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ASSESSING THE PERCEPTIONS OF OLDER PEOPLE REGARDING GERONTOLOGICAL SEXUALITY AS A BASIS FOR EDUCATIONAL PROGRAMMING

DISSERTATION

Presented in Partial Fulfillment of the Requirements for the Degree Doctor of Philosophy in the Graduate School of The Ohio State University

By

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* * * * *

The Ohio State University

1981

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ACKNOWLEDGMENTS

My greatest, deepest, and most sincere thanks is given to my husband, Joseph. He unstintingly gave of himself whenever his advice and assistance were requested. He encouraged and supported me throughout my career in graduate school. He was always there when I needed him.

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I appreciated the technical help in statistics from Dr. Frank Dietrich at Northern Kentucky University who acted as a statistical consultant, and from Fred Ruland in the statistics laboratory at The Ohio State University.
DEDICATION

This work is dedicated to my family whom I dearly love: Joseph, Jeannie, and Marti; and to my parents: Etta and Mitchell Glassman.
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Grow old along with me!
The best is yet to be,
The last of life, for which
the first was made.

Robert Browning
CHAPTER ONE
INTRODUCTION

The proportion of the American population which is 65 years of age or older has increased dramatically and will continue to increase at a rapid rate. There are now more Americans who are older and more older Americans who are living longer.

It is difficult to grow old in American society. Ageism, the discrimination of older citizens because of their age, permeates much of our culture and many of our institutions. This discrimination "robs some 23 million people of selfhood and status and deprives society as a whole of the experience, skills and wisdom of its elders. . . ."

Age discrimination is apparent readily in the area of sexuality. Our older citizens have been conditioned through societal myths and stereotypes to believe that they are no longer sexual beings, and they are considered to be no longer sexually attractive, lovable, touchable, or desirable.
Myths and Stereotypes

The sexual myths and stereotypes perpetuated by society about older people have come to be accepted in many instances by many of the older people themselves. Eric Pfeiffer of Duke University, long a researcher of sexuality and gerontology, has classified three categories of stereotyping about the sexuality of the aging as follows: "Many people believe that sexual desire and sexual activity cease to exist with the onset of old age; or that sexual desire and sexual activity ought to cease to exist with the onset of old age; or that aged people who say they are still sexually active are either morally perverse or engaged in wish-fulfilling deceptions and self-deceptions." According to Pfeiffer these stereotypes have little relationship to actual data.

Leader of the Gray Panthers, Margaret E. Kuhn lists five myths about sex and old age. She contends that these myths are the result of societal pressure and conditioning, are perpetuated like old fairy tales, and are believed even by physicians and other health professionals.

The myths are: "(1) Sex doesn't matter in old age; (2) Interest in sex is abnormal for older people; (3) Remarriage after the loss of a spouse should be discouraged; (4) It is all right for old men to seek younger women as sex partners, but it is ridiculous for old women to be sexually involved with younger men; (5) Older people should
be separated by sex in institutions to avoid problems for the staff and criticism by families and the community.\(^4\)

Attitudes Toward Sexuality in Older People

Our culture views sexual activity and sexual interests among older people as improper.\(^5\) The communications media and advertising industries continue to reinforce the concept that sex is for young people. Older people who are interested in sexual activity are considered to be "dirty old men" and older women are subtly and overtly told that they are unattractive and, therefore, undesirable.

As early as 1952 the New York State Joint Legislative Committee on Problems of the Aging recognized that our culture constrained the sexual adjustment of its older people with a rigid code of taboos. These taboos are based on false data, superstitions, a youth-worshipping society. The committee stated, "We must grow up and realize some of these imposed taboos are ridiculous."\(^6\)

Some adults view any sexual interest or activity on the part of their parents as a threat. This interest in intimate relationships could lead an older single parent to another marriage, and could pose a financial loss to the adult children if the older adult decided to alter his/her will. Adult children may also approach sexual activity for the older parent with "long-dormant Oedipal fears and incest taboos associated with parental figures."\(^7\)
Burnside writes that the "no no" attitude of our society has been accepted by the older person just as society's generally negative view of aging also has been adopted by many older persons. Many older people who find that they have strong sexual desires are overwhelmed with guilt and shame and feel that they are oversexed.8

Need for the Study

In order to deal with older people in a realistic and humane way, both older people and professionals who work with them would benefit from a better understanding of older people's opinions about sexuality, as well as their sexual attitudes and their involvement in sexual activities. Nursing staffs, professionals, and older people themselves need to be aware of the extent and level of opinions about gerontological sexuality, attitudes, and activities to better deal with deficits and self or societally imposed negative attitudes toward gerontological sexuality in older people.

The data that a study like this might generate may have implications for sexuality education for older people, for younger people, and for professionals who deal with people either periodically or on a long-term basis as they are aging. Most importantly, it would provide for older people and for younger people as they grow older a greater appreciation of the changes occurring in themselves.
At present there are no measures for the assessment of older people's opinions and attitudes regarding gerontological sexuality. A major focus of this study, therefore, is to develop an instrument for the assessment of these areas in a normal, older population. This may provide the basis for further research; and, hopefully, will eventually have very practical implications for designing sexuality education programs for older people.

Statement of the Problem

The purpose of this study is threefold: (1) to develop/adapt an instrument for the assessment of opinions and attitudes about gerontological sexuality and sexual activity of a normal population of older people; (2) to establish baseline data; and (3) to consider the implications of the data generated as a basis for educational programming.

This study will attempt to determine which demographic variables have a relationship to sexual opinions, attitudes, and activity of older people.

Research Questions

The several research questions in this study have been divided into five general areas: (1) opinions about sexuality and older people; (2) attitudes about gerontological sexuality; (3) sexual activity; (4) demographic characteristics; and (5) implications for educational
programming. An attempt will be made to distinguish whether the gender of subjects makes any difference in their responses to items in the above areas.

Opinions About Sexuality and Older People

1. Will the sample population have opinions about sexuality which are similar or different from those of authorities in the field of gerontological sexuality?
2. What are the areas in which there are similarities and differences?

Attitudes About Gerontological Sexuality

1. What are the sample population's attitudes concerning sexual issues for older people?

Sexual Activity Levels of Older People

1. What are the types of sexual activity in which older people are engaged?
2. What are the reported levels of sexual activity?
3. How does the sample population compare itself to others in its age group with respect to sexual knowledge, experience, attitudes, activity, and adjustment?

Demographic Characteristics of the Sample Population

1. Sex
2. Age
3. Place of residence
4. Race
5. Religion
6. Living arrangements
7. Number of marriages
8. Number of children
9. Description of present condition of physical health
10. Description of present condition of mental health
11. Medical problems
12. Chronic conditions
13. Education level
14. Income at the time of retirement

Hereafter these are referred to as the demographic characteristics.

Educational Programming

1. What are the sources of knowledge of gerontological sexuality in older people?
2. At what age did most subjects in the sample population learn about gerontological sexuality?
3. Does the sample feel that older people are willing to communicate candidly about sexual matters?
4. What are the suggestions of older people about educational programming in terms of the
qualifications of the teacher and the segregation/integration by sex of the class members?

5. What are the implications for constructing a sexuality education program based on the perceived needs generated by the study?
   a. Deficits in knowledge
   b. Willingness of older people to suggest topics for such a program
   c. Communication about sexuality
   d. Interest of older people for such a program

Limitations

This study is limited to 82 subjects who voluntarily participated; therefore, the sample population is not a randomly selected one. Consequently, the ability of the investigator to generalize is limited to only those volunteers who responded appropriately to the questionnaire.

Delimitations

This study includes the following delimiting factors:

1. All subjects are volunteers who meet the criteria: (1) are unimpaired intellectually, emotionally, and sensorially; and (2) are able to take a paper and pencil test without assistance.

2. Only people age 65 or older may be subjects.
3. Subjects are those who live in the greater Cincinnati area.
4. Subjects are selected from intact groups whenever possible, such as retirement homes and senior citizens’ social organizations.

Definition of Terms

The following terms are defined within the context of this study:

Sexuality - A term that includes all aspects of maleness and femaleness: sociological, philosophical, psychological as well as biological aspects. 9

Older people - Any person age 65 or older.

Attitudes - The posture or position of a person showing or meant to show a mental state, emotion, or mood; the manner of acting, feeling, or thinking that shows one's disposition, opinion.

Activity - The quality or state of being active; action; motion, use of energy; any specific action or pursuit.

Behavior - Manner of behaving; conduct; manners; carriage of oneself, with respect to propriety or morals; deportment. It expresses external appearance or action.

Opinion - A belief not based on absolute certainty or positive knowledge but on what seems true, valid, or probable to one's own mind; what one thinks; judgment.
Unimpaired - Not worsened, lessened, weaker, diminished in quantity, value, or excellence; not lessened in power nor enfeebled.

Inhibited - Held back, restrained, or curbed; prohibited or forbidden; something or someone possessing a mental or psychological process that restrains or suppresses an action, emotion, or thought.

Conservative - Tending to preserve; one who wishes to preserve traditions or institutions and resists innovation or change; adhering to what is old or established.

Liberal - Free; not literal or strict; not narrow or bigoted, broad-minded; favoring reform or progress; one who advocates greater freedom of thought or action.

Intact groups - People who by virtue of interests or living conditions normally associate with one another in the same location; such as social organizations or private retirement homes.

Normal older population - Those people age 65 or older who are unimpaired intellectually, emotionally, ambulatory or not bed-ridden, and can take a paper and pencil test without assistance.
NOTES


3 Ibid.

4 Kuhn, pp. 118-123.

5 Ibid.


CHAPTER TWO
REVIEW OF LITERATURE

It has only been rather recently that much has been written about sexuality in the aging population. The literature related to this study will be reviewed under each of the following nine areas: (1) Myths and stereotypes; (2) Attitudes toward sexuality in older people including those of caretakers; (3) Factors influencing the sexual interests of older people; (4) Physiological changes in the sexual functioning of older people; (5) Sexual behavior of older people; (6) Decline in sexual activity of older people; (7) Sexuality and self-esteem; (8) Sexuality education for older people; and (9) Research techniques previously used among older people regarding gerontological sexuality.

Myths and Stereotypes

Most people, not only older people, have fixed attitudes about sexuality and old age. Stereotypes would suggest that the aging male has little or no socially acceptable sexuality and that sexual interest is unsuitable for women much beyond middle age. Robert Butler, a Washington, D.C. psychiatrist working with
older people, stated that "The average doctor does not really think sex matters in old age."¹

Some of these stereotypes regarding sexuality and aging have resulted from social control mechanisms that have been at work in our society; for example, selections of role partners, the kinds of sexual behaviors engaged in, as well as the occasions for sexual involvement.² Attitudinal disapproval through scandal, gossip, humor, ridicule, or verbal chastisement is the most common form of control.³

Too many people regard the relationship of older people with a chuckle. This social expectation is not lost on the older citizen. The older person as a part of society as a whole regards him/herself as a sexual being who used to be sexual but is no longer. Thus, older people view sexuality that exists in their peer groups rather negatively.

Myths have proven useful in conditioning the victims of age discrimination in its many forms. Some older citizens may lie about their age, about their sexual wants and needs, and reject as unattractive and undesirable wrinkled skin, gray hair, and stiffened joints. The myths may also persuade them to accept the things society does to diminish them so that they actually believe that old age is a disease and their sexuality is a perversion.⁴
Margaret Kuhn's five myths are representative of the general thinking of society about the sexuality of older people. Myth 1 is "Sex doesn't matter in old age." The later years of life are supposed to be and usually are sexless. This myth has been reinforced and linked with the religious tradition that considers sex virtuous only when it is a means of procreation. According to this myth sex and sexuality were to wither away; it made it easy in the past simply to evade or avoid the question of sexuality.

A strong point is made by Kuhn that to rid society of this first myth people must view old age in its positive aspects and strengths. People must bring to old age a fresh appreciation of femaleness and maleness, and see sexuality as a source of happiness, pleasure, and joy.

Myth 2 is "Interest in sex is abnormal for old people." This myth is an aggravated form of ageism that is oppressive and cruel. Interest in sex should normally continue to the very moment rigor mortis sets in. In order to help combat the losses of the later years and some of the anxieties this new developmental phase of life may provoke, older people have to value their bodies and emotions and appreciate their own experience and wisdom. Part of that experience and wisdom is sexuality, and an interest in sexuality is normal rather than abnormal.
Myth 3 is "RemARRiage after the loss of a spouse should be discouraged." Women 65 to 74 suffer the most losses. Alone, they have an acute identity crisis. RemARRiage is also frequently opposed by adult children. Some are afraid of not inheriting their parents' money. Adult children hold rigid Victorian views about their parents' sex life and feel shame and shock that a widowed parent would want to remarry.

Myth 4 is "It is all right for old men to seek younger women as sex partners, but it is ridiculous for older women to be sexually involved with younger men." Old men have many opportunities to meet young women; many more nonmarital partners are available to men. Men also benefit by the "double standard" that condones illicit sexual activity for men but not for women.

Myth 5 is "Old people should be separated by sex in institutions to avoid problems for the staff and criticism by families and the community." This is ageism's ultimate indignity -- institutional segregation by sex and age. This kind of segregation allows no privacy for sexual intimacy.

Attitudes Toward Sexuality in Older People Including Those of Caretakers

"Society's antagonism to sex in the old can be summed up in seven words: Virility at 25 is lechery at
Society has a "peeping Tom" attitude of leering at and classifying with the phrase "dirty old man" the older men in our society. Our culture tells older women constantly and consistently, directly and subtly that they are old and are, therefore, unattractive and undesirable.

In a study conducted with university students and with staff members of a nursing home for older people, LaTorre and Kear attempted to assess attitudes toward sexual behavior in the aged. The data generated from the study yielded three major findings: despite widespread opinion that attitudes toward sex in older people would be negative, the results indicated a lack of negative attitudes when compared to that toward sex in younger individuals. Secondly, there was a finding that subjects in the sample did not believe the existence of sexuality in older people. The third and one of the more relevant findings is that while staff members were not more negative toward sex in older people in comparison to sex in young people, they were more negative toward sex than were the university students. This suggests that caretakers of older people have negative attitudes toward sex which may be expressed toward the older people in their charge.

The authors concluded that it will be necessary to change beliefs and attitudes of people who care for
older people in order that they might understand and accept the older individual's sexual problems, concerns, frustrations, and disappointments.

In many instances the sexless older years are a self-fulfilling prophecy. People begin to believe what society expects and teaches. For our older population society has suggested negative expectations regarding sexual activity in old age.9

Historically society's attitudes have stemmed from early puritanical approaches to sexual activity; this includes the older citizen.10 Another source of sexual puritanism toward older people is the concept that love and sexual activity are reserved for the young and beautiful.

Rubin writes, "The fullest expression of the sexual needs and interests of men and women over sixty cannot take place in a society which denies or ignores the reality of these needs and interests, or in an atmosphere which prevents full and open inquiry into them. Nor can it take place in a soil which nourishes every kind of myth and misconception about these later years. . . . Sexuality after sixty is not an invention of those who are studying it and discovering its extent and its variety of manifestations."11

A study by Davies analyzed jokes and humor of the culture and found that they did indicate attitudes toward
sexuality and aging.12 "The behavioral theory emphasizes that the function of humor is to reduce base drives and to provide stimulus-response situations which make survival easier. What is stressed in this view of humor is an element of superiority over others who are the brunt of the joke."13 Davies surveyed bookstores along a major Toronto street; all books containing generalized collections of jokes were obtained. The jokes were then categorized by major subject area, positive or negative, female or male or both.

Jokes about sexuality were the most frequent category (27%) and the majority (60%) were male-oriented. There were many more older men-younger women jokes and a smaller percentage (21%) of young men-older women jokes. Jokes about older women, although fewer in number than those about men, were largely negative.14 The conclusion Davies reached was that male aging is considered much more positively than female aging, especially for sexual functioning. The negative stereotype of the old unmarried woman is still very strong.

Federal legal codes sometimes reflect society's attitudes regarding sexual relationships between aging people. For example, although many senior citizens might have wanted to get married, one particular Social Security regulation induced 18,000 older men and women in the United States to "live in sin," since a larger monthly pension
was paid to the unmarried and not to the married person.\textsuperscript{15}

This regulation has been abolished.

Speaking as a panelist during the thirty-first annual meeting of the American Geriatrics Society in Toronto, Dr. Alex Comfort had several observations to make about society's attitudes toward sexuality in older people.

He said

\ldots it should be possible to give old people an understanding of normality in which sexuality is treated as a fundamental part of life at their age, just as it is at all other ages.\ldots where we can do it without pressuring or embarrassing them, we need to encourage and support the sexuality of the old. It's a mental, social and probably a physical perservative of their status as persons, and that status our society already attacks in many cruel ways. Sexuality is one of the peak experiences we can always continue to use. We can indeed stop mocking and segregating the old and aging. It is to their sexuality, after all, that we younger people owe our existence.\textsuperscript{16}

Many previous authors have written a great deal about the negative attitudes concerning sexuality and older people that many caretakers of older people hold. The lifelong sexuality concept is totally contrary to folklore and totally contrary to the conceptions of hospital and nursing home administrators.\textsuperscript{17} It is contrary even to the beliefs of many older people themselves.

Some nursing homes, rehabilitation centers, and even acute care hospitals need to revamp outmoded attitudes and restrictive rules about sexual activity among patients. Even if actual intercourse is not possible because of
infirmity, the need persists for the other aspects of sexual relationships such as closeness and sensuality.

Dr. Mary Calderone, executive director of the Sex Information and Education Council of the United States (SIECUS), observes that most nursing home trained personnel and staff reflect conservative community mores or the conventional attitudes of their administrators. All believe that they have to deal with issues far more important than geriatric sexuality.¹⁸

In some nursing homes there is very little privacy. With privacy there at least exists the opportunity for the display of affection and intimacy. Not only must society accept the idea that there is sexuality after 65, but also our culture must actively assist our older citizens to express it fully and to deal with their feelings about it.

It seems as though society has little sympathy for the sexual needs of older people living in the community and less for those in nursing home facilities. On some occasions signs of sexual interest are treated with ridicule, disdain, or horror.¹⁹

"Total care institutions tend to perceive the elderly as sexless. . . . Everyone fears sex and sexual activity. Administrators are concerned that they might not be able to control the private sexual activity; so, they desocialize, forbid, discourage, make sinful, dissuade, and
make unnecessary any display of compassion and sensuality amongst residents of these institutions."\(^{20}\)

Staff and employees also have problems with sexuality in the institutions since they, too, may not be comfortable with their own attitudes toward sexual activity. The lack of privacy in some institutions can be effective in prohibiting or inhibiting sexual activity as are the rules and practices of these facilities. Some institutions make little or no provision for privacy or opportunities for intimacy between spouses or friends.

Both Burnside\(^{21}\) and Glover\(^{22}\) comment on the physical and social restraints imposed upon older people in institutions. In some nursing homes in the United States, single beds and sharing of rooms by persons of the same sex are the practice. In some facilities husband and wife are assigned to different rooms, floors, or even buildings.\(^{23}\) Single or widowed older people are discouraged from any communal living arrangement and from marriage and remarriage.

Factors Influencing the Sexual Interests of Older People

An attending physician for a rural nursing home for many years, Norman West has several observations which help in understanding the factors influencing the sexual interests of the aging person:\(^{24}\)
1. Sexual desire and sexual activity do exist in older people, at least in a significant number of them.

2. Older people are willing to substitute modified forms of sexual activity when necessary.

3. If older people have lost desire or function, they can accept this fact without becoming upset or obsessed by it.

4. They continue to maintain high moral values as far as sex is concerned, and feel strongly that sex on any other basis is less than justified or satisfactory.

5. Their experience has been that sex in itself is not purely mechanical or physiologic, and that the important component needed to make it gratifying is love.

Pfeiffer and Davis have done a study in the determinants of sexual behavior in middle and old age. Their results cover a broad spectrum of sexual activity. They conclude that many diverse factors influence the extent of sexual activity and interest among men in the study; the most important include past sexual experience, age, subjective and objective health factors, and social class. Relatively fewer factors determine the extent of sexual activity and interest among women; they are
principally marital status, age, and enjoyment derived from sexual experience in younger years.

The data support another, more scientific notion, which is the continuity of life style. Persons to whom sex was of great importance early in life are more likely to continue to be sexually active late in life. Persons to whom sex was of little importance early in life will be more likely to reach an early terminus to their sexual activity in later life.

In addition, this study confirms earlier findings that the extent of an aging woman's sexual activity and interest depends heavily upon the availability to her of a societally sanctioned, sexually capable partner.

Physiological Changes in the Sexual Functioning of Older People

There are physiological changes in the sexual functioning of older people which make the pattern of sexual intercourse of older people different from that of youth.

A male does not experience a sudden climacteric; however, his testosterone level gradually drops until about age 60 at which time it stabilizes for the remainder of his life. Lowered testosterone results in: (a) a less firm erection which needs much direct tactile stimulation for development and maintenance; (b) the production of less ejaculatory fluid, which results in less frequent need to ejaculate; (c) a longer stimulative period preceding ejaculation; (d) fewer genital spasms during orgasm; (e) a lowered intensity of orgasm; (f) a qualitative change from an intense generalized focused sensation to a more diffused and generalized feeling of pleasure; and
(g) an increase in the length of the refractory period, during which time a man is unable to ejaculate or possibly to erect.

The lowering of the estrogen level during menopause results in sexual changes for the female, also. (a) There is a delay in the reaction of her clitoris to direct stimulation. (b) The vaginal opening becomes narrower, and there is loss of muscle tone in the vaginal walls. (c) There is less lubrication during excitement. (d) The intensity of her orgasm may be lowered. (e) Estrogen is an anti-androgen hormone, and as her estrogen level drops, the androgen/estrogen ratio in a woman changes. This ratio change may result in increased sexual interest.26

The above changes result in a changed sexual pattern for older couples. Excitement building is slower than in the past and involves more direct tactile stimulation. Intromission is physiologically more difficult—a less rigid penis, a smaller vaginal opening with less vaginal lubrication. There is less vaginal muscle tone to help maintain the erection. Both male and female will take longer to come to the point of orgasm/ejaculation and the orgasmic experience may be less intense than previously. Following ejaculation the male's refractory period will be longer, 12-24 hours, while the female continues without a physiological refractory period throughout her life. These physiological changes, the physiological realities of aging, do not appear to be compatible with the traditional norms concerning sexuality and aging. They do not imply a cessation of sexual activity, but seem to suggest a change in the pattern of that activity.
Sexual Behavior of Older People

Alex Comfort has stated, "Old folks stop having sex for exactly the same reasons they stop riding bicycles: One, they're generally infirm and can't ride; two, someone told them it looks ridiculous, or, three, because they don't have a bicycle." 27

After much research at Duke's Center for the Study of Aging and Human Development, Pfeiffer feels that there are plenty of "bicycles" among older people in spite of social pressures: "Approximately 80 percent of 68 year old men still retain an active sexual interest. Following these men over a period of 10 years shows only 5 percent lost such sexual interest, and at age 78, 75 percent are still sexually interested." 28

Pfeiffer found that marital status makes absolutely no difference on the extent of sexual expression of men. Quite the contrary is true regarding women. Marital status seems to make all the difference. Very few unmarried women report any degree of regular sexual activity in their later years. The unavailability of socially sanctioned sexual partners was the principal reason for discontinuing sexual activity on the part of many women.

When the opportunity and the partners are available, the older person can and does indulge and enjoy sexual intercourse well into old age. 29 Kinsey and his associates
found that the rate of decline in sexual activity in old age did not exceed the rate of decline in their previous decades. They found no point at which old age suddenly entered the picture.

In another study Newman and Nichols reported that only those 75 years and older showed a significantly lower level of sexual activity. They concluded that "given the conditions of reasonably good health and partners who are also physically healthy, elderly persons continue to be sexually active in their seventh, eighth and ninth decades."31

Pfeiffer, Verwoerdt, and Wang conducted a cross-sectional, longitudinal study concerning sexual behavior in aged women and men. They analyzed data about age and sexual activity, age and sexual interest, rising patterns of sexual activity and interest, reasons for stopping intercourse, and age at which intercourse was stopped. They concluded that on the basis of cross-sectional data there was a gradual decline of both activity and interest with advancing age. Longitudinal data, however, revealed that contrary to this general pattern a significant percentage of older individuals showed rising patterns of sexual activity and interest, an important finding not discovered on the basis of cross-sectional data alone. They also found that among aged persons who had already ceased having sexual intercourse, men differed from
women in that they tended to assign responsibility for stopping to themselves while the women regularly attributed this blame to their spouses.

Two out of three men in their early 60's are still sexually active; only one in five is still active in his 80's. Berman and Lief also found that in women about one fifth reported ongoing sexual activity. Ten years later there was virtually no decline in these proportions.

In men a number of factors contributed independently to sexual functioning. Age, antihypertensive drugs, and physical dysfunction ratings correlated negatively with continued active functioning. In women the principal factor involved in continuing sexual functioning was an available and interested partner.

In considering the variability of sexual behavior among older people, Snyder suggests that as the younger age cohort group grows older its members will be more permissive than the members of the previous cohort group. Thus, a greater range of individual differences is likely in the aged population of the future.

The crucial determinant in continuing sexual activity into old age seems to be regularity. Regularity of either intercourse or masturbation is highly correlated with the frequency of a couple's sexual activity. Comfort, Pfeiffer, Rubin, and Masters and Johnson all conclude that regular
sexual performance is the key element in helping maintain effective sexual capacity for both men and women.

Decline in Sexual Activity of Older People

Men, whether married or unmarried, showed a sharp drop of 71 percent in frequency of intercourse in the 72-74 age range. At age 75 the drop settled to 20 percent; this result is corroborated by Kinsey's findings. The evidence concludes that a healthy man should be able to have intercourse at any age, though not many do. There are many reasons why many do not.

One of the primary reasons that men do not engage in intercourse as they age is fear—fear of failure. According to Long the origin of this fear is found in older men's proneness to feelings of depression and unworthiness induced by their altered life circumstances; these feelings have a definite negative effect on male potency. A lack of self-confidence, caused in part by the absence of fairly regular sex habits, is also to blame for impotency.37

Ignorance in many cases compounds fear. Men do not realize that more time is required to achieve an erection and may panic and refrain from further attempts at intercourse. Lack of knowledge perpetuates the current myth that men who engaged in a high level of sexual activity most of their lives can expect to be "burned out" at a rather early age.
Some women do not engage in intercourse as they age because they experience pain in the process. A thin vaginal wall lining accompanied by a loss of elasticity contributes to coital pain, and strong uterine contractions can follow orgasm.

Butler and Lewis attribute decline in the frequency of intercourse to fear of death. Fears of heart attacks and strokes during sexual intercourse may result in twin beds and abstinence. Anxiety, depression, and hostility may accompany these fears as sexuality is inhibited.

The many cardiac patients receive little or no advice as to when or how sexual intercourse can be resumed after a heart attack. Both partners fear that sexual activity will precipitate another attack. The actual incidence of deaths related to sexual intercourse is not known, but death during exercise testing of cardiac patients on a treadmill when the heart rate is much higher and is sustained for a longer period occurs at a rate of only 1 per 10,000 tests.

Another cause for the decline of sexual activity in older people is the "widower's syndrome." This syndrome is typified by a man who is faced with the slow death of his wife after many years of marriage and who abstains from sexual activity during her illness. He becomes unable to function as he is sexually inactive for a long period of time and may be carrying memories and guilt. The male
needs to continue sexual activity to a reasonable degree or he will lose this function. Masters and Johnson feel that re-education and sensual experiencing will gradually relieve the problem.\(^{40}\)

Drugs used for hypertension and nervous disorders adversely affect potency and libido. They include amphetamines, all antidepressants, all tranquilizers, and alcohol. Alcohol is a severe depressant and a contributor to premature ejaculation and impotence. Some physical diseases like diabetes produce varying losses in sexual ability.

Masters and Johnson list several causes for sexual dysfunction in the older age group.\(^{41}\) Physical illness, notably hypertension, heart disease, prostate surgery and aortic stenosis, was correlated with some sexual dysfunction, as was fear of failure. In two cases strict upbringing and sexual ignorance had made sexual functioning difficult.

Sexual dysfunction in older couples in the absence of physical illness, stems from two separate but related issues: (1) Lack of knowledge of changing physiology in the face of aging and (2) dysfunctional marital relationships, either short-term because of life stresses, or long-term because of long-standing problems. Older couples respond to the same techniques as do younger couples with the same kinds of sexual problems.\(^{42}\)
Intercourse techniques pertinent to the needs of older people should be clarified. Physicians must be more specific about the sexual effects of medical problems like coronary attack, vaginal discomfort, arthritis, diabetes, prostatectomy, drugs, alcohol, and medication.

After the age of 60, sexual adjustment often requires more patience and intelligence than it did when the couple were in their thirties. Dr. Masters said: "There are only two factors that must be present for effective sexual function regardless of age. One is a reasonably good state of general health, and the second is an interested and interesting partner." 43

Sexuality and Self-Esteem

Butler and Lewis feel that sex, self-esteem and self-image are closely related. 44 Trained professionals and staff members should help older people deal with their personal feelings, fears, and possible misunderstandings about sex in old age. Because a person is aging and changing does not mean that s/he is losing sexuality as a component of her/his personality.

The older person whose sexuality is discouraged and overtly or covertly inhibited may have her/his self-esteem lowered with resulting depressive, self-deprecating beliefs. 45 This might be the case more with a male than
with a female since sexuality is more often associated traditionally with self-image and self-esteem for the male.

Beginning with a broad definition of sexuality because it is an inseparable part of one's identity and one's self-concept, Hinkley states that there are varied physical, emotional, and relational aspects of which the sexual act itself is but one element.46 To each comes the need to relate to others in terms of her/his sexuality. The older adult, in fact, may have an even greater need to express her/himself as a sexual human being since some of the former means of satisfying those needs for belonging, esteem, and self-actualization may have been eliminated from her/his lifestyle--jobs, spouse, friends, health.

There is a need for love and belonging as part of one's sexuality, a need that does not diminish as one ages. Losses may well increase the desire for need gratification related to one's sexuality. Hinkley suggests that the need for touch as part of our expression of our sexuality is an integral part of the need for self-esteem. In touching and in being touched, we affirm our existence and find justification for our existence.47 The need for self-actualization does not diminish with age. In failing to satisfy sexual needs, we also fail to satisfy some of the self-actualization needs related to our identity.48
Sexuality Education for Older People

Repeatedly throughout the literature and related research, the theme is the same; there is a desperate need for sexuality education not only for older people, but also for those who work with and for older people. Burnside has made several suggestions for interventions to improve the atmosphere of the aging person with regard to sexuality:49

1. To become better educated about sexuality in all stages of human development

2. To increase self-awareness so that we can begin to change our own attitudes as necessary

3. To discuss sexuality openly with staff, peers, and students so that problems can surface and be handled with common sense and honesty, but without embarrassment

4. To assess the milieu in which older people live and to manipulate that milieu to provide more opportunities for them to express their own sexuality

5. To strive to better understand the older person's lifestyle and the life s/he has been accustomed to living. Many lived during the era when sex was not discussed.
6. To study our own approaches and to consider our friendship, touch, companionship, and interest as therapeutic for older people. Not all intimacy occurs in bed.

7. To respect older people, whatever their views on sexuality may be.

8. To be more courageous about intervention on behalf of older people in matters of sexuality.

9. To consider the positive aspects of sexuality in older people.

Sexuality education for older people is important. The social system should be pressed by individuals and groups at all levels through all educational organizations to provide courses, programs and parts of study units on aging and all of its processes. Finkle believes that improved and better disseminated education in human sexuality, particularly as applied to older patients, is clearly needed among members of the medical profession.

Glover states that older people are vitally interested, terribly confused, and hungry for information about the norms of sexuality in the geriatric population. Pfeiffer reports a lessening of taboos and more boldness among older people in asking for help in this area.

Attempts at a solution of the problems existing for older people and suggested approaches for the satisfaction of sexual needs of older people are offered by Ivor
Felstein.\textsuperscript{54} He feels that the elementary step is to educate professionals who can then, as part of their work routine, teach others or possibly unteach others. He advises counseling the disabled, or people without partners, to the understanding that a variety of valid, normal outlets exist and that experimentation can help them discern what best alleviates their individual experience of sexual tension.

A key element in the treatment of sexual functioning in older people is that older people need and want information on the sexual norms of their peers.\textsuperscript{55} They tend to withdraw from social interaction because they do not know what is normative for their age group. According to Masters and Johnson, ignorance is one of the greatest deterrents to effective sexual functioning in all ages, but it has been most damaging to older people.\textsuperscript{56}

Research Techniques Previously Used Among Older People Regarding Gerontological Sexuality

Perhaps the best known research regarding sexuality was done by Alfred Kinsey and his associates Pomeroy, and Martin. His extensive studies of both male and female sexuality were published in 1948 and 1953, respectively. In order to obtain his data Kinsey relied solely upon the interview technique, involving a full year of training for each interviewer before he was ready to take any sexual
histories. The trainee was given an opportunity to interview in the presence of more experienced staff members. In addition there was an opportunity to re-take histories which others had previously taken, and the trainee's own subjects were given re-takes by more experienced interviewers.

Covering tens of thousands of cases, Kinsey allowed a limit of twenty-eight years for these projects. Each interview lasted approximately an hour and a half or two hours. He considered his research a preliminary survey.

Kinsey did an 18-way breakdown by five year periods ranging from a group which had its maximum age at 5, to a group with a maximum age of 90. The research shows only three areas in which statistics were presented for males age 65 and older: age and total sexual outlet/frequency per week, age and the physical and physiological characteristics affecting sexuality, and old age and impotence. The areas for which statistics did not cover this age range were: age and animal contacts, age and homosexual outlets, age and marital intercourse, age and nonmarital intercourse with companions, age and nonmarital intercourse with prostitutes, age and masturbation, age and nocturnal emissions, and age and petting to climax. Although gerontology is listed in the index in the male sexual behavior edition, it is omitted in the female version.
For the female the age range was the same as for the male; however, Kinsey reported that the older groups of women were inadequately represented in the sample. With one exception which was a descriptive table, there are no tables of statistics for single women over age 55 or married women over age 50. Similarly most of the statistical tables described single men to the age of 50 and married men to the age of 60.

With the interview survey technique Kinsey still had some difficulties in obtaining information. He attributed these difficulties to questions asked which were inapplicable to the subject, refusal by the subject to reply, and the subject not answering according to directions.

Kinsey did not ask direct questions about sexual attitudes feeling that the individual's overt sexual experiences were evidence of one's attitudes about sex. Some questions were asked, but Kinsey experienced little confidence in the verbalizations of attitudes which each subject expressed. Kinsey felt that these verbalizations were not those of the subject who was interviewed "but reflections of the attitudes of the culture in which the subject was raised." There were no questions, whatsoever, asked subjects about their sexual knowledge.

Although there was no information elicited about either sexual knowledge or opinions or attitudes about
gerontological sexuality issues Dr. Bernard Starr traveled around the country to senior citizens centers and senior communities administering to volunteers an open-ended questionnaire. The questionnaire asked for the factors which contributed to the sexual life of the respondents. In addition researchers found a wide acceptance of nudity, little self-consciousness about aging bodies and little anxiety about the decline of sexuality as they got older. The biggest problem these researchers encountered was getting past the gatekeepers. Although the respondents took the questionnaires home, there was no information as to how they were returned to the researchers.

Masters and Johnson, in their book Human Sexual Response, spent 48 pages discussing geriatric sexual responses. Their data on aged men and women were obtained from both active participation of their subjects in the laboratory of the investigators and from interviews. There were 20 men and 13 women over age 60 who cooperated actively in these studies. Again these subjects were interviewed in regard to their sexual behavior. As a result of these interviews Masters and Johnson concluded that lack of knowledge was one of the most damaging factors to older people in terms of their sexual functioning.

Eric Pfeiffer at the Duke University Center for the Study of Aging and Human Development has done a great deal of research regarding gerontological sexuality for almost
30 years. With various associates he has looked at sexual behavior in middle and old aged people. In his research with Davis to identify the determinants of sexual behavior in middle and old age, Pfeiffer gathered data on sexual behavior as part of a self-administered medical history questionnaire. With Verwoerdt and Wang Pfeiffer elicited data on sexual behavior during a structured interview. The interviewer was always a psychiatrist. These data were obtained solely about sexual behavior and did not deal in any way with opinions or attitudes about gerontological sexuality.61,62

A pilot study was done on older adults attending a program on human sexuality by Terri Brower and Libby Tanner of the University of Miami in Florida. The two hypotheses formulated were: (1) a significant change in older adults' knowledge about human sexuality will occur following completion of a planned program on human sexuality, and (2) a significant change on older adults' attitudes about human sexuality will occur as a result of attending a planned program on human sexuality.

A pre- and posttest were designed for use for older adults. They were adapted from the Sex Knowledge and Attitude Test (University of Pennsylvania Center for the Study of Sex Education in Medicine, 1972) and Attitude and Knowledge Assessment (Concept Media Human Sexuality and Nursing Practice, 1975). There were many difficulties
encountered by the researchers: (1) the testing caused high anxiety, (2) many subjects could not read the test and had to have the questions read to them, (3) during the testing session one subject became verbally disruptive and stated that it was disgusting to discuss sexuality openly, (4) while 30 subjects took the pretest, only four were able to posttest. Lastly, the subjects involved may have been under psychiatric care and medication. The investigators suggest that a "normal" and better educated sample be used.

Although this study did investigate the attitudes and knowledge of older adults in an institutional setting, the study utilized a questionnaire which did not deal solely with gerontological sexuality, rather it dealt with the area of sexuality in general. According to Brower it was unsuccessful.63

Summary of the Review of Literature

Myths and stereotypes have existed not only for the general population but for older people as well. Many of the stereotypes regarding sexuality and older people were a result of social control mechanisms.

Societal myths have conditioned older people to reject themselves as sexual human beings who may still function normally as sexually active individuals. They see nothing appealing or attractive about their physical appearance and,
consequently, feel that they must be considered undesirable sexually. The myths are reinforced daily in a variety of ways by the multimedia of mass communication.

Margaret Kuhn's five myths are indicative of society's thinking about sexuality and older people. They are (1) Sex doesn't matter in old age, (2) Interest in sex is abnormal for older people, (3) Remarriage after the loss of a spouse should be discouraged, (4) It is all right for old men to seek younger women as sex partners, but it is ridiculous for old women to be sexually involved with younger men, and (5) Old people should be separated by sex in institutions to avoid problems for the staff and criticism by families and the community.

Some of society's negative attitudes toward sexuality in older people have stemmed from our early puritan upbringing. One author has suggested that these attitudes may spring from a long--dormant Oedipal complex.

In analyzing humor it was found that jokes did indicate negative attitudes toward sexuality and aging. The conclusion reached was that male aging is considered much more positively than female aging.

Certain federal codes which were enacted also reflect society's attitudes toward sexuality and older citizens; although no longer in existence today, these laws penalized the older married couple by reducing the size of their individual social security checks.
Much has been written about the negative attitudes of caretakers regarding the older person and sexuality. Many institutions for older people have restrictive codes regarding intimate relationships among residents. The lack of privacy is the most restrictive measure which inhibits sexual activity in institutions.

Older people have sexual interests and a variety of studies have tried to determine what factors influence these interests. The conclusions are that the factors are diverse and broad. The most important factors for men were past sexual experience, age, and health status; for women the most significant factor was the availability of a socially sanctioned, sexually capable partner.

The research has shown also that there is sexual activity well into the seventh, eighth, and ninth decade of life. For men marital status made no difference; it was not the case for women. With good health and with the availability of a healthy partner, older people's sexual activity did not stop. Sexual activity, if enjoyed in the past, continued into old age.

A number of factors did contribute to the decline of sexual activity in older people. One of the primary reasons is fear, fear of failure. Lack of knowledge can compound the fear leading to a vicious cycle of impotence, depression, and impotence. Some women do experience pain during and after intercourse because of the physical
changes in the vagina. Some older people stop having intercourse because of fear of having another heart attack or stroke. The "widower's syndrome," drugs, alcohol, and diseases all may account in some measure for a decline in sexual activity.

Sexual dysfunction in an older couple can be treated using the same techniques that would be applicable for a younger couple. Sexual adjustment for a couple over 60 may require more patience and knowledge than when this couple was younger.

Several researchers firmly believe that sex, self-esteem, and self-image are closely related. Sexuality is an important part of one's identity and self-concept. Losses in old age may increase the desire for sexual gratification as a part of identity.

Sexuality education for older people is vital for their well-being. Not only should they be educated as to the processes of aging and its implication for their sexuality, but also the professionals and staff members who work with older people in order to better understand their needs and concerns. Older people need and want information on the sexual norms of their peers; the lack of information has been very damaging to older people in their sexual functioning.

Much research has been done about gerontological sexuality and almost all of it has been concentrated in
the area of sexual behavior; little has been done in terms of the opinions and attitudes of older people about geriatric sexuality. The most widely cited research about sexuality is that of Kinsey and his associates. By his own admission, however, his research dealt primarily with sexual behavior. Although his statistical tables do cite statistics for women and men over age 65, these are infrequent citations. Kinsey reported that the older groups of women were inadequately represented.

Kinsey collected his data by interview; Bernard Starr used open-ended questionnaires. He distributed them to volunteers who were members of intact groups like social organizations and community retirement homes. His greatest difficulty was in getting past the caretakers.

Unlike Kinsey or Starr, Masters and Johnson gathered their data from both active participation of their subjects in their laboratory and from interview. Their findings, although related to sexual response, had implications for sexuality education. They concluded that ignorance was the greatest deterrent for sexual functioning.

Pfeiffer and his associates looked at sexual behavior. They gathered data as part of a self-administered medical history questionnaire. They also used the interview technique.

After a course of two lessons on human sexuality Brower and Tanner from the University of Miami hoped to see
a significant change in attitudes and knowledge on a post-test. This test was adapted by them from existing instruments on sexual knowledge and attitudes and was geared toward sexuality education in general. It was an unsuccessful pilot study because it induced anxiety in the subjects, was difficult to read, and was not designed for an older population in an institutional setting, some of whom were under psychiatric care and on medication.
NOTES


5Kuhn.

6Kuhn, p. 123.


9Rubin, Isadore cited in Abernethy, p. 51.


13Davies.

14Davies, p. 221.


17 Comfort, p. 56.

18 Calderone, Mary cited in Moss and Moss, pp. 105-106.


23 Burnside, p. 20.


27 Comfort, Alex cited in Downey, p. 57.

28 Pfeiffer, Eric cited in Downey, p. 57.

29 Pfeiffer and Davis.


31 Newman and Nichols, pp. 33-35.

33. Pfeiffer, Verwoerdt, and Wang.


37. Long, p. 238.


40. Masters and Johnson cited in Downey, p. 59.


42. Masters and Johnson cited by Berman and Lief in Oaks, p. 130.

43. Masters and Johnson cited in Downey, p. 59.

44. Butler and Lewis, p. 103.

45. LaTorre and Kear, p. 204.

46. Hinkley.

47. Hinkley.

48. Hinkley.

49. Burnside, pp. 24-25.

50. Davies, p. 224.

51. Finkle, p. 304.

52. Glover, p. 166.
53 Pfeiffer cited in Glover, p. 166.


56 Masters and Johnson cited in Sander, p. 504.


60 Starr, Bernard. "Older Americans Air Their Sexual Views," Questionnaire Results Research on Aging. New York: N.D.

61 Pfeiffer and Davis.

62 Pfeiffer, Verwoerdt, and Wang.

CHAPTER THREE
METHODS AND PROCEDURES

Survey Studies

Survey studies are really difficult to accomplish because of a variety of accompanying difficulties. Kerlinger, author of *Foundations of Behavioral Research*, says that, "Survey research is a useful tool for educational fact finding. It is best adapted to obtaining personal and sociological facts, beliefs, and attitudes."¹ It can be accurate within sampling error, it provides a wide scope and can gather a great deal of information.

Kerlinger also states that the reliability of personal factual items like income, age is high; reliability of attitude responses is harder to determine. The reliability of average responses is higher than reliability of individual responses.²

There are also disadvantages to survey research. The scope of information can be had at the expense of depth. It can be extremely demanding in terms of time and money. It is subject to sampling error. Subjects tend to give socially acceptable answers. It is possible for respondents to detect socially sanctioned ideas and behaviors in some survey instruments.
Frequently used in survey research is the questionnaire. It is easy to administer and saves time for the investigator. There are both advantages and disadvantages in its administration. It is not personal; the subject may feel no obligation to fill it out once s/he has received it; on the other hand the subject may fill it out because s/he experiences a feeling of complete anonymity. Subjects can complete the questionnaire, leave it incomplete, or fill it out incorrectly. Usually there are subjects who agree to participate and then fail to respond. If there is anonymity, the investigator may be unable to check responses given. There is low return of mailed questionnaires. Because of all of these factors, generalizations should be made with great caution. Although extremely difficult to do, survey research can provide for program development through knowledge about an intended audience that the program designer would otherwise not have. It is for this reason that this survey research was done.

This study was designed with a threefold purpose: (1) to develop an instrument for the assessment of opinions about gerontological sexuality, sexual attitudes, and the sexual activity of a normal population of older people in the Cincinnati area; (2) to establish baseline data as a result of the assessment; and (3) to consider the
implications of the data generated as a basis for educational programming.

The variables in this study were the scores on the various sections of the questionnaire and the following demographic characteristics: age, sex, living quarters, race, religion, marital status, number of marriages, number of children, description of present health condition, medical problems, chronic conditions, educational level, and income at the time of retirement. These characteristics as well as the scores on the Opinion, Attitudes, and Activity Sections of the questionnaire were correlated. As part of this intercorrelational matrix, supplementary material was included pertaining to educational programming with items related to communication about sexuality among older people, and their sources of information about gerontological sexuality.

Population and Sample

The target population for this study was adult women and men age 65 and older who were ambulatory, not hospitalized, and who were unimpaired intellectually, sensorially, and emotionally. Subjects were volunteers who felt that they met the above criteria and were able to read and write without assistance.

In selecting the population, the investigator received assistance from the director of the Cincinnati, Ohio, Council
on Aging. He suggested several senior citizen social organizations which have members who in the past had been willing to participate in studies. The investigator also used volunteers who appeared to meet the criteria from senior citizens' residences, either private housing for older people or retirement homes. Where appropriate and whenever possible, the investigator asked staff members who knew potential volunteers to screen them. The staff personnel who worked with many of the older people, by the nature of their working relationship and contact, were able to assess and, therefore, screen volunteers so that the final participants met the criteria of being ambulatory, not hospitalized, and unimpaired intellectually, emotionally, and sensorially. The investigator again screened by carefully looking at the volunteer's responses to the questionnaire to see if they were appropriate to the questions asked.

Development of the Questionnaire

The investigator surveyed and adapted items from several instruments used previously to obtain data from subjects about their sexual knowledge, opinions, attitudes, and levels of activity. These instruments were targeted primarily for a young adult population.

After selecting approximately two hundred items, the investigator adapted or modified the items appropriate for
a target audience of people 65 or older. The items were used as either attitude statements to which subjects might respond "agree," "disagree," or "undecided;" or the items were offered as statements of fact to which the subject responded "agree," "disagree," or "uncertain," where agree equals true and disagree equals false.

Items which appeared to the investigator to be unclear, inappropriate, or duplications, or items for which there were still no conclusive answers were dropped. The remaining items were then grouped into subscales for the attitude section and the opinion section. Within the attitude scales there were four subscales: masturbation, gerontological sexuality, acceptability of sexual behavior, and homosexuality. Within the opinion scales there were three subscales: social/psychological aspects of older sexuality, physiology of older sexuality, and medical aspects of older sexuality.

The items chosen for the activity section of the questionnaire also were adapted for an older target population by the investigator from already existing instruments.

The final section of the questionnaire on educational programming contains those items considered by the investigator to be of significance to a program designer.
Content Validity and Reliability of the Instrument

A logical, step by step procedure was utilized to ensure content validity of the instrument. First, the investigator submitted a tentative instrument to an older married couple, a single older woman, and a widow for their consideration. With their suggestions and revisions incorporated, the instrument was then submitted to a panel of experts, authorities in the areas of sexuality, gerontology, and related fields.

The experts who served as a review panel for the questionnaire were selected because of their expertise in the areas of sexuality and gerontology. They represent a variety of practitioners and theorists in these fields. They are Bonnie Fass, an administrator of a high rise apartment building in Columbus, Ohio, for older people on poverty level incomes; the rents are subsidized by the federal government. Dr. Leopold Liss is professor of Pathology and Psychiatry at The Ohio State University Medical School; as a psychiatrist he deals primarily with geriatric patients. Dr. Henry Angelino is professor of psychology at The Ohio State University and teaches a course on the psychology of aging.

A professor of sociology, Dr. Jerome Kaplan also is an administrator of a nursing home in Mansfield, Ohio. Franklin Nathan is the director of a private nursing home
which offers three levels of living within his institution.

Nan Levin is currently a social worker at the Jewish Community Center, Cincinnati, Ohio, and serves the senior citizen organization, "The Golders," exclusively. Last, Dr. Terri Brower is professor in the Schools of Nursing and Medicine and teaches in the Nurse Practitioner Program dealing with geriatric patients at the University of Miami.

These experts were asked to make editorial comments, reword statements, and indicate on their copy of the questionnaire if they disagreed with the responses of the investigator as to whether the opinion items were true or false. There was 100 percent agreement among the panel of experts regarding the appropriate responses. Also, their suggestions and revisions were incorporated in the instrument where appropriate. The instrument was further refined for content validity as a result of a pilot study.

Pilot Study

A pilot study was conducted by the investigator in the greater Columbus area. With the assistance of Dr. Cory Bates, professor in health education and specialist in gerontology at The Ohio State University, the investigator selected four potential sites for the pilot study project. A list of those sites is in Appendix G. A letter was
mailed to the director or administrator of the site explaining the nature and purpose of the pilot study, describing the criteria to be met by those who might volunteer. The letter further explained that the investigator would follow up the mailing with a personal telephone call.

Before the investigator responded with the follow up telephone call, staff members of two sites called the investigator to say that they felt that the study would not be appropriate for their clients. The administrators of the remaining two sites agreed to have their clients participate in the study.

The investigator met with each administrator where the pilot study would be carried out, explained the study, shared the instrument, and reiterated the criteria to be met by those who might volunteer. She left 21 questionnaires at Heritage Tower and two at the First Community Village. Fourteen subjects at Heritage Tower and both subjects at The First Community Village returned their questionnaires in self-addressed, stamped envelopes. Thus, 16 people participated in the pilot study. The administrator of Heritage Tower was extremely interested in and supportive of the study and requested results when they were available.

After the pilot study several changes were made in the instrument. Because so few subjects selected the weakest responses, the six response scale was modified to a five
response scale with the middle response as "undecided." Items were dropped from the attitude scale because subjects indicated that certain items were difficult to understand.

Because several subjects did not respond to items which were about the opposite sex, statements were added in a cover letter of instructions to answer all items whether or not they pertained to either sex. In addition, there were several reminders on alternate pages of the final questionnaire that subjects were to answer all questions.

After the pilot study, the method of administration was changed from on site groups responding to the questionnaire in the presence of the investigator to individuals receiving the questionnaire with a self-addressed, stamped envelope, completing it on their own, and then returning it by mail to the investigator.

The Final Questionnaire

The first section of the questionnaire, Part I, was a 22 item, true-false opinion test. Part II was a 28 item attitude scale. Part III was a 19 item section to gather descriptive data about the sexual activity of the subjects. It also asked subjects to respond and to compare themselves to others in their age group in terms of sexual knowledge, attitudes, activity, adjustment, and experience. The fourth part of the questionnaire was a 14 item section designed to
obtain demographic data for each respondent. Section V contained items designed to elicit information about educational programming regarding gerontological sexuality. A copy of the complete questionnaire is found in Appendix A. Each of the sections will be discussed in greater detail.

Opinion Section - Part I

The opinion section was designed by the investigator to measure the respondents' beliefs about gerontological social sexuality, and was a 22 item, true-false test. It had three subscales within it: (1) Social/psychological aspects of older sexuality, (2) Physiological aspects of older sexuality, and (3) Medical aspects of older sexuality. Respondents were asked to circle the word AGREE if they agreed with the statement, DISAGREE if they disagreed, and UNCERTAIN if they were unsure of their opinion. An example of an item in the opinion section is "People who stay active sexually are able to continue well into old age."

Attitudes Section - Part II

The attitudes section was a 28 item test designed by the investigator to measure attitudes of older people. Respondents were asked to indicate their feelings about the statements by circling the number 1 if they strongly
agreed, and the number 5 if they strongly disagreed. They were asked to circle the intermediate numbers according to the relative strength of their feelings. They were instructed that there were no right or wrong answers. An example of an item in the attitudes section is "Nursing homes should help older people to have sexual opportunities." This test also had subscales within it: (1) Masturbation and older people, (2) Gerontological sexuality, (3) Acceptability of sexual behavior, and (4) Homosexuality. Both the subscales of the Opinion and Attitude Sections can be found in Appendix B.

Activity Section - Part III

Part III of the questionnaire was designed by the investigator to obtain information about the sexual activities of the older participants. It also asked respondents to compare their knowledge, attitudes, experience, adjustments, and activity in sexual matters to that of others in their peer group. It was an attempt to gather knowledge about their actual levels and kinds of sexual activity. An example of an item in the activity section is "Do you still engage in sexual intercourse?"

The questions in the Activity Section were personal and intimate. There were 19 items to which the subjects were asked to respond; the questionnaire states that subjects are
to answer honestly and to omit any questions they felt were too personal or intrusive.

Demographic Characteristics Section - Part IV

The remaining section of the questionnaire was designed by the investigator to gather descriptive data essential for the completion of the study. A 14 item section, the information called for included sex, age, living quarters, race, religion, marital status, number of marriages, number of children, description of present physical and mental health condition, medical problems, chronic conditions, educational level, and income at the time of retirement.

Educational Programming Section - Part V

Included in the Demographics Section were several questions to which subjects responded. These responses provided some of the information needed to discuss program development for sexuality education for older people. These data did provide the base in terms of implications and guidelines for program development. These areas included: (1) sources of information about sexuality in older people; (2) educational programming suggestions; (3) communication about sexuality by older people; (4) perceptions of older people as to the way in which their sexuality was perceived by younger people.
Final Procedures

A letter was mailed to the directors of retirement housing, subsidized public housing for older people, and administrators of social organizations for senior citizens. The investigator explained in the letter the nature and purpose of the study and described the criteria to be met by those who might volunteer (see Appendix H). The letter stated that the investigator would follow up the mailing with a personal telephone call.

When the investigator called, she requested an appointment with the appropriate staff member(s) to further explain the study. At the follow up appointment, the investigator brought the instrument and subject consent forms and discussed the feasibility of obtaining volunteers at that location. The length of the test session was discussed as well as the best time to approach subjects. Additionally, the investigator discussed her proposed method of dealing with subjects' fears and anxieties. At the meeting the investigator attempted to ascertain the probable number of respondents at that location.

The investigator returned at the prearranged time, day and place and discussed the nature and purpose of the study with potential volunteers. After answering questions, and speaking to concerns, issues, and problems, she asked for volunteers and then distributed the questionnaires with
a cover letter of instructions (Appendix K) and a self-addressed, stamped return envelope.

The investigator also obtained volunteers from mailing lists furnished to her by the directors of private retirement housing. To those potential volunteers was mailed the questionnaires with a letter of instructions, a self-addressed, stamped return envelope, and a cover letter explaining the nature and purpose of the study. This letter also included the directions to return the questionnaire in the stamped envelope if the potential volunteer did not care to participate in the study (Appendix J).

The instrument itself was prepared in jumbo type, appropriate for easy readability. In order to ease the respondents into the questionnaire and lessen any shock quality to the instrument, the sections of the instrument appeared in the following order:

1. Consent form
2. Demographic section
3. Educational programming
4. Attitude section
5. Opinion section
6. Activity section
Reliability and Validity of the Instrument

Reliability of the Questionnaire

Upon the advice of two independent statisticians, the instrument was not analyzed statistically to determine reliability. Rather the instrument was scrutinized by the investigator using internal consistency checks and the results of the pilot study. It is difficult to submit the Opinion Section of the instrument to statistical analysis when the responses of the subjects to true-false items might be conjectures and not based on knowledge or understanding. Even though there were some modifications made to the instrument after the pilot study, the responses from the pilot study and the responses from the present study did indicate reliability.

Validity of the Questionnaire

The instrument was not analyzed for validity other than content validity as previously described. Repeated utilization and the test of time may measure its validity.

Procedural Problems and Limitations of the Study

Procedural Problems of the Study

In order to complete this study these procedural problems had to be addressed:
1. To find, select, adapt, or develop an instrument appropriate to the level of understanding of older subjects.
2. To establish content validity and reliability for the instrument.
3. To gain cooperation from professionals and staff members so that the investigator was allowed to use volunteers from senior citizen housing and social organizations.
4. To establish rapport and create an atmosphere conducive to obtaining candid responses from the older subjects.
5. To obtain a sufficient number of subjects in order to generate data sufficient for a realistic assessment to be made.

Procedural Limitations of the Study

The following limitations were imposed:
1. Subjects had to be able to complete the instrument without assistance. Screening by staff members aided in subject selection.
2. The extent to which subjects were able to comprehend sexuality terminology and subsequently make the appropriate responses. The instrument was submitted to experts in the field for the appropriateness of language.
3. Volunteers as subjects may be the basis of biased responses. As these subjects were not a random sample, they may not be representative of the whole. This is an external validity concern over which the investigator had no control.

4. The investigator's ability to gather a sufficient number of subjects to participate in the study so that an accurate assessment of older people's perceptions of gerontological sexuality could be made. A time limit was imposed for reasons of practicality as to how many subjects were able to be included; generalization, therefore, was limited because of the likelihood of a small, biased sample.

Analysis of the Data

The Opinion Section, Part I, was analyzed by each subject receiving a score for the number of responses which agreed with the panel of experts. This was stated as the number "correct" or "incorrect." Each of the three subscales was scored in the same way. Attention was drawn to deficits in these subareas by recording the number of "uncertain" responses.

Part II, the Attitudes Section, was scored for liberalness or those attitudes which were accepting about sexuality, and for conservativeness or those attitudes which
were restricting concerning sexuality. Each of the four subscales received a score as well.

For the Activity Section, Part III, responses were expressed in terms of percentages for each individual item.

The demographic data were used to describe the characteristics of the sample. Using Pearson $r$ product-moment correlations an intercorrelational matrix was run to determine if specific demographic characteristics were related to the scores of the other sections and their subscales. Chi square contingency tables were run to determine if possibly related variables were contingent upon or independent of one another.

Pearson $r$ product-moment coefficient were used because the variables were scored on an interval basis as the data were coded at intervals. The chi square test for independence was used in analysis because the study dealt with one sample and was concerned with variables that were quantified as mutually exclusive categories. The level of measurement for the variables was for the most part nominal. The statistical significance level of probability was to be determined at the .05 level or greater.

For the Pearson $r$ product-moment coefficient the conventional measures of association were accepted: .70 or higher indicated a very strong relationship; .50 to .69 indicated a substantial association; .30 to .49 indicated
a moderate association; .10 to .29 indicated a low association; and below .10 indicated a negligible association.5

Supplemental and programmatical material was analyzed in the following way: (1) sources of knowledge were rank ordered and expressed in percentages; (2) interest or motivation to learn more about gerontological sexuality was expressed in percentages and was correlated with scores in the Opinion and Attitude Sections; chi squares were also run; (3) communication about sexuality was expressed in percentages; and (4) the way older people saw their own sexuality perceived by younger people was expressed in percentages. All of the items in the questionnaire were included in an intercorrelational matrix. The data were also analyzed to determine what implications there were for educational programming.

Summary

The subjects for this study were normal men and women age 65 or older. Each respondent completed a questionnaire. Part I was a 22 item, true-false-uncertain opinion section about gerontological sexuality. The next section, Part II, measured attitudes; it was a 28 item section with a five scale range. Part III was a 19 questions section surveying subjects about their sexual activity and asking them to compare themselves to others in their peer group concerning knowledge, attitudes, adjustment, experience,
and activity regarding sexuality. Part IV was designed to gather descriptive information for each of the respondents. The questionnaire was given or mailed to volunteers who completed it at their leisure and returned it to the investigator in a self-addressed, stamped envelope.

For the Opinion Section and its subscales the number of correct responses was counted. The Attitudes Section and subscales were measured for liberalness or conservativeness by adjusting the scores to reflect either liberalness or conservativeness and then adding them together. The results of the Activity Section were expressed in percentages. The demographic data were used to describe the sample and to intercorrelate with the rest of the responses to the instrument.

The instrument was analyzed to determine its future usefulness. The last phase of analysis explored and considered the implications of the data generated in terms of educational program development. In addition, there was a discussion of recommendations for further research.
NOTES


2Kerlinger, p. 417.

3Fred Ruland, Statistician, Statistics Laboratory, Cockins Hall, The Ohio State University.

4Frank Dietrich, Statistician, Mathematics Department, Landrum Hall, Northern Kentucky University.

5Kerlinger.
CHAPTER FOUR
PRESENTATION AND ANALYSIS OF DATA

The first section of this chapter describes the sample population in terms of its personal and demographic characteristics. The next two sections deal with the attitudes and opinions held by this sample about gerontological sexuality and are described in terms of associational statistics. The final section presents the responses of the sample to inquiries regarding educational programming.

Descriptive Characteristics

The descriptive characteristics are those obtained in the first section, Part I, of the questionnaire. They include gender, age, living quarters, race, religion, marital status, living arrangement, number of marriages, number of children, description of the present condition of physical and mental health, medical problems, chronic conditions, education level, and income at the time of retirement. In addition this section contains subjects' responses to questions related to educational programming which are analyzed separately.
Respondents

There were originally 92 respondents. Ten subjects were dropped from the study because they failed to respond to various items and, consequently, had too much missing data. Nine items were not analyzed because a large number of subjects failed to respond to them. All of the items that were dropped from the analysis will be discussed in greater detail in Chapter Five. In addition there will also be a discussion as to the determination to drop ten of the original 92 respondents. Therefore, the analysis of the respondents of 82 subjects is presented. All respondents in the study were 65 years of age or older, able to complete the questionnaire without assistance, and mail it back to the investigator. All were volunteers.

Of the 82 respondents 62 were females and 20 were males, 75.6 and 24.4 percent respectively. The youngest respondent was 65, the oldest 85. The largest percentage of people, 47.6 percent, was within the 65 to 69 age range. This range accounted for almost half of all the respondents. The next five year range, 70 to 74 years, accounted for almost 30 percent of the sample. Twenty-three percent, the remainder of the subjects, was in the 75 to 85 age range (see Table 1).

In regard to living quarters there were four categories. Twenty-eight subjects or 34.1 percent responded that they
lived in a house; 25 people or 30.5 percent lived in an apartment; 28 or 34.1 percent lived in housing specifically designed for older people; and one person or 1.3 percent lived in a nursing home.

Table 1: Age Group

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>65 to 69</td>
<td>39</td>
<td>47.6</td>
</tr>
<tr>
<td>70 to 74</td>
<td>24</td>
<td>29.2</td>
</tr>
<tr>
<td>75 to 85</td>
<td>19</td>
<td>23.2</td>
</tr>
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</table>

Table 2: Living Quarters

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>House</td>
<td>28</td>
<td>34.1</td>
</tr>
<tr>
<td>Apartment</td>
<td>25</td>
<td>30.5</td>
</tr>
<tr>
<td>Housing for older people</td>
<td>28</td>
<td>34.1</td>
</tr>
<tr>
<td>Nursing home</td>
<td>1</td>
<td>1.3</td>
</tr>
</tbody>
</table>

There was a small number of black respondents, 4 or 4.9 percent; and all three of the major religions in the United States were represented. Among the subjects 42 or 51.2 percent was Protestant, 26 or 31.7 percent was Catholic, and the remaining 14 subjects or 17.1 percent was Jewish.
Table 3: Religion

<table>
<thead>
<tr>
<th>Religion</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Protestant</td>
<td>42</td>
<td>51.2</td>
</tr>
<tr>
<td>Catholic</td>
<td>26</td>
<td>31.7</td>
</tr>
<tr>
<td>Jewish</td>
<td>14</td>
<td>17.1</td>
</tr>
</tbody>
</table>

All subjects were asked their marital status. Thirty-four or 41.5 percent responded that they were presently married. A little over 2 percent or 2 subjects had never been married. Eight subjects or 9.8 percent were separated/divorced, and the remaining 38 respondents or 46.3 percent were widowed. No one responded either to living with someone of the opposite sex or to living with someone of the same sex.

Table 4: Marital Status

<table>
<thead>
<tr>
<th>Marital Status</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Presently married</td>
<td>34</td>
<td>41.5</td>
</tr>
<tr>
<td>Never married</td>
<td>2</td>
<td>2.4</td>
</tr>
<tr>
<td>Separated/Divorced</td>
<td>8</td>
<td>9.8</td>
</tr>
<tr>
<td>Widowed</td>
<td>38</td>
<td>46.3</td>
</tr>
</tbody>
</table>

Associated with marital status, the next descriptive category was that of number of marriages. The largest number of subjects, almost three fourths, had been married
only once. Sixteen or 19.5 percent had been married twice, 2 or 2.4 percent had been married three times, and one person, 1.2 percent of the sample, had been married four times.

Table 5: Number of Marriages

<table>
<thead>
<tr>
<th>Number of Marriages</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>2</td>
<td>2.4</td>
</tr>
<tr>
<td>1</td>
<td>61</td>
<td>74.4</td>
</tr>
<tr>
<td>2</td>
<td>16</td>
<td>19.5</td>
</tr>
<tr>
<td>3</td>
<td>2</td>
<td>2.4</td>
</tr>
<tr>
<td>4</td>
<td>1</td>
<td>1.2</td>
</tr>
</tbody>
</table>

In terms of children 79 percent of the sample had three children or less. Sixty-nine percent had had two children or less with 27 subjects, 32.9 percent, who responded in this category; almost one third of all respondents had had two children. Thirteen subjects or 15.9 percent had had only one child; 16 subjects, 19.5 percent, reported having no children. Nine subjects, 11 percent, had had four children; 6 subjects, 7.3 percent, had had five children; 2 subjects or 2.4 percent had had six children; and one subject, 1.2 percent, reported having had seven children.
Table 6: Number of Children

<table>
<thead>
<tr>
<th>Number of children</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>16</td>
<td>19.5</td>
</tr>
<tr>
<td>1</td>
<td>13</td>
<td>15.9</td>
</tr>
<tr>
<td>2</td>
<td>27</td>
<td>32.9</td>
</tr>
<tr>
<td>3</td>
<td>8</td>
<td>9.8</td>
</tr>
<tr>
<td>4</td>
<td>9</td>
<td>11.0</td>
</tr>
<tr>
<td>5</td>
<td>6</td>
<td>7.3</td>
</tr>
<tr>
<td>6</td>
<td>2</td>
<td>2.4</td>
</tr>
<tr>
<td>7</td>
<td>1</td>
<td>1.2</td>
</tr>
</tbody>
</table>

In describing this sample it was important for the respondents to assess their physical and mental health. Almost three-fourths reported their physical health as either excellent or good; only 25.6 percent reported their physical health as fair or poor.

Table 7: Physical Health Status

<table>
<thead>
<tr>
<th>Status</th>
<th>Frequency</th>
<th>Cumulative Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Excellent</td>
<td>21</td>
<td>21</td>
<td>25.6</td>
</tr>
<tr>
<td>Good</td>
<td>40</td>
<td>61</td>
<td>48.8</td>
</tr>
<tr>
<td>Fair</td>
<td>20</td>
<td>81</td>
<td>24.4</td>
</tr>
<tr>
<td>Poor</td>
<td>1</td>
<td>82</td>
<td>1.2</td>
</tr>
</tbody>
</table>

In a similar manner subjects rated themselves in terms of their present mental health. It is notable that not one subject saw him/herself as having poor mental health. Fifty percent responded that their mental health was
excellent; 47.6 percent said their mental health was good; and 2.4 percent assessed their mental health as only fair. No subject responded to the poor category.

Table 8: Mental Health Status

<table>
<thead>
<tr>
<th>Status</th>
<th>Frequency</th>
<th>Cumulative Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Excellent</td>
<td>41</td>
<td>41</td>
<td>50.0</td>
</tr>
<tr>
<td>Good</td>
<td>39</td>
<td>80</td>
<td>47.6</td>
</tr>
<tr>
<td>Fair</td>
<td>2</td>
<td>82</td>
<td>2.4</td>
</tr>
</tbody>
</table>

Subjects were asked to describe any serious medical problems they had had. There were eight ailments that could be checked as well as an opportunity to list other ailments that were not stated on the questionnaire. The eight ailments to be checked were the following: hysterectomy, mastectomy, prostate, diabetes, arthritis, heart disease, high blood pressure, and depression. The ninth category was "other."

Twenty-four women, 29.3 percent of the sample, had had a hysterectomy. In terms of the 62 female subjects this is 38.7 percent. Four women reported having had mastectomies. This is 4.9 percent of the whole sample and 6.5 percent of the female subjects. Three men reported having had prostate problems. This is 3.7 percent of the whole sample and 15 percent of the male subjects. Diabetes was reported by 10 subjects or 12.2 percent of the sample; 30 subjects
or 36.6 percent reported arthritis; 10 subjects or 12.2 percent reported heart problems; 26 subjects or 31.7 percent had high blood pressure; and depression was a problem to 10 subjects, 12.2 percent of the sample. Twenty-two percent or 18 subjects checked the category listed as "other."

Table 9: Medical Problems

<table>
<thead>
<tr>
<th>Medical Problems</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hysterectomy</td>
<td>24</td>
<td>29.3</td>
</tr>
<tr>
<td>Mastectomy</td>
<td>4</td>
<td>4.9</td>
</tr>
<tr>
<td>Prostate</td>
<td>3</td>
<td>3.7</td>
</tr>
<tr>
<td>Diabetes</td>
<td>10</td>
<td>12.2</td>
</tr>
<tr>
<td>Arthritis</td>
<td>30</td>
<td>36.6</td>
</tr>
<tr>
<td>Heart</td>
<td>10</td>
<td>12.2</td>
</tr>
<tr>
<td>High blood pressure</td>
<td>26</td>
<td>31.7</td>
</tr>
<tr>
<td>Depression</td>
<td>10</td>
<td>12.2</td>
</tr>
<tr>
<td>Other</td>
<td>18</td>
<td>22.0</td>
</tr>
</tbody>
</table>

Although over a third listed arthritis as a problem and almost a third listed high blood pressure, it is notable that of the 82 subjects, 17 or 21.0 percent cited no physical ailments whatsoever.

The following Table 10 is a listing of ailments written in by respondents under the category "other" and the number of respondents who cited each condition.
Table 10: Other Medical Conditions

<table>
<thead>
<tr>
<th>Condition</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ulcers</td>
<td>3</td>
</tr>
<tr>
<td>Nervous</td>
<td>3</td>
</tr>
<tr>
<td>Hiatal hernia</td>
<td>1</td>
</tr>
<tr>
<td>Allergy</td>
<td>1</td>
</tr>
<tr>
<td>Osteoporosis</td>
<td>1</td>
</tr>
<tr>
<td>Cataracts</td>
<td>1</td>
</tr>
<tr>
<td>Loneliness (sic)</td>
<td>1</td>
</tr>
<tr>
<td>Thyroid</td>
<td>1</td>
</tr>
<tr>
<td>Cancer</td>
<td>3</td>
</tr>
<tr>
<td>Kidney</td>
<td>1</td>
</tr>
<tr>
<td>High cholesterol</td>
<td>1</td>
</tr>
<tr>
<td>Asthma</td>
<td>1</td>
</tr>
</tbody>
</table>

When asked to respond to having any chronic condition other than those mentioned, 7 subjects or 8.5 percent responded that they had a chronic condition (see Table 11).

A large percentage of this sample, 62.1 percent, completed either high school or college. Another 9.8 percent had a post baccalaureate degree. A small percentage,

Table 11: Other Chronic Conditions

<table>
<thead>
<tr>
<th>Condition</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spine curvature</td>
<td>1</td>
</tr>
<tr>
<td>Stomach and intestinal disorders</td>
<td>1</td>
</tr>
<tr>
<td>Allergies</td>
<td>1</td>
</tr>
<tr>
<td>Ulcers</td>
<td>2</td>
</tr>
<tr>
<td>Muniere's disease</td>
<td>1</td>
</tr>
<tr>
<td>Hiatal hernia</td>
<td>1</td>
</tr>
<tr>
<td>Diverticulosis, colitis</td>
<td>1</td>
</tr>
</tbody>
</table>
2.4 percent, reported having had other training; one subject was a LPN and the other had attended business school.

Table 12: Education Level

<table>
<thead>
<tr>
<th>Level of Education</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elementary or grammar</td>
<td>11</td>
<td>13.4</td>
</tr>
<tr>
<td>Junior high school</td>
<td>10</td>
<td>12.2</td>
</tr>
<tr>
<td>Senior high school</td>
<td>31</td>
<td>37.8</td>
</tr>
<tr>
<td>College</td>
<td>20</td>
<td>24.4</td>
</tr>
<tr>
<td>Post baccalaureate</td>
<td>8</td>
<td>9.8</td>
</tr>
<tr>
<td>Other</td>
<td>2</td>
<td>2.4</td>
</tr>
</tbody>
</table>

The modal income at the time of retirement for this sample was $5,000 to $10,000, with 44.3 percent of the subjects in this category. Three subjects did not answer this question. Ten subjects were under $5,000; 35 subjects or 27.8 percent were in the $10,000 to $20,000 category; 13.9 percent placed themselves in the $20,000 to $40,000 range. One respondent answered affirmatively in the over $40,000 category.
Table 13: Income at Retirement

<table>
<thead>
<tr>
<th>Income range</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>No response</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Under $5,000</td>
<td>10</td>
<td>12.7</td>
</tr>
<tr>
<td>$5,000 to $10,000</td>
<td>35</td>
<td>44.3</td>
</tr>
<tr>
<td>$10,000 to $20,000</td>
<td>22</td>
<td>27.8</td>
</tr>
<tr>
<td>$20,000 to $40,000</td>
<td>11</td>
<td>13.9</td>
</tr>
<tr>
<td>Over $40,000</td>
<td>1</td>
<td>1.3</td>
</tr>
</tbody>
</table>

Attitudes Section

The 28 items in the Attitudes Section were subdivided into four areas or components: Masturbation, Older Sexuality, Acceptability of Sexual Behavior, and Homosexuality. Subjects were asked to respond to these items in terms of liberalness versus conservativeness.

The lower the score in this section the more liberal was the attitude; the higher the score the more conservative was the attitude. There were four items in the Masturbation subscale; the lowest possible score was 4, the highest was 20. For the component Masturbation the lowest score was 4, the highest was 20, and the mean score was 12.4. There were 8 items in the Older Sexuality subscale; the lowest possible score was 8, the highest 40. For the component Older Sexuality the lowest score was 9, the highest was 33, the mean score was 18.7.
There were 12 items in the subscale Acceptability of Sexual Behavior; therefore, the lowest possible score was 12, the highest was 60. For this component the lowest score was 13, the highest was 41, and the mean score was 28. Homosexuality was the final subscale with 4 items; therefore, the lowest possible score was 4, the highest was 20. For the component the lowest score was 7, the highest was 20, and the mean score was 14. The summary score reflected the scores of all of the four components. The lowest score was 39, the highest was 112, and the mean was 73.

Table 14: Attitudes Scores

<table>
<thead>
<tr>
<th>Components</th>
<th>Low Liberal</th>
<th>High Conservative</th>
<th>Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>Masturbation (4 items)</td>
<td>4</td>
<td>20</td>
<td>12.4</td>
</tr>
<tr>
<td>Older Sexuality (8 items)</td>
<td>9</td>
<td>33</td>
<td>18.7</td>
</tr>
<tr>
<td>Acceptability of Sexual Behavior (12 items)</td>
<td>13</td>
<td>41</td>
<td>28.0</td>
</tr>
<tr>
<td>Homosexuality (4 items)</td>
<td>7</td>
<td>20</td>
<td>14.0</td>
</tr>
<tr>
<td>Summary score (28 items)</td>
<td>39</td>
<td>112</td>
<td>73.0</td>
</tr>
</tbody>
</table>

Opinions Section

In this section subjects were asked to check "agree," "disagree," or "uncertain" in response to 22 statements. These statements were further subdivided into three subscales:
Social/psychological aspects, Physiological aspects, and Medical aspects of gerontological sexuality.

Every subject received two scores in each of the three components; the first score or u score indicated the number of uncertain answers checked; the second score, c score, was the number of correct answers or answers which were in agreement with the panel of experts.

Table 15: Opinion Scores

<table>
<thead>
<tr>
<th>Components</th>
<th>Percentage Correct</th>
<th>Percentage Incorrect</th>
<th>Percentage Uncertain</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social/psychological (8 items)</td>
<td>72.9</td>
<td>9.7</td>
<td>17.4</td>
</tr>
<tr>
<td>Physiological (10 items)</td>
<td>63.8</td>
<td>9.4</td>
<td>26.8</td>
</tr>
<tr>
<td>Medical (4 items)</td>
<td>43.0</td>
<td>3.0</td>
<td>54.0</td>
</tr>
<tr>
<td>Composite (22 items)</td>
<td>63.3</td>
<td>8.4</td>
<td>28.3</td>
</tr>
</tbody>
</table>

Activity Section

The initial question introducing this section asked if subjects still had an interest in sexual matters. Sixty-three subjects or 76.8 percent said yes; 23.2 percent or 19 subjects said no.

Some of the items in this section asked respondents to compare themselves in several areas with members of their cohort group. The areas of comparison were sexual experience, knowledge, adjustment, attitudes, and activity.
With the exception of attitudes, the subject was asked to select a response which placed her/him "more," "same as," or "less" sexually experienced, knowledgeable, adjusted, or active than others in her/his age group.

Table 16: Peer Comparisons

<table>
<thead>
<tr>
<th>Categories</th>
<th>More Frequency</th>
<th>More Percentage</th>
<th>Same as Frequency</th>
<th>Same as Percentage</th>
<th>Less Frequency</th>
<th>Less Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sexually Experienced</td>
<td>2</td>
<td>12.5</td>
<td>53</td>
<td>66.3</td>
<td>17</td>
<td>21.3</td>
</tr>
<tr>
<td>Knowledgeable</td>
<td>15</td>
<td>18.5</td>
<td>56</td>
<td>69.1</td>
<td>10</td>
<td>12.3</td>
</tr>
<tr>
<td>Adjusted</td>
<td>26</td>
<td>32.5</td>
<td>48</td>
<td>60.0</td>
<td>6</td>
<td>7.5</td>
</tr>
<tr>
<td>Active</td>
<td>29</td>
<td>37.7</td>
<td>41</td>
<td>53.2</td>
<td>7</td>
<td>9.1</td>
</tr>
</tbody>
</table>

In response to the comparison item concerning sexual attitudes, subjects were asked as to whether they were more liberal, about the same as, or more conservative than most in their age group. Almost one third, 32.1 percent or 26 subjects felt that they were more liberal; 35 subjects, 43.2 percent, felt they were the same as; and 20 subjects or 24.7 percent determined that they were more conservative than their peers.

Table 17: Comparison of Sexual Attitudes

<table>
<thead>
<tr>
<th>Comparison</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>More liberal</td>
<td>26</td>
<td>32.1</td>
</tr>
<tr>
<td>About the same</td>
<td>35</td>
<td>43.2</td>
</tr>
<tr>
<td>More conservative</td>
<td>20</td>
<td>24.7</td>
</tr>
</tbody>
</table>
Two items dealt with thinking or dreaming about sexual activity. Nine out of 10 subjects thought about sexual activity either often or occasionally, whereas only 59.3 percent of the sample responded that they similarly dreamed about sexual activity.

Table 18: Think/Dream About Sexual Activity

<table>
<thead>
<tr>
<th>Categories</th>
<th>Often Frequency</th>
<th>Often %</th>
<th>Occasionally Frequency</th>
<th>Occasionally %</th>
<th>Never Frequency</th>
<th>Never %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Think</td>
<td>20</td>
<td>24.4</td>
<td>54</td>
<td>65.9</td>
<td>8</td>
<td>9.8</td>
</tr>
<tr>
<td>Dream</td>
<td>6</td>
<td>7.4</td>
<td>42</td>
<td>51.9</td>
<td>33</td>
<td>40.7</td>
</tr>
</tbody>
</table>

Subjects were asked if they still engaged in sexual intercourse. Twenty-six or 32.1 percent answered yes; 55 or 67.9 percent said no. The follow-up question asked for reasons that subjects did not engage in intercourse. Three subjects did not respond; 26 had previously responded that they still engaged in intercourse. Of the remaining subjects the largest number, 41.8 percent, did not engage in sexual intercourse because of a lack of a partner; 6.3 percent selected the reason of physical illness; none selected mental illness; 11.4 percent were not interested; and 7.6 percent selected "other" but did not specify the reason.
Table 19:
Reasons for Not Engaging in Sexual Intercourse

<table>
<thead>
<tr>
<th>Reasons</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>No partner</td>
<td>33</td>
<td>41.8</td>
</tr>
<tr>
<td>Physical illness</td>
<td>5</td>
<td>6.3</td>
</tr>
<tr>
<td>Not interested</td>
<td>9</td>
<td>11.4</td>
</tr>
<tr>
<td>Other</td>
<td>6</td>
<td>7.6</td>
</tr>
</tbody>
</table>

In response to a question asking if subjects currently had a sexual relationship with someone 25 subjects or 30.9 percent said yes and 56 or 69.1 percent responded no.

Eight items were dropped from the analysis because of insufficient responses from the sample. The items asked the following questions: (1) did the subjects ever masturbate, (2) frequency of masturbation, (3) frequency of sexual intercourse for those who were still active, (4) did the subject have an intimate relationship with someone in the last five years and not engage in sexual intercourse, (5) with whom were their sexual preferences, (6) did sexual activity give them pleasure, (7) when engaged in sexual intercourse, what percentage of the time did subjects reach climax, and (8) when climax was reached, was it by intercourse, masturbation or other means.

Educational Programming

One of the major purposes of the study was to gather information about whether older people would be interested
in educational programming about gerontological sexuality. For that purpose background information was needed as well as suggestions about what to teach, who should teach, and class makeup.

In order to determine where subjects learned about sexuality in older people they were asked to respond by checking the three sources that had been most useful to them. They were given a list of seven sources and an "other" category with a place to specify an unlisted source.

The responses of subjects as to the most useful sources of learning about sexuality and older people are listed in Table 20. The source listed by the largest number of subjects, 75, was "books, magazines, and newspapers." This was followed by "friends" which was chosen by 57 subjects. Ranked third was "television and movies," and it accounted for 38 selections.

Ranked fourth, "doctors," received 28 selections. The remaining choices in rank order fifth through eighth place were "parents or older relatives (even if no longer living)," "professionals who work with older people," "other," and "church or synagogue." The sources listed under "other" were "husbands," "professional educators," "geriatric class and seminars," "experience," "spouse," and "classes."

Subjects were allowed to select three choices. Sixteen people selected only two choices, while 12 chose only one source.
Table 20: Sources of Learning about Sexuality in Older People (Three Choices)

<table>
<thead>
<tr>
<th>Sources</th>
<th>Frequency</th>
<th>Rank Order</th>
</tr>
</thead>
<tbody>
<tr>
<td>Books, magazines, newspapers</td>
<td>75</td>
<td>1</td>
</tr>
<tr>
<td>Friends</td>
<td>57</td>
<td>2</td>
</tr>
<tr>
<td>Television and movies</td>
<td>38</td>
<td>3</td>
</tr>
<tr>
<td>Doctors</td>
<td>28</td>
<td>4</td>
</tr>
<tr>
<td>Parents or older relatives (even if no longer living)</td>
<td>13</td>
<td>5</td>
</tr>
<tr>
<td>Professionals who work with older people</td>
<td>10</td>
<td>6</td>
</tr>
<tr>
<td>Other</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>Church or synagogue</td>
<td>5</td>
<td>8</td>
</tr>
</tbody>
</table>

Subjects were asked to respond as to the age range in which they learned about sexuality in older people. One third or 33.0 percent of the subjects learned after they had reached age 55. This was closely followed by 28.1 percent in the 41 to 55 age category. Decreasing percentages were evident in the remaining responses: 22.0 percent in the category 26 to 40; 15.9 percent were between ages 13 to 25; and one subject, 1.2 percent, said he had learned before the age of 13.
Table 21: Age Learned About Gerontological Sexuality

<table>
<thead>
<tr>
<th>Age Category</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Before 13</td>
<td>1</td>
<td>1.2</td>
</tr>
<tr>
<td>13-25</td>
<td>13</td>
<td>15.9</td>
</tr>
<tr>
<td>26-40</td>
<td>18</td>
<td>22.0</td>
</tr>
<tr>
<td>41-55</td>
<td>23</td>
<td>28.1</td>
</tr>
<tr>
<td>Over 55</td>
<td>27</td>
<td>33.0</td>
</tr>
</tbody>
</table>

Because motivation to learn is important if an educational program is initiated and is to succeed, subjects were asked if they thought that older people would be interested in learning more about gerontological sexuality. One did not respond. Of the remaining 81 subjects there was almost an equal split. Fifty percent said that older people would not be interested; 49.4 percent replied in the affirmative.

If respondents answered yes, that they felt older people would be interested in learning more about gerontological sexuality, they were then asked to check several listed topics that might be of interest. There was an "other" category if the subject wished to write in a topic.

The topic of most interest to the people who responded was "special sexual problems of older people." In descending order this was followed by "loss of partner," "how illness affects sexuality," "sexuality in general,"
"physical changes affecting sexual performance," "how medication affects sexuality," and "other." The respondent who chose the "other" category wrote under "please specify," "what to do if only wife still has sex left."

Table 22: Topics of Interest Regarding Gerontological Sexuality

<table>
<thead>
<tr>
<th>Topics</th>
<th>Frequency</th>
<th>Rank Order</th>
</tr>
</thead>
<tbody>
<tr>
<td>Special sexual problems of older people</td>
<td>27</td>
<td>1</td>
</tr>
<tr>
<td>Loss of partner</td>
<td>22</td>
<td>2</td>
</tr>
<tr>
<td>How illness affects sexuality</td>
<td>20</td>
<td>3</td>
</tr>
<tr>
<td>Physical changes affecting sexual performance</td>
<td>19</td>
<td>4.5</td>
</tr>
<tr>
<td>Sexuality in general</td>
<td>19</td>
<td>4.5</td>
</tr>
<tr>
<td>How medication affects sexuality</td>
<td>15</td>
<td>6</td>
</tr>
<tr>
<td>Other</td>
<td>7</td>
<td>7</td>
</tr>
</tbody>
</table>

Also of importance to an educational planner is the concern of who is most appropriate and best qualified to teach. Subjects were asked which characteristics they would like in an instructor of a program on sexuality in older people; they were allowed to check more than one characteristic. The item that was most often selected was that the instructor should be older than age 50;
the least chosen item was that the instructor be a male. Second in importance to the subjects was that the sex of the instructor did not matter. The item ranked third was the option of having joint instructorship by both female and male. The fourth ranked item stated that the instructor be a female.

Table 23: Characteristics in an Instructor of a Program on Gerontological Sexuality

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Frequency</th>
<th>Rank Order</th>
</tr>
</thead>
<tbody>
<tr>
<td>Over Age 50</td>
<td>47</td>
<td>1</td>
</tr>
<tr>
<td>Instructor's sex does not matter</td>
<td>42</td>
<td>2</td>
</tr>
<tr>
<td>Female and male instruct together</td>
<td>27</td>
<td>3</td>
</tr>
<tr>
<td>Woman Instructor</td>
<td>11</td>
<td>4</td>
</tr>
<tr>
<td>Man Instructor</td>
<td>3</td>
<td>5</td>
</tr>
</tbody>
</table>

A follow-up question asked subjects if a professionally trained person should teach a program about gerontological sexuality; the overwhelming response by 92.2 percent was yes; 7.8 percent said no.

The third question dealing with programming asked subjects which professional people might be suitable as instructors in a program on gerontological sexuality. Subjects were able to check more than one professional
person, and there was a category of "other" for subjects to add their own. Physicians were ranked first; health/family life educators, second. The remaining personnel chosen in descending order were marriage counselors, psychologists, nurses, social workers, and other. The "other" was specified as a religious leader.

Table 24: Suitable Professional Instructors

<table>
<thead>
<tr>
<th>Professionals</th>
<th>Frequency</th>
<th>Rank Order</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician</td>
<td>46</td>
<td>1</td>
</tr>
<tr>
<td>Health/family life educator</td>
<td>38</td>
<td>2</td>
</tr>
<tr>
<td>Marriage counselor</td>
<td>23</td>
<td>3.5</td>
</tr>
<tr>
<td>Psychologist</td>
<td>23</td>
<td>3.5</td>
</tr>
<tr>
<td>Nurse</td>
<td>16</td>
<td>5</td>
</tr>
<tr>
<td>Social worker</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
<td>7</td>
</tr>
</tbody>
</table>

The final question in this set deals with the issue of the makeup of the class when a program on gerontological sexuality is taught. Eight people did not respond. About one-third felt that the program should be taught separately by sex; 23.0 percent felt the teaching should occur with the sexes together; 43.2 percent responded that the sexual makeup of the class did not matter.
Table 25: Class Makeup

<table>
<thead>
<tr>
<th>Makeup</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Separately by sex</td>
<td>25</td>
<td>33.8</td>
</tr>
<tr>
<td>Taught with sexes together</td>
<td>17</td>
<td>23.0</td>
</tr>
<tr>
<td>Not important</td>
<td>32</td>
<td>43.2</td>
</tr>
</tbody>
</table>

The last item in the demographic section asks the subject to select a statement which best describes his/her opinion about how older people feel about communication concerning sexual matters. The largest percentage, 41.6 percent, felt that "Most people would like to know more but are afraid, ashamed, or embarrassed to ask." Seventeen selected the statement "Most people know everything they need to know." Almost one-fifth felt that "most older people would be interested in knowing more about sexuality and aging and would have no hesitation in asking."

The two responses which received the lowest percentages were "Older people are not involved in sexual matters," with 16.9 percent, and "Older people are eager to learn and to talk about sexuality," with 1.3 percent. Five subjects did not respond.
Table 26: Communication Concerning Sexual Matters

<table>
<thead>
<tr>
<th>Communication</th>
<th>Frequency</th>
<th>Percentage</th>
<th>Rank Order</th>
</tr>
</thead>
<tbody>
<tr>
<td>Older people are not involved in sexual matters</td>
<td>14</td>
<td>16.9</td>
<td>4</td>
</tr>
<tr>
<td>Most people would like to know more but are afraid, ashamed, or embarrassed to ask</td>
<td>32</td>
<td>41.6</td>
<td>1</td>
</tr>
<tr>
<td>Most people know everything they need to know</td>
<td>17</td>
<td>22.1</td>
<td>2</td>
</tr>
<tr>
<td>Most older people would be interested in knowing more about sexuality and would have no hesitation in asking</td>
<td>14</td>
<td>18.2</td>
<td>3</td>
</tr>
<tr>
<td>Older people are eager to learn and to talk about sexuality</td>
<td>1</td>
<td>1.3</td>
<td>5</td>
</tr>
</tbody>
</table>

A final question in this set was dropped from analysis because the investigator determined that the question did not contribute to the study. The item asked the respondents to assess the way they perceived younger people felt about gerontological sexuality.

Associational Analyses

The data were analyzed in terms of Pearson r product-moment correlations of attitudes, opinions, and activity
with each other; in terms of their relationships with selected demographic and personal characteristics; and with factors concerning educational programming for gerontological sexuality. Correlations were chosen to quantify the direction and magnitude of relationships between variables. In addition, chi squares were utilized to indicate significant departure from what would be expected normally. Chi square contingency tables were performed to see if two possibly related variables were contingent upon or independent of one another. The following sections discuss the results of the associational analyses and their implications for program development.

Attitudes, Opinions, Activities—Correlations

Correlations were run to determine if statistical relationships existed among attitudes, opinion, and activities; also determined were the direction and the magnitude of the relationships. Included in the correlations were the subscales in the attitude and opinion sections. All subscales of the attitude and opinion sections were significantly related at the .05 level or greater.

In Table 27, the coefficients significant at the .05 level or greater are listed for the Attitudes Section of the questionnaire.
Table 27: Pearson r Correlation Coefficients for Attitude Summary Scores

<table>
<thead>
<tr>
<th>Correlate</th>
<th>Coefficient</th>
<th>Significance Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social/psychological uncertain scores</td>
<td>.474</td>
<td>.0001</td>
</tr>
<tr>
<td>Social/psychological correct scores</td>
<td>-.486</td>
<td>.0001</td>
</tr>
<tr>
<td>Physiological, uncertain scores</td>
<td>.365</td>
<td>.0007</td>
</tr>
<tr>
<td>Physiological, correct scores</td>
<td>-.289</td>
<td>.009</td>
</tr>
<tr>
<td>Medical, uncertain scores</td>
<td>.232</td>
<td>.04</td>
</tr>
<tr>
<td>Medical, correct scores</td>
<td>-.225</td>
<td>.04</td>
</tr>
<tr>
<td>Composite opinion scores, correct</td>
<td>-.399</td>
<td>.0002</td>
</tr>
<tr>
<td>Maintenance of sexual interest</td>
<td>.415</td>
<td>.0001</td>
</tr>
<tr>
<td>Sexual adjustment comparison</td>
<td>.240</td>
<td>.03</td>
</tr>
<tr>
<td>Sexual attitudes comparison</td>
<td>.328</td>
<td>.002</td>
</tr>
<tr>
<td>Thinking about sexual matters</td>
<td>.334</td>
<td>.002</td>
</tr>
<tr>
<td>Total number of uncertain s</td>
<td>.423</td>
<td>.0001</td>
</tr>
</tbody>
</table>

The strongest relationship was between the attitudes score and the number of correct responses in the subscale of Social/psychological gerontological sexuality in the Opinion Section. This may indicate that subjects who
have more factual knowledge in this area tend to be more liberal in their attitudes about gerontological sexuality.

Moderate correlations were found between the attitude scores and uncertain responses on the Social/psychological subscale ($r = .474$), the total number of uncertain responses ($r = .415$), composite opinion score ($r = -.399$), uncertain responses in the gerontological physiology subscale ($r = .365$), thinking about sexual activity ($r = .334$), and comparison of sexual attitudes ($r = .328$).

The remaining variables which had low correlations with the summary scores were, in order of decreasing strength of correlations, correct answers in the subarea of the physiology of gerontological sexuality, comparison of sexual adjustment, uncertain responses and correct responses in the subarea of medical aspects of gerontological sexuality.

In Table 28 the coefficients significant at the .05 level or greater are listed for the Opinion Section of the questionnaire. The variable most highly correlated with the opinion score was the summary score of the Attitudes Section ($r = -.399$).

Three subareas of the Attitudes Section, older sexuality, masturbation, and acceptability of gerontological sexual practices, as well as motivation were the next, most highly correlated variables with the composite opinion scores. The calculated correlation coefficients for those variables ranked second, third, fourth, and fifth were
older sexuality, $r = -0.349$; motivation, $r = -0.329$; masturbation, $r = -0.322$; the acceptability of gerontological sexual behavior, $r = -0.288$.

Table 28: Pearson r Correlation Coefficients for Opinion Composite Scores

<table>
<thead>
<tr>
<th>Correlate</th>
<th>Coefficient</th>
<th>Significance Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Motivation to learn more about gerontological sexuality</td>
<td>-0.329</td>
<td>0.003</td>
</tr>
<tr>
<td>Communication about sexuality</td>
<td>0.254</td>
<td>0.03</td>
</tr>
<tr>
<td>Masturbation</td>
<td>-0.322</td>
<td>0.003</td>
</tr>
<tr>
<td>Older Sexuality</td>
<td>-0.349</td>
<td>0.001</td>
</tr>
<tr>
<td>Acceptability of Gerontological Sexual Behavior</td>
<td>-0.288</td>
<td>0.009</td>
</tr>
<tr>
<td>Summary attitudes scores</td>
<td>-0.399</td>
<td>0.0002</td>
</tr>
<tr>
<td>Maintenance of sexual interest</td>
<td>-0.231</td>
<td>0.04</td>
</tr>
<tr>
<td>Comparison of sexual knowledge</td>
<td>-0.275</td>
<td>0.01</td>
</tr>
<tr>
<td>Comparison of sexual attitudes</td>
<td>-0.286</td>
<td>0.01</td>
</tr>
<tr>
<td>Thinking about sexual matters</td>
<td>-0.228</td>
<td>0.04</td>
</tr>
<tr>
<td>Still engages in sexual intercourse</td>
<td>-0.215</td>
<td>0.05</td>
</tr>
<tr>
<td>Has a current sexual relationship</td>
<td>-0.241</td>
<td>0.03</td>
</tr>
<tr>
<td>Number of ailments checked</td>
<td>0.282</td>
<td>0.01</td>
</tr>
</tbody>
</table>

The last seven variables which were correlated with the composite opinion score were, in order of decreasing strength of correlation, number of ailments, comparison of sexual
knowledge, communication, current sexual relationship, maintenance of sexual interest, thinking about sexual activity, and still having sexual intercourse.

Demographic Characteristics Correlations

Although many demographic characteristics were correlated and were statistically significant at the .05 level or greater, only those which might contribute to the development of an educational program on gerontological sexuality will be presented. The remainder is noted in Appendix M.

There were relationships between the gender of the subject and various questionnaire items. Table 29 describes these correlations.

The negative correlations indicate that the gender is male. Men more than women still think about sexual matters, still engage in intercourse, currently have a sexual relationship with someone, still maintain an interest in sexual concerns, have diabetes, are presently married, and are motivated to learn more about gerontological sexuality. Women more than men have a willingness to communicate about sexuality, have a higher income, and report that their health is either excellent or good.

Those who were married only once reported that they feel less sexually experienced, sexually knowledgeable, sexually adjusted than those who are presently living alone because of being single, divorced/separated, or widowed. On the comparison item of sexual activity those presently
Table 29: Pearson r Correlation Coefficient for Gender and other Variables

<table>
<thead>
<tr>
<th>Correlate</th>
<th>Coefficient</th>
<th>Significance Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Thinking about sexual matters</td>
<td>-.455</td>
<td>.0001</td>
</tr>
<tr>
<td>Still engages in sexual intercourse</td>
<td>-.281</td>
<td>.0111</td>
</tr>
<tr>
<td>Has a current sexual relationship</td>
<td>-.237</td>
<td>.033</td>
</tr>
<tr>
<td>Communication about sexuality</td>
<td>.231</td>
<td>.0431</td>
</tr>
<tr>
<td>Maintenance of sexual interest</td>
<td>-.245</td>
<td>.0268</td>
</tr>
<tr>
<td>Diabetes</td>
<td>-.222</td>
<td>.04</td>
</tr>
<tr>
<td>Presently married</td>
<td>-.325</td>
<td>.003</td>
</tr>
<tr>
<td>Income</td>
<td>.334</td>
<td>.0026</td>
</tr>
<tr>
<td>Motivation to learn more about gerontological sexuality</td>
<td>-.236</td>
<td>.0038</td>
</tr>
<tr>
<td>Status of physical health is excellent or good</td>
<td>.334</td>
<td>.0026</td>
</tr>
</tbody>
</table>

married said that they were more sexually active than others in their peer group. As expected, this group had a negative correlation to the item about not engaging in sexual intercourse (see Table 30).

Subjects who reported that the status of their mental health was either excellent or good had positive correlations with the status of physical health, the subscale in the Attitudes Section of Acceptability of Gerontological Sexual Behavior, better than average sexual adjustment, still
### Table 30: Pearson r Correlation Coefficients for Number of Marriages and other Variables

<table>
<thead>
<tr>
<th>Correlate</th>
<th>Coefficient</th>
<th>Significance Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comparison of sexual experience</td>
<td>-.353</td>
<td>.0013</td>
</tr>
<tr>
<td>Comparison of sexual knowledge</td>
<td>-.322</td>
<td>.0034</td>
</tr>
<tr>
<td>Comparison of sexual adjustment</td>
<td>-.273</td>
<td>.0143</td>
</tr>
<tr>
<td>Comparison of sexual activity</td>
<td>.366</td>
<td>.0011</td>
</tr>
<tr>
<td>No longer engaged in sexual intercourse</td>
<td>-.250</td>
<td>.0266</td>
</tr>
</tbody>
</table>

### Table 31: Pearson r Correlation Coefficients for Mental Health Status and other Variables

<table>
<thead>
<tr>
<th>Correlate</th>
<th>Coefficient</th>
<th>Significance Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Status of physical health</td>
<td>.436</td>
<td>.0001</td>
</tr>
<tr>
<td>Arthritis</td>
<td>-.337</td>
<td>.0020</td>
</tr>
<tr>
<td>Depression</td>
<td>-.393</td>
<td>.0003</td>
</tr>
<tr>
<td>Acceptability of gerontological sexual behavior</td>
<td>.222</td>
<td>.0448</td>
</tr>
<tr>
<td>Comparison of sexual adjustment</td>
<td>.246</td>
<td>.0281</td>
</tr>
<tr>
<td>Still engages in sexual intercourse</td>
<td>.232</td>
<td>.0368</td>
</tr>
<tr>
<td>Current sexual relationship</td>
<td>.291</td>
<td>.0083</td>
</tr>
<tr>
<td>Number of ailments checked</td>
<td>.300</td>
<td>.0062</td>
</tr>
</tbody>
</table>
engaged in sexual intercourse, had a current sexual relationship, and had few physical ailments.

The marital status of subjects was statistically related to several items in the questionnaire. Those subjects who were presently married had more prostate problems, maintained an interest in sexual matters, still thought about sexual activities, still engaged in sexual intercourse, and currently had a sexual relationship. Their marital status had a negative relationship with income, their attitudes about Homosexuality, their comparison of themselves to their peer group regarding sexual activity which was not expected, and their reporting of their physical health as fair or poor.

Table 32: Pearson r Correlation Coefficients for Marital Status and other Variables

<table>
<thead>
<tr>
<th>Correlate</th>
<th>Coefficients</th>
<th>Significance Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prostate</td>
<td>.222</td>
<td>.04</td>
</tr>
<tr>
<td>Income</td>
<td>-.301</td>
<td>.0071</td>
</tr>
<tr>
<td>Homosexuality subscale</td>
<td>-.310</td>
<td>.0046</td>
</tr>
<tr>
<td>Maintenance of sexual interest</td>
<td>.356</td>
<td>.001</td>
</tr>
<tr>
<td>Comparison of sexual activity</td>
<td>-.342</td>
<td>.0023</td>
</tr>
<tr>
<td>Thinking about sexual matters</td>
<td>.356</td>
<td>.001</td>
</tr>
<tr>
<td>Still engages in sexual intercourse</td>
<td>.626</td>
<td>.0001</td>
</tr>
<tr>
<td>Has a current sexual relationship</td>
<td>.583</td>
<td>.001</td>
</tr>
<tr>
<td>Status of physical health either</td>
<td>-.301</td>
<td>.0071</td>
</tr>
<tr>
<td>excellent or good</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Subjects who reported having depression had negative correlations with four other variables indicating that they had a number of physical ailments, did not have a current sexual relationship, and were less sexually experienced and less sexually adjusted than others in their peer group.

Table 33: Pearson r Correlation Coefficients for Depression and other Variables

<table>
<thead>
<tr>
<th>Correlate</th>
<th>Coefficient</th>
<th>Significance Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comparison of sexual experience</td>
<td>-.271</td>
<td>.0149</td>
</tr>
<tr>
<td>Comparison of sexual adjustment</td>
<td>-.228</td>
<td>.0422</td>
</tr>
<tr>
<td>Current sexual relationship</td>
<td>-.251</td>
<td>.0240</td>
</tr>
<tr>
<td>Number of ailments checked</td>
<td>-.362</td>
<td>.0008</td>
</tr>
</tbody>
</table>

The educational level of the sample indicated several statistically significant relationships. As noted in Table 34, the most highly educated subjects were Protestant, had high incomes, learned about gerontological sexuality at a later age, felt that professionally trained instructors would be most appropriate to teach a course about older sexuality, and were most liberal in their attitudes on the subscale Acceptability of Gerontological Sexual Behavior. Like the correlations for Depression, the correlations for
Education are little more than one would find randomly; thus it is questionable if these are indeed statistically significant.

Table 34: Pearson r Correlation Coefficients for Education and other Variables

<table>
<thead>
<tr>
<th>Correlate</th>
<th>Coefficient</th>
<th>Significance Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Religion</td>
<td>-.392</td>
<td>.0003</td>
</tr>
<tr>
<td>Income</td>
<td>.256</td>
<td>.0227</td>
</tr>
<tr>
<td>Age at which older people learned about gerontological sexuality</td>
<td>.219</td>
<td>.0477</td>
</tr>
<tr>
<td>Professionally trained instructor</td>
<td>-.226</td>
<td>.0481</td>
</tr>
<tr>
<td>Acceptability of gerontological sexual behavior</td>
<td>-.264</td>
<td>.0164</td>
</tr>
</tbody>
</table>

The last set of correlations is between the item Motivation to Learn More about Gerontological Sexuality and other variables. Subjects who wanted to learn more about sexuality and older people also had higher incomes, were liberal in their attitudes about Older Sexuality and Acceptability of Gerontological Sexual Behavior, had fewer uncertain responses and more correct responses on the Opinion Section, were more liberal in their sexual attitudes than their peers, were more sexually active than their peers, maintained an interest in sexual matters, and still thought about sexual matters (see Table 35).
Table 35: Pearson r Correlation Coefficients for Motivation to Learn about Gerontological Sexuality and other Variables

<table>
<thead>
<tr>
<th>Correlate</th>
<th>Coefficient</th>
<th>Significance Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Income</td>
<td>-.234</td>
<td>.0389</td>
</tr>
<tr>
<td>Older Sexuality</td>
<td>.225</td>
<td>.0430</td>
</tr>
<tr>
<td>Acceptability of gerontological sexual behavior</td>
<td>.244</td>
<td>.0280</td>
</tr>
<tr>
<td>Uncertain responses Social/psychological aspects Opinion Section</td>
<td>.351</td>
<td>.0013</td>
</tr>
<tr>
<td>Correct responses Social/psychological aspects Opinion Section</td>
<td>-.334</td>
<td>.0023</td>
</tr>
<tr>
<td>Uncertain responses Medical aspects Opinion Section</td>
<td>.244</td>
<td>.0279</td>
</tr>
<tr>
<td>Correct responses Medical aspects Opinion Section</td>
<td>-.297</td>
<td>.0071</td>
</tr>
<tr>
<td>Uncertain responses Physiological aspects Opinion Section</td>
<td>.246</td>
<td>.0270</td>
</tr>
<tr>
<td>Correct responses Physiological aspects Opinion Section</td>
<td>-.249</td>
<td>.0248</td>
</tr>
<tr>
<td>Comparison of sexual attitudes</td>
<td>.331</td>
<td>.0027</td>
</tr>
<tr>
<td>Comparison of sexual activity</td>
<td>-.257</td>
<td>.0241</td>
</tr>
<tr>
<td>Composite score Opinion Section</td>
<td>-.329</td>
<td>.0027</td>
</tr>
<tr>
<td>Maintenance of sexual interest</td>
<td>.255</td>
<td>.0214</td>
</tr>
<tr>
<td>Thinking about sexual matters</td>
<td>.220</td>
<td>.0482</td>
</tr>
<tr>
<td>Total number of uncertain responses</td>
<td>.322</td>
<td>.0034</td>
</tr>
</tbody>
</table>
Attitudes, Opinions, Activity—Chi Square

Chi square contingency tables were run for attitude scores. These scores were divided into quartiles and run in combination with maintaining an interest in sexual matters. At a probability level of .005, the contingency table was statistically significant.

Table 36: Chi square—Attitudes Scores and the Maintenance of Interest in Sexual Matters

<table>
<thead>
<tr>
<th>Quartiles</th>
<th>Obtained frequency</th>
<th>Expected frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Interest</td>
<td>No Interest</td>
</tr>
<tr>
<td>1 - most liberal</td>
<td>14</td>
<td>1</td>
</tr>
<tr>
<td>2 - liberal</td>
<td>19</td>
<td>4</td>
</tr>
<tr>
<td>3 - conservative</td>
<td>19</td>
<td>3</td>
</tr>
<tr>
<td>4 - most conserv-</td>
<td>11</td>
<td>11</td>
</tr>
</tbody>
</table>

At the .02 level of probability, a chi square was run with the attitudes scores and the total number of uncertain responses in the Opinion Section. For purposes of the contingency table, the uncertain scores were divided into two categories: subjects who had less than six uncertain and those who had six or more. The following table reflects this statistic. This table may indicate that subjects who were more certain of their opinions and seemed to have more factual knowledge also were more liberal in their attitudes than those who responded with more uncertain answers.
Table 37: Chi square - Attitude Scores and Uncertain Answers in the Opinion Section

<table>
<thead>
<tr>
<th>Uncertain responses</th>
<th>Obtained frequency</th>
<th>Expected frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Liberal</td>
<td>Conservative</td>
</tr>
<tr>
<td>Less than 6</td>
<td>23</td>
<td>16</td>
</tr>
<tr>
<td>Six or more</td>
<td>15</td>
<td>28</td>
</tr>
</tbody>
</table>

A chi square was run with age as the variable and the attitude scores. Subjects were blocked into age groups of 65 to 69, 70 to 74, and 75 to 85. Statistically liberal attitudes were inversely proportionate to age. The probability level was .04.

Table 38: Chi square - Attitude Scores and Age Range

<table>
<thead>
<tr>
<th>Attitude</th>
<th>Obtained frequency</th>
<th>Expected frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>65-69, 70-74, 75-85</td>
<td>65-69, 70-74, 75-85</td>
</tr>
<tr>
<td>Liberal</td>
<td>22 12 4</td>
<td>18.1 11.1 8.8</td>
</tr>
<tr>
<td>Conservative</td>
<td>17 12 15</td>
<td>20.9 12.9 10.2</td>
</tr>
</tbody>
</table>

Significant at the .003 probability level was a contingency table run with attitude scores blocked into quartiles from most to least liberal and the opinion scores, blocked into halves of more correct and less correct.
Table 39: Chi square - Attitude Scores and Opinion Scores

<table>
<thead>
<tr>
<th>Attitude Quartiles</th>
<th>Obtained frequency</th>
<th>Expected frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>More Correct</td>
<td>Less Correct</td>
</tr>
<tr>
<td>1 - most liberal</td>
<td>5</td>
<td>10</td>
</tr>
<tr>
<td>2</td>
<td>7</td>
<td>16</td>
</tr>
<tr>
<td>3</td>
<td>16</td>
<td>11</td>
</tr>
<tr>
<td>4 - most conservative</td>
<td>18</td>
<td>4</td>
</tr>
</tbody>
</table>

Chi squares were run for opinion scores. A contingency table was calculated with opinion scores divided into quartiles and motivation to learn more about gerontological sexuality responses; it was statistically significant at the probability level of .03.

Table 40: Chi square - Opinion Scores and Responses to Motivation to Learn about Gerontological Sexuality

<table>
<thead>
<tr>
<th>Opinion Quartiles</th>
<th>Obtained frequency</th>
<th>Expected frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>1 - More correct</td>
<td>6</td>
<td>13</td>
</tr>
<tr>
<td>2</td>
<td>7</td>
<td>14</td>
</tr>
<tr>
<td>3</td>
<td>10</td>
<td>6</td>
</tr>
<tr>
<td>4 - Less correct</td>
<td>17</td>
<td>8</td>
</tr>
</tbody>
</table>
This may indicate that people who are already knowledgeable may be less motivated to learn than people who scored poorly on the Opinion Section.

A contingency table was run with uncertain responses in the Opinion Section, low and high, and responses positive and negative as to whether older people would be motivated to learn more about gerontological sexuality. The probability level of this chi square is statistically significant at .003.

Table 41: Chi square – Uncertain Responses and Motivation to Learn about Gerontological Sexuality

<table>
<thead>
<tr>
<th>Uncertains</th>
<th>Obtained frequency</th>
<th>Expected frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes (Motivated)</td>
<td>No (Motivated)</td>
</tr>
<tr>
<td>Less than 6</td>
<td>26</td>
<td>13</td>
</tr>
<tr>
<td></td>
<td>19.3</td>
<td>19.7</td>
</tr>
<tr>
<td>More than 6</td>
<td>14</td>
<td>28</td>
</tr>
<tr>
<td></td>
<td>20.7</td>
<td>21.3</td>
</tr>
</tbody>
</table>

Contingency Tables Not Statistically Significant at the .05 Level or Greater

There were many other contingency tables run which were not statistically significant at the .05 probability level or greater. The following is a listing of those tables:

1. Number of uncertain responses in the Opinion Section by gender, age range, living arrangement, age at which older people first learned about
gerontological sexuality, by race, religion, marital status, number of marriages, by education, income, by a professionally trained instructor, by class makeup, by communication about sexuality, by still maintaining an interest in sexual matters, by comparison of sexual experience, sexual knowledge, sexual adjustment, sexual attitudes, and sexual activity, thinking and dreaming about sexual matters.

2. Summary attitude scores blocked into halves denoting liberalism or conservativeness of attitudes by gender, living arrangement, race, religion, marital status, number of marriages, education, income, age at which older people first learned about gerontological sexuality, motivation to learn more about sexuality in older people, by a professionally trained instructor, by communication, maintenance of an interest in sexual matters, and by comparison of peers with sexual experience, knowledge, adjustment, attitudes, and experience, by thinking and dreaming about sexual matters.

3. Composite opinion scores by gender, age, living arrangement, race, religion, marital status, number of marriages, education income, age at which older people first learned about
gerontological sexuality, motivation to learn more about older sexuality, a professionally trained instructor, class makeup, communication about sexuality, maintenance of sexual interest, by comparison of sexual experience, knowledge, adjustment, attitude, and activity, and thinking and dreaming about sexual matters.

Summary

Of the 82 respondents, 62 were female and 20 were male. The youngest was 65 and the oldest 85; most of the subjects were between 65 and 69. About equal number is subjects lived in apartments, homes, and housing designated specifically for older people. One subject lived in a nursing home.

Blacks constituted 4.9 percent of the sample. Protestants accounted for 51.2 percent. Catholics about 31.7 percent, and Jews about 17.1 percent. Most subjects were either widowed or married, and almost three fourths had been married only once. Most, 68.3 percent, had had two or fewer children.

A large percentage of the sample had completed either high school or college. The modal income was $5,000 to $10,000.

For the Attitudes Section the lowest score, that is the most liberal, was 39; the highest score or most conservative, was 112 with a mean of 73. A summary of
the Opinion Section shows that 63.3 percent of all responses were in agreement with the panel of experts and, thus, counted as correct, 8.4 were incorrect, and 28.3 percent were marked as uncertain. The Activity Section asked for comparisons by subjects to cohorts in the areas of sexual experience, knowledge, and adjustment, activity, and attitudes. In all areas the majority ranked themselves as comparable to others in their peer group. The majority of subjects occasionally thought and dreamed about sexual matters.

Almost one third of the sample still engaged in sexual intercourse. The reason given most frequently for not engaging was the lack of a partner. Twenty-five subjects still maintained a sexual relationship with someone.

A strong relationship existed between the attitude scores and opinion subscale of Social/psychological aspects of gerontological sexuality, \( r = -0.486 \). As was expected marital status was strongly correlated with still engaging in sexual intercourse, \( r = 0.626 \), and with having a current sexual relationship, \( r = 0.583 \). Gender was most correlated with thinking about sexual matters, \( r = -0.455 \).

Chi square contingency tables that were statistically significant at the .05 level or greater were the following: attitude scores and maintaining an interest in sexual matters; attitude scores and the number of uncertain responses for the Opinion Section; attitude scores and age;
attitude scores and opinion scores; opinion scores and motivation to learn more about gerontological sexuality. At the probability level of .05, there were no contingencies that were statistically significant for the actual levels of sexual activity.

In terms of educational programming, items the sample chose as the sources from which they learned most about gerontological sexuality were books, magazines, and newspapers, friends, and television and movies. The modal age at which they learned the most about older people and sexuality was over 55. The sample was split almost evenly in its response as to whether older people were motivated or interested in learning about gerontological sexuality.

The topic that was ranked first among topics of interest for a gerontological sexuality course was "specific sexual problems of older people." Most respondents felt that an instructor should be over 50, should be professionally trained, and should be a physician, a health/family life educator, or a psychologist or marriage counselor. It was not important to most subjects whether the class should be taught with the sexes together or separated.
CHAPTER FIVE
CONCLUSIONS, DISCUSSION, IMPLICATIONS
AND RECOMMENDATIONS

The first portion of this chapter presents conclusions of the findings relevant to the research questions. The second section discusses the sampling difficulties encountered by the investigator. The next section attempts to identify and discuss the reasons why some subjects did not respond to several items in the Activity Section of the questionnaire. The remaining sections deal with implications of the data generated and recommendations for future research.

Conclusions of the Findings
Relevant to the Research Questions

Opinions About Gerontological Sexuality

The sample population was broadly diverse in its opinions; there were those who were very knowledgeable about gerontological sexuality and those who knew very little. Without question the sample demonstrated a lack of knowledge about the medical aspects of older sexuality; this was the subarea where the largest number of "uncertain" responses occurred. Indeed, there were subjects who did
score any correct responses to these items. In this older population it would certainly meet the needs of this sample to devote a major amount of time to the medical aspects of older sexuality. The sample seemed most knowledgeable about older sexuality in the subarea of Social/Psychological aspects.

Attitudes about Gerontological Sexuality

This sample held a broad range of attitudes with regard to the subscales of the Attitudes Section. As a whole the subjects were very non-accepting of homosexuality; they tended to be far more accepting of the expression of sexuality in older people. There seemed to be the most conservative views expressed about masturbation; this was indicated in the Activity Section where several subjects refused to respond to any items about their involvement with masturbation. The sample saw itself as comparable to others in its peer group with respect to sexual knowledge, experience, attitudes, adjustment, and activity.

Sexual Activity Levels of Older People

One third of the subjects responded that they still engaged in sexual intercourse. The majority of respondents who no longer were sexually active were widows who had no sexual partners. Although the respondents were asked if they masturbated, many subjects answered related items
inconsistently, incorrectly, and some not at all. This may indicate that respondents did not feel comfortable answering a question about masturbation or felt the items were too personal. Older people still think and dream about sexual matters. Thinking about sexual activity was more prevalent than dreaming.

Discussion of Sampling Difficulties

Sampling difficulties are a real concern of survey research since they are one of the major factors which jeopardizes external validity. There were difficulties encountered by the investigator in attempting to obtain volunteers to participate in a study about gerontological sexuality. The very nature of the topic sexuality is intimate, personal and unspoken. Furthermore many of the subjects, age 65 or older, were raised at a time when the topic of sexuality was taboo to discuss or even mention. Therefore, it was very difficult to obtain subjects for the study.

Several potential subjects to whom the questionnaire was mailed, returned it appropriately to the investigator with comments typifying the resistance of many older people.

"In my estimation this is a bunch of trash and you must be, too, if you spend your time on such a subject for your doctorate. Am ashamed you are connected with Ohio State."
"This questionnaire is an insult to intelligent, decent moral individuals -- I refuse to answer any of the questions."

"Dear Linda O---

The questionnaire met 2 belligerent receptions at the mail box! I'm going on 75 -- a doctor's spinster daughter, and don't know, really, what you're talking about. I would like to be one part of most of the happily marrieds here, but am very glad I am not you with the thesis on you hands!" (This was signed)

"Sorry I can not fill these forms."

"Your judgement is poor. Get a new subject!"

"When the Kinsey report came out, my friends, my husband and I wondered what kind of person would answer such questions.

Now my friends, my husband and I wondered who would answer such questions as you ask. I know now. I have heard of no one who has answered them either here or at ______________ (name of another retirement village)."

This last letter demonstrates a kind of social networking among older people who reside in private retirement villages.
One of the greatest problems in obtaining subjects was in "getting past the gatekeepers," the caretakers, those social workers, administrators, and directors who feel that this topic is not appropriate for their older clientele.

"I have been asked by the residents of the apartment building in our Retirement Complex that the mailing list I sent you for your survey be destroyed. Some of the residents were upset with the survey and want to be reassured that the mailing list will not be circulated in Ohio State University for other surveys or any other project. I assured them you did not intend to do anything with the list beyond your initial survey. Thank you for your cooperation." (Administrator)

"In regards to the questionnaire received 8/19/80, due to the delicate subject matter covered, we do not wish to present it's contents to the senior citizens at this time. Thank you for considering the

"I am in receipt of your letter dated June 30, 1980, requesting volunteers, men and women, to respond to a questionnaire you have developed for a research paper."
This letter is to inform you that we do not feel it is appropriate for our clientele to participate in this research. By definition of "participants in daycare, they are either physically and/or emotionally handicapped. We do not feel they would be an adequate sampling."

"I'm sorry to return the questionnaires unanswered, but I feel it is inappropriate for our current residents. I think sex education is certainly important and necessary for older people, but I don't think ____________ can assist you in this particular survey."

The investigator found that when she was invited to speak to a group of potential subjects personally and explain the nature and purpose of the study, and the administration of the questionnaire, there was some scepticism, some laughter, but always enthusiastic older people volunteering themselves, spouses, and friends for the project.

Four of the 82 subjects wrote comments on their completed questionnaires. The comments are reproduced here as they were written on the last page of the questionnaire. They demonstrate the range of attitudes among this group.

"My second husband passed away when I was 45 years old and I never even had a date or a close friend
after that because I was working 8 to 16 hours a day
and keeping a home together for my parents and sister
so I didn't have time to think nor want any part of
sex. Not so when my husbands lived."

"My answers to your questions were influenced by
the fact that I was a marriage counselor to all ages
and did graduate study in that area."

"It is not necessary to add to the sexual
revolutions. Problems are being created which would
not ordinarily exist. Being married is not primarily
sex-- it is LOVE. cooking--housekeeping rearing
children, companionship--taking care during illness--
death and recovery. These are better for mental
health than promoting the necessity of sex for
happiness."

"In my youth sex was hush hush and shameful. What
I see and hear now makes me relize what I missed. Wish
only once for another man to see what it would be like.
Im chicken so I guess masturbation will be the closest
thing I'll feel for a climax, I'm afraid the Old
Fashion Girl in my days missed a lot. Wish there was
a place where Older people could go and get a little
love and not be afraid."
Determination to Drop Questionnaire Items

Eight items in the Activity Section were dropped from the analysis of data because a number of subjects did not respond to them. These items dealt with frequency of intercourse, whether the subject masturbated, frequency of masturbation, having an intimate but non-sexual relationship with someone, sexual preference, getting pleasure from sexual activity, and reaching climax.

There might be several reasons for either not responding to the items or for responding inappropriately. Although almost one third of the subjects answered that they still engaged in sexual intercourse, 80 subjects responded as to how frequently they engaged. Although 75 subjects answered that they did masturbate, only 62 responded to the item on frequency of masturbation. Perhaps, subjects felt that it is not socially sanctioned to masturbate and did not answer; the Masturbation Subscale certainly indicated that many subjects are nonaccepting of masturbation.

Many of the sample were widows and this may account for the fact that several subjects did not respond to the item about having an intimate relationship with someone that did not include intercourse. Most of these women responded that they no longer engaged in intercourse because of a lack of a partner.
Eight subjects failed to respond to the item about their sexual preference. Some may not have understood what the item asked for. Seventeen people failed to respond to the item as to whether sexual activity gave them pleasure. Again, this may have indicated that many of the sample are not engaged in any sexual activity, or some subjects may have felt this information was too personal.

The reliability of the responses to the items about what percentage of the time did the subjects reach climax and by what means is questionable. Sixty-five and 64 responded respectively; this is not consistent with the responses to other items regarding intercourse and masturbation. For these reasons these items were dropped from the data analysis.

Data Collection Instrument

The survey instrument was a questionnaire designed by the investigator with five sections. Part I was designed to elicit personal and demographic information about the respondents. It was in this section that subjects responded to items with implications for educational programming; sources of information concerning gerontological sexuality, age at which they learned most about older sexuality, and evaluation of various components of a sexuality program.
The initial items in this section gathered data about gender, age, place of residence, race, religion, living arrangements, number of marriages, number of children, description of present physical and mental health, medical problems, chronic conditions, educational level, and income at the time of retirement.

Part II of the questionnaire was an Attitude Section. Subjects were asked to indicate on a five point scale with three being neutral how strongly they agreed or disagreed with a given statement. This section had four subscales, each of which was scored separately: Masturbation and Older People; Gerontological Sexuality; Acceptability of Gerontological Sexual Behavior; and Homosexuality. A low score indicated a more liberal attitude and a high score indicated a more conservative attitude.

Part III was the Opinion Section designed to measure the respondents' beliefs about gerontological sexuality. The section was subdivided into three subscales: Social/psychological aspects of gerontological sexuality; Physiological aspects of older sexuality; and the Medical aspects of the same. Respondents indicated whether they agreed, disagreed, or were uncertain about a given statement. The respondent was scored as answering correctly if her/his response was in agreement with the responses of the panel of experts who were in unanimous
agreement in their responses to the items in the Opinion Section.

The fourth section of the questionnaire dealt with the sexual activities of the subjects. It also asked respondents to compare their sexual knowledge, attitudes, experience, activity, and adjustment to that of their peers. This section was designed to gather data about actual levels of sexual activity and reasons for not engaging in sexual intercourse.

Scattered throughout the questionnaire were items dealing directly with or with implications for educational programming for gerontological sexuality.

Sample

Descriptive Characteristics

The sample population for this survey was adult men and women age 65 or older who were ambulatory, not hospitalized, and who were unimpaired intellectually, sensorially, and emotionally. The sample subjects were all volunteers obtained by the investigator with the assistance of local professionals who worked with the Cincinnati Council on Aging; some were contacted directly by the investigator. There were 82 subjects in the sample.

The sample was diverse in terms of its descriptive characteristics. About three-fourths were women. The majority of subjects were within the 65 to 69 age range.
One subject lived in a nursing home; the remaining subjects were almost equally divided among private homes, private apartments, and housing specifically designated for older people.

Blacks accounted for only 4.9 percent of the subjects. Fifty-one and two tenths percent were Protestant, 31.7 percent were Catholic, and 17.1 percent were Jewish. Most subjects were either widowed or still married with the vast majority only married once. The modal number of children was two.

Seventy-four and four tenths percent reported the present state of their physical health to be either excellent or good; 97.6 percent reported their present mental health status as excellent or good. Almost one third of the women had had hysterectomies, only 3.7 percent of the men had had prostate problems. Thirty-six and six tenths percent reported arthritis; 31.7 percent had high blood pressure. Twenty-one percent of the subjects listed no physical ailments whatsoever. Eighteen subjects had 13 medical ailments which were not listed on the questionnaire, and 8.5 percent of the subjects reported 7 chronic conditions also not listed.

The educational level of these older subjects was surprisingly high. Thirty-seven and eight tenths percent had completed high school; 24.4 percent, almost one fourth had a baccalaureate degree; almost 10 percent had completed
graduate work. The modal income for this sample was $5,000 to $10,000 followed by $10,000 to $20,000.

Attitudes and Opinions Section

The scores on the attitude scale and subscales represent a broad range of attitudes among the sample of older people about gerontological sexuality. The same can be said about the scores on the opinion scale and subscales; the composite opinion scores represent a broad range of opinions/knowledge among the sample regarding gerontological sexuality with the most uncertainty in the subarea of medical aspects.

Activity Section

Most subjects felt that they were at the same sexual activity level when compared to their peers. The majority of subjects in the sample responded that they did occasionally think and dream about sexual matters. Almost one third of the sample said that they still engaged in sexual intercourse. Of the reaming who did not, the majority said it was because there was no partner. This is confirmed by the literature as the chief reason older women no longer engage in sexual intercourse - the lack of a socially sanctioned partner.
Educational Programming

Subjects were asked to respond to a set of questions in order to gather data which could be useful in designing an educational program about gerontological sexuality. The source of learning about sexuality in older people most often cited was books, magazines, and newspapers. The second and third ranked sources were friends and television and movies, respectively. Doctors were ranked fourth.

It was anticipated that most of the subjects learned about gerontological sexuality after the age of 55, and that assumption was confirmed by the data. Only 1.2 percent learned before the age of 13. With each succeeding age range the percentages increased.

When asked to respond to a question about motivation to learn about gerontological sexuality, the sample split evenly. Half said older people would be interested to learn more; half said older people would not. The respondents who answered affirmatively that older people would be interested in learning more about older sexuality were asked to choose topics that would be of interest. All six topics were selected with rather equal distribution. Ranked first, second, and third were special sexual problems of older people, loss of a partner, and how illness affects sexuality, respectively. Ranked fourth and sixth were physical changes affecting sexual performance, sexuality in general, and how medication affects sexuality.
Subjects were asked what characteristics would be appropriate for an instructor of a program about gerontological sexuality. The responses indicated that an instructor should be over age 50, the sex of the instructor was unimportant. Ninety-two and two tenths percent said that the instructor should be a professional trained person. The most suitable professional to teach was a physician; next ranked in order were health/family life educator, psychologist or family counselor, nurse, social worker, and "other" specified by the respondent as a religious leader.

The majority of subjects felt that the sexual makeup of the class was not important. However, it must be noted that 33.8 percent, about one-third, felt that a program should be taught with the sexes separated. This would be a real consideration for the program planner.

Finally, subjects were asked to assess how older people felt about communication concerning sexual matters. Communication is an important element in any educational program, but is crucial for one about sexuality. The largest percentage of subjects, 41.6 percent, felt that most older people would like to know more about sexuality in the later years, but would be afraid, ashamed, or embarrassed to ask.
Implications for Educational Programming
Based on Data Analysis

Based on data analysis there are several implications for educational programming:

1. Most widows do not engage in sexual intercourse because they do not have a partner. This is supported by the literature. It seems important, then, in an educational programming to deal with the issue of sexuality and the lack of a partner; this would also affect both men and women with spouses who are incapable of sexual intercourse.

2. Most of the subjects still think about and sometimes dream about sex, although the majority are not actively engaged in sexual intercourse. Though interest in sexual activity is maintained, there seems to be few if any socially acceptable outlets through which to channel sexual expression. An educational program would be the likely place for discussion of masturbation as an appropriate sexual outlet. Even though it was demonstrated that most subjects feel strongly negative about masturbation, this is a topic about which current thought is quite different from the beliefs with which many of the older subjects were raised. As a sexual outlet, touching could be emphasized in an educational program as
an expression of communication and affection. That sexual intercourse is not the only method of expressing intimacy and affection must be supported and reinforced.

3. Notably, those subjects who had liberal attitudes also responded to maintaining an interest in sexual matters. A related finding was that subjects who fell into the youngest age range had the most liberal attitudes. Therefore, it seems logical to begin an educational program earlier than the age of 65. This is supported by the data generated by the study which indicated that most older people learn about gerontological sexuality as they age with the majority learning at age 55 or older. This age pattern of learning combined with liberal attitudes and a maintenance of sexual interest in the youngest age range of 65 to 69 might suggest that an educational program about older sexuality would seem most effective for people at or near age 55.

4. As was expected, those subjects who had the greatest number of correct responses and the least number of uncertain responses also had the most liberal attitudes. This has implications for educational programming. It is crucial that
people have knowledge about gerontological sexuality. It seems the acquisition of knowledge is statistically related to attitudes. Consequently, knowledge and liberal attitudes may make the older person more comfortable or better adjusted sexually, and more able to express her/his sexuality through a variety of channels.

5. Those subjects who had fewer correct responses and more uncertain responses in the Opinion Section felt that older people would be interested in learning more about gerontological sexuality. Those who really need to know, felt that others would also need to know, and recognized that same need in themselves. In terms of educational programming motivation to learn is important. If people want to learn, then in all probability they will learn if the education program is tailored to their needs.

6. Subjects indicated that a professionally trained instructor over age 50 would be preferred; this is understandable, as someone who is older would understand better the needs and feelings of potential students. The sex of the instructor was unimportant. However, the sample chose the physician as the professional most suitable as the instructor. Historically, most people have
been brought up to believe that the physician is the most knowledgeable about sexuality. Although most physicians are familiar with the physiology of the human body, they may have had little training in geriatric physiology, psychology, and human sexuality. It was interesting to note that subjects ranked the health/family life educator as the professional next preferred as the instructor of a course on gerontological sexuality. This may have occurred because the investigator used the term "health education" in the letter of explanation accompanying the questionnaire. Most of the subjects would not be familiar with the phrase "health/family life educator," a relatively new professional.

7. Most respondents felt that the makeup of the class was unimportant, but about one third of the sample did state a preference for a class taught separately by sex. Therefore, classes segregated by sexes might be more successful. These subjects were brought up during an era when sexuality was not discussed openly and never with members of the opposite sex.

8. The area in which most deficits in knowledge occurred was that of the medical aspects of
gerontological sexuality. This was followed by the physiological aspects. These deficits were reinforced by the selection of topics for such a program by subjects and by a chi square contingency indicating that people who had fewer correct responses in the Opinion Section were interested in learning more about older sexuality. The sample was interested in learning about all of the topics suggested by the questionnaire. In rank order the topics were special sexual problems of older people, loss of a partner, how illness affects sexuality, sexuality in general, physical changes affecting sexual performance, and how medication affects sexuality.

9. Subjects felt that most older people would like to know more about gerontological sexuality but were afraid, ashamed, or embarrassed to ask. There are two implications to consider. First, some communication skills and techniques may need to be an integral component of any course concerning older sexuality; and, perhaps, with a class separated by sex, with topics of real interest, with motivated class members, and with a trained instructor, communication might become less difficult.
10. The sources from which most subjects learned about gerontological sexuality were books, magazines, and newspapers. Friends and television and movies were ranked second and third respectively. More recently, as older sexuality has become more popularly discussed, there are more journal and newspaper articles written for consumption by the public. Where appropriate these could be compiled and used as resource material in a class. Appropriate television programming and movies might also be available and utilized.

11. About half of the sample felt that older people would be motivated or interested in learning more about gerontological sexuality. Those subjects who had more uncertain responses in the Opinion Section felt older people would be interested in learning. It appears that in this sample there was sufficient support and need for such an educational program.

Recommendations for Future Research

As a result of the findings and experiences involved in completing this study, several recommendations have evolved:

1. The survey instrument should be further examined for validation and reliability. The instrument
could yet again be revised and administered to determine if the questions which were unanswered, answered incorrectly, answered inconsistently could be clarified to elicit better responses. The subscales of Masturbation and Homosexuality in the Attitude Section, as well as the Medical aspects of gerontological sexuality in the Opinion Section, should be expanded. The questionnaire should also be examined to determine what modifications might be needed in order to administer it to an impaired target population.

2. An examination of the attitudes of caretakers would be of great benefit for further researchers interested in this area of gerontological sexuality. One of the greatest difficulties of this study was to obtain volunteers, not only because sexuality is an intimate, private and sensitive subject, but also because many of the professionals who work and deal with older people may underestimate the ability of their clientele to deal with the area of sexuality.

3. A similar study using more subjects would assist in determining if the results of this study are generalizable to a population larger than the sample.
4. A similar study using subjects who are not intact might identify differences in the sample populations that might suggest differences in program design for people who are impaired mentally, physically, and sensorially.

5. A study to see if non-intact people can respond appropriately to the questionnaire.

6. There is information still to be obtained about specific details of educational programming which further research might uncover: 
   a. program scheduling
   b. probable success of such a program
   c. length and format of such a program
   d. course of study
   e. means of evaluation
   f. possible instructor
   g. promotional campaign
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APPENDIX A

DATA COLLECTION INSTRUMENT
INFORMED CONSENT

I consent to participate in a study focussing on sexuality in people 65 and older. Linda Olasov has explained that the purpose of this study is to determine what older people know and think about sexuality in older people, as well as explore the amount and kind of sexual activity older people are experiencing. The results of such a study may be used as a basis to design an education program if needs are expressed.

I acknowledge that I have had the opportunity to obtain additional information regarding the study and that any questions I have raised have been answered to my full satisfaction.

I confirm that my participation as a subject is entirely voluntary. No force of any kind has been used to obtain my cooperation.

I understand that I may withdraw my consent and stop my participation at any time during the investigation.

I have been informed of the procedures and understand what will be required of me as a subject.

I understand that all of my responses will be confidential, anonymous and my rights to privacy will be protected.

I fully understand this consent form.

I wish to give my cooperation as a subject.

Date:____________________ Signed:____________________

(Participant)

(Investigator) (Person Authorized to Consent for participant if required.)
Demographic Data

1. Subject number ______

2. (Circle one)
   a. female
   b. male

3. Age ______

4. I live in a (circle one)
   a. house
   b. apartment
   c. housing specifically designated for older people

5. Race (circle one)
   a. White
   b. Black
   c. Oriental
   d. Indian
   e. Other: (please specify) ______

6. Religion (circle one)
   a. Protestant
   b. Catholic
   c. Jewish
   d. Moslem
   e. Other: (please specify) ______

7. Living arrangement (circle one)
   a. Presently married
   b. Never married
   c. Separated or divorced
   d. Widowed
   e. Living with a person of the opposite sex and not married
   f. Living with a person of the same sex

8. Number of marriages ______

9. Number of children ______

10. How would you describe your present physical health? (circle one)
    a. Excellent
    b. Good
    c. Fair
    d. Poor
11. How would you describe your present mental health?  
(circle one)  
a. Excellent  
b. Good  
c. Fair  
d. Poor  

12. Check any serious medical problems that you have had:  
___ a. Hysterectomy  
___ b. Mastectomy (breast removal)  
___ c. Prostate  
___ d. Diabetes  
___ e. Arthritis  
___ f. Heart disease  
___ g. High blood pressure  
___ h. Depression  
___ i. Other: (please specify)__________________________  

13. Do you have any chronic condition other than those mentioned? (circle one)  
a. Yes (if yes, please specify)__________________________  
b. No  

14. Education (circle highest completed)  
a. Elementary/grammar school  
b. Junior high school  
c. Senior high school  
d. College  
e. Post baccalaureate degree  
f. Other: (please specify)__________________________  

15. Income at the time of retirement (circle one)  
a. Under $5,000  
b. $5,000 to $10,000  
c. $10,000 to $20,000  
d. $20,000 to $40,000  
e. Over $40,000  

16. From the sources listed below check the three which have been most useful to you in learning about sexuality in older people.  
___ a. Friends  
___ b. TV and movies  
___ c. Books, magazines, and newspapers  
___ d. Doctors  
___ e. Professionals who work with older people  
___ f. Parents or older relatives (even if no longer living)  
___ g. Church or synagogue  
___ h. Other: (please specify)__________________________
17. Most of what I know about sexuality in older people I learned (circle one)
   a. Before age 13
   b. 13 to 25
   c. 26 to 40
   d. 41 to 55
   e. Over 55

18. Do you think older people would be interested in learning more about sexuality in older people? (circle one)
   a. Yes
   b. No

19. If you answered yes, what do you think they would like to have more information about or discuss? You may check more than one topic.
   ___ a. Sexuality in general
   ___ b. Special sexual problems of older people
   ___ c. Physical changes affecting sexual performance
   ___ d. How illness affects sexuality
   ___ e. How medication affects sexuality
   ___ f. Loss of partner
   ___ g. Other: (please specify) _________________________________

20. What characteristics would you like in an instructor of a program on sexuality in older people? You may check more than one topic.
   ___ a. Over age 50
   ___ b. Woman
   ___ c. Man
   ___ d. Both woman and man together
   ___ e. Instructor's sex does not matter

21. Should a professionally trained person teach the program? (circle one)
   a. Yes
   b. No

22. If you answered yes, circle those people you feel would be suitable. You may check more than one person.
   ___ a. Health educator/family life educator
   ___ b. Marriage counselor
   ___ c. Nurse
   ___ d. Physician
   ___ e. Psychologist
   ___ f. Social worker
   ___ g. Other: (please specify) _________________________________
23. When such a program is initiated, the participants should be taught (circle one)
   a. Separately by sex
   b. Taught with the sexes together
   c. Not important

24. Check the one statement below which best describes your opinion about how older people feel about communication concerning sexual matters.
   ___ a. Older people are not involved in sexual matters.
   ___ b. Most people would like to know more but are afraid, ashamed, or embarrassed to ask.
   ___ c. Most people know everything they need to know.
   ___ d. Most older people would be interested in knowing more about sexuality and aging and would have no hesitation in asking.
   ___ e. Older people are eager to learn and to talk about sexuality.

25. Which of the following statements best characterizes the way you think younger people feel about sexuality in older people? Check one only.
   ___ a. Sexuality in older people is natural and normal.
   ___ b. Sexuality is appropriate if the older people are interested.
   ___ c. Sexuality should include hand holding, kissing, and embraces; beyond that it is improper.
   ___ d. Sexuality in older people is humorous, because they are sexually unattractive.
   ___ e. Sexuality in older people is shameful and indecent.
ATTITUDES

DIRECTIONS: Please indicate your feelings about each of the following statements.
Do this by circling the number most appropriate. If you feel that you strongly
agree with any given item, then circle the number "1"; if you strongly disagree
circle the number "5". Circle 2, 3, or 4 according to your feelings about the
statement. There are no right or wrong answers; we really want to know how
you feel. Please answer all items; answer even if the item is about the opposite
sex.

I FEEL THAT. . . .

<table>
<thead>
<tr>
<th>IFEEL THAT</th>
<th>STRONGLY</th>
<th>AGREE</th>
<th>AGREE</th>
<th>UNDECIDED</th>
<th>DISAGREE</th>
<th>STRONGLY</th>
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<tbody>
<tr>
<td>26. People over 50 can have a good sexual life.</td>
<td>1</td>
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<td>27. It is important for a couple to reach climax (&quot;come&quot;) together.</td>
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<td>28. If intercourse presents a problem for older people, they should consider the possibility of other forms of sexual stimulation.</td>
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<td>29. Masturbation (self-stimulation) should stop after one gets married.</td>
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<tr>
<td>30. Women should lose interest in sexual activity after menopause (change of life).</td>
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<td>2</td>
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<td>31. The only normal position for intercourse is man on top, woman on the bottom.</td>
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<tr>
<td>32. Oral sex is immoral.</td>
<td>1</td>
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<tr>
<td>33. A hysterectomy should not signal the end of sex activities for a woman.</td>
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<td>2</td>
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<tr>
<td>34. There should be no laws against homosexuality (loving sexually someone of the same sex).</td>
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<td>2</td>
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<tr>
<td>35. If you do not have a partner for sexual activity, it is OK to masturbate.</td>
<td>1</td>
<td>2</td>
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<tr>
<td>36. Older women do not need sexual activity as much as older men do.</td>
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<td>2</td>
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<td>37. One can demonstrate love by means other than just sexual intercourse.</td>
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<td>38. Older people are less sexually attractive to each other than younger people are to each other.</td>
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<tr>
<td>39. There is nothing wrong with homosexuality.</td>
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<tr>
<td>Item</td>
<td>Strongly Agree</td>
<td>Agree</td>
<td>Undecided</td>
<td>Disagree</td>
<td>Strongly Disagree</td>
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<td>40. It is healthy for an older person to think about sexual matters.</td>
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<td>41. If my child were homosexual, I could accept it.</td>
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<tr>
<td>42. Interest in sexual activity after 65 is shameful and indecent.</td>
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<tr>
<td>43. Masturbation is wrong if you are over 50.</td>
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<td>44. Nursing homes should help older people to have sexual opportunities.</td>
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<td>45. When an older person loses a partner, it is OK to turn to someone of the same sex for sexual comfort.</td>
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<td>46. Older people should not seek help for their problems.</td>
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<td>47. Older people ought to maintain an active sex life as long as they can.</td>
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<td>48. Older men should have more sexual freedom than older women.</td>
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</table>
### 49. People with serious medical problems should have no sexual activity.

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<tr>
<th>STRONGLY AGREE</th>
<th>AGREE</th>
<th>UNDECIDED</th>
<th>DISAGREE</th>
<th>STRONGLY DISAGREE</th>
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### 50. An active sex life in older people is just as normal as for younger people.

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<tr>
<th>STRONGLY AGREE</th>
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### 51. Older people should practice masturbation for pleasure and to relieve sexual tensions.

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<tr>
<th>STRONGLY AGREE</th>
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<th>UNDECIDED</th>
<th>DISAGREE</th>
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### 52. Older people should be interested in sexual activity.

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<tr>
<th>STRONGLY AGREE</th>
<th>AGREE</th>
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### 53. Older people may be able to enjoy sexual activity more than when they were younger.

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<tr>
<th>STRONGLY AGREE</th>
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<th>UNDECIDED</th>
<th>DISAGREE</th>
<th>STRONGLY DISAGREE</th>
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### OPINIONS

**DIRECTIONS:** Listed below are statements about sexuality in older people. We want to know whether most of the time you would agree or disagree with each of the statements. Please check the line which best reflects your opinion. If you are unsure, check the line under "UNCERTAIN." Please answer all items; answer even if the item is about the opposite sex.

### 54. The various losses which older people experience have no effect on their sexual activity.

<table>
<thead>
<tr>
<th>AGREE</th>
<th>DISAGREE</th>
<th>UNCERTAIN</th>
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</table>
55. Men over 50 are unable to father children.  

56. Most women over 55 are unable to have children.

57. Worrying about being able to perform sexually is one of the most common sources of sexual problems for older men.

58. The effects of aging can cause pain during intercourse for a woman.

59. In order to have intercourse an older man needs more touching than a younger man.

60. Older men do not ejaculate ("come") as strongly as before.

61. People who stay active sexually are able to continue well into old age.

62. One of the reasons that there may be less sexual activity for older people is because society supports that view.

63. Drinking does not cause a man to have problems with erection.

64. Men over 70 cannot have an erection.

65. Older men must wait longer from one sexual act to the next.
66. Diabetes frequently causes a man to have difficulties obtaining an erection.

67. People may have less desire for sexual activity as they get older.

68. For some women menopause (change of life) is the beginning of a better sex life.

69. Most older women stop having intercourse because of lack of a partner.

70. Exercise helps improve the sex life of older people.

71. Men cannot have intercourse after any type of prostate surgery.

72. Medications can lessen sexual desire.

73. A woman with a hysterectomy (uterus/womb removed) can still have a climax during intercourse.

74. Control of disease can restore sexual functioning.

75. Depression often results in sexual problems.
ACTIVITY

DIRECTIONS: The following questions relate to sexual activity, your levels of experience, and will aid our understanding of the relationship among opinions, attitudes, and behavior. Please answer honestly. You may omit any questions if you find them too personal. Circle the letter of the answer which best fits you.

76. Do you find that you still have an interest in sexual matters?
   a. Yes
   b. No

77. How do you think you compare with your group's experience in sex?
   a. More experienced than most
   b. As experienced as most
   c. Less experienced than most

78. How do you think you compare with your age group's knowledge about sex?
   a. More knowledgeable than most
   b. As knowledgeable as most
   c. Less knowledgeable than most

79. How do you think you compare with your age group's sexual adjustment?
   a. More adjusted than most
   b. As adjusted as most
   c. Less adjusted than most

80. How do you think you compare with your age group's attitudes about sex?
   a. More liberal than most
   b. About the same as most
   c. More conservative than most

81. Do you believe others in your age group are sexually active?
   a. Less than you
   b. About the same as you
   c. More than you

82. Do you think about sexual activity?
   a. Often
   b. Never
   c. Occasionally
83. Do you dream about sexual activity?  
a. Often  
b. Never  
c. Occasionally

84. Do you engage in sexual intercourse?  
a. Yes  
b. No

85. If you do not engage in sexual intercourse it is because  
a. There is no partner  
b. Physical illness  
c. Mental illness  
d. Not interested  
e. Other: (please specify) _____________________________

86. If you do engage in sexual intercourse the frequency is  
a. More than once a week  
b. About once a week  
c. More than once a month  
d. At least once a month  
e. Less than once a month

87. Have you ever masturbated?  
a. Yes  
b. No

88. If you masturbate, how often does it occur?  
a. More than once a week  
b. About once a week  
c. More than once a month  
d. At least once a month  
e. Less than once a month

89. Do you have a sexual relationship with someone now?  
a. Yes  
b. No

90. Have you had an intimate relationship with someone in the last five years and not engaged in sexual intercourse?  
a. Yes  
b. No

91. With whom do you prefer to have sexual relationships?  
a. Someone of the opposite sex  
b. Someone of the same sex  
c. People of both sexes
92. Does your sexual activity give you pleasure?
   a. Yes
   b. No

93. When you engage in sexual activity, what percentage of the time do you reach climax?
   a. About 25%
   b. 26 to 50%
   c. 51 to 75%
   d. Almost all of the time

94. Generally when you reach climax, it is during
   a. Intercourse
   b. Masturbation

Please be sure that you have answered all pertinent items in this section. Then be sure that you have answered all of the questions in the other sections.

Your responses are totally anonymous.

Thank you so very much for your time, effort, and thoughtfulness in filling out this questionnaire. Your responses will be extremely helpful. You have made a real contribution in helping to understand older people and their needs.
APPENDIX B

SUBSCALES ATTITUDE AND OPINION SECTIONS
Attitudes - Subscale Masturbation

1. Item - 29, Masturbation (self-stimulation) should stop after one gets married.

2. Item - 35, If you do not have a partner for sexual activity, it is OK to masturbate.

3. Item - 43, Masturbation is wrong if you are over 50.

4. Item - 51, Older people should practice masturbation for pleasure and to relieve sexual tensions.

Attitudes - Subscale Older Sexuality

1. Item - 26, People over 50 can have a good sexual life.

2. Item - 38, Older people are less sexually attractive to each other than younger people are to each other.

3. Item - 40, It is healthy for an older person to think about sexual matters.

4. Item - 42, Interest in sexual activity after 65 is shameful and indecent.

5. Item - 47, Older people ought to maintain an active sex life as long as they can.

6. Item - 50, An active sex life in older people is just as normal as for younger people.

7. Item - 52, Older people should be interested in sexual activity.

8. Item - 53, Older people may be able to enjoy sexual activity more than when they were younger.

Attitudes - Subscale Acceptability of Gerontological Sexual Behavior

1. Item - 27, It is important for a couple to reach climax ("come") together.

2. Item - 28, If intercourse presents a problem for older people, they should consider the possibility of other forms of sexual stimulation.

3. Item - 30, Women should lose interest in sexual activity after menopause (change of life).
4. Item - 31, The only normal position for intercourse is man on top, woman on the bottom.

5. Item - 32, Oral sex is immoral.

6. Item - 33, A hysterectomy should not signal the end of sex activities for a woman.

7. Item - 36, Older women do not need sexual activity as much as older men do.

8. Item - 37, One can demonstrate love by means other than just sexual intercourse.

9. Item - 44, Nursing homes should help older people to have sexual opportunities.

10. Item - 46, Older people should not seek help for their problems.

11. Item - 48, Older men should have more sexual freedom than older women.

12. Item - 49, People with serious medical problems should have no sexual activity.

Attitudes - Subscale Homosexuality

1. Item - 34, There should be no laws against homosexuality (loving sexually someone of the same sex).

2. Item - 39, There is nothing wrong with homosexuality.

3. Item - 41, If my child were homosexual, I could accept it.

4. Item - 45, When an older person loses a partner, it is OK to turn to someone of the same sex for sexual comfort.

Opinions - Subscale Social/psychological aspects of gerontological sexuality

1. Item - 54, The various losses which older people experience have no effect on their sexual activity.

2. Item - 57, Worrying about being able to perform sexually is one of the most common sources of sexual problems for older men.
3. Item - 61, People who stay active sexually are able to continue well into old age.

4. Item - 62, One of the reasons that there may be less sexual activity for older people is because society supports that view.

5. Item - 67, People may have less desire for sexual activity as they get older.

6. Item - 68, For some women menopause (change of life) is the beginning of a better sex life.

7. Item - 69, Most older women stop having intercourse because of lack of a partner.

8. Item - 75, Depression often results in sexual problems.

Opinions - Subscale Physiological aspects of gerontological sexuality

1. Item - 55, Men over 50 are unable to father children.

2. Item - 56, Most women over 55 are unable to have children.

3. Item - 58, The effects of aging can cause pain during intercourse for a woman.

4. Item - 59, In order to have intercourse an older man needs more touching than a younger man.

5. Item - 60, Older men do not ejaculate ("come") as strongly as before.

6. Item - 63, Drinking does not cause a man to have problems with erection.

7. Item - 64, Men over 70 cannot have an erection.

8. Item - 65, Older men must wait longer from one sexual act to the next.

9. Item - 70, Exercise helps improve the sex life of older people.

10. Item - 73, A woman with a hysterectomy (uterus/womb removed) can still have a climax during intercourse.
Opinions - Subscale Medical aspects of gerontological sexuality

1. Item - 66, Diabetes frequently causes a man to have difficulties obtaining an erection.

2. Item - 72, Men cannot have intercourse after any type of prostate surgery.

3. Item - 72, Medications can lessen sexual desire.

4. Item - 74, Control of disease can restore sexual functioning.
APPENDIX C

SOURCES OF QUESTIONNAIRE ITEMS

2Human Sexuality and Nursing Practice (Filmstrip). Costa Mesa, California: Concept Media, 1975.


APPENDIX D

JURY OF EXPERTS
Ms. Bonnie Fass  
Administrator  
Heritage Tower  
Columbus, Ohio

Dr. Leopold Liss  
Professor of Pathology and Psychiatry  
The Ohio State University Medical School  
Columbus, Ohio

Dr. Henry R. Angelino  
Professor of Psychology  
The Ohio State University  
Columbus, Ohio

Dr. Jerome Kaplan  
Professor of Sociology  
The Ohio State University - Mansfield Campus  
Mansfield, Ohio

Mr. Franklin Nathan  
Director  
Glen Manor  
Cincinnati, Ohio

Ms. Nancy Levin  
Social Worker - Golden Agers  
Jewish Community Center  
Cincinnati, Ohio

Dr. Terri Brower  
Professor Schools of Nursing and Medicine  
Nurse Practitioner Program  
University of Miami  
Miami, Florida
APPENDIX E

(Letter sent to suggested panel of experts asking them to scrutinize the instrument for content validity.)
I am a doctoral student at The Ohio State University in health education. My research is entitled Assessing the Perceptions of Older People Regarding Their Sexuality as a Basis for Program Development. As part of my dissertation I am developing/adapting an instrument for the assessment, a paper and pencil test to be completed by volunteer subjects without assistance.

I am asking you as an acknowledged authority in either gerontology or a related area to assist me with my research. Would you be willing to serve on my panel of experts and scrutinize my instrument for content validity? This would take approximately 30 minutes to one hour of your time and would help me immensely.

Would you please let me know by the enclosed return post card as soon as possible? Many thanks, indeed, for your consideration.

Most sincerely,
Linda L. Olasov
Graduate Teaching Associate
Health Education Division
The Ohio State University
APPENDIX F

(Letter sent to those people agreeing to be a member of panel of experts to scrutinize the instrument for content validity.)
Thank you for agreeing to serve on my panel of experts to establish content validity for my questionnaire. Enclosed is a copy of the instrument for your consideration. The subjects for whom it is intended hopefully will be a "normal," older population; that is, people 65 and older who are unimpaired intellectually, emotionally, and sensorially. They should be able to respond to the questionnaire in written form without assistance.

On your copy of the instrument would you please mark any items for which the indicated answer (agree or disagree) is incorrect. In addition, please feel free to make editorial comments or reword statements where you feel they are unsuitable or could be better stated.

I would appreciate your returning this instrument to me within two weeks. Thank you so much for your time and assistance.

Sincerely yours,
Linda L. Olasov
Graduate Teaching Associate
Health Education Division
The Ohio State University
APPENDIX G

(List of organizations or retirement housing units contacted who agreed to participate in the pilot study* and those who did not.)
*Bonnie Fass, Administrator
Heritage Towers
1145 College Avenue
Columbus, Ohio 43209

*Dick Crabb, Director
First Community Village
1800 Riverside Drive
Columbus, Ohio 43214

Lois Gordon
McDowell Senior Center
241 McDowell
Columbus, Ohio 43215

Sue Ulric
Summit Senior Center
Second and Summit
95 East Second
Columbus, Ohio 43201
APPENDIX H

(Letter sent to directors of housing specifically designated for older people or directors of social organizations for older people.)
As a doctoral student in health education at The Ohio State University, my research is in gerontology. The purpose of the research is threefold: (1) to develop a standardized instrument to assess the perceptions of sexuality in older people; (2) to establish baseline data for this instrument; and (3) to evaluate the implications of this information as a basis for program development.

The questionnaire I have developed is a paper and pencil test, printed in jumbo type, which takes approximately one to one and a half hours to complete. The test collects information about demographic characteristics, educational programming, sexual opinions, attitudes, and activity.

For this study I need as volunteers women and men age 65 and older who meet the following criteria: (1) currently not hospitalized; (2) unimpaired intellectually, emotionally, and sensorially; and (3) able to read and write without assistance.

Your assistance in my research would be appreciated. I will call you soon to arrange an appointment. The results of my study may be shared with you and your staff, if you wish, to consider in programming for your clients.

Many thanks for your consideration.

Linda L. Olasov
Graduate Teaching Associate
Health Education Division
The Ohio State University
APPENDIX I

(Letter sent to those directors of senior citizens groups or residential centers who requested a copy of the questionnaire and further explanation of the procedure for the administration of the questionnaire.)
This is a copy of the questionnaire used in a pilot study. I have written in some of the proposed revisions and omissions suggested for the final questionnaire. It would come to the volunteer typed in jumbo print with a cover letter of explanation and a self-addressed, stamped manila envelope. Accompanying the questionnaire would be a consent form to be read and signed by the subject. It would be detached from the questionnaire so that the responses of the subject would remain absolutely anonymous.

I would deeply appreciate your help in obtaining the participation of anyone who might be willing to fill out this questionnaire. Because you know your group, you would be able to approach those whom you feel might participate. I will call you after September 1, 1980.

Many, many thanks,
Linda Olasov
Graduate Teaching Associate
Health Education Division
The Ohio State University

793-0232
APPENDIX J

(Letter sent to possible volunteers whose names were on a mailing list for private housing designated for older people.)
I am a doctoral candidate in health education at The Ohio State University. For my dissertation I have chosen to do research in the area of sexuality and older people. The results of the responses may be used as a basis for designing an educational program.

If you are willing to respond to the questionnaire, I would greatly appreciate your efforts. The time needed to respond is about thirty minutes. The questionnaire is marked only by subject number and is totally anonymous. There is a consent form to be signed, but you can detach it and keep it or sign it and trust me to detach it after the questionnaire is returned to me. Just disregard the instructions about the consent form on the following page.

If you do not wish to respond to the questionnaire, please mail it back to me in the self-addressed, stamped manila envelope.

Many, many thanks for your consideration,

Linda Olasov
APPENDIX K

(Cover letter attached to the questionnaire explaining how to fill it out and return it by mail to the investigator.)
This is a questionnaire to study sexuality in people 65 and older. Your answers are important as they may be used as a basis to design an educational program.

First, please read and sign the two-page consent form. Give it to the person from whom you received the questionnaire. Next, fill out the questionnaire at your convenience. Read the questions carefully. Please answer all of the questions, even those that are about the opposite sex. Please follow the directions for the question; if the question requests that you circle or check only one answer, then only select one response. It is very important to answer all of the questions.

When you have completed the questionnaire, please put it in the self-addressed, stamped manila envelope and drop it into the nearest mailbox. Please return the questionnaire as soon as possible. We plan to complete the study by November 1, 1980.

Thank you very much for your participation in this research.

Most sincerely,
Linda Olasov
APPENDIX L

(List of organizations or housing units specifically designated for older people contacted who agreed to participate in the study* and those that did not.)
*Hillrise Senior Center
1500 Groesbeck Road
Cincinnati, Ohio

*Lincoln Heights Senior Citizens
House of Joy
989 Adams Street
Cincinnati, Ohio

*Mariemont Assembly for Older Adults
Mari Elders Center
3906 Plainfield Road
Cincinnati, Ohio

*North College Hill Community Seniors Inc.
6891 Simpson Avenue
Cincinnati, Ohio

*Norwood Community Senior Center
1810 Courtland Avenue
Norwood, Ohio

*Clifton Senior Center
900 Rue de la Paix
Cincinnati, Ohio

*Orthodox Jewish Home for the Aged
1171 Towne
Cincinnati, Ohio

*Jewish Community Center
1580 Summit Road
Cincinnati, Ohio

*Winton Hills Senior Center
667 Dutch Colony Drive
Cincinnati, Ohio

*Llanfair
1701 Llanfair
Cincinnati, Ohio

*The Essex House
7610 Reading Road
Cincinnati, Ohio

*A retirement home. The administrator asked that the name not be mentioned in the study.
Delhi Senior Community Center
647 Neeb Road
Cincinnati, Ohio

Salvation Army Day Care Center
Central Parkway and Clay Streets
Cincinnati, Ohio

Harrison Senior Center
300 George Street
Harrison, Ohio

Salem Senior Center
6137 Salem
Cincinnati, Ohio

Sycamore Senior Center
4131 Cooper Road
Cincinnati, Ohio

West College Hill Senior Center
6225 Betts Avenue
Cincinnati, Ohio

Sem Laurels
Mound and Hickory
Milford, Ohio

Seven Hills Community House
717 Ezzard Charles Drive
Cincinnati, Ohio

Hyde Park Center
2800 Erie Avenue
Cincinnati, Ohio

Judson Village
2373 Harrison Avenue
Cincinnati, Ohio

Beechknoll
6550 Hamilton Avenue
Cincinnati, Ohio

Bethesda Scarlet Oaks
440 Lafayette Avenue
Cincinnati, Ohio

Hilltop
2586 LaFeuille
Cincinnati, Ohio
Marjorie P. Lee
3550 Shaw Avenue
Cincinnati, Ohio

Montgomery Care Center
7777 Cooper Road
Cincinnati, Ohio

Glen Manor
6969 Glen Meadow Lane
Cincinnati, Ohio

Sem Villa
201 Mound
Milford, Ohio

Hillcrest
1831 Losantiville

*Butterfield Senior Center
22 Garfield Place
Cincinnati, Ohio
APPENDIX M

(Significant corelations at the .05 probability level or greater not listed in the text.)
### Pearson r Correlation Coefficients for Living Arrangement and other Variables

<table>
<thead>
<tr>
<th>Correlate</th>
<th>Coefficient</th>
<th>Significance Level</th>
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<tr>
<td>Age</td>
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<tr>
<td>Number of children</td>
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<td>.02</td>
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<tr>
<td>Prostate</td>
<td>-.233</td>
<td>.03</td>
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<tr>
<td>Education</td>
<td>.265</td>
<td>.016</td>
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<tr>
<td>Age at which older people learned about gerontological sexuality</td>
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<tr>
<td>Homosexuality</td>
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<tr>
<td>Summary of attitudes scores</td>
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<td>.0421</td>
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<tr>
<td>Status of Mental Health</td>
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<td>.0169</td>
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### Pearson r Correlation Coefficients for Number of Children and other Variables

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<th>Coefficient</th>
<th>Significance Level</th>
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<tbody>
<tr>
<td>Race</td>
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<td>.05</td>
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<tr>
<td>Prostate</td>
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<td>.0006</td>
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<td>Education</td>
<td>-.312</td>
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<td>Still engages in sexual intercourse</td>
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<td>.027</td>
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<td>Religion</td>
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<td>Communication about gerontological sexuality</td>
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### Pearson r Correlation Coefficients for Status of Physical Health and other Variables

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<tr>
<td>Arthritis</td>
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<tr>
<td>Number of ailments checked</td>
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<tr>
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Pearson r Correlation Coefficients for Hysterectomy and other Variables

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<td>Arthritis</td>
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<tr>
<td>Number of ailments checked</td>
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<td>.0005</td>
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<tr>
<td>Uncertain responses Physiologic aspects Opinion Section</td>
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<td>Correct responses Physiologic aspects Opinion Section</td>
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<td>Composite Opinion scores</td>
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Pearson r Correlation Coefficients for Prostate

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<td>.02</td>
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<tr>
<td>Communication about gerontological sexuality</td>
<td>-.241</td>
<td>.0349</td>
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Pearson r Correlation Coefficients for Arthritis

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<tr>
<td>High blood pressure</td>
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<td>Depression</td>
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<td>Number of ailments checked</td>
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<td>Correct responses Physiologic aspects Opinion Section</td>
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<tr>
<td>Total number of uncertainties</td>
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<td>.0086</td>
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### Pearson r Correlation Coefficients for Diabetes

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<tbody>
<tr>
<td>Heart disease</td>
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<td>.0037</td>
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<tr>
<td>High blood pressure</td>
<td>.227</td>
<td>.0407</td>
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</table>

### Pearson r Correlation Coefficients for Heart Disease

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<tr>
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<tr>
<td>Comparison of sexual adjustment</td>
<td>-.228</td>
<td>.0422</td>
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### Pearson r Correlation Coefficients for High Blood Pressure

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<th>Significance Level</th>
</tr>
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<tbody>
<tr>
<td>Motivation to learn more about gerontological sexuality</td>
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<td>.0050</td>
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### Pearson r Correlation Coefficients for Chronic Conditions

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<td>Professionally trained instructor</td>
<td>-.245</td>
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### Pearson r Correlation Coefficients for Income

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<tbody>
<tr>
<td>Thinking about sexual matters</td>
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<td>.0007</td>
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<td>Acceptability of gerontological sexual behavior</td>
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<td>Current responses Medical aspect in Opinion Section</td>
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<td>Comparison of sexual attitudes</td>
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<td>Still engages in sexual intercourse</td>
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Pearson r Correlation Coefficients for Age at Which Older People Learned about Gerontological Sexuality

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<thead>
<tr>
<th>Correlate</th>
<th>Coefficient</th>
<th>Significance Level</th>
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</thead>
<tbody>
<tr>
<td>Professionally trained instructor</td>
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<td>.0352</td>
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<td>Comparison of sexual attitudes</td>
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