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Nursing Home Caregivers Attitudes Regarding Sexual Behavior of Nursing Home
Residents:

A Cross Sectional Survey

MSW Clinical Research Paper

Submitted by Teresa Madsen

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School of Social Work

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Abstract

Sexual needs do not disappear as a person ages. It is possible for older adults to maintain their desired level of sexual activity if the environment is accepting and accommodating for the adults' needs. Those who are institutionalized in nursing homes often have fewer opportunities to meet their needs than those who are not. The purpose of this project was to explore nursing home caregivers' attitudes toward sexual behavior in their residents and thus assist in identifying areas for further education and educational programming that will allow residents to lead full and happy lives and meet the needs of the older adult. Data was gathered in nursing homes in a Midwestern metropolitan area using a survey comprised of questions from the 2009 AARP sexuality study. Statistical tests including t-tests, ANOVA, and correlations were used to examine the relationship between demographic variables and the attitude scale score devised for this study. The findings indicated that there were no significant relationships between the variables and the attitudes scale score. The scale score itself was distributed indicating only moderate acceptance of sexual behavior by caregivers. The findings indicate that further education on the sexual needs and rights of older adults may be necessary to allow for nursing home residents to meet their needs without facing judgment and shame.

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Introduction

As the baby boom generation ages, the population distribution is changing dramatically (Howden & Meyer, 2011). It is estimated that by 2030, more than twenty percent of the population will be over the age of sixty five (Howden & Meyer, 2011). Many of these older adults will experience chronic illnesses which require them to have twenty four hour care in order to stay healthy and safe. Unlike previous generations, in their youth, this generation experienced a culture of sexual freedom and expression, making identifying attitudes towards sexual activity in older adults crucial as sexuality, most likely, will be more visible with this population (Rheaume & Mitty, 2008).

It is possible for older adults to maintain their desired level of sexual activity if the environment is accepting and accommodating for the adults' needs. However, older adults who are institutionalized in nursing homes often have fewer opportunities to get their sexual needs met as they are constantly in the presence of nursing staff, which may judge and shame the residents. This study focuses on those who serve the elderly, asking what are nursing home caregivers' attitudes towards the sexual behavior of the older adult residents with whom they work? This knowledge will assist in identifying areas for further education and educational programming that will allow residents to lead full and happy lives. The following is a review of the literature which provides a foundation for the current study, beginning with theories of development in old age, and continuing on to describe research on physiological changes in sexual functioning, sexual behavioral changes, views of society on older adult sexuality with a brief look into GLBT issues, and finally, the nursing home environment.

Characteristics of Sexuality in the Elderly

Developmental Theories

Developmental theories attempt to explain how the average person progresses through life. Within the psychosocial literature, there is much of debate on how to age successfully (Sharpe, 2004). A few of these theories include the theories of aging and activities, including disengagement theory, activity theory, and continuity theory; and Erickson's psychosocial stages of development. The following includes a review of these theories and their relationship to sexuality in older adults.

Theories of Aging and Activity

Theories of aging and activity describe "successful aging" (Kastenbaum, 1965; Sharpe, 2004; Papalia, Olds, & Feldman, 2007) as identified by the activity level of the individual. Successful aging activities not only relate to engaging in leisure activities, but also relationships, and with that, sexual behavior. The three theories of activity and aging, disengagement, activity, and continuity, have very different assumptions on how to age successfully (Kastenbaum, 1965).

Disengagement Theory. Disengagement theory states that as humans age, they have a natural tendency to disengage from activities and other people (Kastenbaum, 1965; Papalia, Olds, & Feldman, 2007; Sharpe, 2004). The theorists propose that decreased participation is voluntary and universal and begins in middle adulthood when traditional roles, such as worker and parent, are no longer at the forefront. People are thought to anticipate this change and adjust to it, changing their style of interaction from active to passive. They are thought to disengage further because they are less likely to be

chosen for new roles such as new relationships and careers (Sharpe, 2004). This theory may reinforce many ageist stereotypes of older adults being alone and sedentary (Sharpe, 2004). It is also possible that this theory perpetuates discrimination such as forced retirement and socially sterile nursing homes, as they are seen as fulfilling the older adults' desire to withdraw.

Activity Theory. Activity theory has a similar premise as disengagement theory. They both measure successful aging by the activity level of the individual (Kastenbaum, 1965; Papalia, Olds, & Feldman, 2007; Sharpe, 2004). While disengagement theory states older adults age most successfully when they begin to withdraw from activities and relationship, activity theory instead posits that older people age most successfully when they are engaged in an increased amount of activities (Kastenbaum, 1965; Papalia, Olds, & Feldman, 2007; Sharpe, 2004). Activity theory states that successful aging occurs when the older adult experiences a full range of activities to fill their day. The theory is that an increase in activities in late life as well as an increased number of roles played will increase life satisfaction and even lengthen one's life (Kastenbaum, 1965; Papalia, Olds, & Feldman, 2007; Sharpe, 2004).

Continuity Theory. Continuity theory states that the best sign of aging satisfactorily is not the number of roles or activities a person is engaged in, but rather if the level of activity is consistent with what the person wants (Kastenbaum, 1965; Papalia, Olds, & Feldman, 2007; Sharpe, 2004). The theorists state that late life is often dealt with the same way earlier stages were, people who are highly active will tend to stay highly active and vice versa. End of life satisfaction is then related to whether or not a person continues at their preferred level of activity (Sharpe, 2004). Research indicates

that current attitudes towards older adult sexuality are negative, as current societal belief is that sexual interest declines and disappears in old age (Aizenberg, Weizman, & Barak, 2002). However research on sexual behavior in older adults is more indicative of interest in sexual activity remaining fairly constant throughout adulthood (Miles & Parker, 1999), much like continuity theory for activity. This discrepancy impacts how staff of nursing homes will respond to the sexual behavior they witness.

Erik Erikson's Theory of Psychosocial Development

Erik Erikson's (1986) theory of psychosocial development covers eight stages across the life span. Each stage has a focal struggle between two predispositions and a resulting strength that occurs from balancing the two (Erikson, Erikson, & Kivnick, 1986; Papalia, Olds, & Feldman, 2007; Sharpe, 2004). The focal struggle identified for late adulthood is ego integrity versus ego despair. Ego integrity refers to acceptance of how one has lived and is still living while ego despair is focusing on past regrets and current deficits. The emerging strength that comes from finding the balance between these two opposing ideas is wisdom (Erikson, Erikson, & Kivnick, 1986). Erikson et al (1986) define wisdom as having detached concern with life itself, in the face of death itself, and learning to convey the integrity of experience despite experiencing a decrease in functioning. Part of this struggle includes the individual being satisfied and accepting of their current functioning regarding his or her sexuality. If the individual is accepting of his or her current level of functioning in the realm of his or her sexuality, independent of the individual actively engaging in sexual activity, than he or she will experience increased ego integrity over despair (Sharpe, 2004).

While this is the primary struggle for older adults, Erickson et al (1986) indicate individuals are never only dealing with the focal struggle of their life stage. They are also engaged in anticipation of future struggles and re-experiencing tensions inadequately integrated when they were focal. Many older adults revisit the previous stage of intimacy versus isolation which is thought to occur when an individual is a young adult.

Due to decrease in physical functioning, and deaths of friends and family members, many older adults begin to face isolation if they do not pursue new friendships and relationships. This puts the older adults at increased risk for isolation rather than intimacy, especially if the individual is placed in a setting that does not recognize their sexuality. Instead, staff needs to help foster the formation of new relationships and allow for those relationships to become intimate. Staff acceptance and positive attitude towards interpersonal relationships will assist the individuals in avoiding isolation. It is also important for staff to have a positive attitude towards new relationships because even without staff derision and intervention, it can be difficult for older adults to enter new relationships in later life because availability of partners is limited, especially in a nursing home setting, and there is already a stigma attached to older adults and their sexuality within society.

Gerotranscendence

The theoretical concept of gerotranscendence found its roots in disengagement theory (Jonson & Magnusson, 2001). Both disengagement theory and gerotranscendence classify old age as a period of life that is significantly different from middle age (Jonson & Magnusson, 2001). Disengagement theory posited that there is a natural withdrawal from activities and others as a person ages, and despite this withdrawal, many were still

satisfied with their life. Gerotranscendence theory posits that as people age their consciousness changes and becomes cosmic and detached leading to a natural withdrawal (Jonson & Magnusson, 2001). There are a number of alterations that accompany this process including: an increased feeling of cosmic communication with the universe; a redefinition of time, space, and objects; a redefinition of the perception of life and death; increased affinity with past and future generations; a decrease in superfluous social interactions; decrease in interest in material objects; a decrease in self-centeredness; and more time spent in meditation (Jonson & Magnusson, 2001). This theory has weak empirical evidence, but this may be due to the process being obstructed by societal expectations, especially in the Western hemisphere.

Physiological Changes

There are basic changes the human body experiences as it ages which impact many aspects of daily life, including sexuality. Human skin becomes fragile, muscles weaker and bones more frail and many individuals will experience metabolic changes which impacts our digestion and energy levels (Crooks & Baur, 2008). Both men and women experience a great deal of changes in their sexual organs and hormones as they age, impacting their experience of their own sexuality.

There are several changes that occur in men that are normative but may influence their sexual activity. Men experience a decreased production of testosterone that stabilizes at about age sixty (Sharpe, 2004). Their testicles reduce in size and firmness (Crooks & Baur, 2008; Sharpe, 2004; Zeiss & Kasl-Godley, 2001). The testicles also produce fewer sperm and less pre-ejaculate fluid (Crooks & Baur, 2008; Sharpe, 2004;

Zeiss & Kasl-Godley, 2001). Their prostates increase in size. Erections are often less firm and less durable.

There is a noted increase in sexual dysfunction in older adults that is not considered to be a part of aging. Rather than being related to physiological changes of the sexual anatomy, it is often attributed to underlying medical conditions and medications. Finally, unlike women, men do not go through a phase comparable to menopause, and remain fertile throughout their life span.

Women also experience several changes which impact how they experience their sexuality and their own sexual functioning. As women age, there is a shortening and a narrowing of the vagina (Sharpe, 2004; Zeiss & Kasl-Godley, 2001). Vaginal secretions are often less acidic which increases risk for vaginal infections (Sharpe, 2004). The amount of estrogen produced is decreased, which leads to decreased clitoris size, increased stress incontinence, and a graying and thinning of pubic hair (Crooks & Baur, 2008). Women become more at risk for cystitis, which is an inflammation of the bladder which may be caused by a urinary tract infection, certain medications, radiation therapy, catheter use, or other illness which may lead to a decrease in sexual desire (Crooks & Baur, 2008). Women have completed menopause by this time, and unlike men, are now infertile.

The changes in sexual physiology also cause changes in the sexual response cycle of older adults (Crooks & Baur, 2008). The sexual response cycle includes four phases: drive, arousal, release, and refractory (Sharpe, 2004). The drive phase is the desire for sexual release. This phase remains pretty stable throughout the lifespan. The arousal

phase is the first physiological response to sexual arousal (Crooks & Baur, 2008). Responses include increased heart rate and blood pressure, penile and clitoral erection, and increased lubrication (Crooks & Baur, 2008). In later life, women experience a decrease in estrogen, atrophy of tissues, a decrease in vaso-congestion and lubrication, and both men and women may experience a prolonged arousal stage and an increased need for more direct stimulation (Crooks & Baur, 2008; Zeiss & Kasl-Godley, 2001; Sharpe, 2004). The third stage, the release stage where orgasm is achieved, is affected by aging in minimal ways. Orgasm continues to be experienced in the same way as earlier in life, however men will notice a decrease in volume of ejaculation and the orgasm will be less forceful. Women may experience pain during orgasm due to the contractions of the uterus and vagina becoming less rhythmic and coordinated (Sharpe, 2004; Zeiss & Kasl-Godley, 2001). It has been noted that women who are multi-orgasmic in earlier years often remain so in later life (Sharpe, 2004). The final stage, the refractory phase, heart rate, blood pressure and breathing rates return to normal, clitoral and penile erections subside, and there is a rest period before excitement can occur again (Crooks & Baur, 2008). Following orgasm, older adult males return to the unexcited phase more quickly, and they take longer to become excited again. Post-menopausal women may experience a lack of cervical dilation (Sharpe, 2004; Crooks & Baur, 2008; Zeiss & Kasl-Godley, 2001).

All of these changes in sexual response and physiology impact how older adults experience their sexuality, and how they satisfy their needs. Nursing home caregivers need to be aware of physical changes as well as sexual behavioral changes to gain a better understanding of older adult sexuality and to foster positive, informed attitudes.

Sexual Behavioral Changes

Much as the physical body changes as a person ages, a person's behavior will evolve as well. The focus of sex shifts as need and ability is altered. Instead of intercourse being the primary sexual activity, the focus expands to include activities such as simple caressing, sexual touching, kissing and hugging as methods of expressing sexual intimacy and satisfying sexual desires (Miles & Parker, 1999; Zeiss & Kasl-Godley, 2001). These are the most common forms of sexual behaviors in older adults with partners and are reported to occur at least once per week (AARP, 2009). The frequency of intercourse declines with age, although it declines slower in those who engage in sexual activity often (Rheaume & Mitty, 2008; Miles & Parker, 1999; Zeiss & Kasl-Godley, 2001). Studies have also indicated that those who are single and dating are often more sexually active than married couples (AARP, 2009). This is possibly related to one partner in the married couple having health complication. This is in contrast to single adults as the single adults who have serious health complications will often not be dating, giving single adults who are dating more of a chance to engage in sexual activity than married couples where one partner may be chronically ill (AARP, 2009).

Society and late life sexuality

Society is a barometer for how the majority feels about a certain topic and societal views can be used as a guide for where a push for change may be needed. In regards to older adult sexuality, the majority of American society harbors the attitude of older adults as asexual and lacking interest in sexual activity. The literature indicates that society views the sexual timetable as sexual interest the following. Sexual interest begins in

adolescence and reaches its peak in young/mid adulthood. It is then perceived to diminish as the ability and desire to procreate diminishes thus creating the attitude that older adults should have no interest in sexual activity (Miles & Parker, 1999; Reingold & Burros, 2004). Research has shown that society tends to have a negative viewpoint towards sexual expression in late adulthood (Miles & Parker, 1999; Reingold & Burros, 2004; Skultety, 2007). These viewpoints indicate a presence of ageism in regard to sexuality (Miles & Parker, 1999; Reingold & Burros, 2004; Skultety, 2007). This may be related to society's view of older adults being unattractive and the desire to remain youthful (Pangman & Seguire, 2000; Reingold & Burros, 2004).

Society's message to adults is that sex is for younger people, although they consider their sexuality as a positive aspect in their lives (Aizenberg, Weizman, & Barak, 2002; Skultety, 2007). This societal message has influenced how older adults feel about their own sexuality, causing feelings of shame when the individual desires sexual activity. Research has shown that a lack of understanding from healthcare professionals may compel older adults, especially older women, to conform to society's expectations of older adults not participating in positive sexual behavior (Aizenberg, Weizman, & Barak, 2002; Skultety, 2007). This can create a sense of shame around sexual feelings and desires and damage the individual's self esteem.

Chronically Ill Seniors. Many older adults face chronic health problems such as chronic obstructive pulmonary disease, congestive heart failure, chronic kidney disease, osteoporosis, and others. These adults may spend much of their time in bed due to their condition. Studies have shown that interest in sex does not diminish for these adults (Pangman & Seguire, 2000). Despite continued interest, these adults are often unable to

participate in sexual activity, and may place less importance on participation than those who are well (Pangman & Seguire, 2000).

The sexuality of the chronically ill older adult is often invisible due to the societal myth that when chronically ill, older adults automatically lose interest in sexual activity (Pangman & Seguire, 2000). This myth distorts societal attitudes about older adults and fosters negative and devaluing reactions in regards to the individual's sexuality (Pangman & Seguire, 2000). It is important for staff working with these individuals to recognize and validate feelings of loss around opportunities for intimate relationships (Pangman & Seguire, 2000). Chronically ill older adults who are still able to participate in sexual activity should be allowed to pursue this desire appropriately without risk of derision or consequence from staff.

GLBT Seniors. A group that is often not addressed or considered in the nursing home environment is the gay, lesbian, bisexual, transgendered (GLBT) community. This group was surveyed and over half felt that nursing homes are unfriendly to GLBT issues (Smith, McCaslin, Chang, Martinez, & McGrew, 2010). Research indicates that GLBT seniors in nursing homes often revert back to hiding their sexuality because they feel that nursing homes are ill-equipped to meet their needs (Butler, 2004). These older adults often worry about and experience loneliness and isolation (Smith, McCaslin, Chang, Martinez, & McGrew, 2010). It is very common for nursing homes to require having a roommate. Along with this, the residents in a nursing home often do not have a choice of who they room with and GLBT seniors often are apprehensive of revealing their sexuality to their mandated roommate as they may be faced with derision (Butler, 2004).

Not only do GLBT seniors face ageism, but they must also contend with homophobia, heterosexism and transphobia (Butler, 2004).

Transgendered seniors in particular have a difficult time in the nursing home setting. There is often a question of which gender should they room with. Many nursing homes would prefer to room the seniors with a person who matches their biological gender, however transgendered seniors prefer to room with the gender they identify with (Butler,2004).

Sexuality in Nursing Homes

Nursing Home Caregivers Attitudes towards Sexual Behavior

Research indicates that as many as ten to twenty percent of male residents and three percent of female residents without dementia are sexually active (Miles & Parker, 1999). These statistics indicate that sexual behavior in nursing homes should be addressed and policies and procedures should be examined and revised if needed to ensure residents' safety, dignity, freedom and right to intimate relationships are protected. Current nursing home policies are often very restrictive and hinder residents' potential for developing close, intimate relationships that the residents desire.

Regulation of sexual behavior in nursing homes occurs with policy directly relating to sexual activity as well as policies that at first glance appear to not have any relationship to sexuality. These policies include but are not limited to: enforced dining partners, lack of roommate choice, semi-private rooms, night checks, supervision of relationships, curfews, surveillance, an absence of do not disturb signs, and physical restraints (Miles & Parker, 1999). These policies restrict resident interactions and inhibit

intimate relationships from occurring. Loss of inhibition in late adulthood relating to cognitive disorders such as dementia sometimes result in exhibition of inappropriate sexual behavior, for example masturbating in public. These exhibitions are often labeled as behaviors which result in shame for the resident. These exhibitions can be problematic to differentiate with healthy sexual behavior, especially when cognitive deficits are involved, so much of the time all sexual behavior occurring between two unmarried residents or alone is considered a behavior.

Because of the difficulty differentiating exhibitions of healthy sexual expression from inappropriate sexual behavior in this setting, most instances of sexual expression are considered negative behaviors (Miles & Parker, 1999). Due to the label of behaviors, consequences and interventions are often used to deter the sexual expression. These interventions are often demeaning and shaming. Residents have been deprived of privacy (Miles & Parker, 1999). The residents have been restrained or forced to wear clothing that restricts access to their own bodies (Miles & Parker, 1999). Partners have been separated from each other, and those who pursue sexual expression independently have been forced to subterfuge to get their needs met (for example, locking themselves in bathrooms in order to obtain privacy) (Miles & Parker, 1999). Residents experience undignified and inhumane responses to their natural sexual expression. Many of the nursing homes use these consequences to protect themselves from lawsuits involving sexual harassment and assault between residents (Miles & Parker, 1999). Especially with vulnerable adults who may not have the cognitive capacities to make sound decisions, there is a risk for residents being taken advantage of sexually. It is difficult for the institution to find balance between right to sexuality and protecting the residents

from harm and the institution from lawsuits (Miles & Parker, 1999). Residents also experience derision from staff when expressing sexual desire (Miles & Parker, 1999), which is a comment on how society views sexuality in older adults (discussed above).

For many nursing facilities, these strict policies are related to possible resident harm and legal ramifications if the sexual activity is not consensual, or if one or both of the adults participating are demented and are unable to give consent. Despite these legitimate concerns, residents have a right to pursue relationships that improves their quality of life, as the need to have a physical connection with another person is a basic but powerful human need that lasts throughout the lifetime (Reingold & Burros, 2004).

Conclusion

This literature review discussed various issues surrounding older adult sexuality in a nursing home setting as well as caregivers attitudes towards it. The discussion of these issues such as changes in physiology and sexual behavior, societal attitudes towards sexuality in older adults, and the current state of affairs in nursing homes regarding resident sexuality lead up to the question: What are nursing home caregivers' attitudes towards the sexuality of nursing home residents? This larger question will attempt to be answered through the analysis of four smaller research questions examining if there is a difference in nursing home caregivers attitudes towards the sexuality of nursing home residents in regards to: age, gender, ethnicity, and the number of years the caregiver has worked with older adults.

Conceptual Framework

This study is grounded in Erikson's (1986) theory of psychosocial development. Erikson's theory of psychosocial developmental stages is discussed at length in the literature review above. This particular theory proposes the revisiting of stages throughout the entire lifespan. Many older adults experience this revisit, especially with the stage intimacy versus isolation.

As discussed in the literature review, the theory of psychosocial development identifies eight stages of development throughout the lifespan; trust versus mistrust; autonomy versus shame and doubt; initiative versus guilt; industry versus inferiority; identity versus role confusion; intimacy versus isolation; generativity versus stagnation; and ego integrity versus ego despair (Erikson, Erikson, & Kivnick, 1986). While Erikson asserts that people follow a general path through these focal struggles, he also asserts that people will revisit stages as events happen in their lives to instigate the particular struggle (Erikson, Erikson, & Kivnick, 1986).

Since Erikson et al (1986) state that individuals never truly leave behind struggles they have dealt with in the past, it is not surprising to see older adults revisiting intimacy versus isolation. Older adults face issues of intimacy and isolation as their friends and loved ones pass away, limiting their intimate relationships. They must revisit this stage as they attempt to form new relationships in an attempt to avoid isolation. In the nursing home setting this is particularly difficult due to separation, chronic illness, cognitive impairments, and a limited availability of possible partners. Using this theory as a framework behind this study emphasizes the importance of positive caregiver attitudes

towards resident relationships and sexuality in order to minimize the barriers residents face in forming intimate relationships.

This study will look at attachment through a developmental standpoint. It will explore the attitudes of nursing home caregivers regarding the sexual behavior of their residents. Exploration of the participants' attitudes towards sexual behavior in their clients will give insight to practitioners on where more education about late life sexuality may be necessary in order to ensure dignity and satisfaction in future generations of nursing home residents, and to minimize barriers that residents face in forming healthy, intimate relationships.

Methods

Research Design

This study investigated the question: what are the attitudes of nursing home caregivers towards the sexual behavior of nursing home residents'? This question is interesting because as the older adult population grows, the issue of resident rights in the nursing home setting, including rights to sexuality and intimate relationships, will be more visible. The current method of addressing sexual behavior in nursing home is often demeaning to the resident and often does not respect the individual's rights. Increased knowledge of what current caregiver attitudes are towards resident sexuality will allow for specific education regarding sexual behavior and resident rights. To answer the question a quantitative research design involving a cross sectional survey of nursing home caregivers (specifically, nursing assistants) at three different facilities was performed. A cross sectional survey focuses on a cross section of a population at one point in time (Monette, Sullivan, & DeJong, 2008). The survey asked participants questions about their demographic characteristics and their attitudes toward the sexual behavior of the residents in the facilities in which they work.

Sample

The sample is comprised of 54 nursing assistants currently working in three nursing homes in a Midwestern metropolitan area. A nursing home or skilled nursing facility is an institution that provides rehabilitation and various medical and nursing procedures. Approximately 20 participants were be sampled from each facility. The number of participants varied based on how many of the sampled caregivers chose to participate in the survey. The administrative staffs of approximately 30 nursing homes in

the metropolitan area were contacted via email requesting permission for a survey to be performed and three agreed to participate in the study (See Appendix B for consent letters). Surveys were completed in the facilities that agreed to participate. Facilities were found through the Care Options Network. The Care Options Network is an information resource for senior care professionals. The network collects information on care providers such as hospitals, clinics, skilled nursing facilities, assisted living facilities, independent senior housing, home care services, adult day services, hospice care, care management services, community agencies, medical equipment providers, mental health services, physicians, respite care providers, parish nurse programs, conservators and guardians, elder law attorneys, therapy services, and transportation (Care Options Network and Volunteers of America of Minnesota, 2011).

Protection of Human Subjects

In order to protect those completing the survey this study was reviewed by the Institutional Review Board at a Midwestern university. No identifying information was obtained in the survey about the individuals or about the facility where they are employed. Consent was implied by completion of the survey as stated in the consent form which appeared at the beginning of the survey. There were no risks or benefits to this survey.

Data Collection

The survey was created by the researcher using questions adapted from AARP's Sexuality and Relationship Study (2009). In August of 2009, Knowledge Networks, under contract to AARP, administered a survey about sexual attitudes and practices. Questions for this study were chosen from that survey based on the questions subject

matter (attitudes as opposed to practices) and the questions ability to be altered to address those working with older adults, rather than the older adults themselves. The original survey questions were written to be answered by the older adults themselves and cover a much more extensive range of topics including sexual behavior, sexually transmitted diseases, attitudes towards relationships, health questions, and financial questions. Many of these topics do not apply to this particular research study and therefore questions were chosen if they were relatable to the current subject. The questions were then adapted to change the subject of the questions from the participant to the older adults with whom the participant works. The AARP Sexuality and Relationship study questions have been pre-tested for reliability and validity in their original form. The adapted questions have not been tested and so the reliability and validity cannot be guaranteed.

Of the seventy questions on the original study (AARP, 2009), eighteen were chosen to be adapted for this study, and questions to obtain sample demographics were added, making the survey a total of twenty two questions long. The questions adapted for use in this study address importance of their residents' sexual relationships and activity, enjoyment of residents in sex, purpose of sex, cultural views of sex, frequency of resident sexual activities, and whether protection against sexually transmitted infections should be available. Each of them will be scored using a Likert scale. Question 23 consists of the scale score of the likert scale matrix that the researcher will complete upon analysis of the data. The scale is a sum of the scores on questions 1 through 18 which address attitudes towards nursing home resident sexuality. Questions 5 through 13 Likert scales are reversed and were reverse scored for the scale score. A higher score on the scale score indicated an attitude of increased acceptance of sexual behavior in older adults. A lower

scale score indicated low acceptance of sexual behavior in older adults. Demographic questions included the participants gender, age, ethnicity, and how many years they have worked with older adults.

Approximately 30 nursing homes in a Midwestern metropolitan area were contacted via email requesting if they would participate in the survey. Those who gave permission, had surveys distributed by the researcher to the nursing assistants who have agreed to participate when approached by their facility. The directors of the facilities gathered a group willing to participate in the survey. This researcher invited the participants to participate at a staff meeting. The researcher read the prepared script inviting participation and consent. Each participant was given a cover letter along with the survey explaining the survey's purpose and explaining the voluntary and anonymous nature of the study. The participants were given the survey to complete and the researcher exited the room while it was being completed. Participants who chose not to participate were instructed to scribble on the survey and turn it in to maintain the anonymous nature of the study (See Appendix A). Participants will place their completed or scribbled on surveys in a manila envelope, which were collected when all participants had completed the survey.

Data Analysis

Variables. Descriptive statistics were run for all demographic information including ethnicity, age, number of years worked and gender. Frequency distributions were used to describe the distribution of ethnic and gender within the sample. Measures of central tendency were used to describe the distribution of age and number of years worked with

older adults. Results were displayed in bar charts and histograms. Measure of central tendency were used to describe the distribution of attitudes among the participants by using the attitudes scale score in question 23, as described above.

Research Question One. The first question this study addressed is “Is there a difference in the attitudes of nursing home caregivers towards the sexual behavior of nursing home residents based on the worker’s age?” The independent variable was age while the dependent variable was their views on sexuality based on the perception scale scores in the survey.

The variable of age was operationalized by question 19, which read “Please indicate your age” with a space for the participant to fill in his or her age. The variable of attitudes towards sexuality was operationalized by the attitudes scale score in question 23, described above.

In order to examine the relationship between the two variables, a correlation was performed on the data collected. Based on the research presented in the literature review, it was hypothesized that there would be a connection between age of the worker and their view of older adult sexuality, with older workers reporting more acceptance of nursing home residents’ sexuality than younger workers.

Research Question 2. The second question this study addressed is “Is there a difference in the attitudes of nursing home caregivers towards the sexual behavior of nursing home residents based on the worker’s gender?” While the literature review did not comment on the effect of gender on perceptions of older adult sexuality, there was research covered on gender difference on sexuality as a whole, which suggests there is no significant

difference between the genders and their attitudes towards sexuality (Wilson, S.M., 1990). The independent variable was gender while the dependent variable was their views on sexuality based on the perception scale scores in the survey.

The variable of gender was operationalized by question 22, which reads “Please indicate your gender” with choices of male, female, transgendered or intersex. The variable of attitudes towards sexuality was operationalized by the attitudes scale score in question 23, described above.

In order to examine the relationship between the two variables, an ANOVA test was performed on the data collected. Given this information, it was hypothesized that the data will support the findings of previous research and gender will not have a significant effect on attitudes towards sexuality.

Research Question 3. The third question this study addressed is “Is there a difference in the attitudes of nursing home caregivers towards the sexual behavior of nursing home residents based on the worker’s ethnicity?” The independent variable was ethnicity while the dependent variable was their views on sexuality based on the perception scale scores in the survey.

The variable of ethnicity was operationalized by question 20, which read “Please indicate your ethnicity” with choices of African American, African, Asian, Hispanic or Latino, White, Native Hawaiian or Pacific Islander, and American Indian or Alaska native. The variable of attitudes towards sexuality was operationalized by the attitudes scale score in question 23, described above.

In order to examine the relationship between the two variables, an ANOVA test was performed on the data collected. Although the literature did not discuss the effect of ethnicity or race on attitudes towards sexuality in older adults, it was hypothesized that there will be no significant difference on attitudes towards nursing home residents between various ethnicities.

Research Question 4. The fourth question this study addressed was “Is there a difference in the attitudes of nursing home caregivers towards the sexual behavior of nursing home residents based on how many years the participant has worked with older adults?” The independent variable was number of years worked while the dependent variable was their views on sexuality based on the perception scale scores in the survey.

The variable of number of years worked was operationalized by question 21, which read “Please indicate how many years you have worked with older adults in various settings” with a space for the participant to write in the number of years. The variable of attitudes towards sexuality was operationalized by the attitudes scale score in question 23, described above.

In order to examine the relationship between the two variables, a correlation was performed on the data collected. The literature review did not address the effect of length of employment in the field on attitudes of sexuality in nursing home residents. It was hypothesized that length of employment based on years will have a positive effect on the participants attitudes towards sexuality in nursing home residents.

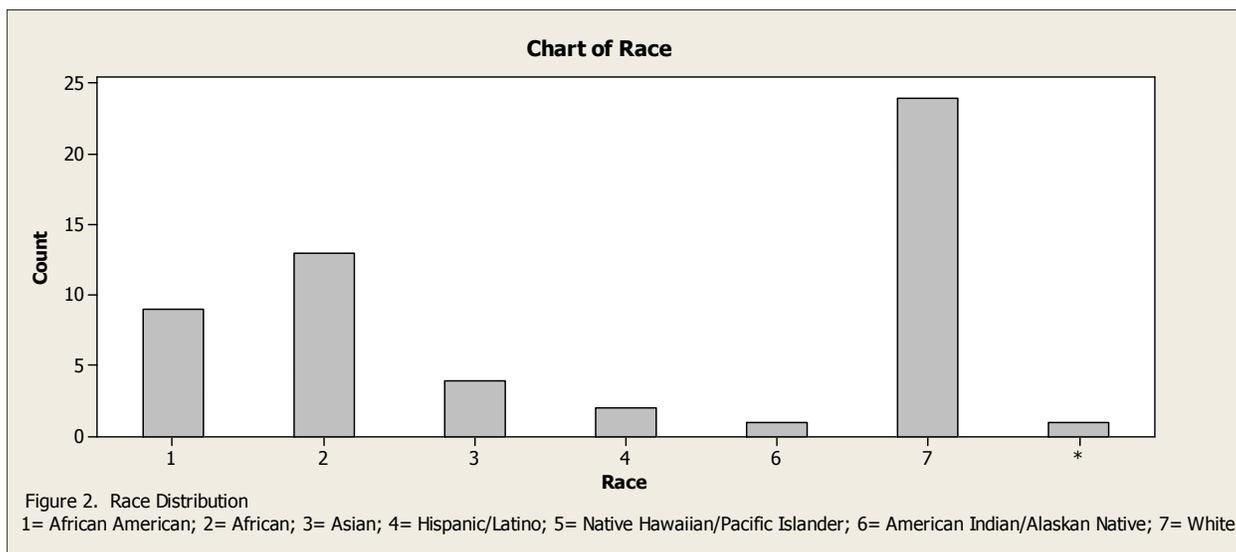
Strengths and Limitations

There are limitations and benefits to any research performed. The largest limitation is that the questions adapted for this survey and this collection of questions have not been tested for validity or reliability. Despite them being pulled from a tested survey, the changes in the questions' wording, order of the questions, and selection of questions most likely has a large impact on the reliability and validity. More limitations that this survey proposes is that this format does not include participants who may be illiterate, or unable to read in English. Those who choose to participate are more likely open about sexuality which will skew the results. This study is being conducted with a very small sample in a metropolitan area of a Midwestern state, which impacts whether or not the results would be generalizable to the public.

Along with limitations, however, there are several benefits to this study. The population of America is aging and about twenty percent will be composed of adults over 65 by 2030 (Howden & Meyer, 2011). With advances in medicine and technology, people are living longer. Many of these adults will at some point need nursing care whether it be in-home, at an assisted living, transitional care, or long term care. It is important for those receiving these services feel safe and free from judgment. Determining what current attitudes are towards older adult sexuality among nursing home caregivers (in this particular study, nursing assistants) provides a clue as to where more education and training may be needed, and where society is as a whole regarding the issue.

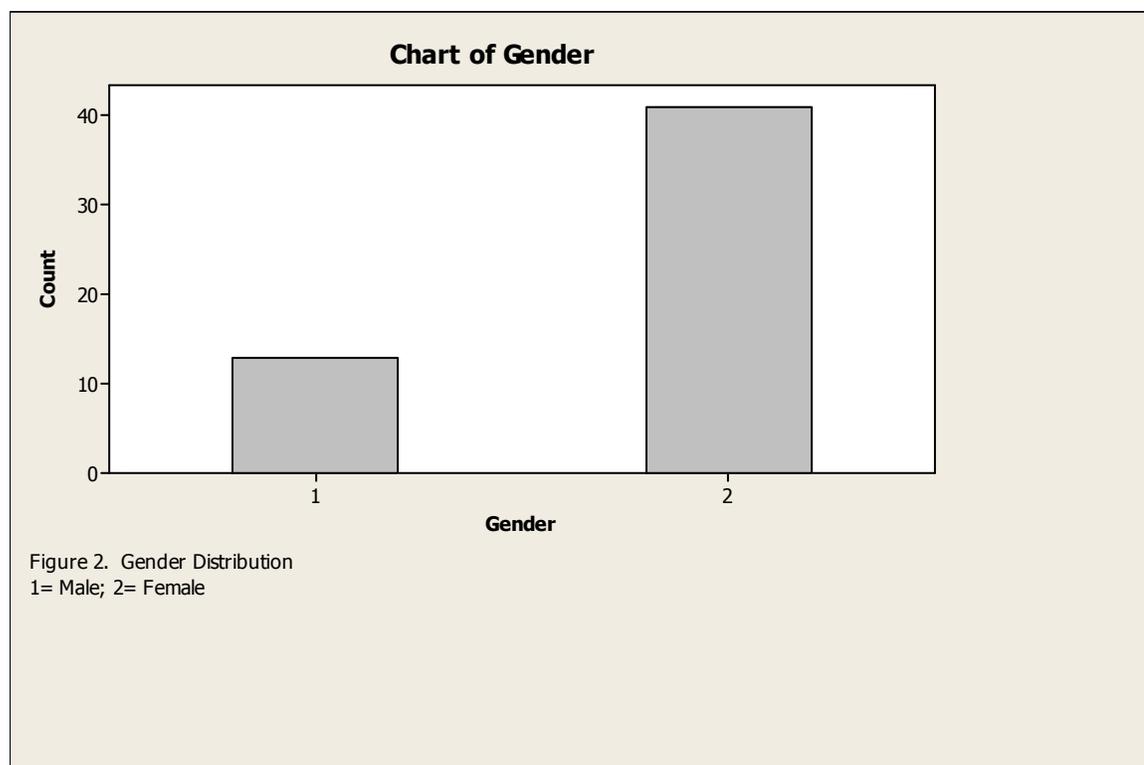
Findings

This survey was distributed at three nursing homes in a Midwestern metropolitan area to fifty four nursing assistants. It strove to examine the question of “what are nursing home caregivers attitudes towards nursing home residents’ sexual behavior?” The survey presented various statements regarding older adult sexuality of which the respondent rated their level of agreement or disagreement. The responses to these statements were then compared against the respondent’s gender, race, age, and the number of years he or she has worked with older adults. The total sample included thirteen males and forty-one females (Figure 1). This breakdown is reflective of an over-abundance of female caregivers in these particular settings.



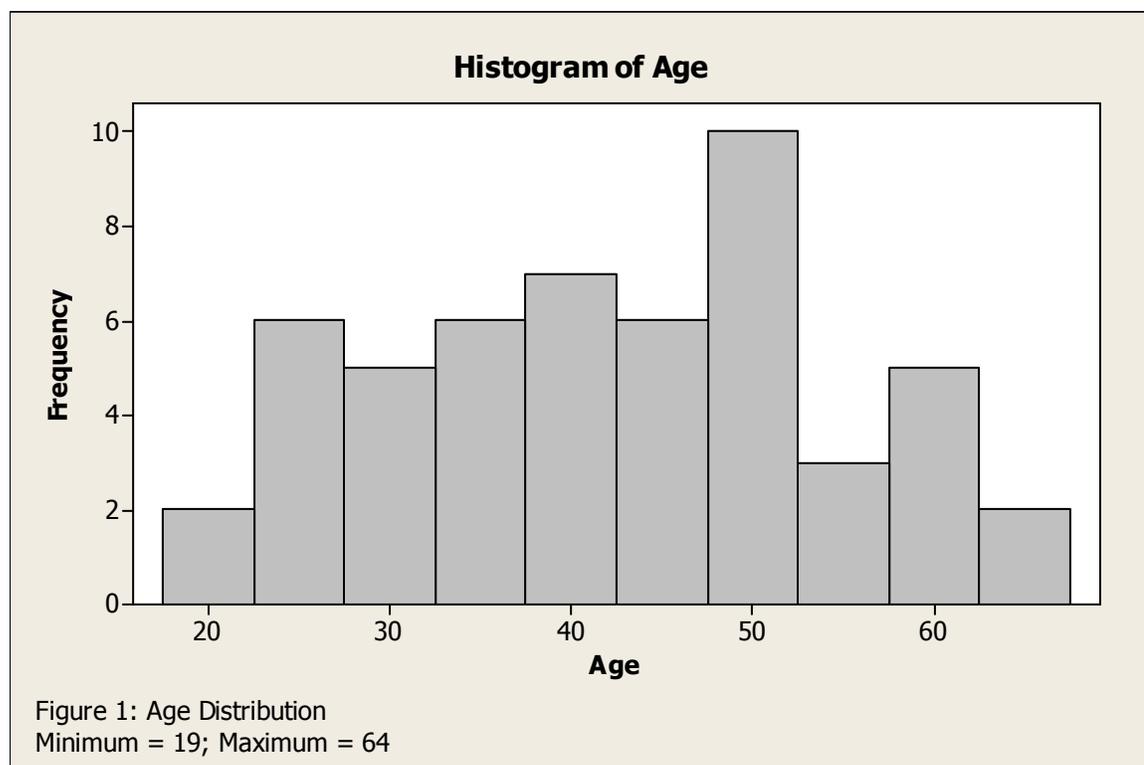
Distribution of race/ethnicity was fairly diverse, although the majority of respondents were white with 24 respondents with the second most prominent being caregivers who were African American with 13 respondents, caregivers who were African came in third

with nine respondents; there were four caregivers of Asian descent, and one individual who was American Indian/Alaskan Native (Figure 2).



Age. The total number of participants in this study was 54. Two of those participants declined to respond to this question. Of the 52 respondents, the mean age was 41.65 with a standard deviation of 11.84. The median was 42.50 with a range of 19 to 64. In the first quartile, 25% of the respondents were between the ages of 19 and 32.50. In the second quartile, 25% of the respondents were between the ages of 32.50 and 42.50. The third quartile shows that 25% of respondents are between the ages of 42.50 and 48.75, while the fourth quartile shows that 25% of the respondents were between the ages of 48.75 and 64 years of age.

The histogram in Figure 3 shows that the distribution of the responses resemble normal distribution with the data slightly negatively skewed.



Years Worked. There were 54 respondents of whom three declined to answer this question. Of the 51 respondents, the mean number of years worked with older adults was 13.22 with a standard deviation of 10.20 years. The median was 11 years with a range of one to 34. In the first quartile, 25% of the respondents worked with older adults between 1 and 4 years. In the second quartile, 25% of the respondents indicated having worked with older adults between four and 11 years. The third quartile shows that 25% of respondents estimated working with older adults between 11 and 20 years, while the fourth quartile shows that 25% of the respondents indicated having worked with older adults between 20 and 34 years.

The histogram in Figure 4 shows that the responses were positively skewed.



Attitudes toward Sexual Behavior Scale Score. Of the 54 respondents, the mean attitude score was 3.256778 with a standard deviation of 0.48099. The median was 3.277778 with a range of two to 4.61111. In the first quartile, 25% of the respondents had a score between two and three. In the second quartile, 25% of the respondents had a score between three and 3.25678. The third quartile shows that 25% of respondents received a score between 3.25678 and 3.48611, while the fourth quartile shows that 25% of the respondents received a score between 3.48611 and 4.61111. The concentration of the data is in the second and third quartiles.

Research Question One. The first question this study addressed was “Is there a difference in the attitudes of nursing home staffs towards the sexuality of nursing home

residents based on the worker's age?" The study hypothesized that the participants age will be associated with their views on sexuality based on the perception scale scores in the survey.

Based on the research presented in the literature review, it was hypothesized that there would be a connection between age of the worker and their view of older adult sexuality, with older workers reporting more acceptance of nursing home residents' sexuality than younger workers. In order to examine this relationship, a correlation was performed on the data collected. The result of the correlation was a relationship of 0.128 with a p value of 0.366, indicating there is no correlation between the two variables and that the finding is not significant.

Research Question 2. The second question this study addressed is "Is there a difference in the attitudes of nursing home staffs towards the sexuality of nursing home residents based on the worker's gender?" The study hypothesized that the participants gender will not be associated with their views on sexuality based on the perception scale scores in the survey. In order to examine the relationship between the two variables, an ANOVA test was to be performed on the data. However, the participants of the survey identified themselves of two of four variables, and therefore, a t-test was performed on the data collected instead due to there only being two variables to analyze, rather than four. The data revealed that there is no significant difference between the genders which supports the hypothesis. The mean score for males was 3.174 while the mean for females was 3.283, with a p-value of 0.573.

Research Question 3. The third question this study addressed is “Is there a difference in the attitudes of nursing home staffs towards the sexuality of nursing home residents based on the worker’s ethnicity?” The hypothesis was that ethnicity would not have an effect on nursing assistant attitudes.

In order to examine the relationship between the two variables, an ANOVA test was performed on the data collected. The data supported that there was no significant difference between ethnicities and attitudes toward the sexual behavior of residents as the ANOVA test revealed a p-value of 0.739.

Research Question 4. The fourth question this study addressed is “Is there a difference in the attitudes of nursing home staffs towards the sexuality of nursing home residents based on how many years the participant has worked with older adults?”

In order to examine the relationship between the two variables a correlation was performed on the data collected. The study hypothesized that there would be a significant difference in attitudes of nursing home caregivers towards resident sexual behavior with an increase in accepting attitudes (higher scale score) the longer he or she has worked with older adults. The result of the correlation was a relationship of 0.210 with a p value of 0.139, indicating a slight correlation but one that is not significant, between length of time worked with older adults and attitudes toward sexual behavior in their resident (see Figure 6.)

Discussion

This study aimed to examine the differences in nursing home caregivers attitudes towards sexual behavior in their residents based on gender, age, ethnicity, and the number of years the caregiver has worked with the elderly population. Overall the results were not statistically significant and did not point to attitudes towards sexual behavior being influenced by any of these factors. This is contrary to evidence presented in the literature which suggested a more negative viewpoint towards sexual behavior in nursing home residents.

When testing age of the respondent against the attitudes, no significant correlation was found. It was thought that there would be a correlation showing that as age increases, sexual behavior in elderly residents would increase as well. This was thought to be true because of similar life-stage and acceptance of sexual behavior in those who are closer to being peers. Research has shown that society tends to have a negative viewpoint towards sexual expression in late adulthood (Miles & Parker, 1999; Reingold & Burros, 2004; Skultety, 2007).

Society's message to adults is that sex is for younger people, although they consider their sexuality as a positive aspect in their lives (Aizenberg, Weizman, & Barak, 2002; Skultety, 2007). This societal message has influenced how older adults feel about their own sexuality, causing feelings of shame when the individual desires sexual activity. Those who are closer in age to the residents and still experience healthy sexuality were thought to have more positive attitude toward sexual behavior in older

adults. Since there was no significant correlation, it is questionable whether that assertion is true.

Next, a comparison was made between genders and attitudes towards sexual behavior. It was hypothesized that there would be no significant difference. This was supported, much as the literature had suggested. Wilson, S.M. (1990) lent evidence to suggest that there is no significant difference between genders in regards to attitudes towards sexuality, which was supported by the data received from nursing home caregivers.

When the respondents' race was compared with their attitudes score, it was predicted that there would be no significant difference between races and their attitudes towards sexual behavior. This was corroborated by the data collected, though the diversity of the sample was limited. The literature review did not present any evidence for or against the hypothesis.

Finally, this study looked to see if there was a correlation between the number of years a caregiver worked with the population and their attitudes toward sexual behavior. It was hypothesized that the more experience the caregiver had with the population, the more open they would be toward sexual behavior in their residents. Instead, it was found not to have an effect. There was no literature found on this topic and therefore none presented in the literature review.

As stated in the literature review, there are strict policies surrounding sexual behavior in nursing homes. Miles and Parker (1999) and Reingold and Burros (2004) presented evidence that sexual behavior in the nursing home setting is unwelcome and

frowned upon to the point of serious interventions when it occurs (restrictive clothing, restraint, separation, etc.). The neutral results of the survey are not consistent with an unwelcoming attitude.

While the results of this particular study were not significant, the subject warrants further study due to the evidence suggested in the literature review that attitudes towards resident sexual behavior tend to be strongly negative. The study was a small scale survey that surveyed caregivers from only three facilities within a Midwestern metropolitan area. In order to be reasonably confident that there is no differences in attitudes toward sexual behavior when looking at ethnicity or gender, and no correlation when looking at age and number of years worked, a larger scale study needs to be performed. This larger scale study would need to include not only urban and suburban areas, but also rural areas, and be spread across the country.

There were multiple problems with the survey that presented during analysis of the data. There were two questions in particular that provided difficulty with analysis. The first question was question five, which stated “Sexual activity is a duty to one’s spouse/partner.” It is possible to interpret this question in two different ways, and determining whether to reverse code the responses or not was tricky. On one hand, if reverse coded, the question becomes more about free will and choice to participate in sexual activity rather than it being duty. On the other hand if the question is coded as is, it focuses on the necessity of sexual activity in a healthy relationship between two people.

Another question that provided some difficulty was question number fourteen which read “How do you think your residents would rate their level of sexual desire?”

The difficulty with this question presented with validity. Is this question testing what it is meant to? The intended interpretation of this question was for the respondents to rate how the residents would rate the level of their desire for sexual activity. This could be misinterpreted as how their residents would rate how desirable others find them. These two interpretations are very different and could significantly alter how the respondents answer the question. This significantly impacts the validity of that question.

It was discussed earlier that this particular survey has not been tested for validity and reliability due to the alterations made on the questions. Before performing this survey again, this survey should be tested for reliability and validity to ensure significant results.

Future Research

Further research in this area could include several other variables which may impact a person's attitude towards sexual behavior. These variables include the respondent's religion, social economic status, and political affiliation. Religion and political affiliation especially coincide with particular viewpoints towards sexual behavior. It would also be prudent to examine the attitudes of administrative staff in nursing homes. The administrative staffs are the ones who develop the rules dictating proper behavior in residents, and the consequences for breaking these rules. So despite the attitudes of the direct caregivers, the policies of the nursing homes are mostly created based on the attitudes of those in upper management. Finally, it would be interesting to examine the difference in attitudes in nursing home social workers and the nursing staff. It would also

be pertinent to examine views of those working with the older adult population in other capacities such as in assisted living facilities or in home nursing care.

Implications for Social Work

As discussed in the literature review, current nursing home policies are often very restrictive and hinder residents' potential for developing close, intimate relationships that the residents desire. Residents have a right to pursue relationships that improves their quality of life, as the need to have a physical connection with another person is a basic but powerful human need that lasts throughout the lifetime (Reingold & Burros, 2004). The ambiguous results of the survey may indicate the need for an education program that speaks to different ages, races, genders, etc. in order to educate all nursing home caregivers regarding issues of older adult sexuality.

Beyond education, it is the duty social workers to work towards protecting dignity and worth of the person as well as maintaining their self determination regarding their sexual activity (National Association of Social Workers, 2008). Restricting and denying the residents' relationships and sexual encounters diminishes their self-determination, and implementing consequences such as restrictive clothing and separation is undignified. To follow the code of ethics education, restructuring of policies, and awareness of attitudes must be implemented.

Conclusion

The results of this study did not point to any significant differences across ages, races, genders, or length of time worked with the population, however, there is still many areas this field of study could explore. It is important to consider the residents dignity and self-determination when thinking about whether or not to place restrictions on the residents' rights to sexual relationships with others. The literature review indicated that current policies and procedures in many nursing homes are restrictive and demeaning to residents. Many of the reasons behind the policies is to keep the residents safe from sexual exploitation, especially if they are not cognitively able to make safe decisions, and to keep the nursing home from being liable if unwanted sexual relationships happen or if a relationship goes sour. There needs to be a balance between maintaining the rights and self determination of the residents and keeping them safe as well. More research in this area could prove critical.

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Appendix A: Cover Letter and Survey

Dear Participant,

You are invited to participate in a research study investigating differences in attitudes of nursing home staffs towards the sexuality of nursing home residents. This study is being conducted by a student in the Masters of Social Work program. Your facility was contacted via the Care Options Network and asked to participate in this survey. You were selected as a possible participant in this research because of your position as a nursing assistant within the facility. The purpose of this study is to examine the differences in attitudes towards sexuality in the nursing home setting with regards to age, race, gender, and the number of years worked in the elder care field. There will be approximately 60 participants.

To ensure confidentiality, no identifying information will be collected during the survey. Any information obtained in connection with this research study that could identify your facility will be kept confidential. In any written reports or publications, no one and no facility will be identified or identifiable and only group data will be presented. I will keep the research results in a password protected computer and only I and my advisor will have access to the records while I work on this project. I will finish analyzing the data by May 19th, 2012. I will then destroy all original reports and identifying information that can be linked back to you or the facility you work for.

If you decide to participate, you will be asked to fill out a 22 question survey about attitudes towards sexuality of your nursing home residents. This survey should take no more than 15 minutes to complete. There are no risks or benefits to participating in this study. Participation in this research study is voluntary. Your decision whether or not to participate will not affect your future relations with the facility you work for or the university in any way. You may choose to refuse any question if you so choose. If you decide to participate, you are free to stop at any time without affecting these relationships, and no further data will be collected. Your consent is implied by your completion of this survey.

If you have any questions, please feel free to contact me. You may ask questions now, or if you have any additional questions later, the faculty advisor will be happy to answer them. If you have other questions or concerns regarding the study and would like to talk to someone other than the researcher(s), you may also contact the chair of the Institutional Review Board.

Thank you for your participation!

Nursing Home Staffs Attitudes Regarding Sexuality of Nursing Home Residents

Section A: Please Circle Answer of Best Fit.

1. How important do you think it is to your residents to have a satisfying sexual relationship?

1	2	3	4	5
Not Important			Extremely	
Important				

2. How important do you think it is to your residents to have a good relationship with a spouse or partner?

1	2	3	4	5
Not Important			Extremely	
Important				

3. Sexual activity is important to my residents overall quality of life.

1	2	3	4	5
Disagree Strongly		No Opinion		Agree Strongly

4. Sexual activity is a critical part of a good relationship.

1	2	3	4	5
Disagree Strongly		No Opinion		Agree Strongly

5. Sexual activity is a duty to one's spouse/partner.

1	2	3	4	5
Disagree Strongly		No Opinion		Agree Strongly

6. Sexual activity is a pleasurable, but unnecessary, part of a good relationship.

1	2	3	4	5
Disagree Strongly		No Opinion		Agree Strongly

7. Sex becomes less important to people as they age

- | | | | | |
|-------------------|---|------------|---|----------------|
| 1 | 2 | 3 | 4 | 5 |
| Disagree Strongly | | No Opinion | | Agree Strongly |
8. I do not think my residents particularly enjoy sex.
- | | | | | |
|-------------------|---|------------|---|----------------|
| 1 | 2 | 3 | 4 | 5 |
| Disagree Strongly | | No Opinion | | Agree Strongly |
9. I think my residents would be happy never having sex again.
- | | | | | |
|-------------------|---|------------|---|----------------|
| 1 | 2 | 3 | 4 | 5 |
| Disagree Strongly | | No Opinion | | Agree Strongly |
10. Sex is only for younger people.
- | | | | | |
|-------------------|---|------------|---|----------------|
| 1 | 2 | 3 | 4 | 5 |
| Disagree Strongly | | No Opinion | | Agree Strongly |
11. People should not have a sexual relationship if they are not married.
- | | | | | |
|-------------------|---|------------|---|----------------|
| 1 | 2 | 3 | 4 | 5 |
| Disagree Strongly | | No Opinion | | Agree Strongly |
12. There is too much emphasis on sex in our culture today.
- | | | | | |
|-------------------|---|------------|---|----------------|
| 1 | 2 | 3 | 4 | 5 |
| Disagree Strongly | | No Opinion | | Agree Strongly |
13. Sex is primarily for procreation.
- | | | | | |
|-------------------|---|------------|---|----------------|
| 1 | 2 | 3 | 4 | 5 |
| Disagree Strongly | | No Opinion | | Agree Strongly |
14. How do you think your residents would rate their level of sexual desire?
- | | | | | |
|-------------|---|---------|---|------|
| 1 | 2 | 3 | 4 | 5 |
| Nonexistent | | Neutral | | High |
15. How frequently do you think your residents have sexual thoughts, fantasies or erotic dreams?

1	2	3	4	5
Never		Occasionally		Daily

16. How many of your residents do you think are now engaged in sexual behavior?

1	2	3	4	5
None		About Half		All

17. How satisfied do you think your residents are with the frequency of sexual activity they engage in?

1	2	3	4	5
Unsatisfied		Neutral		Very Satisfied

18. Methods of protection (condoms, dental dams) should be available to residents should they wish to participate in sexual activity.

1	2	3	4	5
Disagree Strongly		No Opinion		Agree Strongly

Section B: Demographic Information

19. Please indicate your age. ____

20. Please indicate your ethnicity.

- a. African American
- b. African
- c. Asian
- d. Hispanic or Latino
- e. Native Hawaiian or Pacific Islander
- f. American Indian or Alaskan Native
- g. White

21. Please indicate how many years you have worked with older adults in various settings. ____

22. Please indicate your gender.

- a. Male
- b. Female
- c. Transgendered
- d. Intersexed

23. (For researchers use only) Attitudes Scale Score (Questions 1-18; Note: Questions 6-13 are reverse coded.

24. (For researchers use only) Case #: