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Attitudes about sexual intimacy in the Veterans Home of California-Barstow

Eric Efren Reyes

ATTITUDES ABOUT SEXUAL INTIMACY IN THE VETERANS HOME OF CALIFORNIA—BARSTOW

A Project

Presented to the

Faculty of

California State University,

San Bernardino

In Partial Fulfillment

of the Requirements for the Degree

Master of Social Work

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ABSTRACT

This study explored staff attitudes about sexual intimacy in the Veterans Home of California—Barstow (VHCB). A quantitative method was used to obtain this knowledge which consisted of 26 questions from the Aging, Sexual Knowledge, and Attitude Scale (ASKAS) (White, 1982). Participants were twenty-seven VHCB staff members.. The data collected were used for the purpose of understanding, and then formulating suggestions for implementing better institutional interventions and policy in the VHCB. Results of the study indicated a measure of permissive attitude exists among VHCB staff with respect to sexual intimacy. VHCB staff desire education and training with respect to sexuality and intimacy among the residents they serve. This implies guidelines are needed to help VHCB staff understand and deal with sexuality in a more positive and sensitive manner. The study also suggests VHCB administration and social work services could work in tandem to develop an institutional policy on sexual intimacy that would enhance the quality of life of VHCB residents.

ACKNOWLEDGMENTS

It is a pleasure to thank those who helped make this research possible. To my faculty advisor, Professor Rosemary McCaslin Ph.D., A.C.S.W., you are a true giant in the field of gerontology and social work education. You helped me to better understand the research material and the aspects of aging. Most importantly, you helped me to consider the beauty of experiencing my own and other's aging.

To Professor Thomas Davis Ph.D., you demystified the process of research methodology for me and helped me to clearly see that data can be relevant towards influencing institutional change.

To my colleague and friend, Allison Hixon who helped me to better understand using SPSS. Your display of patience and professionalism helped guide me through a variety of roadblocks and challenging situations.

Finally, I would like to thank and make special reference to Mr. William Rigole, S.L.C.S.W, who serves as the Chief Psychiatric Social Work Services Supervisor in the Veterans Home of California, Barstow. Without the institution, I could not have acquired the data.

DEDICATION

With love, I dedicate this work to my wife Genoveva, whose continued support, patience, and counsel helped me to complete it. To my sons Andrew, Eric, and Kevin, you inspire me daily to become more devoted to the well-being of others. To my parents Maria and Tony, and to my mother in law Angelita, I now see that if we manage to live long enough, we will have achieved the beautifully distinct honor of being elder.

I also dedicate this work to the entire staff of the Veterans Home of California—Barstow and especially to its current and future residents. Most importantly, to our elder veterans who honorably served their country, willingly to pay the ultimate sacrifice. You deserve to live in a place you can call home and trust that those who now serve you do so with resolute respect, understanding, and support of your well-being.

I love you.

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CHAPTER ONE

INTRODUCTION

Sex and sexual intimacy are considered activities of daily living (ADL) for aging and elder people. While frequency of sexual activity may decline as people age, it remains an important aspect of life (Sigelman, 1999). Social work practitioners are expected to help provide services to people in need and to address social problems (NASW, 2008). This research study is conducted with the intention of providing data about Veterans Home of California—Barstow staff attitudes that would reinforce and support contributions to social work effort at the micro and macro-level, including development of an institutional policy that sensitively addresses protecting the sexual rights and conjugal privacy of all its residents.

Problem Statement

Many people by the age of 65 or older have something or other wrong with their bodies. While colds and allergies tend to become less frequent with age, chronic diseases and disorders become more common (Hobbes, 1996). National Health surveys indicate more than 85% of the 65+

age group have at least one chronic impairment whether it is a sensory loss, a physical disability, or a degenerative disease (Sigelman, 1999). Notwithstanding, about 70% of people 65 and older report they are in excellent, very good, or good health (Hobbes, 1996). Moreover, relatively few say they need assistance with activities of daily living (ADL), though the figure climbs with age from 9% of those aged 65 to 69, to 50% of those aged 85 and older (Hobbes, 1996). Also, while chronic disease or disability tends to decrease an older person's sense of well-being, many people with arthritis, diabetes and other chronic issues, are no less content with their lives than anyone else (Sigelman, 1999). The majority of older people are able to retain their sense of well-being and ability to function independently notwithstanding an increased likelihood of impairment.

Sexual intimacy is an ADL and not typically ever addressed or included in treatment plans, especially in skilled nursing facilities where privacy is virtually non-existent. Moreover, sexual intimacy is a topic hardly discussed in nursing homes and it is suggested that some staff tend to become afraid or embarrassed to talk about sexual intimacy with the residents they serve (Smith,

2011). It is also suggested that nurses lack the skill or knowledge to at least refer the issue to social service practitioners, other nursing staff, physical therapists, and physicians. Smith (2011) suggests the problem should be treated in a multidisciplinary team approach when assisting the resident, for example, with such things as conjugal privacy, or, if they should require information to address such things as back pain, arthritis and sex. Or, for example, a multidisciplinary team approach could be used when addressing sexual positions after the patient has been released from hip surgery or is in a wheelchair, or may require a device to assist with a sexual position.

I was approached by the Chief Psychiatric Social Work Services Administrator (SWSS) of the Veterans Homes of California—Barstow (VHCB), to write a position paper with regard to geriatric sexuality and conjugal visitation. This request coincided with the timing of a social work department course requirement at California State University, San Bernardino to develop a policy proposal that could lead to institutional or organizational change.

We agreed to assist each other with these objectives. Under his direction, guidance and approval, an exploratory qualitative opinion survey was delivered to five Chief Psychiatric Social Workers of the Veterans Homes of California (VHC) asking if a policy on geriatric sexuality and conjugal privacy existed in their respective VHC institutions in Yountville, Lancaster, Chula Vista, Barstow, and Ventura. As a result all responded they did not have a policy on geriatric sexuality and conjugal privacy. Three of five provided their opinion about what elements they thought could be included in such a policy, compiled as follows: 1) Care plan for privacy; 2) Consideration of cognitive level of functioning; 3) Health status; 4) Privacy in a conjugal visitation location on-site; 5) Safe sex; 6) Staff training.

Purpose of the Study

The purpose of this study was to measure staff attitudes about sexual intimacy in the Veterans Home of California–Barstow (VHCB). Currently, a policy on sexual intimacy and conjugal privacy does not exist in the VHCB, but there is an interest in the formulation of such a

policy. Attitudes of health professionals who serve, work with, and who have an impact on the elderly residents of the VHCB, are worthy of measurement and study, if hypothetically, the data could yield useful analysis that may help influence sensitive formulation of an institutional policy on sexual intimacy in the VHCB.

This study is not about sexuality and aging per se, instead it purports to measure staff attitudes towards sexual intimacy in the VHCB. The VHCB provides housing for veterans including access to medical, dental, and psychiatric services in domiciliary, skilled nursing, and intermediate care facilities. These services are provided with the goal of enabling all residents to achieve their highest quality of life in an atmosphere of dignity and respect (CDVA, 2010).

The VHCB staff includes all people who work with the aging population who have an impact on their lives. (e.g. health care aides, nutrition services, housekeeping, registered nurses, clinical social workers, recreational therapists, physical therapists, a chief medical officer, psychiatrist, administrators, board representatives, a chaplain, volunteer coordinators, etc.).

In the VHCB domiciliary setting, residents live independently. Staff assist some residents who may have functional limitations but are otherwise able to perform activities of daily living (ADL) with only minimal assistance (CDVA, 2010). In the intermediate setting, residents require the assistance of intermittent licensed nursing assistance with their medications and treatments, and they generally require assistance with many of their ADL (CDVA, 2010). In the skilled nursing setting, residents are provided care on a 24-hour basis that is more comprehensive than intermediate care but less comprehensive than acute care. In this setting, staff provide residents with rehabilitation therapies, nursing, pharmaceutical, and dietary services. Additionally, staff provide residents with a memory care program which is focused on the supervised environment for veterans with symptoms of confusion, memory loss or for veterans who have difficulty making decisions, solving problems or participating in conversations (CDVA, 2010).

Significance of the Project for Social Work

VHCB Social Work Services would like to see a study measuring professional staff attitudes about intimacy in

the VHCB. Comparable aspects of the study exist in the private sector of resident care. However, policy with respect to sexual expression and intimacy in the VHCB does not exist. Fortunately, the comparable aspects of the literature are applicable to this fresh study of the public sector. For example, the selected literature contain generalizable constructs and premises as presented, and they are relevant because they allow for critique of individual, ethical, and philosophical assumptions in regard to sexual expression, privacy, and other considerations such as the task social workers are charged with addressing in the VHCB with respect to sexual intimacy.

This study would reinforce and support contributions to social work effort at the macro-level, including development of an institutional policy that sensitively addresses protecting the sexual rights and conjugal privacy of all residents of the VHCB.

At the micro-level, "sexual intimacy" theoretically could become operationalized as a construct in the resident-strengths portion of the Psychosocial History Evaluations (SHE) conducted by social workers. The SHE is where sensitive notes may be written regarding candid

discussion between the social worker and the resident about his or her sexual intimacy needs and/or history. These written discussions could then be used in consideration of a resident's individual and confidential care plan for treatment and discussed during the multidisciplinary team meetings (MDT).

This study measures staff attitudes about sexual intimacy in order to develop better individual resident care plans. Knowing staff attitudes about sexual intimacy may help social workers address care plan concerns during the assessment, planning, implementation, evaluation, and ongoing follow-up in accordance with the generalist intervention model. This study resolved the question as to whether a measure of permissive staff attitudes would help develop better and more sensitive resident care planning and that would help develop a more sensitive institutional policy in regard to resident's right to sexual intimacy and conjugal privacy.

CHAPTER TWO

LITERATURE REVIEW

Introduction

Researchers studied the attitudes of nursing facility professionals about the sexual intimacy needs of its residents. The selected literature, assumes sensitivity to differing opinions professional caregivers have about sexual intimacy, and with respect to residents with cognitive or physical disabilities. The literature also suggests that differing values exist among professional caregivers (Roper, Winifred, & Tiernay, 2000). These values are worthy of serious consideration in that they influence further discussion about future drafting of an institutional policy addressing the sexual intimacy needs of the population served in the Veterans Home of California—Barstow (VHCB).

Sex is an Activity of Daily Living

Literature suggests that sex is an activity of daily living (ADL) for many elderly people (Smith, 2011). One study indicates that frequency of sexual activity declines as people age, however, sex remains a very important part of life for older adults (Sigelman, 1999).

Smith, (2011) suggests that stakeholders such as social workers, doctors, clinicians, nurses, and non-clinical staff need to also be aware that in most cases, even if sexual activity declines, intimacy continues to grow as people age. Mental, emotional, and physical factors may play a role in the loss of desire for sex, companionship, and romantic expressions of intimacy, however, this may be more of an exception instead of the rule (Smith, 2011).

While elderly residents may not necessarily express their love and intimacy outwardly to other people, they still do things for each other as signs of loving affection and they will most likely not share what they feel with any of the above stakeholders unless they are prompted by them, through sensitive questions (Smith, 2011). For example, older women tend to find more difficulty encountering partners, and they actually outnumber men of the same age, and they tend to hold a sense of loyalty for their husbands or partners who have died. Men, however, tend to seek companionship and sexual desire in later life (Smith, 2011).

Additionally, researchers measured the views of caregivers in the private sector with respect to

residents' sexual expression. Results indicated that respondents generally held a positive orientation with respect to the cognitively and non-cognitively impaired (Holmes, Reingold, & Teresi, 1997). In contrast, while the sample reported an overall positive attitude towards resident sexuality, a problem exists because sexual expression is still denied at times or found to be unacceptable by some administrators who tend to hold a more conservative point of view (Holmes, Reingold, & Teresi, 1997).

In comparison, other literature suggested that nursing home staff tend to view the sexual needs of elderly residents as problematic rather than expressions of love and intimacy. For example, one qualitative study suggested staff tended to lack tolerance, or held negative and insincere attitudes towards the sexual expression of elderly residents while considering sexual behavior, especially among those with dementia as a major source of difficulty (Shuttleworth, Russel, Weerakoon, & Dune, 2010). Moreover, the study suggested disruptive sexual behavior became greater where staff lacked guidance or training. Their negative responses had implications about the "quality of care" the residents

were receiving (Shuttleworth, Russel, Weerakoon, & Dune, 2010).

Barriers and Staff Education

Another qualitative study measured nursing staff attitudes toward elderly resident sexuality. The study yielded an analysis that distinguished four common staff approaches to resident sexuality based on cultural, educational, religious background, and life experience (Roach, 2003). The four approaches were described as follows:

1. Standing Guard: This happens when staff, who would deny having their own uncomfortable feelings, would inevitably avoid addressing the sexual needs of anyone, consequently resulting in health decline of the resident. Moreover this attitude is typical in homes where resident sexuality is strongly discouraged (Roach, 2003).
2. Reactive Protection: This was comparable to the Standing Guard attitude, only the environment became one where resident's sexuality was encouraged. In order to avoid being perceived

as creating a barrier for resident's sexual expression, staff would instead use their own morals and religious or cultural values to suggest protecting the resident. This attitude became potentially more harmful because it was inconsistent and tended to place emphasis on enforcing the hidden moral agenda of the individual staff members (Roach, 2003).

3. Guarding the Guards: This happened when staff members offered approaches to resident sexuality that was not accepted by the nursing home which would enforce its own restrictive organizational standards (Roach, 2003). Staff inevitably would tend to guard the sexual desires of the residents against other staff members, in order to protect the intimacy rights of the residents (Roach, 2003).
4. Proactive Protection: This approach was considered as the best because management provided training on resident sexuality and educated staff members with strategies designed to help them respond to the issue of sexual intimacy with dignity, respect, and consistency

(Roach, 2003). This approach produced measurably positive outcomes both for the residents and the staff. Resident sexuality was not oppressed and staff became more comfortable when dealing with diverse sexual expressions, and with increased awareness and sensitivity.

One quantitative study partially validates the above "proactive protection" approach as being the best because it recognizes the need for staff education. The study suggested that dementia is more prevalent in nursing homes, and as a result, staff would tend to become alarmed whenever cognitively impaired residents expressed their sexuality (Mayers, 1998). The study was designed to determine the desire for training by nursing staff to effectively deal with sexually active elderly residents whom the majority had been diagnosed with dementia. It suggested that geriatric nursing staff received little or no specialized training to help residents deal with their sexual behavior (Mayers, 1998). The study also suggested training should focus on desensitizing staff so that they can talk about sex issues freely in order to gain information from the resident and his or her family (Mayers, 1998).

Intimacy is a Human Right

Another cross-sectional, within-study design measured the overall level of acceptability of sexual relationships among the elderly, including other factors that may alter acceptability (Esterle, Sastre, & Mullet, 2011). The researchers suggested that a majority of the participants considered sexual relationships acceptable regardless of age. Moreover, they considered sexual intimacy a probable human right not conditioned on the concrete circumstance of living in a nursing home, nor conditioned on a social circumstance limited to partners' marital status (Esterle, Sastre, & Mullet, 2011). The study indicated a minority (18%) believed acceptability was conditioned on privacy and another minority (25%) believed acceptability was conditioned on privacy and marital status (Esterle, Sastre, & Mullet, 2011). The study also suggested that nursing institutions must be expected to adapt to the sexual needs of the resident and not the other way around (Esterle, Sastre, & Mullet, 2011).

Privacy Regulations

Other literature suggests nursing home residents have a right to personal privacy, accommodations, medical treatment, written communications, personal care, visits, and meetings of family and resident groups (Doll, 2012, p. 185). Doll (2012) also suggests that the "Right to personal privacy" means residents have the right to privacy with whomever they wish, including the right to full visual, auditory, and, visits for other activities (p. 186).

Theories Guiding Conceptualization

The *Roper-Tierney-Logan Model of Nursing* (Roper, Winifred, & Tiernay, 2000), suggests that sex is an activity of living. This model affirms Smith's (2011) assertion that sex is an activity of daily living and it also places an emphasis on considering "health" as not merely an absence of disease, but as an opportunity to create well-being which includes maximizing human potential (Roper, Winifred, & Tiernay, 2000). This model is used as a basis for this study at the Veterans Home of California—Barstow.

One theory guiding this study is *Person and Environment in Social Constructivist Theory* (Kondrat, 2008). The constructivist perspective views individuals as impacted by a variety of dynamic meanings and processes that are used to make sense of their own environment, and that knowledge and reality are human constructs (Kondrat, 2008). This allows for a more qualitative and interpretive form of studying another's reality, from the perspective of their own environment. Human beings are instrumental in forming their own environment according to their own capacity and while larger macro structures do impact the individual, likewise individuals impact the structure of their own interpersonal micro reality (Kondrat, 2008).

The Veterans Homes of California are "macro environments" made up of their own constructs while professional caregivers, as well as the residents they serve, are "micro-realists" who actively participate in that environment. Professional caregivers are capable of influencing the constructs of that macro environment to better serve the needs of its residents. "Micro" and "Macro" are dynamically linked (Kondrat, 2008), therefore

the residents, their professional caregivers, and the institution are dynamically linked.

Another critical consideration regards the theory of *"Operationalizing" Person-in-Environment* (Kondrat, 2008). Social Work Services in the Veterans Homes of California conduct assessments of their residents utilizing psychosocial history evaluations to better understand individuals in their current environment, which includes a better understanding of their common problems as they exist in that environment. The assessment appears to emulate a Person-In-Environment (PIE) classification system used to code common population problems (Kondrat, 2008). The PIE looks at four basic factors:

1. Individuals problems in their social functioning
2. Problems in the environment which affect a person's problems
3. Mental health problems (using the DSM)
4. Health problems based on a medical model (Kondrat, 2008)

This researcher suggests that "sexual intimacy" could become operationalized as a construct in the resident-strengths portion of the psychosocial history

evaluations at the VHCB. The potential to have a discussion about sexual intimacy during a confidential resident interview is doable in the initial psychosocial history evaluation from a "strengths-based perspective."

Summary

Sex is an activity of daily living and is an important part in the life of the elderly (Sigelman, 1999) (Smith, 2011) (Roper, Winifred, & Tiernay, 2000). Staff tend to express a positive orientation toward sexual expression and they recognize a problem that sexual expression is denied at times by administration (Holmes, Reingold, & Teresi, 1997). In contrast, staff appear to lack tolerance with, and hold negative and insincere attitudes toward the sexual expression of elderly residents with respect to particular situations. Additionally, staff tend to consider sexual behavior, especially among those with dementia, a major source of difficulty (Shuttleworth, Russel, Weerakoon, & Dune, 2010). Staff require education or training that must include focus on desensitizing staff so that they could talk freely about sex issues (Mayers, 1998). Additionally, staff tend to agree sexual intimacy is

probably a human right not conditioned on whether a person resides in a nursing facility and not conditioned on marital status (Esterle, Sastre, & Mullet, 2011). All the above literature were selected because they contain generalizable constructs and premises as presented, and they are relevant because they allow for critique of individual, ethical, and philosophical assumptions in regard to sexual expression, privacy, and other considerations such as the task social workers are charged with addressing in the VHCB with respect to sexual intimacy.

CHAPTER THREE

METHODS

Introduction

This chapter discusses the study design which used the attitude portion of the Aging Sexuality Knowledge and Attitudes Scale (ASKAS) (White, 1982). This scale is useful for measuring the permissive and non-permissive attitudes of people who work with older persons, and any group of people who have any impact on them (p. 493). The population sample consisted of twenty-seven VHCB staff members who work directly with the aging residents of the VHCB and/or who have an impact on their lives. The section on Data Collection and Instruments will discuss reliability and validity of the instrument used to measure staff attitudes. The procedure for collecting the data consisted of providing and collecting a written questionnaire that consisted of 26 questions on a 7-point Likert scale and one descriptive question asking only for the participant's state staff title. Demographic questions (other than staff title) were avoided at the request of the VHCB institution in order to protect the participant from any possible identification. Otherwise,

permission for this study would not have been granted at the local level and would have been relegated to the state level. This chapter also includes a discussion on the protection of human subjects, voluntary participation, confidentiality, and a debriefing statement. Finally, the data may lend itself to permissive attitude-increased sexual activity relationships in the area of aging sexuality, and may present fertile ground for further study by social work practitioners and clinicians working with older persons with sexual intimacy issues.

Study Design

Research for this study was conducted using the attitude portion of the Aging Sexuality Knowledge and Attitudes Scale (ASKAS) (White, 1982). The ASKAS was designed for use with older persons, people who work with older persons, and any group of people who have an impact on the aged (p. 493). The ASKAS questions were designed to measure sexual attitudes and sexual knowledge through the use of items dealing with the age-related and non-age-related changes in sexuality and the context of sexuality for the aged (p. 493).

For the purpose of this quantitative study, only the attitude portion of the ASKAS were used consisting of 26 questions on a 7-point Likert scale as to the extent of agreement or disagreement with the stated question (p. 494).

This study answers the question as to whether a measure of staff attitude exists toward sexual intimacy in the Veterans Home of California—Barstow (VHCB). At the micro-level, the acquired knowledge may be useful towards exploring the development of better resident care planning for treatment at the VHCB. At the macro-level, the knowledge may be generalizable towards exploring a possible formulation of a sensitive institutional policy on sexual intimacy and conjugal privacy in the VHCB.

Sampling

The study sampling consisted of twenty-seven VHCB Staff (36%) from approximately seventy-five available. Participants comprised of a variety of state staff positions that worked directly with the aging resident population, and/or whom had a direct impact on their lives. These included non-licensed staff, nursing staff, and social work services staff which included the chief

medical officer who also serves as head of the social work services department.

Data Collection and Instruments

Non-licensed staff (N = 11), social work services staff (N = 7), and nursing staff (N = 9) of the Veterans Home of California–Barstow (VHCB), completed the attitude portion of the Aging Sexuality Knowledge and Attitude Scale (ASKAS) (White, 1982). The ASKAS was developed by Charles B. White in 1982 to measure knowledge and attitudes about sexuality. Twenty six questions measuring attitude are rated on a 7 point Likert scale where 1 means to "disagree" and 7 means to "agree."

A score closer to 1 could indicate a permissive attitude about sexual expression, meaning for example, that the participant had disagreed with statements such as "Nursing homes have no obligation to provide adequate privacy for residents who desire to be alone, either by themselves or as a couple." Or, for example, "Institutions such as nursing homes ought not to encourage or support sexual activity of any sort in its residents."

A score closer to 7 could also indicate a permissive attitude about sexual expression, meaning that the participant had agreed with statements such as "I would support sex education courses for the staff of nursing homes" or, for example, "Institutions such as nursing homes should provide privacy so as to allow residents to engage in sexual behavior without fear of intrusion or observation."

Reliability

The Aging Sexuality Knowledge and Attitude Scale (ASKAS) (White, 1982) is validated as reliable because a meta-analysis of other institutions with sample sizes of 15 to 279 yielded a reliability coefficient (alpha) score of > .90. All participants were those who work closely with elder residents or who impact their lives.

Validity

Internal validity of the Aging Sexuality Knowledge and Attitude Scale (ASKAS) (White, 1982) was validated by researchers who used a pre-test, post-test with an experimental control group. External validity could become questionable in that it is conceivable participants could have responded with a permissive

attitude contrary to their personal values, and more in union with their perception of what they believe ought be their professional attitude in accordance with professional values and/or the culture of the institution, or the culture of the institution where they were professionally trained.

Written permission to use the attitude portion of the ASKAS was not required, nonetheless, a reference is provided in Appendix A.

Procedures

Permission to collect data at the VHCB was given by the chief psychiatric social work services supervisor of the VHCB. The questionnaire (Appendix A) with a consent form (Appendix B) and debriefing statement (Appendix C) explaining the study was provided to the participants at the VHCB. Flyers (Appendix D) requesting staff participation in the staff break room were distributed and posted throughout the VHCB campus one week prior to the first day.

Two weeks prior, during stand-up meetings, the chief psychiatric social work services supervisor made announcements to other supervisors, administration, and

VHCB staff of other departments, that this researcher would be on campus in the staff break room those days to administer the survey and to collect the data.

Of approximately 75 available staff, 27 (36%) participated. Staff comprised of administrative, certified, registered, licensed, housekeeping, food service, office, and technical positions, and the survey was administered during two day shifts between 6:30am and 1:00pm.

Careful measure was taken to prevent any of the questionnaire surveys to float around the Veterans Home. This was done in order to protect the residents from seeing what some could have considered very sensitive questions related to them. Therefore, each survey was numbered and collected in that same order, in the staff break room. Staff were not permitted to take the survey outside of the staff break room.

Protection of Human Subjects

This study was conducted in accordance with the guidelines and approval of the Institutional Review Board at California State University, San Bernardino and in accordance guidelines for the conduct of research

involving human subjects at the National Institutes of Health(Gottesman & Sandler, 2004). To ensure anonymity, other than official state staff titles, names and other personal information were not requested. Participants were informed their participation was voluntary, consensual, and confidential. The informed consent language is provided in Appendix B, and the debriefing statement is provided in Appendix C of this study.

This study was designed to explore staff attitudes only, and was not designed to include any control or comparison groups. The factors explored did not include any investigation of resident treatment by the study participants. The data was collected in an uncontrolled environment and because the study was strictly designed as evidence-based and non-experimental, it is not generalizable to any larger population beyond the Veterans Home of California—Barstow.

Moreover, this study is relegated to a lower level of evidence and falls in exempt category, i.e., administrative review and approval in accordance with the guidelines for the conduct of research involving human subjects at the National Institutes of Health (NIH), which is a federal government agency. The agency

guidelines allow for exemption because while the research involved human subjects, it did not expose them to any physical, social, or psychological risks (Gottesman & Sandler, 2004, p. 8).

All data is locked in a file cabinet that is accessible only to this researcher. The data will be destroyed three years after this project is published.

Data Analysis

A quantitative procedure was utilized to test whether a measure of permissive attitude exists among staff who work directly with and/or impact the lives of the elder residents at the Veterans Home of California—Barstow (VHCB). As many VHCB staff possible were invited to participate in the survey. Approximately 75 VHCB staff were available during the two morning shifts that this researcher was present to administer the survey. 27 surveys were completed for a response rate of 36%.

Eleven items on the scale were reverse coded and the data was analyzed using IBM SPSS Statistics Version 20. Measures of frequencies and percents were obtained and analyzed for all variables. The responses that were between one and seven on the 26 items measured attitude

on the Aging Sexuality Knowledge and Attitude Scale (ASKAS) (White, 1981). These were computed to provide a single attitude score per survey. The mean score and standard deviation were obtained to answer whether a measure of permissive attitude existed among each VHCB participant with 1 indicating "agree" and 7 indicating "disagree."

Summary

Twenty-seven VHCB staff completed the attitude portion of the Aging Sexuality Knowledge and Attitude Scale (ASKAS) (White, 1982). The questions were designed to measure sexual attitudes and sexual knowledge through the use of items dealing with the age-related and non-age-related changes in sexuality and the context of sexuality for the aged (p. 493). The mean score and standard deviation were obtained to answer whether a measure of permissive attitude existed among each VHCB participant with 1 indicating "agree" and 7 indicating "disagree."

CHAPTER FOUR

RESULTS

Introduction

Chapter Four will provide the results of this study through a presentation of the findings, demographics, individual items, and individual questions. The results indicate that participants have a strong measure of permissive attitude with respect to sexual intimacy in the Veterans Home of California–Barstow.

Presentation of the Findings

The results of this study address the question as to whether a measure of permissive staff attitude exists about sexual intimacy at the Veterans Home of California-Barstow (VHCB). Twenty-seven surveys were completed out of approximately 75 participants for a return rate of 36%.

Demographics

Twenty-seven participants' staff titles are presented in Appendix D. No other demographics were utilized in this study.

Individual Items

There were no significant correlations between the staff titles and the survey questions in this study. Instead, a Cronbach's alpha test of reliability was run on the reverse coded questions (N = 11) of the attitude scale with the result of .540, and a Cronbach's alpha based on standardized items of the attitude scale indicated a result of .551.

Permissive attitude was scorable as either a 1 or 7 depending on the question, with 1 meaning "agree" and 7 meaning "disagree." In other words, permissive attitude is indicated by either a favorable or an unfavorable opinion, depending on the question asked. For the twenty-seven surveys, the mean "attitude" score computed on the Likert scale was M = 91.4444 and the standard deviation was SD = 11.75825.

Three T-Tests of significance were used to analyze staff groups collapsed as follows: Non Licensed Staff, Social Work Services Staff, and Nursing Staff (Table 1) indicating non-significant results. A Cronbach's Alpha test of reliability was run on the permissive attitude questions (N = 11) with a result of .540 and .551 on the Cronbach's Alpha test on standardized items (Table 2).

Individual Questions

Staff titles (Appendix D) were the only demographic utilized in this study. Results indicated a strong level of permissive staff attitude with respect to sexual intimacy in the Veterans Home. For example, the result for question 3 ("Institutions such as nursing homes ought not to encourage or support sexual activity of any sort in its residents") indicated that 74.1% of VHCB participants (N = 20) have a permissive attitude, or unfavorable opinion indicated by "disagree" (M = 2.5556, SD = 1.90815).

The result for question 5 ("Nursing homes have no obligation to provide adequate privacy for residents who desire to be alone, either by themselves or as a couple") indicated that 81.5% of VHCB participants (N = 22) have a permissive attitude, or unfavorable opinion indicated by "disagree" (M = 1.9630, SD = 1.28547).

The result for question 16 ("I would support sex education courses for the staff of nursing homes") indicated that 88.9% of VHCB participants (N = 24) have a permissive attitude, or favorable opinion. They responded with a 3 (strongly agree) (M = 5.8889, SD = 1.73944).

The result for question 24 ("Institutions such as nursing homes should provide privacy so as to allow residents to engage in sexual behavior without fear of intrusion or observation") indicated that 88.8% of VHCB participants (N = 24) have a permissive attitude, or favorable opinion. They responded with a 3 (strongly agree) (M = 5.7778, SD = 1.45002).

Seventeen questions (1, 2, 4, 6, 8, 10, 11, 12, 14, 15, 19, 20, 21, 22, 23, 25, and 26) resulted in overwhelming permissive attitude responses (> 65%) by VHCB staff. For example, question 23 ("Masturbation is harmful and should be avoided") had 20 participants (74.1%) respond with a 7 (Disagree), 2 participants (7.4%) respond with a 6 (Somewhat Disagree), and 3 participants (11.1%) with a 5 (Strongly Disagree).

Three questions (7, 17, and 18) resulted in notable majority permissive attitude responses (> 50.5%) by VHCB staff, but not necessarily at each side of the Likert scale. For example, question 7 ("If a relative of mine, living in a nursing home, was to have a sexual relationship with another resident I would complain to the management") had 14 participants (51.9%) respond with a 7 (Disagree), 1 participant (3.7%) respond with a 6

(Somewhat Disagree), 2 participants (7.4%) respond with a 5 (Strongly Disagree), and 6 participants (22.2%) respond with a 4 (I Don't Know).

Two questions (9 and 13) also resulted in notable majority permissive attitude responses (> 50.5%) by VHCB staff but on each end of the scoring scale. For example, question 13 ("I feel I know all I need to know about sexuality in the aged") had 9 participants (33.3%) respond with a 7 (Disagree), 5 participants (18.5%) respond with a 6 (Somewhat Disagree), 2 participants (7.4%) respond with a 5 (Strongly Disagree), 2 participants (7.4%) respond with a 3 (Strongly Agree), 2 participants (7.4%) respond with a 2 (Somewhat Agree), and 7 participants (25.9%) respond with a 1 (Agree).

Summary

Chapter Four presented the finding that a strong measure of permissive staff attitude exists about sexual intimacy in the Veterans Home of California—Barstow. Twenty-seven surveys resulted with a mean attitude score (M = 91.444) and standard deviation (SD = 11.75825). Result examples of individual questions were presented with distinctions between overwhelming permissive

attitude responses (> 65%), close majority permissive attitude responses (> 63), and notable permissive attitude responses (> 50.5). Three T-Tests of significance were used to analyze staff groups (Table 1.) which indicated non-significant results, and a Cronbach's Alpha test of reliability was run on the permissive attitude questions (N = 11) with a result of .540 and .551 on the Cronbach's Alpha test on standardized items (Table 2).

Table 1. T-Tests

Group Statistics

	Target Variable	N	Mean	Std. Deviation	Std. Error Mean
ASKAS questions	Non Licensed Staff	11	94.5455	11.22821	3.38543
	SW Services Staff	7	87.4286	7.43544	2.81033

Group Statistics

	Target Variable	N	Mean	Std. Deviation	Std. Error Mean
ASKAS questions	Non Licensed Staff	11	94.5455	11.22821	3.38543
	Nursing Staff	9	90.7778	14.91457	4.97152

Group Statistics

	Target Variable	N	Mean	Std. Deviation	Std. Error Mean
ASKAS questions	SW Services Staff	7	87.4286	7.43544	2.81033
	Nursing Staff	9	90.7778	14.91457	4.97152

Table 2. Cronbach's Alpha Scores

Reliability Statistics

Cronbach's Alpha	Cronbach's Alpha Based on Standardized Items	N of Items
.540	.551	11

CHAPTER FIVE

DISCUSSION

Introduction

The purpose of this study was to measure staff attitudes about sexual intimacy among the elderly residents of the Veterans Home of California–Barstow (VHCB) and to determine if a measure of "permissive" attitude exists, to address the need for staff training or education with respect to sexual intimacy and conjugal privacy in long-term care. Additionally, because policy on resident sexual intimacy and conjugal privacy does not exist in the VHCB, Chapter Five will present suggestions for the inclusion of elements in such a policy.

This chapter will also present a discussion about the implications of the study results, a brief discussion of its limitations, recommendations for social work practice, and formation of an institutional policy at the Veterans Home of California–Barstow. Chapter Five will conclude by suggesting further research be conducted on the remaining Veterans Homes of California, and will present a sample sexuality policy for the consideration of the Veterans Home of California–Barstow towards the

development of its own institutional policy on sexuality and conjugal privacy.

Discussion

Results of this study indicate staff have strong permissive attitudes toward sexual intimacy among the aging residents of the Veterans Home of California-Barstow (VHCB). These results are consistent with other study results where staff reported an overall positive attitude towards resident sexuality, but where a problem existed in that sexual expression was still denied at times or found to be unacceptable by some who tend to hold a more conservative point of view (Holmes, Reingold, & Teresi, 1997).

The Aging Sexuality Knowledge and Attitude Scale (ASKAS) (White, 1982) was used for this study. Results for items 12, 13, 16, and 20 imply that staff of the Veterans Home of California—Barstow (VHCB) appear to favor a staff training program where they could be made aware of or sensitized to understanding sexuality among the population they serve.

Item 12 stated: "I would like to know more about the changes in sexual functioning in older years." Ten

participants (37%) agreed, five participants (18.5%) somewhat agreed, and three participants (11.1%) strongly agreed.

Item 13 of the AKSAS stated, "I feel I know all I need to know about sexuality in the aged." Nine participants (33.3%) disagreed, five participants (18.5%) somewhat disagreed, and two participants (7.4%) strongly disagreed.

Item 16 of the ASKAS survey stated, "I would support sex education courses for the staff of nursing homes." Sixteen participants (59.3%) agreed, two participants (7.4%) somewhat agreed, and six participants (22.2%) strongly agreed.

Item 20 of the ASKAS survey stated, "Staff of nursing homes ought to be trained or educated with regard to sexuality in the aged and/or disabled." Seventeen participants (63.0%) agreed, and seven participants (25.9%) strongly agreed.

Results for items 3, 5, 10, 19, 22, 24, and 25 imply that staff of the Veterans Home of California—Barstow (VHCB) appear to favor an institutional policy where sexual intimacy and conjugal privacy are permitted among the residents they serve.

Item 3 of the ASKAS survey stated, "Institutions such as nursing homes ought not to encourage or support sexual activity of any sort in its residents." Twelve participants (44.4%) disagreed, four participants (14.8%) somewhat disagreed, and four participants (14.8%) strongly disagreed.

Item 5 of the ASKAS survey stated, "Nursing homes have no obligation to provide adequate privacy for residents who desire to be alone, either by themselves or as a couple." Fifteen participants (55.6%) disagreed, four participants (14.8%) somewhat disagreed, and three participants (11.1) strongly disagreed.

Item 10 of the ASKAS survey stated, "If I knew that a particular nursing home permitted and supported sexual activity in residents who desired such, I would not place a relative in that nursing home." Sixteen participants (59.3%) disagreed, five participants (18.5%) somewhat disagreed, and two participants (7.4%) strongly disagreed.

Item 19 of the ASKAS survey stated, "Institutions such as nursing homes ought to provide large enough beds for couples who desire such to sleep together." Fourteen participants (51.9%) agreed, four participants (14.8%)

somewhat agreed, and six participants (22.2%) strongly agreed.

Item 22 of the ASKAS survey stated, "Institutions such as nursing homes should provide opportunities for the social interaction of men and women." Fourteen participants (51.9%) agreed, three participants (11.1%) somewhat agreed, and five participants (18.5%) strongly agreed.

Item 24 of the ASKAS survey stated, "Institutions such as nursing homes should provide privacy so as to allow residents to engage in sexual behavior without fear of intrusion or observation." Thirteen participants (48.1%) agreed, one participant (3.7%) somewhat agreed, and ten participants (37.0%) strongly agreed.

Item 25 of the ASKAS survey stated, "If family members object to a widowed relative engaging in sexual relations with another resident of a nursing home, it is the obligation of the management and staff to make certain that such sexual activity is prevented." Ten participants (37.0%) disagreed, five participants (18.5%) somewhat disagreed, six participants (22.2%) strongly disagreed.

The results clearly imply VHCB staff tend to tolerate resident sexuality and suggest staff have a positive attitude toward training and education with respect to sexuality in long-term care. Results also imply VHCB staff would be amenable towards an institutional policy that would address sexual intimacy and conjugal privacy among the residents of the Veterans Home of California–Barstow.

Limitations

The response rate of 36% of staff members, albeit decent, could be considered a limitation because one cannot assume twenty-seven day-shift participants represent the opinions of the entire Veterans Home of California–Barstow (VHCB) staff. Due to time and logistical constraints, and the design of this exploratory study, it was not made available to VHCB staff during other work shifts, including night and weekends.

Another limitation is that this study could be generalizable to staff at the VHCB, but not generalizable to all day-shift staff at other Veterans Homes throughout California.

A final limitation could be in regard to external validity of the ASKAS survey where it is conceivable staff could have responded with permissive attitudes, against their own personal values or opinions. Instead, they could have based their responses on what they feel are professional parameters or based on their professional training.

Recommendations for Social Work Practice, Policy and Research

Currently, the Veterans Home of California–Barstow does not have an institutional policy with respect to staff training or on resident sexual intimacy and conjugal privacy.

Opinions about what elements other social workers from other Veterans Homes of California (VHC) thought could be included in such a policy were collected in an earlier study. These elements were compiled as follows: 1) Care plan for privacy; 2) Consideration of cognitive level of functioning; 3) Health status; 4) Privacy in a conjugal visitation location on-site; 5) Safe sex; 6) Staff training.

To address these elements, I recommend that Gayle Appel Doll's work (Doll, 2012) be considered by both

social work services and administration of the Veterans Home of California–Barstow (VHCB) with respect to working in tandem on staff training and the development of its own institutional policy on sexuality and conjugal privacy.

Staff Training

In regard to permissive staff attitudes toward training or education, research suggested attitudes are relatively easy to change through training programs that focus on debunking myths about older adult sexuality, and are successful in helping staff recognize sexuality as a basic human need that does not disappear with age (Doll, 2012, p. 55). Doll also suggested staff may perceive resident sexual expression as innapropriate when viewed through their own moral lens (p. 56).

With respect to dementia, for example, Doll (2012) suggested staff could be taught about the behavioral effects of frontal lobe degeneration where loss of social judgement and weakened impulse control, and a lack of understanding of consequences of sexual acts, are not necessarily willful or malicious (p. 56). Moreover, Doll (2012) stated that because there are too few private spaces in resident homes, caregivers could be taught

strategies to divert residents to other activities, and that staff could be trained on innapropriate expressions as possibly representative of unfulfilled needs for intimacy that occur from close personal relationships (p. 56).

Finally, Doll (2012) suggested staff could be encouraged to develop more caring relationships with residents that may be helpful to them in fullfilling their need for intimacy (p. 56).

To challenge and change assumptions, Doll (2012) suggested staff could learn facts about sexuality in aging populations, examine the types of sexual expression, and explore strategies for redirecting inappropriate sexual activity. After single-offering trainings, staff focus-groups reported that they were more likely to view resident intimacy and sexuality as positives and had taken steps to provide privacy for residents (hanging a do-not-disturb sign on a resident's door, waiting for a response before entering a room after knocking, finding activities outside the room for a roommate while a couple shares private time) (p. 60).

Doll (2012) suggested perhaps the most important goal of training is that it should happen before any

staff member witnesses a resident sexually expressing him or herself. She stated that facilities could provide information during the new staff member's orientation about resident sexual needs and how they are expected to respond to resident sexuality (p. 61). She also suggested training initiatives could evolve into regularly scheduled in-service sessions where staff would generate their own agendas for continual discussions of sexual issues specific to their home (p. 61).

Developing Institutional Policy

With respect to the development of a sexuality policy, Doll (2012) outlines a series of steps resident home institutions could take. This includes assembling key stakeholders such as, health care or personal support workers, nutritionists or dieticians, housekeepers, registered nurses, licensed practical nurses, social workers, recreational therapists, physiotherapists, physicians, families, administrators, board representatives, pastoral care representatives, volunteer coordinators, ethicists, residents, and ombudsmen (p. 231). She suggested stakeholder input is necessary in policy development in order to help consider all sides of the issue related to resident sexuality (p. 230).

In writing the policy, Doll (2012) suggested after all the information is gathered, that the stakeholder group could begin drafting a working policy document. This could include ensuring a specific reference to sexual expression is written into the organization's mission statement (p. 234). She suggested situations should be addressed by the organizational policy by including some of the following selected items.

1. Admissions: Admission is the best time to gather information about new residents and could include sexual orientation, sleeping arrangements at home, and current level of sexual interest and activity (p. 234). Doll (2012) suggested respect for a truly person-centered approach by making these questions "optional" because each resident has the right to privacy regarding their sexual history (p. 234).
2. Consent: Doll (2012) suggested four points; (A) Sexual expression should be allowed if both parties and their family members consent and if the benefits outweigh the risks. (B) Care staff may decide whether to permit sexual behavior or

activity and should draw upon family guidance.

(C) Staff members will be responsible for determining and documenting consent, for discussing risks with the resident and family members, and for developing a care plan.

(D) The organization will work to find a mutually agreeable solution when family members object to consensual behavior between residents (p. 236).

3. Risk: Doll (2012) suggested an assessment procedure to determine the level of risk associated with sexual behavior. She stated, for example, that the policy could include a determination of what level of risk is acceptable or it can more broadly state that the risk level would be determined on an individual basis (p. 236).

4. Shared Rooms: Doll (2012) suggested the policy may include stipulations to address a resident's desire to share a room with someone with whom he or she is engaged in an intimate relationship. She also stated there may be

additional policies for conjugal visit rooms (p. 236).

5. Sexual ethics committee: Doll (2012) suggested an organization may choose to call this group by some other name, but it is important that a team be assembled to review instances of sexual expression and to identify, implement, and evaluate possible interventions, as required (p. 236).

6. Resident sexual education and support: Doll (2012) suggested residents who choose to engage in sexual activity should be taught the risks of spreading sexually transmitted diseases. She said that many are unaware of the risks and will need to learn safe sex practices. She suggested resident sex education should also include information about the physiological changes that are a normal part of aging and how they may affect sexual performance, as well as the effects of certain medications on sexual function (p. 236).

After drafting the policy, Doll (2012) suggested the stakeholder group circulate it to staff, the resident

council, and family members for their input. They should take the time to gather feedback and revisit and modify the drafted policy (p. 237).

Finally, Doll (2012) recommended the policy be reviewed at least every two years after its implementation in order to see if it adequately reflects current understanding of sexual expression in long-term care (p. 237).

According to Doll (2012), Ballard (1996) listed the following indicators for whether a care facility has adopted a respectful approach to resident sexuality:

- The organization enhances resident well-being using a holistic approach that considers social, emotional, spiritual, physical, and sexual needs (p. 237).
- Staff members feel comfortable addressing resident needs for intimacy and sexuality and can use strategies for dealing with specific situations that involve residents and their families (p. 237).
- The organization's administration has established guidelines for policies and

practices for resolving dilemmas involving intimate relationships between residents (p. 238).

- Families and legal guardians have a clear understanding prior to a resident's admission of the potential for intimate relationships and the organization's policies on such matters. A sexual history profile is completed on admission (p. 238).

Conclusions

Survey results indicated a permissive attitude by staff of the Veterans Home of California–Barstow (VHCB) in regard to resident sexual intimacy. VHCB is interested in this study because a policy with respect to sexual intimacy and conjugal privacy does not exist there, and therefore it appears that little guidance is available for how to respond when sexual expression becomes an issue.

Due to the study limitations, I suggest more research be conducted at all Veterans Homes of California in order to gain a larger sampling of participants.

However, permission to conduct such a study could only be granted at a state level instead of the local level.

Moreover, only attitudes were examined by using the attitude questions of the ASKAS. The knowledge questions were not utilized. I believe this information would have been useful. Additionally, in order to broaden the number and types of participants, and to study whether any significant relationships exist between the questions and the participants, I suggest more demographic information be gathered to include participant age, gender, and other information such as the length of time working at the Veterans home.

VHCB staff appear to have an understanding that sexual intimacy is normal and beneficial to VHCB residents. Support and understanding from VHCB administration and other staff may be critical toward improving the well-being of the residents served there. Also, more research may prove beneficial towards improving the well-being of the residents of other Veterans Homes of California. I believe this study is an important first step towards that end.

Appendix F provides a Sample Sexuality Policy which I suggest the Veterans Home of California-Barstow could

utilize as a model for its own formulation of a much needed institutional policy on sexual intimacy and conjugal privacy.

APPENDIX A

QUESTIONNAIRE

QUESTIONNAIRE

SCALE FOR THE ASSESSMENT OF ATTITUDES REGARDING SEXUALITY IN THE AGED

- This questionnaire is designed to measure your attitude regarding sexuality in the aged. This is not a test so there are no right or wrong answers.
- **Please do not include your name or any personal information.**
- **WHAT IS YOUR STATE STAFF TITLE?** _____

Please answer each item as carefully and as accurately as you can by placing a number beside each one as follows:

1. **Disagree**
2. **Somewhat Disagree**
3. **Strongly Disagree**
4. **I Don't Know**
5. **Strongly Agree**
6. **Somewhat Agree**
7. **Agree**

---

1. _____Aged people have little interest in sexuality (aged = 65+ years of age).
2. _____An aged person who shows sexual interest brings disgrace to himself/herself.
3. _____Institutions such as nursing homes ought not to encourage or support sexual activity of any sort in its residents.
4. _____Male and female residents of nursing homes ought to live on separate floors or in separate wings of the nursing home.
5. _____Nursing homes have no obligation to provide adequate privacy for residents who desire to be alone, either by themselves or as a couple.
6. _____As one becomes older (say past 65) interest in sexuality inevitably disappears.

For items 7, 8, and 9: If a relative of mine, living in a nursing home, was to have a sexual relationship with another resident I would:

7. _____Complain to the management.
8. _____Move my relative from this institution.
9. _____Stay out of it as it is not my concern.

10. _____If I knew that a particular nursing home permitted and supported sexual activity in residents who desired such, I would not place a relative in that nursing home.

11. _____It is immoral for older persons to engage in recreational sex.

12. _____I would like to know more about the changes in sexual functioning in older years.

13. _____I feel I know all I need to know about sexuality in the aged.

14. _____I would complain to the management if I knew of sexual activity between any residents of a nursing home.

15. _____I would support sex education courses for aged residents of nursing homes.

16. _____I would support sex education courses for the staff of nursing homes.

17. _____Masturbation is an acceptable sexual activity for older males.

18. _____Masturbation is an acceptable sexual activity for older females.

19. _____Institutions such as nursing homes ought to provide large enough beds for couples who desire such to sleep together.

20. _____Staff of nursing homes ought to be trained or educated with regard to sexuality in the aged and/or disabled.

21. _____Residents of nursing homes ought not to engage in sexual activity of any sort.

22. _____Institutions such as nursing homes should provide opportunities for the social interaction of men and women.

23. _____Masturbation is harmful and ought to be avoided.

24. _____Institutions such as nursing homes should provide privacy so as to allow residents to engage in sexual behavior without fear of intrusion or observation.

25. _____If family members object to a widowed relative engaging in sexual relations with another resident of a nursing home, it is the obligation of the management and staff to make certain that such sexual activity is prevented.

26. _____Sexual relations outside the context of marriage are always wrong.

White, C. B. (1982). A Scale for the Assessment of Attitudes and Knowledge Regarding Sexuality in the Aged. *Archives of Sexual Behavior*, *11* (6), 491-502.

APPENDIX B

INFORMED CONSENT

CONSENT FORM

You are invited to participate in this study conducted by Eric Reyes MA Ed, and supervised by Rosemary McCaslin PhD at California State University, San Bernardino. We hope to learn about staff attitudes about sexual intimacy in the Veterans Home of California—Barstow. You were selected as a possible participant in this study because you are a professional staff member of the VHCB.

This study is approved by the Institutional Review Board's School of Social Work Sub-Committee of the California State University, San Bernardino. We are asking that you take this survey which takes about 5 to 10 minutes to complete. Any information that is obtained in connection with this study and that can be identified with you will remain strictly confidential and will not be disclosed to any individual or institution.

There are no foreseeable risks if you decide to participate, however you are free to withdraw your consent and to discontinue participation at any time without penalty or prejudice.

If you have any additional questions, please call Dr. Rosemary McCaslin PhD at (909) 537-5507 and she will be happy to answer them.

APPENDIX C

DEBRIEFING STATEMENT

DEBRIEFING STATEMENT

Thank you for your participation which is helpful to this study. Final results will be made available in July of 2012. All results will be grouped together; therefore individual results will not be available. Your participation will remain strictly confidential. If you have any additional questions regarding this research, please contact Dr. Rosemary McCaslin PhD at: (909) 537-5507, or Eric Reyes MA Ed at (760) 680-1035.

APPENDIX D

DEMOGRAPHICS

Veterans Home of California – Barstow Staff Titles are the only demographic used.

VHCB STATE STAFF TITLES	Frequency	Percent	Valid Percent	Cumulative Percent
Activity Coordinator	1	3.7	3.7	3.7
Conservation Worker	1	3.7	3.7	7.4
Chief Medical Officer	1	3.7	3.7	11.1
Clinical Social Worker	2	7.4	7.4	18.5
CNA	3	11.1	11.1	29.6
Food Manager	1	3.7	3.7	33.3
Housekeeper	5	18.5	18.5	51.9
Kitchen Worker	1	3.7	3.7	55.6
Office Tech	1	3.7	3.7	59.3
Registered Nurse	1	3.7	3.7	63.0
SW Intern	3	11.1	11.1	74.1
Standards Compliance Officer	1	3.7	3.7	77.8
SVN	5	18.5	18.5	96.3
SW/Psychiatrist	1	3.7	3.7	100.0
Total	27	100.0	100.0	

APPENDIX E

STAFF FLYER

ATTENTION ALL STAFF

You are cordially invited to participate in a brief (5 – 10 minutes or less) survey being conducted by Eric Reyes MSW Candidate, who is a graduate student of California Statue University, San Bernardino.

WHERE:

STAFF BREAK ROOM

WHEN:

January 27th from 6:30 AM to 1:00 PM

February 3rd from 6:30 AM to 1:00 PM.

APPENDIX F

SAMPLE SEXUALITY POLICY

SAMPLE SEXUALITY POLICY

(Name of Facility and Date)

POLICY MEMORANDUM

Intimate Relationships of and Sexual Activities by Residents

Purpose:

To affirm the facility's support for the intimate relationships of and sexual activities by the residents.

Policies:

1. The facility supports and places no unreasonable conditions on the sexual activities of the residents.
2. The facility provides both anticipatory and situational supports for the intimate relationships and sexual activities of the residents.
3. The facility provides appropriate risk-related health information to residents and their healthcare surrogates relating to its residents' intimate relationships and sexual activities.
4. The facility provides staff training and education regarding this policy, the procedure and the role of staff in relationship to this policy, and related procedures.
5. Notwithstanding its policy of providing support for its residents' sexual activities, some resident sexual activities may be so problematic that they cannot be supported.
6. Upon admission, the facility informs the resident's primary contact person of policies 1 and 2.
7. Upon admission, the facility seeks information from the resident's primary contact person that may be helpful in anticipating and supporting the resident's intimate relationships and sexual activities.
8. The facility informs the primary contact person of observed sexual contact involving the resident.
9. The facility's care-plan process includes review of the intimate relationships and sexual activities of residents.
10. The facility's policies concerning abuse, including sexual abuse, are contained in separate policy memoranda.
11. The facility will assess whether observed intimate relationships or sexual activities are abusive. Each such assessment will be documented.

Source: Center for Practical Bioethics. (2006). Considerations regarding the needs of long-term care residents for intimate relationships and sexual activity. Retrieved from http://www.practicalabioethics.org/wp-content/uploads/2011/07/Intimacy_Guidelines_Aug2007.pdf. Reprinted with permission (Doll, 2012, p. 242).

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