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The Effects of Geriatric Sexual Orientation on Caregiver Reactions to Resident Sexual Behavior Within Long-Term Care Facilities

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THE EFFECTS OF GERIATRIC SEXUAL ORIENTATION ON CAREGIVER REACTIONS TO RESIDENT SEXUAL BEHAVIOR WITHIN LONG TERM CARE FACILITIES

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ABSTRACT

The Effects of Geriatric Sexual Orientation on Caregiver Reactions to Resident Sexual Behavior within Long Term Care Facilities

Andrew J. Ahrendt Minnesota State University, Mankato, 2014.

Within the paucity of literature regarding older adult sexuality, a larger dearth exists concerning biases of long-term care facility staff toward gay and lesbian older adult residents. Prior literature has documented that LGBT (lesbian, gay, bisexual, and transgender) individuals' perceive that they do not receive the same quality of care as that of heterosexual individuals within long-term care facilities. Thus researchers aimed to evaluate whether these biases truly exist within care facilities that can prevent holistic care from being comprehensively provided to everyone regardless of sexual orientation. 153 residential care facility staff members from two separate facilities read one of three vignettes. Each vignette described a scenario in which a staff member walks in on two residents engaging in sexual activity. Residents' gender was manipulated in the three vignettes (male/female, male/male, female/female). Following this, participants completed two questionnaires assessing their views toward older adult sexuality, as well as their opinions on how well the staff member responded to the situation. Although no main effects were discovered for vignette type, exploratory analysis yielded that the facility where participants were employed was significantly related to their levels of situation approval. Along with this main effect, an interaction effect was discovered between vignette and facility type with caregivers' situational approval level. More specifically, Facility 2's mean values were significantly higher (indicating less staff member approval) for the male/female and female/female vignettes as compared to Facility 1's vignette approval ratings. Researchers did not confirm their hypothesis that male/male relationships would be stigmatized, but postulate that this could be reflective of the preponderance of male residents in facility 2. Furthermore researchers believe that the significant main and interaction effects discovered are indicative of overall pathologizing of older women's sexuality as lower approval rates for women existed across both facilities.

DEDICATION

Dedicated to my loving family and friends who pushed me to do the hard stuff, the stuff that is worth doing, and who believed in me before I believed in myself.

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INTRODUCTION

Though sexual functioning may decrease with age (largely due to contributing physical health factors including disease, injury, or side effects of medication), sexual interest and sexual activity may not. This notion was supported by a recent study that focused on identifying the prevalence of aging individuals' (57 to 85 years of age) sexual activity in relation to variables of age and health status, using a national probability sample of 3,005 United States adults (Lindau, et al., 2007). Although a potential limitation to this study is that sexual activity was classified as being strictly based on genital-to-genital contact, overall relative frequency of sexual activity was found to be similar across individuals' lifespan with men and women. Specifically, older adult respondents who were more sexually active were similar to sexual activity rates reported for adults 18 to 59 years of age according to the 1992 National Health and Social Life Survey (NHSLS). These results supported prior research by Bretschneider and McCoy (1988), showing that present sexual behavior amongst older adults 80-102 years of age was significantly correlated to prior levels of sexual interest.

Furthermore, the 25-year longitudinal study conducted by Busse et al., (1985) found that interest in sex and sexual activity continues into old age. Supplementing these findings, a 2005 American Association of Retired Persons (AARP) survey composed of 1,400 respondents reported that 24% of females and 30% of males between the ages of 60 and 70 had engaged in sexual relations at least once a week (Jacoby, 2005), and roughly 56% and 74% of married females and males at or above the age of 60 reported being sexually active (Diokno, Brown, and Herzog, 1990). Similar results have been documented within the media, as a *Parade* magazine survey of 1,604 adults 65-97 found that 40% had engaged in sex an 2.5 times per month (Clements, 1996).

Although these studies are limited in the fact that they may be lacking scientific integrity, they nonetheless illustrate that older adults are not only interested in sexual activity, but also actively engaging in it to a higher degree than is often perceived. Furthermore, it is important to understand that although the previously listed literature makes evident the fact that older adults are interested in sexual activity, these studies strictly used genital contact as criteria for sexual contact to have occurred.

Understanding how older adults view, as well as define sex is essential for long term care facilities and staff members to meet residents' social, biological, and psychological needs, and to ensure that quality, holistic care is provided. Although an overall dearth of research exists regarding older adult sexuality, numerous studies have documented that older adults still have sexual desire, and regard sexuality as an important part of their lives, but often do not view sexual activity as being solely constrained to intercourse. For example, the importance of touching and caressing increased in sexual value while the frequency and importance of sexual intercourse after the age of 80 did not (Bretschneider & McCoy, 1988). The importance of sexuality amongst older individuals cannot be disregarded as 49% of women, and 69% of men reported that sex is important within their lives (Clements, 1996), and into their later years as older adults above the age of 80 self-reported having expressed high sexual desire (DeLamater & Sill, 2005).

Although society's tolerance of sex, sexuality, and sexually explicit material has continually increased over the years, with the prevalence of sex in the media, on the internet, and on television, society's understanding of sexuality is still lagging. Rather than viewing sex as a multifaceted aspect of an individual's personality that encompasses their sexual beliefs, attitudes, values, behavior, and knowledge throughout their lifespan (SIECUS, 2014), society has commonly constrained sexuality to its biological components. These interpretations medicalize human

sexuality and fail to consider or account for the psychological and social influences that compose sexuality (DeLamater & Sill, 2005). As a result of this view, older adult sexuality has become stigmatized, and society's views of what is acceptable have been constrained to the young. Reserving sexuality to being only for the young and fertile alienates older adults, and has left society susceptible to detrimental misconceptions toward this population.

Even though it has been empirically supported that older adults still value and enjoy sex, damaging ageist stereotypes toward sex and sexual activity are prevalent within long-term care facilities, often leading to older adults believing their sexual desires are abnormal (Doll, 2012, p. 22). Statements such as the one made by a nursing home administrator in which he stated, "This is Kansas, we don't have any sexual orientation here" are detrimental not only to the residents, but to staff members as ignorant, unfounded negative biases can arise and easily become accepted by staff members as well as other residents (Doll, Bolender, & Hoffman, 2011). This thought that not only sexual orientation, but sexuality in general is absent within nursing homes was not supported by Doll et al., (2011) as almost all of the 90 nursing home administrators polled during a 2009 study examining the prevalence of sexuality within nursing homes acknowledged that at least some sexual activity was occurring on a frequent basis.

While not all facility staff have such an avidly unfounded and biased approach toward the prevalence of sexuality as the Kansas administrator quoted above, a main obstacle still exists regarding the contradictory nature between theory and practice. As most nursing home staff and administrators recognize that older adults have sexual desires and needs, but do not find offering support for these needs to be important (Wasow & Loeb, 1979). Furthermore, a Kansas State University Center survey revealed that staff members' views toward sexual expression among residents were largely negative, and viewed as an anomalous issue that should be corrected (Doll,

2012, p. 46). The implementation of such methods as isolation, relocation, or the use of medication to deter sexual activity amongst residents is not only detrimental to residents overall wellbeing, but an infringement upon residents personal rights (Doll, 2012, p. 54-55; Parsons, 1995). Staff decisions to implement such approaches can result in overall lower quality of life, and even declines in resident overall health (Roach, 2004).

Furthermore, it is well known amongst medical professionals that older lesbian, gay, bisexual, and transgender (LGBT) individuals are subject to and often face ageism, as well heterosexism within long term care facilities. Schatz and O'Hanlan (1994) reported that two-thirds of doctors and medical students had knowledge of prejudices and biases in the caregiving provided to LGBT individuals, with almost 90% reporting through questionnaires that they had heard disapproving remarks made by medical professionals in regard to these individuals. Furthermore, Heaphy, Yip, and Thompson (2003) found only 35% of LGBT individuals believed that health professionals have positive attitudes toward homosexuality, and 73 % of LGBT survey respondents stated that they believe LGBT individuals are discriminated against within medical facilities based on their sexuality (Johnson, Jackson, Arnette, & Koffman, 2005). Thus it is easy to understand why a 2006 MetLife survey found that only 14% of older LGBT adults felt it was okay to be open about their sexuality when entering into a long-term care facility (MetLife, 2006). Whether discrimination is real or perceived, it is not necessarily the issue here. Simply having LGBT individuals believe they are not receiving the same level of care as heterosexuals is distressing and emotionally damaging for this population (Bennet & Thompson, 1980; Doll, 2012, p 166-167; Schatz & O'Hanlan, 1994).

Ensuring that holistic care is provided for these individuals is more important than ever before as the geriatric population is the fastest growing segment of the United States population

and is estimated to comprise 20% of the United States total population by 2030 (Federal Interagency Forum on Aging-Related Statistics, 2010). Along with sheer populace, the baby boomer cohort brings a new openness to ideas vastly differing from previous geriatric generations. Baby boomers are less reserved, less modest, and more open to and tolerant of change, and new ideas. Being that the baby boomers have lived during times of growing acceptance of less conservative sexuality (Robinson, 2002), experts hypothesized that more LGBT individuals will be more comfortable with coming out, and staying out into their older years. As a result of this it is expected that the LGBT census will increase as individuals are presumed to be more sexually open as they enter long-term care facilities (Doll, 2012, p. 159). Specifically, Cohen, Curry, Jenkins, Walker, and Hogstel (2008) estimated that roughly 120,000 to 300,000 older LGBT adults will reside within nursing homes by 2030. Thus it is essential that the prevalence of these biases be assessed within these facilities now in order to develop an empirically founded direction for the future improvement of long-term care, and its relationship with LGBT older adults. This process is vital in creating a positive environment, in which all people are welcome, and holistic health care is truly provided to all individuals no matter their sexual identity or orientation.

Purpose of Study

Due to the fact that prior literature has documented that LGBT individuals perceive they do not receive the same quality of care as that of heterosexual individuals within long-term care facilities, researchers aimed to evaluate whether these biases truly exist within care facilities that can prevent holistic care from being comprehensively provided to everyone regardless of sexual orientation. The current study will assess the prevalence of detrimental caregiver beliefs in order to gain an understanding of the extent that these biases exist, as well as the nature, and common factors involved within the composition of bias within these facilities. If bias is found, future

research can focus on developing and implementing informational sexuality education programs within these facilities in order to improve an ethical standard of care for all older adult residents' sexual needs.

Researchers primarily hypothesize that staff members will display less favorable attitudes regarding sexual behavior amongst older adults overall, and this will be evident by overall lower mean values on the General Attitudes Questionnaire. Second, researchers believe that same-sex sexual behavior will be stigmatized significantly more than heterosexual sexual behavior, and as a result of this, overall mean scores on the Case Vignette Questionnaire will be higher for individuals that received the vignettes in which the interaction was male/male (Appendix B2) and female/female (Appendix B3) as compared to the male/female vignette (Appendix B1). Specifically researchers believe that the male/male vignette (Appendix B2) will be approved of the least, followed by the female/female vignette (Appendix B3) due to established societal norms.

CHAPTER 2

METHODS

Participants

Data was collected from 153 residential care facility staff members located in the Midwestern United States. Participants consisted of long term care facility employees and were recruited from two separate Midwestern based facilities. Facilities were selected based on prior openness to research projects conducted by Minnesota State University's Department of Psychology. Inclusion criteria for the study did not limit participants by job type, but rather only required that a worker's job must involve the potential of interacting with residents on a daily basis within the facility. The participants' ages ranged from 20 to 80 (*M*=44.02 years, SD=13.27), and had an average 15.18 years (SD=11.28) of experience working with older adults and 13.87 years (SD=10.15) working within long-term care. The sample was composed of 125 self-identified females and 9 self-identified males. Regarding sexual orientation, 100 participants identified themselves being heterosexual, 2 participants identified as being gay/lesbian and 3 participants described themselves as bisexual. The ethnic identity of our sample was composed of three ethnic categories with Caucasian (n=126) making up the vast majority of participants, followed by African American (n=14), and Hispanic (n=1) participants. Please refer to Tables 1 and 2 for more demographic information.

Procedures

Due to the varying nature of the procedures used in Facility 1 compared to Facility 2, each procedure will be described independently from each other. Also, in order to protect

the anonymity of each facility, exact bed counts were not provided for either Midwestern based facility.

Facility 1

Facility 1 is a religiously affiliated facility that serves over 500 older adults through residential, short-, and long-term care services on a daily basis. Prior to conducting research at Facility 1, researchers met the facility's administrators to discuss the best manner in which to reach a majority of employed caregivers. Facility 1 participants were recruited to participate in the study by briefly informing staff members about the nature of the study at the beginning of a regularly scheduled staff meeting. Participants were informed that participation within the study was completely voluntary, anonymous, and independent of their work. Following the researchers' brief study description, the facility administrators conducting the staff meeting reiterated the voluntary and anonymous nature of the data collection. After the completion of each staff meeting, questionnaire packets (Appendix A-F) were distributed to all willing participants in the room. Consent to participate within the research experiment was obtained from each participant by placing the informed consent form (Appendix A) at the beginning of the packet. This form briefly educated individuals as to the purpose of the study, specific information about the study including, and also included a brief statement informing participants that by continuing on to the survey, participants were affirming they had read, understood, and were consenting to participate in the study.

Facility 2

Facility 2 was a public residential facility that provided care services to approximately 300 older adults on a daily basis. One week prior to data collection, the

researchers composed a paper-sized poster that was hung in various locations around the facility briefly discussing the nature of the research project. This recruitment method was recommended by the facility. Participants were given the opportunity to partake in the study following their individual team meetings that were held throughout the day on a unit-to-unit basis. Team meetings consisted of all caregivers of a particular care unit, and all caregivers were required to participate in team meetings prior to the start of their shift. Researchers informed workers about the study during team meetings and caregivers were allowed to participate at the completion of each team meeting prior to starting work on their unit. Participants were informed that participation within the study was completely voluntary, anonymous, and independent of the facility in which they worked. Following the researchers' brief study description, the facility administrators conducting the team meeting reiterated the voluntary and anonymous nature of the data collection.

After the completion of each staff meeting, questionnaire packets (Appendix A-F) were distributed to all willing participants in the room. Consent to participate within the research experiment was obtained from each participant by placing the informed consent form (Appendix A) at the beginning of the packet. This form briefly educated individuals as to the purpose of the study, specific information about the study including, and also included a brief statement informing participants that by continuing on to the survey, participants were affirming they had read, understood, and were consenting to participate in the study.

Although individual procedures slightly differed for each facility, administration of the questionnaires was held constant across both settings and involved random distribution of questionnaire packets to participants. Questionnaires were placed in a random order

through the use of a random number generator that consisted of three numbers (one for each of the vignette conditions). Although questionnaires were equally sequenced, participant's withdrawal from the experiment following reading the consent form influenced the frequency that each condition was represented. This can be seen by the unequal amount of vignettes competed across both facilities (Table 1).

Materials

Questionnaire Packet (Appendix A-F)

The questionnaire packet administered to consenting participants consisted of an informed consent form (Appendix A), one of three brief case vignettes (Appendices B1, B2, and B3), followed by a case vignette questionnaire (Appendix C), a general attitudes questionnaire (Appendix D), a demographics form (Appendix E), and a debriefing form (Appendix F).

Informed Consent Form (Appendix A)

The informed consent form briefly educated individuals as to the purpose of the study, and specific information including a) the average length of time it took to complete the packet (10-15 minutes), b) the minimal risk of participating in the study, c) the absence of personal benefit or compensation related to participating in the study, d) the voluntary nature of participating, and e) the researchers' contact information. Additionally, the document stated that by continuing on to the survey, participants were affirming that they had read, understood, and were consenting to participate in the study. Since it would have been the only document linking the participants to the study, signed consent forms were not collected in order to maintain participant anonymity.

Case Vignettes (Appendices B1-B3)

All case vignettes depicted a scenario in which a female staff member (Stacy) entered a resident's room (resident A) in order to make sure the resident was all right, since she did not receive a response after knocking on the door. Upon entering the room, the Stacy noticed the resident was not alone in his/her bed, and was engaging in sexual activity with another resident (resident B). After witnessing this situation, Stacy apologized for her intrusion, and left the room closing the door behind her.

Participants were randomly assigned one of three vignettes to read. The independent variable that was manipulated was the gender of the residents within each vignette. Thus the three possible vignettes that participants could receive differed based on resident A and resident B's gender with the three separate conditions being male/female (Appendix B1), male/male (Appendix B2) and female/female (Appendix B3). These vignettes were modeled after an educational vignette found within the book *Sexuality & Long-Term Care*, (Doll, 2012) that was written in order to teach individuals on how to avoid inappropriate reactions to resident sexuality.

Case Vignette Questionnaire (Appendix C)

The Case Vignette Questionnaire assessed staff members' views on whether or not the staff member within the vignette (Stacy) acted appropriately within the situation. The questionnaire asked participants to circle the response that most closely resembled the level of agreement they had in relation to specific statements relating to the case vignette (e.g., "After witnessing the sexual activity, Stacy responded in a professional manner"). Response options were on a 5-point, Likert-style scale with the anchors, *Strongly Agree* to

Strongly Disagree. The questions used were devised from prior measures used to evaluate caregivers' perceptions of the appropriateness of late-life sexuality.

General Attitudes Questionnaire (Appendix D)

The General Attitudes Questionnaire measured staff members' attitudes toward older adult sexuality, and consisted 6 questions from the Attitude Questions subscale of the Aging Sexual Knowledge and Attitudes Scale (ASKAS). This subscale was selected for this study as it is designed to measure general attitudes toward sexual activity in older adults. Researchers chose to use 6 of the 26 questions that compose the subscale rather than all of the 26 questions in order to keep the questionnaire succinct. Questions were selected based on the fact that they either strictly relate to older adults sexuality in general or the acceptance of older adult sexuality within a care facility.

Hammond (1979), as well as White and Catania (1981), used the ASKAS measure within the context of a sexual education program for professionals who work with older adults (caregivers), and found that significant changes occurred in participants' attitudes becoming more permissive from pre-test to post-test for individuals who received educational intervention compared to the control group.

The reliability of the ASKAS was found to be very positive and at acceptable levels for the Attitude Questions subscale (26 items; $\alpha = .87$), as well as the test-retest reliability ($r = .72$, $n = 30$) for nursing home staff and families of older adults. Although reliability of these specific questions were not directly assessed, researchers do not see this as a weakness due to the split-half reliability ($r = .86$, $n = 163$) for nursing home staff members.

The questionnaire evaluated participants' attitudes by having them circle the response that most closely resembled the level of agreement they had in relation to older

adult sexuality (e.g., "Institutions, such as nursing home, and long-term care facilities ought not to encourage or support sexual activity of any sort in their residents"). Similar to the Case Vignette Questionnaire, response options were on a 5-point, Likert-style scale with the anchors, *Strongly Agree* to *Strongly Disagree*.

Demographics Form (Appendix E)

The demographics form assessed participants' age, race/ethnicity, gender, sexual orientation, occupation, number of years working with older adults, and the number of years and months they had worked in long term care. All questions used an open-ended question format in which participants could write in their own answers. Forced choice questions included relationship status (*single, casually dating [no committed partner], partnered [boyfriend, girlfriend, significant other, fiancé, etc.], legal partnership [married, civil union],* and *other* [fill-in response option]), level of agreement that religion is very important in their life (*strongly agree* to *strongly disagree*), whether they had received staff training regarding handling sexual situations (*yes* or *no*), and if so than did this training occur within the past year (*yes* or *no*).

Debriefing Form (Appendix F)

The Debriefing Form educated participants that the purpose of the study was to ascertain whether biases exist toward same-gender and opposite-gender older adult sexuality. The form provided contact information for the researchers, thanked participants for partaking in the study, and asked them to not share their experience of taking the study with others in order to ensure unbiased, accurate results from other participants.

Table 1
Descriptive statistics of participants age, importance of religion, and years of work history.

	Facility 1		Facility 2	
	Mean	Std. Deviation	Mean	Std. Deviation
Age	42.69	14.35	45.26	12.14
Importance of Religion	2.09	1.07	2.10	1.19
Years Working with Older Adults	13.97	10.94	16.26	11.54
Years Working in Long-Term Care	11.12	8.46	15.36	10.72

*Religion was scored using a Likert scale with lower scores indicating higher levels of importance within an individual's life

Table 2

Descriptive frequency and percent statistics for race/ethnicity, gender, sexual orientation, and relationship status by facility.

		Facility 1		Facility 2		Both Facilities	
		Frequency	Percent	Frequency	Percent	Frequency	Percent
Race/Ethnicity							
	White	65	92.9	61	73.5	126	82.4
	Black	1	1.4	13	15.7	14	9.2
	Hispanic	1	1.4	0	0	1	0.7
	Missing	3	4.3	9	10.8	12	7.8
	Total	70	100.0	83	100.0	153	100
Gender							
	Male	7	10.0	12	14.5	19	12.4
	Female	62	88.6	63	75.9	125	81.7
	Missing	1	1.4	8	9.6	9	5.9
	Total	70	100.0	83	100.0	153	100.0
Sexual Orientation							
	Heterosexual	44	62.9	56	67.5	100	65.4
	Homosexual	0	0	2	2.4	2	1.3
	Other	0	0	3	3.6	3	2.0
	Missing	26	37.1	22	26.5	48	31.4
	Total	70	100.0	83	100.0	153	100.0
Relationship Status							
	Single	8	11.4	16	19.3	24	15.7
	Casually Dating	2	2.9	5	6.0	7	4.6
	Partnered	15	21.4	14	16.9	29	19.0
	Legal Partnership	40	57.1	39	47.0	79	51.6
	Other	3	4.3	1	1.2	4	2.6
	Missing	2	2.9	8	9.6	10	6.5
	Total	70	100.0	83	100.0	153	100.0

CHAPTER 3

RESULTS

The total data set consisted of 153 caregivers with 70 participants being gathered from Facility 1 and 83 from Facility 2. Case Vignette Questionnaire (CVQ) and General Attitudes Questionnaire (GAQ) mean values were calculated using standard relative mean procedures in order to account only for the number of responses provided by each participant as opposed to deflating overall mean values by treating missing values as zeroes.

A univariate analysis of variance test was run in order to assess whether a significant difference existed between vignette type (B1, B2, and B3), and mean value of the CVQ. Levene's test revealed that the assumption of homogeneity of variances was violated ($F = 5.1$, $p = .007$). As such degrees of freedom were adjusted to compensate for this violation using the Brown-Forsythe robust *F* value. The main effect of the vignette type and the mean value of the CVQ were not significant using a critical alpha of .05 (F (2, 121.77) = 1.18, $p = .31$). This means that no significant difference was found between the type of vignette participants read and their mean amount of agreement that they felt on the CVQ.

A second univariate analysis of variance test was used to evaluating whether a significant difference existed between the type of vignette (B1, B2, and B3), and the mean value of the GAQ. The main effect of the type of vignette and the mean value of the GAQ were found to be not significant using a critical alpha of .05 (F (2,151) = .002, p = .998). Thus no significant difference existed between the type of vignette that participants read and the amount of agreement they had on the GAQ.

Following this examination further exploratory analysis were examined in order to assess whether an effect existed between facility and vignette on CVQ and GAQ scores. A significant main effect was found between facility and CVQ using a critical alpha of .05 (F (1,150) = 6.86,

p = .01). This indicates that overall participants scores on the CVQ were lower for Facility 1 (μ = 2.17, SD = .76) as compared to Facility 2 (μ = 2.52, SD = .88). Furthermore a significant main interaction effect was discovered between facility and vignette type on CVQ using a critical alpha of .05 (F (2,150) = 3.28, p = .04). Specifically, Male/Female sexual activity approval rating on the CVQ was found to be significantly different across facilities t(46) = 3.95, p = .009. Please refer to Table 1 and Figure 1 for descriptive statistics.

Table 3

Descriptive statistics of case vignette questionnaire by facility and vignette.

Facility	Vignette	Case vignette Questionnaire		
		Mean	Std. Deviation	N
Facility 1	Male and Female	1.99**	.92	16
	Male and Male	2.28	.72	31
	Female and Female	2.23	.71	23
	Total	2.20*	.76	70
Facility 2	Male and Female	2.81**	1.01	32
	Male and Male	2.26	.69	30
	Female and Female	2.51	.82	19
	Total	2.53*	.88	81
Total	Male and Female	2.54	1.04	48
	Male and Male	2.27	.70	61
	Female and Female	2.36	.76	42
	Total	2.38	.84	151

Note.*p < .05, **p < .01

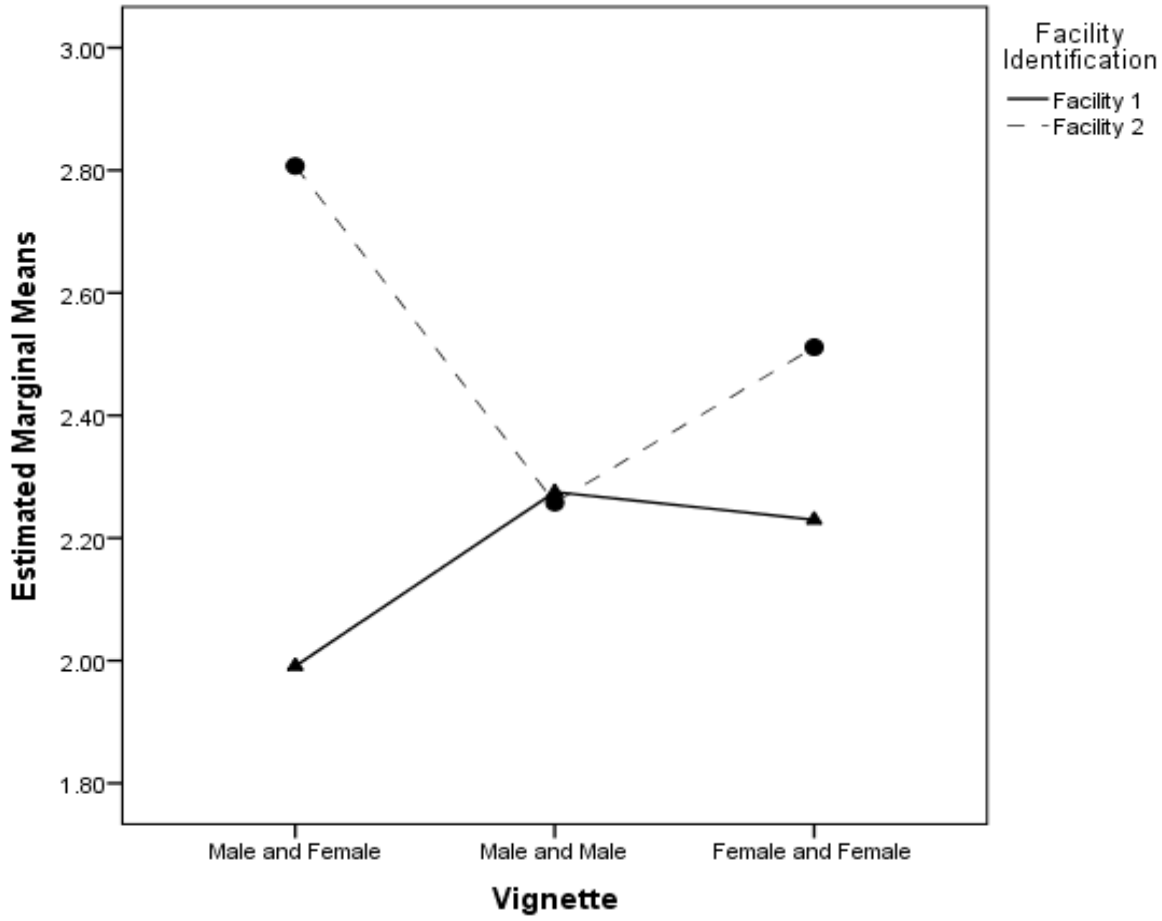

Figure 1. Case vignette questionnaire mean values by facility.

CHAPTER 4

DISCUSSION

This study contributes to the slowly growing, limited body of knowledge concerning sexuality biases within long-term care facilities. It examines the prevalence of staff knowledge of late life sexuality, as well as assesses whether staff members' attitudes differ regarding sexual interaction of individuals of varying sexual orientation. The results of our study elucidate that staff members' views toward sexuality in long-term care can be bidirectionally influenced by the facility in which they work, or the facility in which they seek employment. Researchers conclude that further investigation of LGBT LTC facility resident's perceived bias be conducted; in addition to evaluating staff members' training regarding older adult sexual health.

The results of this study demonstrate that overall, staff members ascribe to believing that older adult sexuality is acceptable, as a universal strong approval rating was found regarding the GAQ. Participants' approval scores of Stacy's actions across all vignettes were found to be lower, illustrating participants as a whole approved of Stacy's actions. Furthermore no significant differences were detected between the various vignette types when comparing all participants. This leads researchers to believe that participants' views did not differ based on the type of sexual interaction (Male/Female, Male/Male, and Female/Female) that was occurring within the vignette. These results are very positive from a holistic care approach as it appears that no bias is present regarding the sexual orientation of long-term care residents.

Investigators hypothesize that a potential explanation for the lack of agreement between the reported biases within the literature and results of the study could be a consequence of overt discrimination within LTC facilities, or inaccurate older LGBT resident perceptions. To elaborate, the discrepancy between participants' bias and the perceptions of LGBT older adults may be due to

micro-aggressions that staff members may not realize they are exhibiting. Such interactions may cause residents distress while concurrently not being evident in measures that rely on self-evaluation. Additionally, older LGBT residents' perception of caregiver bias may be resultant of prior life experiences. Due to experiencing a greater degree of discrimination throughout their lifetime, LGBT individuals may be more prone to interpreting interactions as being biased. As a result of this interpretation, it is important that all caregivers be aware of this perception, so that they may make take appropriate steps necessary (overcompensation, communication) to ensure that they are representing an environment that is welcoming. It is for these reasons that researchers recommend the nature of perceived discrimination be evaluated to a greater degree.

Upon further examination of the data, significant differences were found between the facility in which participants were employed, and their overall CVQ approval rating. Researchers hypothesize the significant difference between approval rating regardless of the type of vignette in which participants read could be attributed to participants' interpretations of what the questionnaire was asking, and greater prevalence of specific care types that were present within the facility.

Researchers believe the significant difference regarding participants' interpretations of what the questionnaire was asking could be responsible for the significant difference between overall approval ratings. Many participants from Facility 2 wrote in additional questions at the bottom or on the side of the CVQ, that were all directed toward the same theme of assessing whether either or both of the participants were able to provide consent to participate in the sexual act. For this reason, speculate that participants at Facility 2 may have assumed Stacy was also uncertain of the consent involved in the sexual act, and as a result, they were less approving of her overall actions. This could be reflective of the training that is emphasized within Facility 2 as

compared to Facility 1. Even though participants at Facility 1 on average wrote less additional material than those at Facility 2, researchers were unable to detect a common theme amongst these responses.

While no discernable difference is believed to be present within the overall competency of care providers across facilities, researchers hypothesize that Facility 2 places more of an emphasis on assessing whether individuals are able to provide consent, and are consenting to partake in sexual activity. Based on the researchers' observations within the facility, a greater emphasis was placed on dementia care within Facility 2. As a result, it appeared participants were more apt to consider whether or not Stacy had taken into account whether or not each individual within the vignettes was able to provide consent to engage in sexual activity. Subsequently, it seems that the combination of emphasizing that it is essential to assess residents' ability to consent rather than accepting it at their word could have caused participants to view Stacy's behavior as less acceptable.

Researchers did not confirm their hypothesis that male/male sexual activity would be stigmatized to a greater degree than other sexual interaction dyads across all participants. Additionally the male/male condition was rated the most similarly of all vignette types between both of the facilities (Facility 1 $\mu = 2.28$, SD = .72, Facility 2 $\mu = 2.26$, SD = .69). However, these results do not tell the entire story as the male/male vignette was accepted the least for Facility 1, and the most for Facility 2. Researchers postulate that these results could be indicative of two possible facility factors.

Regarding the higher amount of stigmatization within Facility 1, researchers believe the lower CVQ approval ratings for the male/male vignette can be resultant of the religious affiliation

of Facility 1. Being that Facility 1 has a Christian (specifically Lutheran) affiliation; researchers believe that it is more likely that staff members share these values as compared to staff members within a public facility. Researchers reason this is largely due to the commonly accepted traditional Christian based moral stance against homosexuality. CVQ approval ratings for Facility 1 were higher for the male/female vignette as compared to the other vignettes detailing same sex sexual activity. Further evidence of this effect can be seen by the significantly higher CVQ approval ratings for the male/female vignette for Facility 1 as compared to Facility 2.

Concerning the higher male/male approval rating that was present within Facility 2; researchers theorize this could be reflective of the preponderance of male residents within the facility. Due to the greater number of male residents within the facility, staff members were more apt to be exposed to the male sexual behavior, including male/male sexual behavior. Through this exposure, it can be hypothesized that participants are more likely to be accepting of this behavior. These results are reflected by the male/male vignette being the most approved, compared to the male/female and female/female vignettes within Facility 2.

Another potential explanation pertaining to the lesser degree of participant CVQ approval ratings for female sexuality could be due to the overall pathologizing of older women's sexuality, as lower approval rates for women existed across both facilities. Researchers contend that the reason sexual activity within these facilities was more prevalently viewed as negative when it involved a woman is because of the unfounded, but widely accepted social construct that older women are no longer interested in sexual behavior. Resulting from this belief, LTC facility workers viewed sexual activity as being less acceptable when it involved women as it was paired with the idea that it must be a result of something wrong occurring (non-consent, hypersexuality). This is resultant of socially accepted views that older women are not viewed as being as sexual as

older men, further supporting the social construct that sexual activity is no longer acceptable for older women as they no longer can reproduce.

Limitations

Potential limitations that were present within the current study include only sampling LTC facilities as compared to conducting research within short-term care, assisted living, or nursing home facilities. Additionally, researchers cite both LTC facilities were located within a smaller geographic region of the Midwestern United States and as a result, the overall generalizability of these findings is limited to this region. Furthermore, the overall demographics of participants within the study was composed of a majority of heterosexual Caucasian females, while it is common that a majority of staff members in LTC facilities are women, the other variables are not reflective of the population. Lastly, vignette types were not equally distributed amongst participants, or within facilities due to random distribution.

Implications

The results of this study warrant that research be conducted regarding older adults' perception of caregiver bias, in addition to further investigating caregivers' perceptions of older adults' sexual activity. By gaining a more thorough understanding of the nature of older LGBT adults perception of caregiver bias, researchers will be able to take steps to rectify the situation. Specifically, if it is a result of staff members' micro-aggressions, or residents' incorrect interpretation of actions being biased in nature, researchers recommend improving both staff and resident education within these facilities, as well as cultivating resident and staff communication improvement regarding this issue. Due to significantly lower overall CVQ approval scores being present within Facility 2 as compared to Facility 1, researchers believe that the nature of these ratings be further examined. If upon further review, it becomes evident that individuals were more

disapproving even after gaining knowledge that both residents were consenting to sexual activity, researchers recommend further researching the impact of a sexuality training protocol implemented in LTC facilities to ensure a universal standard of care for older adult sexual behavior, regardless of sexual orientation. Additionally, researchers believe researching the implementation of a sexuality training protocol within Facility 1 is warranted despite its significantly higher overall CVQ approval scores. This is due to Facility 1 having lower (although not statistically significant) approval ratings regarding vignettes describing lesbian and gay sexual activity.

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APPENDIX A

Informed Consent Document

You are invited to participate in a research study that will examine reactions to sexual activity among older adults in long-term care facilities. Dr. Eric Sprankle, a clinical psychologist and assistant professor at Minnesota State University, Mankato, and Andrew Ahrendt, a clinical psychology graduate student are conducting this study.

Background Information

The purpose of this research is to better understand the consistency of staff reactions to older adult sexual activity within long-term care facilities. This information may be useful for future research in developing staff training or education programs. All data collected will be used solely for this purpose.

Procedures

If you consent to participate you will be asked to read a vignette that generally describes a worker witnessing a sexual act. Following reading the vignette, participants will be asked to complete a survey inquiring about their thoughts regarding the appropriateness of the way in which the situation was handled. Lastly, participants will be asked to complete a brief survey about their general attitudes toward older adult sexuality. It is estimated to take 10-15 minutes to complete the surveys.

Risks and Benefits of Being in the Study

Despite the vague sexual nature of this study, there is minimal risk for participating, as this study is primarily focused on your reactions to how a staff member handles a situation within a long-term care facility. You may be concerned about disclosing personal information, but only non-identifying demographic data will be collected, and all of this will be kept completely anonymous with no way for the researchers to identify specific participants.

There are no personal benefits or compensation related to participation.

Confidentiality

The surveys are anonymous and participant responses cannot be traced to any identifying information. Only Dr. Eric Sprankle and his research assistants will have secured access to the raw data. The surveys will be stored in a locked cabinet in Dr. Sprankle's office for 7 years, after which they will be destroyed.

Voluntary Nature of the Study

Participation in this study is voluntary. Your decision whether or not to participate will not affect your current or future relationships with Minnesota State University, any of its affiliates, or the research team. If you decide to participate, you are free to withdraw at any time without penalty.

Contacts and Questions

If you have any questions, you are encouraged to contact Dr. Eric Sprankle (the principal investigator) at Minnesota State University, Armstrong Hall 23, 507-389-5825 or by email at eric.sprankle@mnsu.edu.

If you have any questions or concerns regarding this study and would like to talk to someone other than the researcher, or if you have questions/concerns about the treatment of human subjects, you are encouraged to contact the Dean of Graduate Studies and Research at Minnesota State University, Mankato, Dr. Barry Ries at 507-389-1242 via phone or at barry.ries@mnsu.edu via email.

Consent

By continuing on to the survey, you affirm that you have read and understood the above information and consent to participate. Please keep this page for you records.

APPENDIX B-1

Case Vignette

While at work Stacy, a staff member at (facility name*) knocked on an older adult resident's door. She did not receive a response, so she again knocked on the door. Once again she did not receive a response so she decided to enter the room. While walking into the room she was surprised to find that the resident was not alone in his bed. The older male resident was engaging in sexual activity with another older female resident

After realizing her intrusion Stacy immediately apologized and stated the reason she entered his room was to make sure he was ok. She then again apologized for her invasion of privacy and left the room, closing the door behind her.

APPENDIX B-2

Case Vignette

While at work Stacy, a staff member at (facility name*) knocked on an older adult resident's door. She did not receive a response, so she again knocked on the door. Once again she did not receive a response so she decided to enter the room. While walking into the room she was surprised to find that the resident was not alone in his bed. The older male resident was engaging in sexual activity with another older male resident

After realizing her intrusion Stacy immediately apologized and stated the reason she entered his room was to make sure he was ok. She then again apologized for her invasion of privacy and left the room, closing the door behind her.

APPENDIX B-3

Case Vignette

While at work Stacy, a staff member at (facility name*) knocked on an older adult resident's door. She did not receive a response, so she again knocked on the door. Once again she did not receive a response so she decided to enter the room. While walking into the room she was surprised to find that the resident was not alone in her bed. The older female resident was engaging in sexual activity with another older female resident

After realizing her intrusion Stacy immediately apologized and stated the reason she entered her room was to make sure she was ok. She then again apologized for her invasion of privacy and left the room, closing the door behind her.

APPENDIX C

Case Vignette Questionnaire

Directions: Please circle the response that most closely resembles your opinion on the case vignette you just read. Remember, your responses are anonymous.

1) After witnessing the sexual activity, Stacy responded in a professional manner.

Strongly Agree Agree Neutral Disagree Strongly disagree

2) After witnessing the sexual activity, I feel I would have responded in a similar manner as Stacy.

Strongly Agree Agree Neutral Disagree Strongly disagree

3) After witnessing the sexual activity, Stacy was ensuring the safety of the residents.

Strongly Agree Agree Neutral Disagree Strongly disagree

4) After witnessing the sexual activity, Stacy was ensuring the privacy of the residents.

Strongly Agree Agree Neutral Disagree Strongly disagree

5) After witnessing the sexual activity, Stacy was ensuring the sexual rights of the residents.

Strongly Agree Agree Neutral Disagree Strongly disagree

6) There was nothing morally wrong with what Stacy witnessed.

Strongly Agree Agree Neutral Disagree Strongly disagree

7) There was nothing unhealthy with what Stacy witnessed.

Strongly Agree Agree Neutral Disagree Strongly disagree

8) After witnessing the sexual activity, was Stacy following (facility name**) policy on sexual behavior? Yes No I don't know

9) If you believe the staff member (Stacy) did not respond appropriately, how should she have responded? Please write your response in the space below.

** Individual Facility names were used for each vignette

APPENDIX D

General Attitudes Questionnaire

Directions: Please select the answer that best fits your personal view toward each question. Remember, your responses are anonymous.

1) Aged people have little interest in sexuality. (Aged = 65 + years of age.)

Strongly Agree Agree Neutral Disagree Strongly disagree

2) An aged person who shows sexual interest brings disgrace to himself/herself.

Strongly Agree Agree Neutral Disagree Strongly disagree

3) Institutions, such as nursing home, long-term care facilities, ought not to encourage or support sexual activity of any sort in their residents.

Strongly Agree Agree Neutral Disagree Strongly disagree

4) Male and female residents of nursing homes ought to live on separate floors or separate wings of the nursing home.

Strongly Agree Agree Neutral Disagree Strongly disagree

5) Nursing homes have no obligation to provide adequate privacy for residents who desire to be alone, either by themselves or as a couple.

Strongly Agree Agree Neutral Disagree Strongly disagree

6) As one becomes older (say, past 65) interest in sexuality inevitably disappears.

Strongly Agree Agree Neutral Disagree Strongly disagree

APPENDIX E

Demographics Form

Directions: Please provide answers to the following demographic questions. Remember, your responses are anonymous.

1. Age_____

2. Race/Ethnicity_____

3. Gender_____

4. Sexual Orientation_____

5. Job position title_____

6. Years of experience working with older adults_____

7. Relationship Status:

    a) single

    b) casually dating (no committed partner)

    c) partnered (boyfriend, girlfriend, significant other, fiancé, etc)

    d) legal partnership (married, civil union)

    e) other_____

8. Religion is very important in my life.

    a) strongly agree

    b) agree

    c) neutral

    d) disagree

    e) strongly disagree

9. Have you received staff training regarding handling sexual situations?

Yes or No If so within the past year ? Yes or No

10. How long have you worked in long-term-care? _____ years _____months

APPENDIX F

Debriefing Form

The vignette that you read today was created and intended to be used to gather information regarding matters of sexual health in order to improve overall patient care. This study is attempting to ascertain whether biases exist against older adult sexuality, and specifically, gay and lesbian older adults. If you would like more information about this study, or would like to know the results when the study is complete, please let me know and I will give you contact information for the lead researchers. Although it is tempting to share your experiences with this study with others, I ask that you do not. Otherwise, we will not be able to obtain accurate, unbiased data. I greatly appreciate your cooperation in keeping your experiences with this study confidential. Thank you for your time and participation in this study.