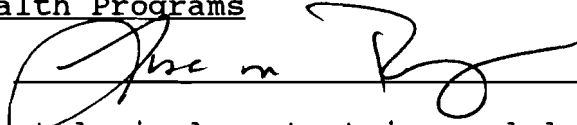


AN ABSTRACT OF THE THESIS OF

Brenda Lea Wimer for the Master of Science in Clinical Psychology presented on April 1, 1996

Title: Perceptions of Elderly Sexuality Among Students in Graduate Mental Health Programs

Abstract approved: \_\_\_\_\_



Increased gerontological content is needed in curricula preparing students to be mental health professionals.

Elderly individuals are one of the fastest growing segments of our population. These individuals have ever-present needs that mental health professionals must be prepared to confront while providing the best services possible.

Unfortunately, one of the areas most often neglected is elderly sexuality. This study utilized the Aging Sexuality Knowledge and Attitude Scale to assess the perceptions of graduate students in mental health programs (clinical psychology, rehabilitation education, counseling education, and art therapy). Although no significant difference between graduate programs was found, the current sample means for knowledge and attitude were significantly less than groups found in the research literature, indicating greater knowledge and more sensitive attitudes from sample participants. Knowledge and attitude significantly positively correlated. The implications of these results were discussed.

PERCEPTIONS OF ELDERLY SEXUALITY AMONG STUDENTS IN  
GRADUATE MENTAL HEALTH PROGRAMS

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A Thesis  
Presented to  
the Division of Psychology and Special Education  
EMPORIA STATE UNIVERSITY

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In Partial Fulfillment  
of the Requirements for the Degree  
Master of Science

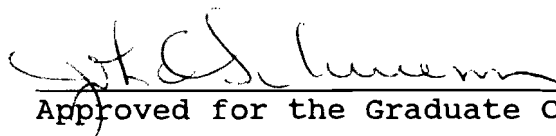
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by  
Brenda Lea Wimer

May 1996

A handwritten signature in black ink, appearing to read "Kenneth A. Hearn", with a long horizontal stroke extending to the right.

Approved for the Division of Psychology  
and Special Education

A handwritten signature in black ink, appearing to read "J. O. Schumann", with a long horizontal stroke extending to the right.

Approved for the Graduate Council

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I dedicate this thesis to my family and friends. I thank each one of you for all the support and encouragement. Sincere thanks to Dr. Reboy for her direction and guidance as my thesis chair and to Dr. Holmes and Dr. Weaver for graciously acting as committee members. Most of all, I thank God for providing me with the determination and strength to complete this project.

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## CHAPTER 1

### INTRODUCTION

Infused in our society is the myth that elderly individuals do not have the same needs they did when they were younger. One of the largest misconceptions surrounds the sexuality of older adults. There is a common perception that elderly people no longer have a need to engage in sexual behavior. This misconception may be centered around the idea that they are incapable of having sexual intercourse (Hammond & Bonney, 1985). For some, this may be true, but the need for physical attention still exists.

Unfortunately, many mental health professionals believe the stereotypes about the elderly. Many of those being trained to help people adjust or deal with life circumstances are not prepared to confront the challenges the elderly face. There is a lack of training with respect to the lives of older adults.

This paper will assess the extent of knowledge about and attitudes towards the sexuality of older adults by students in the mental health professions of clinical psychology, rehabilitation education, counseling education, and art therapy. Students' levels of knowledge will be determined as well as their attitudes. Then, the relationship between knowledge and attitudes will be examined.



## Literature Review

### Definition of Elderly

As with many other terms, our definition of "old age" changes as we mature. Although the cutoff point is steadily moving further away, Dorfman (1994) indicates "old age" continues to refer to those 65 and older. Rogers (1979) emphasizes that from a chronological point of view, old age begins at 65. Also, the common governmental guidelines classify those age 65 and older as senior citizens (Cross, 1993). This author will also define elderly as those 65 and older. Terms utilized to classify those 65 and older include elderly, older people, the aged, older adults, and seniors (Dorfman, 1994; Rogers, 1979; Schulz & Ewen, 1988).

### Sexuality Among the Elderly

Aging individuals have the potential to be sexually active and are truly sexual beings (Steinke & Bergen, 1986). Kaplan (1990) indicated that approximately 70% of healthy 70 year olds remain sexually active. Woodard (1992) offered evidence that "sex is good and plentiful, even after 60" (p. 71). There is more opportunity for the expression of sexuality in the older years (Steinke & Bergen, 1986). "Sexual passion, pleasure and playfulness are not just for the young and the beautiful. The empty nest may actually be the love nest" (Woodard, 1992, p. 71).

Research demonstrates that the elderly continue to have and express sexual desires (Cross, 1993; Kaplan, 1990;

Steinke & Bergen, 1986; Woodard, 1992), but there is some indication the amount of physical activity facilitates these desires. Steinke and Bergen (1986) claim consistent sexual action is important to maintain physiological response. A significant positive relationship exists between pre-60 sexual attention and activity and behavior from ages 60 to 90 (Libman, 1989; Reiss, 1988). Physical and mental well-being are enhanced by older adults strong interest and participation in sexual activity (Steinke & Bergen, 1986).

Although sexual activity among the elderly does not come to an abrupt halt once one reaches a certain age, people do experience changes in their sexual functioning. There are some inevitable age-related changes in sexual physiology, just as there are in hearing, seeing, thinking, and other abilities.

Male sexuality peaks at age 17 and then gradually declines, whereas females do not reach their full sexual potential until their latter 30s or early 40s. Following their peak, their sexuality also gradually declines with age (Kaplan, 1990). However, both genders can easily adapt if they are adequately informed and prepared.

Growing older does not result in complete decline of all sexual functioning. Sexual response is multidimensional and has a specific affect in each phase of the response cycle (Kaplan, 1990; Libman, 1989). For example, the orgasm phase consists of the reflex contractions of certain genital

muscles. For males, the refractory period, or time it takes for ejaculation to be possible again, increases greatly with age. This period lengthens from a few minutes at the age of 17 up to 48 hours at the age of 70. However, women do not have a defined refractory period at any age.

The excitement phase involves the increased volume of blood in the genital area, resulting in penile erection in men and vaginal swelling and lubrication in women. With age, the excitement phase for women consists of diminished lubrication and swelling caused by the lack of estrogen due to menopause. Vaginal dryness, atrophy, and physical trauma to the genitalia are results of the decreased estrogen. In men, changes in the excitement phase include softer erections and an increased need for stimulation. Other effects of age include a decrease in testosterone, loss of sexual flush, and decrease in nipple erection (Kaplan, 1990; Kellett, 1991). Lack of understanding of these gradual changes in sexual physiology often results in a false view of elderly sexuality.

### Reasons for Misconceptions

Although studies reflecting enhancement of the aging process are growing in number, investigations of sexuality among the elderly are commonly neglected (Weinstein & Rosen, 1988). Reiss's (1988) investigation considers the shortage of research regarding sexuality of aging to be due to common denial mechanisms, misconceptions, and resistances (e.g., no

consistent sample size). For example, a majority of old and young respondents agree with the following statements: Most old people have no interest in or capacity for sexual behavior, and most older people are set in their ways and are unable to change. Steinke and Bergen (1986) suggest that society falls prey to ageism that is "the prejudice that stereotypes the elderly" (p. 6). Resistance to research of this subject stems from the perception that research is depressing because it often concerns elderly mental and physical decline, social losses, economic or health problems, and death (Safford, 1991). Denial of the special needs of this population is common, mostly due to fear of the unknown. Denial also results from anxiety generated by the thought of one's own grandparents participating in sexual activity (Reiss, 1988). For many, conceptualizing this aspect of their grandparents' relationship is difficult.

General views expressed by society toward elderly sexuality have been characterized as highly negative. Commonly, older adults are not allowed the sexual freedom the younger generations have. They are often "[f]orced into mandatory retirement from sexual activity" (Steinke & Bergen, 1986, p. 6). Being denied their sexuality for so long, many elderly individuals accept themselves as being asexual (Steinke & Bergen, 1986). This negative consensus is the result of several widely held beliefs regarding

sexuality among the elderly. First of all, many believe sexual functioning is one of the first biological mechanisms to succumb to the aging process (Kaplan, 1990). Also, the beliefs that sexuality is wrong or is not prevalent among the aging are commonly maintained. In actuality, the opposite is true.

Sexual needs do not suffer an abrupt change with age (Rotberg, 1987). The majority of healthy people remain sexually active well into advanced old age, which confirms that the loss of sexuality is not an inevitable part of aging. In fact, sexuality is one of the last faculties of our functioning to decline with age (Kaplan, 1990).

Narrow definitions of "sexual activity" also result in these misconceptions. For many, the definitions are confined to the specific activities of intercourse, ejaculation and orgasm. The concept of "sexual activity" needs to be expanded to include more sensual activities and more qualitative perceptions. Thus, older adults' repertoire of sexual activity could include such things as cuddling, necking, and petting and would not have to always conclude with intercourse. A more holistic approach may limit the occurrence of the self-fulfilling prophecy that sexual activity dramatically declines or even ceases with old age (Weinstein & Rosen, 1988).

Recognition of these continuing interests in sexual activity is a vital aspect in understanding the aging

process. Other aspects involved in increased understanding include knowledge and attitude toward sexuality among the elderly.

### Knowledge and Training in the Mental Health Professions

Libman (1989) stresses the importance of investigating sexuality in aging. There are many realities to be faced of sexuality in the aging individual, but complexities in the definition and evaluation of sexual expression and experience must be overcome. Hillman and Stricker (1994) define an individual's knowledge of sexuality among older adults as

his or her level of cognizance of the physiological changes associated with aging including impact of illness and medications on sexual potential, of the variety of sexual behaviors available other than intercourse, and of the informational resources available to elderly persons. (p. 256)

Researchers postulate that lack of knowledge regarding the aging process may be one reason for many misconceptions. Low levels of knowledge were found among samples of both college students and adults age 65 and older. Lack of knowledge is also the reason for negative attitudes toward the elderly population as a whole. Consideration of the linkage between knowledge and attitude regarding older adult sexuality is increasing among researchers (Hillman & Stricker, 1994).

These negative views are held by average citizens as well as many health care professionals. In a comparison of attitudes of freshman and senior medical students, Tarbox, Connors, and Faillace (1987) established an apparent prejudice against the elderly. This study implied a high rate of negative attitudes among medical students, physicians, and psychiatrists. Approximately 20% reported they did not like old people, and many did not even attempt to visit those in nursing homes.

Knowledge deficits also pose a serious problem. Dye and Sassenrath (1979) suggested that professionals were not consistently able to distinguish changes in normal aging from disease processes in the elderly. This is an unfortunate finding because health care professionals can expect to spend as much as 75% of their practice time with the elderly. More than 50% of master's level social workers alone may be involved in providing services for the elderly (Reed, Beall, & Baumhover, 1992). Clearly, this is an established concern.

Myers, Lousch and Sweeney (1991) found less than half of the required or elective courses in counselor preparation programs included curricular units related to older persons' counseling needs. Within elective courses, there was a low level (< 15%) of inclusion of gerontological content. In survey of 361 psychology-related doctoral units in the United States, Okun, Stock, and Weir (1985) noted less than

16 units integrated adult development and aging with clinical, counseling, and community psychology. The numbers have not increased significantly in the past 10 years.

Beall, Baumhover, Simpson, and Pieroni (1991) surveyed students in two small practice training programs to determine their knowledge about and attitudes towards the older adult clientele. As with many of society's pressed issues, lack of time seems to be a major influence on professional attitudes. Subjects reported the greatest single barrier was the additional time required to diagnose and treat older people. The researchers also noted knowledge deficits concerning the aging process. Subjects identified one of the other significant barriers as being insufficient instruction regarding geriatric concerns. In Reed, Beall, and Baumhover's (1992) study, approximately 60% of their subjects reported never having had a course that dealt specifically with aging. Nursing students identified the greatest limitation in gerontological education as insufficient curriculum time and lack of academic role models. Social work students perceived a lack of hands-on work with the elderly as the greatest obstacle.

Kline and Kline (1991) acknowledged differences in education greatly affect scores on knowledge scales. However, they maintain general work experience with the elderly cannot substitute for formal training in gerontology. They emphasized the importance of a formal



gerontological/geriatric curriculum for those whose work brings them into significant contact with older persons. Carmel, Cwikel, and Galinsky (1992) also supported the notion formal lectures are a more effective way of transmitting knowledge than group discussions and contacts with older people. Stanley and Burggraf (1986) realized many health care professionals are trained to focus on a persons' improvement to optimal health, which makes it difficult for many to deal with the elderly. They need to be taught how to accept the aging individual's status, and should be encouraged to promote health maintenance and rehabilitation. Kosberg and Wangum (1992) felt emphasis on older adults would provide students with a deep concern for the elderly and their treatment.

Awareness that these aged people continue to have sexual needs and desires and the acceptance of the implications of that condition are essential to successful support and treatment supplied by mental health professionals. Negative stereotypes and attitudes must be dealt with if the elderly are to receive the care they deserve (Reiss, 1988; Steinke & Bergen, 1986). Rich et al. (1985) expressed the need to improve the quality and quantity of mental health professionals. Standards in our society are continually rising. Adults are better educated and will demand a higher quality of services as they grow older.

Research must be conducted regarding the preparation students are receiving before entering the helping profession's work force. Specialized courses concerning different populations should be required for degree candidacy. The elderly citizens are often neglected and treated unfairly because of lack of understanding of their circumstances. Ethically, a person must give the best help possible to a client. Adequately assisting the elderly is more difficult if those being trained in helping professions are not sufficiently educated.

Agreesti (1992) emphasized the need to inject specialized training into curriculums for students in advanced degree programs. Helping mental health professionals become more aware of the implicit values (e.g., religious, moral) operating in treatment and the ethical obstacles (e.g., physical and mental health) for each individual case is a necessary step. Knowledge needs to encompass not only the psychological changes accompanying aging, but also the physical. Society as a whole is subject to believing the various myths and supporting the diverse stereotypes about elderly sexuality, therefore those wanting to help others adjust in the best ways possible should be well educated. They must be informed about the elderly population and sexuality. People do not disappear after they reach a certain age, and neither do their needs. Expression of sexuality is a natural process and should not

be denied for anyone. The best way to help older adults adjust is to have an understanding of their life changes and the best means to cope with these changes.

#### The Aging Sexuality Knowledge and Attitude Scale

The Aging Sexuality Knowledge and Attitude Scale (ASKAS) (White, 1982) is a psychometric test designed to assess individuals' knowledge and attitudes concerning older adult sexual behavior. White and Catania (1982) showed in a pretest-posttest comparison that attitudes towards elderly sexuality can be influenced through knowledge gained in an educational program. Various other studies also support the notion of an existing relationship between knowledge and attitudes. Story (1989) established a correlation between greater knowledge and more positive attitudes. She submits students ( $r = .64$ ) are more open to the idea of elderly sexuality than older adults themselves ( $r = .46$ ) and recommends that older adults need more in-depth education about their sexuality and sexual functioning. Elderly persons are greatly influenced by the attitudes of health care providers, same age cohorts, and society as a whole (Hillman & Stricker, 1994). More in-depth education may reduce the impact of others' views on the behavior of older individuals.

Hammond and Bonney (1985), Salamon and Charytan (1984), and Tarbox et al. (1987) found that increased knowledge influenced both young and old participants' attitudes

towards sexuality among the elderly. Hillman and Stricker (1993) attempted to gain more generalizable information in regards to the attitudes of young adults. They administered the ASKAS to college students in introductory psychology courses. A significant positive knowledge/attitude relationship was reported.

### Summary

Clearly, elderly individuals each need to be seen as a total person, one that is thinking, feeling, exhibits ongoing sexual needs, and is capable of sexual expression. They need to know having these needs and desires and expressing them as they wish, along with accurate information and affirmation that they play a vital role in our society, are acceptable (Steinke & Bergen, 1986). All the factors associated with growing old should be the concerns of those who seek to achieve psychological, physiological, and social well-being as they progress through this stage of life (Weinstein & Rosen, 1988).

Viewing geriatric sexuality positively could help diminish many of the stereotypes surrounding elderly sexuality (Steinke & Bergen, 1986). Research findings are the key to beginning the erosion of these myths, stereotypes and negative views. Educating those preparing to be health care providers is one way to begin the battle against these inaccurate perceptions. Times and views of sexuality have changed in recent years, and a new perspective may need to

be gained before any approach to the subject can even be suggested.

A clear perspective concerning the amount and type of preparation about elderly sexuality graduate students in helping professions are receiving would assist in determining what avenues need to be taken for further research. It would also establish how well educators are doing in preparing the students to maximize client benefits. Increased knowledge and understanding would improve practitioner's ability to meet the life demands of the elderly. The present study attempted to measure the knowledge and attitudes held by graduate students in the following helping professions: clinical psychology, rehabilitation education, counseling education, and art therapy courses.

The following hypotheses were examined. First, compared to previous samples, the overall level of knowledge and attitudes for the current sample is low. Second, graduate students in various mental health degree programs differ in level of knowledge. Third, graduate students in various mental health degree programs differ in acceptance of attitudes. Fourth, the amount of knowledge one has and one's attitude towards older adult sexuality are positively correlated.

## CHAPTER 2

### METHOD

#### Participants

The target population included graduate students majoring in one of the following mental health professions: clinical psychology, rehabilitation education, counseling education, or art therapy. The sample consisted of 75 students, and was derived from intact graduate level clinical psychology, rehabilitation education, counseling education, and art therapy courses at Emporia State University, Emporia, Kansas.

#### Design

The independent variable for both Hypothesis 2 and Hypothesis 3 was the type of graduate program. Amount of knowledge was the dependent variable for Hypothesis 2. Respondents' attitudes was the dependent variable for Hypothesis 3.

#### Instrument

The Aging Sexual Knowledge and Attitude Scale (ASKAS) (White, 1982) is an instrument used for the assessment of social cognitions regarding the aged. The ASKAS (Appendix A) was first developed by White (1982) and is designed to assess one's knowledge about and attitudes towards elderly sexuality. It differs from other sexual and attitudinal scales in that it is designed exclusively to encompass issues of the aged.

The ASKAS consists of 61 statements. The first 35 are true-false knowledge items. These statements measure knowledge about sexuality of the aged. The remaining 26 statements measure attitudes towards elderly sexuality and are responded to on a 7-point Likert scale.

The instrument is objectively scored. The possible range of scores for the knowledge subscale is 35 to 105, and for the attitude subscale it is 26 to 182. For the knowledge scale, a low score indicates high knowledge. A low score on the attitude scale is indicative of a more accepting attitude.

In the knowledge section, for items 1 through 35, "true" was given 1 point, "false" 2 points, and "don't know" was given 3 points. However, items 1, 10, 14, 17, 20, 30, and 31 were reversed scored, where "true" was given 2 points and "false" 1 point. Choosing "don't know" as a response always resulted in a score of 3. The attitude statements, 36 through 61, were each scored according to the value selected by the respondent, with the exception of items 44, 47, 48, 50, 51, 52, 53, 54, 55, 57, and 59. The scoring for these items was also reversed (White, 1981).

Hillman and Stricker (1994) reviewed several studies that have utilized the ASKAS instrument. Slightly higher reliabilities have been found for the knowledge section of the scale in comparison to the attitude portion. Reliability measures have been above 0.85. White (1982)

indicated the various determinants of reliability including positive split-half correlations between .83 and .91, alpha coefficients between .83 and .93 which are representative of internal item homogeneity, and high positive correlations between .72 and .97 among repeated testings signifying test-retest reliability.

Validity is attested to by the numerous data from other researchers (Hillman & Stricker, 1994; White, 1982). The validity has been examined by pretest/posttest with educational intervention for several separate groups; including older persons, individuals who work with older adults, and adult family members of the aged. In all cases the educational intervention resulted in a significant increase in knowledge and more accepting attitudes in comparison to the control groups (White & Catania, 1981).

Hillman and Stricker (1994), White (1982), and White and Catania (1982) established that the scale could be used on several different subject pools. These include the aged, families of the aged, and nurses dealing with the aged. The ASKAS has also been employed with younger adults (Hillman & Stricker, 1993).

### Procedure

The participants were tested in groups. The administration procedures were conducted in the same manner. After everyone was seated, informed consent forms (Appendix B) were dispersed. Participants were instructed to follow



along as the researcher read the form aloud. Following the recognition of consent, by signing the form, each of these forms was collected. Next, the Aging Sexuality Knowledge and Attitude Scale (ASKAS) and a demographic sheet (Appendix C) were distributed. Participants were asked to read the instructions carefully as the experimenter read them aloud.

I am going to read you some instructions on how to complete the survey. First of all, when the instructions have been read, you may turn the page and complete the demographic information. This information only serves the purpose of helping the researcher categorize the data. It will in no way serve as a way to identify participants. Upon completion of the demographic information, you may turn the page and begin the survey. Please read the instructions carefully. The first portion of the survey consists of 35 true/false, and don't know statements. If you think the statement is correct, you would circle the word "true." If you think the statement is incorrect, you would circle "false." If you cannot answer the question, circle "don't know." The second portion of the survey is a set of statements for which you indicate your amount of agreement, using Likert scale ranging from 7 to 1. If you strongly agree with the statement you would circle the number 7. However, if you strongly disagree with the statement you would

circle the number 1. Take your time and read the statements carefully. Please respond honestly and openly. If you have any questions, let the researcher know.

Once the instructions were given, the participants completed the scale at their own pace until it was finished. After completion and collection of the surveys, the participants were debriefed and thanked for their participation. Each data collection session lasted approximately 20 minutes.

Due to the lack of an inadequate number of responses from the initial proceedings, the researcher also mailed out surveys to students enrolled in the various programs. The response rate of mailed surveys was 86% and constituted 16% of the total sample for this study.

## CHAPTER 3

### RESULTS

The total sample consisted of 75 graduate students, 16 males and 59 females. Nineteen students were from the clinical psychology program. The rehabilitation education, counselor education, and art therapy programs were each represented by 18 students.

The hypotheses were tested by conducting analyses of variance (ANOVA) and correlation. To test Hypothesis 1, two oneway ANOVAs were conducted separately on the mean amount of knowledge and mean attitudes for the six groups presented in Table 1. A oneway ANOVA was conducted to test Hypothesis 2. The independent variable was the type of graduate program; the dependent variable was the amount of knowledge. Hypothesis 3 was also tested with the use of a oneway ANOVA. In this analysis, the independent variable was also the type of graduate program, but the dependent variable was respondents' attitudes. For Hypothesis 4, a Pearson product-moment correlation was conducted to establish the relationship between knowledge and attitude. When necessary, a Tukey test of post hoc comparisons was performed.

Table 1 depicts how the current sample compares to the samples from previous studies. For knowledge, the group independent variable was significant,  $F(5, 593) = 7.26, p < .01$ . Mental health students in the current sample possessed

the same level of knowledge as nursing home residents, persons who worked with the aged, and nursing home staff. However, these students' level of knowledge was significantly greater than the community aged group (i.e., independent living elderly) and the families of the aged. The community aged group possessed more knowledge than the families of the aged.

For attitudes, the group independent variable was significant,  $F(5, 593) = 28.88, p < .001$ . The mental health students' attitudes were equivalent to those maintained by nursing home staff but were more accepting than those of the families of the aged, persons who worked with the aged, nursing home residents, and community aged. Families of the aged and persons who worked with the aged attitudes did not differ significantly, but these groups' attitudes were higher than nursing home residents and community aged. The attitudes of nursing home residents and community aged were equal.

The level of knowledge across majors was determined by the use of an ANOVA. Hypothesis 2 predicted that students in mental health profession training programs would differ in levels of knowledge about elderly sexuality. The results are listed in Table 2. There was no significant difference between the means of the various mental health programs,  $F(3, 72) = 1.71, p > .05$ .

Table 1

Comparison of Previous ASKAS Means<sup>a</sup> to Current Sample Means

Group	<u>n</u>	Mean	SD
Mental health students	73		
Knowledge		61.52	13.51
Attitudes		60.00	19.20
Nursing home residents <sup>b</sup>	273		
Knowledge		65.62	15.09
Attitudes		84.56	23.32
Community aged <sup>c</sup>	30		
Knowledge		73.73	12.52
Attitudes		86.40	17.28
Families of aged <sup>c</sup>	30		
Knowledge		78.00	13.61
Attitudes		75.00	22.66
Persons who worked with aged <sup>c</sup>	30		
Knowledge		62.46	12.50
Attitudes		76.00	17.60
Nursing home staff <sup>c</sup>	163		
Knowledge		64.19	17.25
Attitudes		61.08	25.79

<sup>a</sup>The possible range of ASKAS scores are as follows: Knowledge=35-105;

Attitudes=26-182. <sup>b</sup>White, 1981 <sup>c</sup>White and Catania, 1981

Table 2

Means and Standard Deviations for Knowledge by Mental Health Training Program

Major	<u>n</u>	Mean	SD
Clinical psychology	19	56.26	12.25
Rehabilitation education	18	63.50	12.11
Counseling education	18	65.67	14.82
Art therapy	18	60.94	13.94

An ANOVA was also utilized to determine if the students in mental health professions maintain accepting attitudes about elderly sexuality. Hypothesis 3 predicted that these students would differ in attitudes of acceptance towards the elderly. The results are listed in Table 3. Again, there was no significant difference across programs,  $F(3, 72) = 1.02, p > .05$ .

A Pearson product-moment correlation assessed the relationship between knowledge and attitude. The correlation was .33 ( $p < .01$ ). When level of knowledge was high, attitudes were somewhat more accepting, and when level of knowledge was low, attitudes were less accepting.

Table 3

Means and Standard Deviations for Attitudes by Mental Health Training Program

Major	<u>n</u>	Mean	SD
Clinical psychology	19	55.63	15.90
Rehabilitation education	18	56.78	16.92
Counseling education	18	63.00	19.37
Art therapy	18	64.83	23.79



## CHAPTER 4

### DISCUSSION

The purpose of this study was to examine knowledge and attitudes toward elderly sexuality by students in different mental health training programs. The relationship between knowledge and attitudes was also assessed. The literature supports a positive relationship between knowledge and attitudes. The literature also furnishes studies that have assessed knowledge and attitudes of those in various human service professions. However, there has been little research on the mental health services. This study includes results on the level of knowledge and attitudes toward elderly sexuality among graduate students preparing to be mental health professionals.

#### Hypothesis 1

Hypothesis 1 predicted that the overall level of knowledge and attitudes for mental health students was low in comparison to formerly tested groups. Hypothesis 1 was not supported. This present group's level of knowledge was higher than two of the groups listed in Table 1. Attitudes for the mental health students were more accepting than four of the groups in Table 1.

Determining why this sample's general levels of knowledge and attitudes were higher than formerly tested groups is difficult. Level of education may have some bearing on the results. The students were all receiving

advanced degrees. Therefore, they may have had more exposure to topics regarding elderly sexuality.

Interestingly, all of the other groups were in direct contact with the elderly. It is plausible to ask if direct contact with the elderly negatively influences attitudes. Personally working with adults experiencing mental and physical decline may impact attitudes.

### Hypothesis 2

Hypothesis 2 predicted that levels of knowledge of students in various mental health training programs would differ. No significant difference was found among the programs; therefore, Hypothesis 2 was not supported.

### Hypothesis 3

Hypothesis 3 predicted that students' in various mental health programs would have differing attitudes regarding elderly sexuality. Again, no difference across programs was found. Hypothesis 3 was not supported. Perhaps, those preparing to be mental health professionals maintain relatively accepting attitudes towards all populations.

### Hypothesis 4

The fourth hypothesis was supported. There is a significant relationship between knowledge about and attitude toward elderly sexuality. As level of knowledge increases, attitudes are more accepting. These findings concur with the literature (Kline & Kline, 1991; Hillman & Striker, 1994; Story, 1989; White, 1982) which states that

attitudes toward elderly sexuality can be influenced by knowledge gained in an educational program.

#### Limitations

White (1981) indicated that the means he listed were not to be used as normative but purely as representative of group variation in ASKAS performance. Thus, determining whether this sample's scores should be considered high, moderate, or low in terms of level of knowledge and attitudes is difficult. The present sample's means appear relatively low.

Emphasis in the literature for increased knowledge about elderly sexuality (Agreesti, 1992; Hillman & Striker, 1994; Libman, 1989; Rich et al., 1985) is not supported by the current results. Caution must be of the utmost importance when making this assumption. Many of the previous studies utilized a pretest/posttest format to determine if educational intervention affected knowledge and attitude scores. There may have been a great improvement on scores from pretest to posttest, thus making the pretest scores appear to be higher (higher scores = lower knowledge and less accepting attitudes).

Another limitation may be homogeneity of the groups sampled. There was little between group variance which may affect the generalizability of the results. The fact that all of the subjects were from the same university may have some bearing on the results. These programs all seem to be

conducted in close to the same manner. Therefore, differences across programs were limited. Homogeneity may have also been influenced by participant's tendency to respond according to socially acceptable standards, thus allowing them to appear open-minded and accepting.

A final limitation may be the availability of participants in the study. An increased number of participants from each discipline may have increased heterogeneity between groups. Also, the need to mail out surveys may not have arisen, although the response rate for the mailed surveys was 86%.

#### Implications

As with Story's (1989) research, this study supports a knowledge/attitude relationship for this domain topic. Hammond and Bonney (1985), Salamon and Charytan (1984) and Tarbox et al. (1987) found that increased knowledge influenced participants' attitudes towards elderly sexuality. The point seems clear that increasing knowledge about elderly sexuality will influence the attitudes of many. One place to increase knowledge is in the schools where educational intervention is the most viable. Agreesti (1992) emphasizes the need to implement more training into the curricula. Of high importance are those preparing to be mental health professionals. The quality of service given is vital to the adjustment of growing older, and the need

for improvement of this quality of services provided by mental health professionals is stressed (Rich et al., 1985).

#### Future Research

Given an aging population in the United States, positive attitudes and knowledge about elderly sexuality is becoming increasingly important. Although this sample's scores evidence a higher amount of knowledge and more acceptive attitudes in comparison to other groups, there is no way to determine if these students have the knowledge to serve the elderly to the best of their ability. One could assume that if these students were well prepared, their scores would have been representative of even higher levels of knowledge and more accepting attitudes. Kline and Kline (1991) found that education does raise scores on knowledge scales. Okun, et al.(1985) noted that very few facilities integrated gerontological content into the clinical and counseling psychology disciplines. Perhaps this university, along with many other facilities, needs to increase its gerontological content to better prepare its students.

The results of the current study could be the motivation for this particular institution to conduct a more in-depth experiment to assess the general knowledge of students to determine if more gerontological content is needed in the curriculum. The ASKAS could be used as a pretest/posttest measure to establish the effectiveness of educational intervention. This might allow a clearer

perspective of how high the knowledge of the students is and how accepting the attitudes maintained actually are.

Improved knowledge and attitudes following the educational intervention would support the assumption that this intervention is beneficial.

Another line of research could explore knowledge levels among the elderly themselves. White developed and used this scale in the 1980s to test older adults and their families. Exploring the response of a more contemporary elderly population may be beneficial. Steinke and Bergen (1986), Story (1989), and White (1981) all implied the older adults themselves have the least amount of knowledge and the least accepting attitudes towards their own sexuality. However, Steinke and Bergen (1986) also point out that most of these negative attitudes are a result of societal reactions to the subject. Therefore, if society's views of sexuality are becoming more accepting, asking if similar patterns are occurring among the elderly is reasonable.

The older adult population would also be a vital source for ascertaining the kinds of services needed to ease their adjustment. This information would in turn assist in determining what forms of curriculum are the most beneficial. Carmel, Cwikel, and Galinsky (1992) and Kline and Kline (1991) contend that formal gerontological lectures are a more effective way of increasing knowledge, whereas students in Reed, Beall, and Baumhover's (1992) study felt

that hands-on contact with the elderly would be more beneficial. Along with kinds of services needed, quality of services provided is also important. The elderly adults could also be a means to assess the quality of services they are receiving. Rich et al. (1985) implied that a higher quality of services would be demanded by this population because they are better educated than in the past.

One final area worth exploring would be to discern whether the knowledge and attitudes about elderly sexuality held by men and women differ. One gender may appear to be more comfortable dealing with older adult sexuality or may benefit from a particular type of training more than the other gender.

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## Appendix A

**The first 35 statements are TRUE/FALSE and DON'T KNOW. You are to circle the response you feel is correct.**

(Circle your response)

1. Sexual activity in aged persons is often dangerous to their health.	True	False	Don't Know
2. Males over the age of 65 typically take longer to attain an erection of their penis than do younger males.	True	False	Don't Know
3. Males over the age of 65 usually experience a reduction in intensity of orgasm relative to younger males.	True	False	Don't Know
4. The firmness of erection in aged males is often less than that of younger persons.	True	False	Don't Know
5. The older female (65+years of age) has reduced vaginal lubrication secretion relative to younger females.	True	False	Don't Know
6. The aged female takes longer to achieve adequate vaginal lubrication relative to younger females.	True	False	Don't Know
7. The older female may experience painful intercourse due to reduced elasticity of the vagina and reduced vaginal lubrication.	True	False	Don't Know
8. Sexuality is typically a life-long need.	True	False	Don't Know
9. Sexual behavior in older people (65+) increases the risk of heart attack.	True	False	Don't Know
10. Most males over the age of 65 are unable to engage in sexual intercourse.	True	False	Don't Know
11. The relatively most sexually active younger people tend to become the relatively most sexually active older people.	True	False	Don't Know
12. There is evidence that sexual activity in older persons has beneficial physical effects on the participants.	True	False	Don't Know
13. Sexual activity may be psychologically beneficial to older persons.	True	False	Don't Know

14. Most older females are sexually unresponsive.	True	False	Don't Know
15. The sex urge typically increases with age in males over 65.	True	False	Don't Know
16. Prescription drugs may alter a person's sex drive.	True	False	Don't Know
17. Females after menopause, have a psychologically induced need for sexual activity.	True	False	Don't Know
18. Basically, changes with advanced age (65+) in sexuality involve a slowing of response time rather than a reduction of interest in sex.	True	False	Don't Know
19. Older males typically experience a reduced need to ejaculate and hence may maintain an erection of the penis for a longer time than younger males.	True	False	Don't Know
20. Older males and females cannot act as sex partners as both need younger partners for stimulation.	True	False	Don't Know
21. The most common determinant of the frequency of sexual activity in older couples is the interest or lack of interest of the husband in a sexual relationship with his wife.	True	False	Don't Know
22. Barbiturates, tranquilizers, and alcohol may lower the sexual arousal levels of aged persons and interfere with sexual responsiveness.	True	False	Don't Know
23. Sexual disinterest in aged persons may be a reflection of a psychological state of depression.	True	False	Don't Know
24. There is a decrease in frequency of sexual activity with old age in males.	True	False	Don't Know
25. There is a greater decrease in male sexuality with age than there is in female sexuality.	True	False	Don't Know
26. Heavy consumption of cigarettes may diminish sexual desire.	True	False	Don't Know
27. An important factor in the maintenance of sexual responsiveness in the aging male is the consistency of sexual activity throughout his life.	True	False	Don't Know

28. Fear of the inability to perform sexually may bring about an inability to perform sexually in older males.	True	False	Don't Know
29. The ending of sexual activity in old age is most likely and primarily due to social and psychological causes rather than biological and physical causes.	True	False	Don't Know
30. Excessive masturbation may bring about an early onset of mental confusion and dementia in the aged.	True	False	Don't Know
31. There is an inevitable loss of sexual satisfaction in postmenopausal women.	True	False	Don't Know
32. Secondary impotence (or non-physiologically caused) increases in males over the age of 60 relative to younger males.	True	False	Don't Know
33. Impotence in aged males may literally be effectively treated and cured in many instances.	True	False	Don't Know
34. In the absence of severe physical disability males and females may maintain sexual interest and activity well into their 80's and 90's.	True	False	Don't Know
35. Masturbation in older males and females has beneficial effects on the maintenance of sexual responsiveness.	True	False	Don't Know

**This portion of the test contains 26 statements to be responded to on a 7-point Likert scale. You are to rank the amount of agreement or disagreement with each statement.**

7=strongly agree							
6=agree							
5=somewhat agree							
4=indifferent							
3=somewhat disagree							
2=disagree							
1=strongly disagree							
	SA	A	SWA	I	SWD	D	SD
36. Aged people have little interest in sexuality. (Aged = 65+ years of age).	7	6	5	4	3	2	1
37. An aged person who shows sexual interest brings disgrace to himself/herself.	7	6	5	4	3	2	1
38. Institutions, such as nursing homes, ought not to encourage or support sexual activity of any sort in its residents.	7	6	5	4	3	2	1

39. Male and female residents of nursing homes ought to live on separate floors or separate wings of the nursing home.	7	6	5	4	3	2	1
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40. Nursing homes have no obligation to provide adequate privacy for residents who desire to be alone, either by themselves or as a couple.	7	6	5	4	3	2	1
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41. as one becomes older (say past 65) interest in sexuality inevitably disappears.	7	6	5	4	3	2	1
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**For items 42, 43, and 44: If a relative of mine, living in a nursing home, was to have a sexual relationship with another resident I would:**

42. Complain to the management.	7	6	5	4	3	2	1
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43. Move my relative from this institution.	7	6	5	4	3	2	1
---	---	---	---	---	---	---	---

44. Stay out of it as it is not my concern.	7	6	5	4	3	2	1
---	---	---	---	---	---	---	---

45. If I knew that a particular nursing home permitted and supported sexual activity in residents who desired such, I would not place a relative in that nursing home.	7	6	5	4	3	2	1
--	---	---	---	---	---	---	---

46. It is immoral for older persons to engage in recreational sex.	7	6	5	4	3	2	1
--	---	---	---	---	---	---	---

47. I would like to know more about the changes in sexual functioning in older years.	7	6	5	4	3	2	1
---	---	---	---	---	---	---	---

48. I feel I know all I need to know about sexuality in the aged.	7	6	5	4	3	2	1
---	---	---	---	---	---	---	---

49. I would complain to the management if I knew of sexual activity between any residents of a nursing home.	7	6	5	4	3	2	1
--	---	---	---	---	---	---	---

50. I would support sex education courses for aged residents of nursing homes.	7	6	5	4	3	2	1
--	---	---	---	---	---	---	---

51. I would support sex education for the staff of nursing homes.	7	6	5	4	3	2	1
---	---	---	---	---	---	---	---

52. Masturbation is an acceptable sexual activity for older males.	7	6	5	4	3	2	1
--	---	---	---	---	---	---	---

53. Masturbation is an acceptable sexual activity for older females.	7	6	5	4	3	2	1
--	---	---	---	---	---	---	---



54. Institutions, such as the nursing home, ought to provide large enough beds for couples who desire such to sleep together.	7	6	5	4	3	2	1
55. Staff of nursing homes ought to be trained or educated with regard to sexuality in the aged and/or disabled.	7	6	5	4	3	2	1
56. Residents of nursing homes ought not to engage in sexual activity of any sort.	7	6	5	4	3	2	1
57. Institutions such as nursing homes should provide opportunities for the social interaction of men and women.	7	6	5	4	3	2	1
58. Masturbation is harmful and ought to be avoided.	7	6	5	4	3	2	1
59. Institutions, such as nursing homes, should provide privacy such as to allow residents to engage in sexual behavior without fear of intrusion or observation.	7	6	5	4	3	2	1
60. If family members object to a widowed relative engaging in sexual relations with another resident of a nursing home, it is the obligation of the management and staff to make certain that such sexual activity is prevented.	7	6	5	4	3	2	1
61. Sexual relations outside the context of marriage are always wrong.	7	6	5	4	3	2	1

## Appendix B

### Informed Consent Form

Please read the following statements, and if you agree with them sign your name at the bottom of the form. If you have any questions, please ask.

I agree to participate in this research which is being conducted by Brenda L. Wimer who is investigating attitudes and perceptions of elderly individuals. I understand that this study will take about 20 minutes of my time and requires only that I complete 2 questionnaires. Further, I am fully aware that I **may withdraw from this research at any time** and that I will not be penalized in any way for doing so. I also understand that my **confidentiality** will be protected. My name will not be used in the report of this research.

Thank you for your participation.

\_\_\_\_\_  
(Participant's signature)

\_\_\_\_\_  
(date)

\_\_\_\_\_  
(Experimenter's signature)

THIS PROJECT HAS BEEN REVIEWED BY THE EMPORIA STATE  
UNIVERSITY COMMITTEE FOR THE PROTECTION OF HUMAN  
SUBJECTS

## Appendix C

### DEMOGRAPHIC INFORMATION

Please answer the following questions:

SEX:            male                      female

AGE:            \_\_\_\_\_

MAJOR FIELD OF STUDY            \_\_\_\_\_

YEAR IN PROGRAM            1ST            2ND

LIST GRADUATE COURSES TAKEN WHICH HAVE DISCUSSED ISSUES  
RELATED TO THE ELDERLY POPULATION (65+):

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

I, Brenda L. Wimer, hereby submit this thesis to Emporia State University as partial fulfillment of the requirements for an advanced degree. I agree that the Library of the University may make it available for use in accordance with its regulations governing materials of this type. I further agree that quoting, photocopying, or other reproduction of this document is allowed for private study, scholarship (including teaching) and research purposes of a nonprofit nature. No copying which involves potential financial gain will be allowed without written permission of the author.

Brenda L. Wimer  
Signature of Author

April 1, 1996  
Date

Perceptions of Elderly Sexuality Among  
Students in Graduate Mental Health  
Programs

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