair because they could see me. The only way they could see me, maybe somebody else that has my story." (Resident 2)

Residents' negative attitudes toward their own sexual expression is not surprising due to the ableist comments cited from staff and experiences within society as a whole.

- This resident shares how a mentor at an early age made her believe she had to overcompensate with her expression because of her disability: "...When I was in the high school back in the early seventies, I had this nurse, and so he told me, you have to go one step further, because you're in a wheelchair. People will look and they will judge you, so don't give them anything, be as normal - with quotes, again - as you can be, because the world will look at you and they will judge you, because you're in a wheelchair. (Resident 12)
- Resident shares how he struggles to be seen by potential partners because of his disability: "A lot of people can't get past the wheelchair to see Sean, the gay man. They see Sean, the man in the wheelchair… This is why I'm not too worried about finding somebody because I guess my thought is that I probably won't ever find somebody because I'm in a wheelchair." (Resident 2)
- Resident shares her experience having a disability and needing to ask staff for assistance getting her sex toy: "I also have a personal toy that I like to use at night and sometimes the staff kind of embarrass me because they say they don't understand why I have to use it and stuff. It just gets to be a little embarrassing and quite

uncomfortable because for one thing I don't have a boyfriend or a husband anymore, so." (Resident 11)

Theme 3:
Equity over equality: How disability and sexual expression need to be supported in continuing care homes.

This theme discusses the unique environment of continuing care homes and the importance of an evidence informed and intersectional approach to resident sexual expression. This theme discusses how key social identities (ie. disability, age, gender, sexuality) intersect in continuing care homes and inform how residents need support for their disability and sexual expression to not only co-exist, but flourish.

Sexual expression is important in continuing care because it is part of the human experience. Disability does not negate this!

- "The world is a wonderful place and tasty and sexy are just, they're part of what makes the world wonderful." (Resident 1)
- "The staff need to be taught that we are still sexual beings. That it does not end because we're in long-term care." (Resident 2)
- "It just hit me, the very idea to have discussions on sexuality. We don't have that – sexual expression. There is no discussion on sexual expression. You should have that. That's part of people's lives." (Resident 2)
- "I don't feel that a long-term care facility is a very sexy place to be." (Resident 6)

When we think of sex education in today's society, we may think of accessible abortion, engaging sexual health classes, or free condoms in a jar (all of this will be expanded on and backed by literature showing approaches to sexual wellness)-- but these approaches do not fit the prominent need for residents living in continuing care homes. We need equity, not equality. We see the diverse experiences of residents living with disabilities in continuing care homes through their personal stories:

- "...I'm looking forward to some more experiments. I'm aware of various tantalizing things, but I did realize is with the two bandages that I've been using in lieu of the compression stockings that I had and that's another thing, I'm supposed to be getting new set, but they haven't measured me yet. But I was looking at them and thinking oh well, what might be interesting and easier to keep clean is using a tube bandage because of the elasticity and taking a condom and using it as the inside so, that sperm can be kept confined and then just discarded instead of using say a flashlight that has to be cleaned afterwards. But using a condom as kind of the inner skin and with suitable lubricant and all that sort of stuff, making an artificial vagina for myself. So, I've got all the bits now and I just have to do the experiment. Once I'm sufficiently rested and feeling up to it. But I certainly have an adequate pornography collection to masturbate to, but I just haven't had the inclination to take that on just yet." (Resident 1)
- "I'll read a good book for a good tingle, you know, like a good romance novel, to give you a good, like, to feel good." (Resident 12)

- Resident shares how dancing in wheelchairs fostered intimacy for residents at his former home: “They had dance lessons for us. It’s where they taught two people in wheelchairs to dance. You actually had intimacy there for people in the wheelchair. You learned to dance together. Now, they had a couple who were in wheelchairs – I forget their names, but they taught people in wheelchairs to dance together. Now, it is a possibility. Most people think it’s not possible, but you can dance together, and you have that intimacy.” (Resident 2)
- “Well, I think just connecting with other people is the important thing, not so much the sexual part of life, but just having human connections.” (Resident 6)
- Resident: “I hold hands quite a bit with Judy because she really needs it.”

Interviewer: “What do you think she needs it for? What does it give her?”
Resident: “Well, she’s got so much against her and her health is not good and her husband he comes in, so she needs somebody to be like that. And her daughter knows that I do it. And her daughter is quite happy about it. Yeah.”
Interviewer: “How do you think it nourishes Judy? Like you say that she’s got so much going on for her, how do you think it nourishes her? How do you know it helps?”
Resident: “Well, she brightens up. She just like, she turns a different colour. Yup.” (Resident 4)

Draft 4 - June 17, 2025

Theme 1 – Contrasting descriptions of disability when residents speak about themselves versus others.

In this theme, I discuss the contrasting ways residents articulate their own experiences of disability and sexual expression in comparison to how they describe those of their friends or partners.

1.1 Residents described disability as simply another aspect of a person's identity and as something that should not diminish their experience of intimacy or sexuality. The following quotes demonstrate residents' positive views toward having a romantic or sexual relationship with someone with a disability.

- "...If I met the right one it wouldn't matter if she's in a wheelchair now or she's got some kind of other disability." (Resident 3)
- "Well, you see, for me, I never look at the outside of the package. I've always looked at the inside as I'm talking to somebody. And I don't see outside. I see inside. I see the person, the package. I unwrap a person first, you can say. I look at the inside to see the person, you know, not the packaging." (Resident 2)

1.2 Even residents who were not in a romantic or sexual relationship themselves expressed support and encouragement towards intimate connections between continuing care residents.

- Interviewer: "But that touch of her husband is still, that still really makes her beam, doesn't it?
  Resident: "It does, yeah."

  Interviewer: "And how do people respond when they see that married couple?"

  Resident: "I guess they say 'go for it boy, go for it!'" (Resident 4)
- "The other thing, that I would like to see, is more places in facilities where couples could be together. This would be especially for older couples that have been together for many years and now have to face being separated because one person needs more care than the other. After all those years with each other, they are now separated and cannot rely on the comfort that they have always received from the other one, be this sexual or not." (Resident 6)
- "We should be encouraging every facility to have that, you know, where if you want to spend the night with your loved one, but they still need the medical care of the facility, and you cannot bring them home with you. But you can actually spend the night with them, so you can have that intimacy with them." (Resident 2)

1.3 Despite many participants expressing positive views of attraction, support, or encouragement towards their disabled friends or partners, their views about disability were often more negative when directed toward themselves.

- Regarding what she would need if she were to get into a romantic relationship, Resident 6 said: "Well, it would be a matter of actually meeting up with someone that could accept this type of situation that I'm in a wheelchair and I can't take care of myself and that type of thing." (Resident 6)

- "I don't want to be a burden and I don't want someone to feel like, you know, I'm burdening them or they're burdening me." (Resident 3)
- Regarding if a romantic relationship would be supported in the continuing care home: "I'm sure we would be fine, but the thing is she can walk, I can't. I think that's a drawback. That's a problem because I feel inadequate because I'm stuck in my chair and she can walk. That's the big difference." (Resident 7)
- When a resident expressed interest in another resident: "...He told me once that because we're both in wheelchairs he didn't think we could do anything, so." (Resident 11)
- "I've always thought, you know, as I met someone- I'd have to see somebody in a wheelchair because they could see me. The only way they could see me, maybe somebody else that has my story." (Resident 2)

Theme 2 – Ableism exacerbates institutional barriers to sexual expression.

In this theme, I discuss how residents identify structural and interpersonal barriers to sexual expression through care home policies, staff, and lack of knowledge surrounding disability as it pertains to sexual expression.

2.1 Individuals live in continuing care homes for a variety of reasons, including assistance with daily tasks, social support, and health management. While sexual expression is a normal part of human life, many residents face barriers to sexual expression through the staff and systems that are intended to support them.

- Resident 11 shared her experience having a disability and needing to ask staff for assistance getting her sex toy: "I also have a personal toy that I like to use at night and sometimes the staff kind of embarrass me because they say they don't understand why I have to use it and stuff. It just gets to be a little embarrassing and quite uncomfortable" (Resident 11)
    - Resident 3 also discusses his experiences when he had a girlfriend and the challenges they faced when being intimate in the care home. "She felt kind of nervous, shy kind of. Like, if we decided to be- get a little romantic, you know, because the door doesn't lock. So of course, you just come up with ways and we did but she still would feel kind of like she's on the clock, you know. They want me out of here by 11:00. Your times to be romantic are kind of cut in quarters." (Resident 3)
    - "It was like you're kind of like a junior high or high school kid again. You know, it really does feel that way kind of. Like you're sneaking." (Resident 3)
    - "Because you're single, well, now you're in long-term care. Well, that ends your life altogether. If the two of you meet or something like that. We discourage them from getting too close. If you see a couple kissing or something like that, "ah, ah, ah," you got to stop that." (Resident 2)
- "The staff need to be taught that we are still sexual beings. That it does not end because we're in long-term care." (Resident 2)

2.2 Over a third of participants identified that dependency on staff for their basic needs can undermine their sense of self and inhibit sexual expression.

- Resident 3 shares how needing assistance to be intimate with a partner can feel extremely discouraging and takes him out of the headspace for intimacy. “A part of [me wonders] will I ever get to be like intimate with somebody again because I mean, well, there’s the hospital not wanting your company to stay, but then… I got to go through such a rigamarole. You got to get, you know, lifted into the best and then you got to get disrobed and then you got to get… I mean I got to wear a brief and, you know, you just, I mean, kind of start feeling like an overstuffed sausage… by the time you get into your bed you kind of lost that loving feeling.” (Resident 3)
- Resident 6 shares how her modesty is consistently challenged by care staff who don’t value the same level of privacy as her. “The thing that I find hardest in here is that there isn’t a lot of modesty allowed here because all these people are changing you and seeing you naked and yet, you’re supposed to go into the dining room and interact with them as friends.” (Resident 6)
- “It’s important that I feel important, whether or not they like it, I don’t care.” (Resident 8)

Theme 3 – Despite the challenging contexts, residents still found opportunities for sexual pleasure, emotional intimacy, and the tastiness of life.

In this theme, I discuss the innovation and joy that residents cultivate in continuing care homes despite internalized stigma and institutional barriers surrounding disability and sexual expression.

3.1 Disability acted as a prompt for innovation in one’s sexual expression.

- I was sort of figuring I would still be independently masturbating and the most I’ve thought about is well, potentially, you know, look through the back ads in the Sun and that sort of stuff and see who would come in.” (Resident 1)
- Resident 2 discusses how his communication changed after coming out as gay and living in a continuing care home. Resident 2 expresses how he takes any opportunity he can when he’s outside of his care home to tell potential suitors how he truly feels. “I met a couple of men, and one man in particular, who is a friend, we kiss when we meet… The first time I stood up he said, ‘Oh, you’re a big boy.’ ‘Yes, darling, and everything works.’ I’m able to say that because it shocks my mother. He said, ‘You’re very straight forward.’ I said, ‘Yes, I am. I don’t have time not to be.’” (Resident 2)
- “The two bandages that I’ve been using in lieu of the compression stockings that I had… I was looking at them and thinking oh, well, what might be interesting and easier to keep clean is using a tube bandage because of the elasticity and taking a condom and using it as the inside, so that sperm can be kept confined and then just discarded, instead of using, say, a fleshlight that has to be cleaned afterwards. But using a condom as kind of the inner skin and with suitable lubricant and all that sort of stuff, making an artificial vagina for myself. So, I’ve got all the bits now and I just have to do the experiment.” (Resident 1)
- “I’ll read a good book for a good tingle, you know, like a good romance novel.” (Resident 12)

3.2 Disability as a catalyst for a change in perspective.

- "When I moved in here, I said, 'Now, you can tell everybody because I mean within 15 minutes of knowing me, you know that I'm gay.' I have flags on my door, the multi-coloured flags of acceptance. I wear a band of the multi-coloured acceptance. And you certainly know that I'm gay with talking to me." (Resident 2)
- Resident 2 discusses how after his brain injury, his whole perspective on life and disability changed. "It took my voice. It took my vision. I have only tunnel vision. It took so much away from me. But it gave so much to me. I mean most people look at what you lose. You have to look what you still have and what you gained. I mean I was blessed being able to see from this side of the fence. I took care of people in this condition for 25 years. Now, I get to see what they have gone through. What horror and hellish and mistakes I made for 25 years." (Resident 2)
- Resident 7 shares how before his brain injury "I was a player" and "I always relied on my looks." He shares that his perspective on relationships has completely changed. "Before I had no conscience. Now I care." (Resident 7)
- Resident 3 states that he would happily date a woman who has a disability but shares how his opinion was different before his disability progressed. "I'm just trying to think of my own self when I wasn't crippled and didn't even know I would be. Like I probably wouldn't – I wouldn't say no to going out with somebody who was in a wheelchair, but it would probably not be like I – you know, I would probably go with the walking people. And kind of now I'm like, Jesus, am I so shallow that I would think that way?" (Resident 3)

3.3 Supportive outliers within the stagnant systems of continuing care.

- Resident 11 shares how the recreational therapist and her practicum student helped her replace her broken vibrator. "They were able to order it online for me and they just used a credit card and then I paid them back for it." (Resident 11)
- Resident 2 shares how the gay manager of his continuing care home agreed to sit with him when he told his mom he was gay after vulnerably approaching her. "I said, 'my mother probably knows, but I need to say the words and I want you present, if you could, please, because I'm very nervous about this. I need to say the words to her.'" (Resident 2)
- "They treat you like a person, and they just bend over backward to do anything to help me. If I need something they'll bend over backwards to do it. And so it's the way they think means a lot to me." (Resident 4)