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An Investigation of sexuality and life satisfaction of institutionalized aged

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AN INVESTIGATION OF SEXUALITY AND LIFE SATISFACTION
OF INSTITUTIONALIZED AGED

by

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Approved



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CHAPTER I

INTRODUCTION

A review of gerontological research reveals a dearth of information relating to the sexual activity of the aged and the degree to which this impacts upon overall life satisfaction. The goal of this study is to look at these issues in hopes of enabling those serving the aged, especially social workers, to better understand this aspect of their clients.

Demographic data indicates that each year about half a million Americans reach the age of 65. By the year 2000 it is predicted that 15% of the total American population will be comprised of the elderly. Although the number of persons within this age cohort is steadily increasing, it represents a forgotten minority whose needs remain unmet.

The definition of "elderly" has changed. In 1900 the average life expectancy was 47 years; today it is 70.4 years. Fully half of all older persons are over 73, and one million are 85 and over. In 1970 there were 106,441 centenarians (Butler, 1975). Of the half million people reaching 65 each year, 26% will experience institutionalization at least once before their deaths, and 8% of those will die in institutions. Although only 4.8% of the total population are in fact institutionalized at any one time, this 4.8% represents approximately one million people (Palmore, 1970).

Even though everyone ages differently, the basic components associated with aging remain the same: loss, change, and adjustment. Significant losses include position in society, possessions, friends, and mates. These necessitate change and accompanying adjustments which become increasingly difficult with age. Bereavement may be one of the most crucial concerns of the elderly and of those who are involved with them, either professionally or personally. (Shanes, 1962)

Any change is a reminder of the aging process, and these decrements can be frightening as predictors of things to come (Kalish, 1975, p. 58). Neither the process of aging nor the state of being old is pathological, strange or deviant except as the result of certain unpleasant occurrences that tend to be age related, much as other unpleasant occurrences are associated with the pre-school years or middle years of life. (ibid., p. 1)

An unpleasant occurrence generally associated with aging begins with a change in a person's self-image. This process occurs when it is realized that youth, so highly valued by American society, has diminished. Physiological changes are paramount. There are more variations in biological and behavioral functioning in older persons than in younger persons. Changes in appearance, wrinkles, gray hair, are culturally defined as negative. Psychomotor performance levels decrease with age. The more notable physical changes include decrements in visual and auditory capacities (MacFarland, 1968 and Kalish, 1975), resulting in impaired communication and ensuing social isolation. The lens of the eye loses elasticity causing the farsightedness, common to most older people. Depth perception and pupil functioning also diminish with age. Hearing impairments affect 13% of individuals between 65 and 70, and 26% of those 75 and older (Riley, 1968). Compounding these sensory deficits is a high incidence of dizziness which serves

as a major cause of injury in older persons (Birren, 1964). Older persons experience an increase in illness, diseases and accidents, and a correspondingly lengthened recovery period. It is noted that the course of medical problems does not often change for the better and numerous adjustments must be made (Kalish, 1975).

In addition, pervasive cultural variables have had an enormous impact on the 65-and-above age cohort. Major factors of the 20th century which have been most directly influential include breakdown of familial ties leading to nuclear family constellations which serve to further isolate and alienate the very old. This breakdown has been facilitated by technological advancements, most notably automation and mass media. One result of this process seems to be ageism, or discrimination against people because of their chronological age. These elderly persons have experienced industrialization, the Great Depression, and two World Wars. Currently they battle the spiraling cost of health care and severe inflation compounded by enforced early retirement and resultant income reduction. Most elderly state that their greatest need is money or goods and services which can be purchased with money (Kalish, 1975). The uncertainty of the times, dramatized by a rising crime rate where the elderly are most often victims, greatly contributes to the feelings of vulnerability so common to the aged and maximizes the sense of loss of security.

One concern of this study is sexuality among the aged, since every person, regardless of age, is a sexual being. Society, however, has been slow to recognize this fact and has not accepted sexual activity among the aged. Along with the lack of social sanctioning, elderly

persons are very susceptible to the myriad of myths, half-truths, misinformation, and incomplete data which affect their attitudes toward sexuality. Furthermore, older persons are susceptible to negative stereotypes of themselves as sexual beings. However, the effect of actual sexual activity upon overall life satisfaction among the aged has yet to be determined. Because there has been no empirical evidence concerning this, the degree of relationship between sexual activity and life satisfaction remains unknown. Since human beings remain sexual throughout life, and a large proportion of the elderly are institutionalized, this study will focus attention on the relationship between life satisfaction and sexuality among the institutionalized aged. It is important for social workers to explore these concepts, as empirically validated knowledge can be used as guidelines for professional values and practice.

CHAPTER II

INSTITUTIONS FOR THE AGED

INSTITUTIONAL FUNCTION AND DEFINITION

Institutions for the aged are designed and function as protective environments for those whose declining years are accompanied by physical, mental, economic, and social handicaps. Operating as isolated social communities, they serve as the primary caretakers and providers of our elderly. Acknowledging the existence of the varying degrees of organizational structure, restrictions, and residential expectations, the reality is that this society has relinquished its responsibility regarding the old to institutional bodies designated for that purpose.

Morton Lieberman (1969) conceptually defines institutions as "residential facilities providing one or more central services that meet some particular need of the client and/or society". He notes that such settings suggest indefinite residency and involve a major change from community living. Goffman (1960) developed a more analytical description and saw institutions as "symbolized by barriers to social intercourse with the outside". He states that institutionalization is an all-encompassing environment in that (1) all aspects of life are conducted in the same place under the same single authority; (2) all daily activities are carried out with the immediate company of others; (3) all daily activities are scheduled; and (4) all enforced activities are brought together as parts of a rational plan to fulfill the aims of

the institution. Total institutionalization is an other-directed, self-perpetuating lifestyle. Townsend (1962) summarizes that people in institutions live communally with a minimum of privacy, subsist in a kind of defensive shell of isolation, experience restricted mobility with little access to society. They are oriented toward a system in which they are expected to submit, to be routinized, to forego self-determination. From this perspective, the general effect of institutionalization on older adults can be depersonalization of the individual, which is manifested as inertia, depression, and social isolation.

Pincus (1968) has a more comprehensive scheme for examining institutions. He sees institutional life as an end result of the complexity of several factors. He states that an institutional environment is created by the interrelationship of its particular physical characteristics, of its governing rules and regulations, and of its staff's attitudes and behavior. These factors co-exist to produce varying degrees of privacy, structure, resources, and integration with the outside community. These are salient components that determine a distinct psycho-social milieu which in turn yields predictable behavior in the institution's residents. Included in this institutional category are such environments as supervised geriatric residences, homes for the aged, nursing homes, domiciliaries, and mental hospitals. These settings differ by the level of care they offer, the nature of their residents and by the degree of social interaction and personal independence generated.

Bennett and Nahemow (1965) ranked these five kinds of institutions for the aged from those least institutionalized to those most institu-

tionalized. Their evaluation listed them respectively as retirement communities, homes for the aged, domiciliaries, nursing homes, and mental hospitals. The aged adults most likely to be found in these institutions are generally white, female, older, and living alone. Significant to the selection process are such factors as marital status, family relationships, financial resources, alternative living arrangements, and health status. Kraus, et. al. (1976) compared long-term institutional residences with a matched group of community residences. It was found that individuals residing in the institutions were, on the average, older, had lower incomes, fewer spouses, more physical ailments, and less social involvement prior to institutionalization. Most elderly stated that the main reason for institutionalization was to avoid becoming an excessive burden to their families.

There are further differences among the institutions. Specifically, those in homes for the aged tend to have more resources; e.g., individual capability of awaiting placement, family impetus or money. Self-care and ambulatory skill are standard requirements for acceptance into homes for the aged. Therefore, these residents tend to be more physically and mentally intact, youthful, and are more resourceful than people found in other institutions. In contrast, the nursing home population is older and significantly more physically handicapped. They consist of people who are usually admitted as a result of a crisis, and are in need of skilled or intermediate nursing care. Nursing homes are viewed by the elderly as 'the end of the road'.

Historically, the mental hospital has accepted older persons not suitable for nursing homes because of problematic behaviors such as

agitation, suicidal tendencies, aggression or paranoia. During the 1960's and 1970's, older persons who were simply disoriented or confused were placed in nursing homes or community-based boarding homes. The more severely impaired continued to need psychiatric hospitalization.

In summary, there is differentiation of residents in various institutions. Those in old age homes are considered the 'nicest' and most capable; those in nursing homes are the most physically disabled; and those in state hospitals are the most severely mentally impaired.

THE NEGATIVE IMPACT OF INSTITUTIONALIZATION

Bennett and Nahemow (1965) analyzed social adjustment in institutions for the aged. They defined adjustment as the ability to fit oneself into an ongoing social situation and identified three hierarchical components of that process: social integration, evaluation, and conformity. They discovered, in accordance with the formation of their institutional hierarchy, that the negative impact of institutionalization lessened considerably as the opportunity for socialization and community involvement increased.

Nevertheless, there exists a commonly-held theory (Aldrich and Mendkoff, 1963; Blenker, 1967; Goldfarb, Shahinian and Turner, 1966; Jasnau, 1967; and Lieberman, 1961) that institutionalization has adverse effects upon the physical survival and psychological well-being of aged adults. Researchers have labeled the psychological effects as:

...poor adjustment; depression and unhappiness; intellectual ineffectiveness because of decreased energy; negative self-image; feelings of personal insignificance and impotency; and the view of the self as old. Following institutionalization and especially after relocation, residents tend to be docile, submissive, show a low range of interests and activities, and live in the past rather than in the future. They are withdrawn and unresponsive in relationship to others and feel increased anxiety which focuses on the feeling of death. (Lieberman, 1969)

Townsend (1962) in his comparison studies found that institutionalized groups seemed to have an impaired level of overall adjustment, reduced capacity for independent thought and action, a depressive mood tone, and problems involving self-esteem. Goldfarb (1959) and Pollack et. al. (1967) both observed a display of negative self-image expressed verbally and non-verbally through crying and avoidance. These behaviors are characteristic of a widespread symptomology found in institutions for the aged. Halbfinger (1976) noted feelings of frustration, hopelessness and powerlessness in residents who had no one to talk to, and that the institution provided few supports for the development of sustaining friendships. In turn, residents did not form close relationships, did not exercise much self-determination and rather submitted to the orderly routine. The environment worked on the residents and residents in turn affected the environment.

The psycho-social elements associated with adjustment to institutionalization are cognitive functioning, body orientation, personality traits, time perspective, affect states, relations with people, and self-image. Lieberman, Prock, and Tobin (1968) made a cross-sectional study comparing three groups (institutionalized, community, and waiting list) on these seven areas of functioning. Those in institutions had more disorientation to time and space; more disorganization in the area

of cognitive functioning; showed more preoccupation with their body and issues relating to their body; were less constricted in their emotional responsiveness; and less anxious but just as depressed as those on the waiting list.

The effects of institutionalization on the health of older persons cannot be ignored. Rahe (1969) determined life changes and object losses affect the overall health status of a person. Therefore, involuntary relocation and institutionalization as well as the anticipation of these two events have enormous ramifications for affecting the physical survival of older persons. Those persons institutionalized are less physically able than those non-institutionalized, and those experiencing relocation often become ill, are hospitalized, and/or experience activity restrictions (Lawton and Yaffe, 1967; Lieberman, Prock and Tobin, 1968). Bourestom and Tars (1974) noted that following relocation, residents become more pessimistic about their state of health, stopped participating in psycho-social activities, grew less active with both staff and fellow patients, and felt staff members were not interested in them. Miller and Lieberman (1965) noted more occurrences of confusion, memory defects and bizarre behavior following institutionalization, especially within the first two months of adjustment. The Killian (1970) and Aldrich (1964) studies found that transfer from one institution to another increased mortality. They also learned that patients whose adjustment to institutionalization was satisfactory or angry were more likely to survive relocation than those who had been neurotic, depressed, or psychotic. In addition, those whose reactions to impending relocation were judged to be philosophical, angry, anxious,

or regressed were more likely to survive than those who were depressed, denying or psychotic. Studies (Costello and Tanaka, 1961; Tobin, 1968) described high mortality of aged subjects within one year or less of institutionalization. Particularly high rates were found among men, the very old, the individuals with poor health, severe brain dysfunction, and those characterized by passivity. In 1970, Killian studied a group of deinstitutionalized older persons. The highest mortality rates were found in the groups forced to relocate in environments most alien to their prior institutional experiences. The lowest rate was among the group that stayed in the original setting. As can be expected, the older, non-ambulatory members had the highest mortality rates in any of the groups.

Institutionalization is a complex process and it becomes very difficult on an empirical basis to isolate what differences can be attributed to the characteristics of institutional life alone or to some other variable. Lieberman, Prock, and Tobin (1968) felt that data should be examined at three points in time to adequately reflect the process and what happens: Phase I, when the person first seriously considers moving into an institution; Phase II, just before and just after entrance; Phase III, after a period of adjustment to the institution. This theory supports the idea that a longitudinal study would be more appropriate to the situation than a cross-sectional one. However, most of the research has been cross-sectional in nature and involves comparing groups of people living in the institutions to both those in the community and those in transition.

OTHER PERSPECTIVES OF INSTITUTIONALIZATION

Other researchers have indicated that institutionalization does not necessarily have to have detrimental effects on all older persons. Linkages have been established between external institutional elements and specific behaviors. Reingold and Dobrof (1965) found that staff valued and responded differentially to residents which resulted in both an increase in valued behavior and a decrease in undesired behavior. Mercer (1978) found a high negative correlation between hopelessness and activity, especially if the activity was designed to increase control and choice. Halbfinger (1976) identified institutionalization as being beneficial to the resident when s/he was offered activities that most closely resembled a pre-institutional experience, and when relationships with staff were mutually gratifying. Donahue, Hunter, and Coons (1953) showed that an increase in formal activities as well as an expectation for participation produced more social relationships and a greater sense of overall life satisfaction. Silverstone and Wynter (1975) also discovered a richer level of social adjustment occurred when members of the opposite sex were introduced to previously segregated floors in a home for the aged. Offering the opportunity for male-female interaction to the institutionalized elderly offset shrinkage in their social life space. Donahue, Coons, and Gotterman (1969) found that a supportive milieu which provided both means and motivation for the residents to use their mental, social and physical abilities produced pride, self-confidence, and higher levels of independent functionings. Anderson (1967) found that interaction and self-esteem are more closely associated than are institutionalization and self-esteem. She proposed that

institutionalization can increase the quantity and quality of interaction and therefore raise self-esteem, particularly if a person has been isolated. Oberleider (1976) discussed the negative behaviors and attitudes associated with institutionalization, but spoke of them as part of the resident's normal regression under stress. He considered these reactions as appropriate to the continuing internal and external changes with which older people must cope, the demands of the new life roles they must fulfill in the institutions, and the reality that they are awaiting possible illness and death.

Different institutional environments produce varying demands resulting in a myriad of adaptive personality types. Turner, Tobin, and Lieberman (1972) discovered that those people possessing personality traits already congruent with an institution's expectations were viewed as better adjusted and more acceptable than those with non-corresponding characteristics. The greater the degree of rigidity within an institution, the more negative is the impact on the individual. Thus negativity must be viewed correspondingly with institutional milieu and procedure.

In a similar vein, K.F. Jasnau (1967) examined elements which affect the mortality rates of older persons. These include (a) how the institutionalization or relocation is carried out; (b) the degree of choice that the patients have in the change; (c) the adequacy of preparation by support people; and (d) the meaning of "institutionalization" for the individual. There tends to be an increased mortality rate if the change is involuntary, if there is little preparation, and if institutionalization is dreaded.

The variable of self-selection is also an important consideration when measuring negative impact. The person who applies to an institution is likely to be incapacitated. Concomitant with the radical environmental changes are adverse effects attributed to some aspect of the institutionalization, such as poor diet, infections, poor medical care, and sensory deprivation. Kasl (1972) mentions that it is not possible to disentangle (a) self-selection from effects of institutionalization; (b) effects of moving into an institution from effects of living in it; and (c) differential survival from effects of the institution.

The significance of institutional life is far-reaching in its influence. (See Table I) In addition to the effects upon the physical well-being of residents, sexual functioning is also affected by the process of institutionalization itself. We will now look more closely at sexual functioning in the aged.

TABLE I

RESEARCH ON THE IMPACT OF INSTITUTIONALIZATION AND SUGGESTED CHANGES

I. <u>Conclusions Specify or Suggest Negative Impact.</u>			
AUTHOR(S)	YEAR	CONCLUSIONS	
A. Negative Psycho-Social Impact:			
Goldfarb	1959	negative self-image; crying and avoidance behavior	
Townsend	1962	negative self-esteem; depression; low independence	
Miller and Lieberman	1965	confusion; poor memory; bizarre behavior	
Pollack, et. al.	1967	negative self-image; crying and avoidance behavior	
Lieberman, Prock, and Tobin	1968	disorientation; disorganization; negative body image	
Lieberman	1969	depression; negative self-image; low interest; low activity	
Bourestom and Tars	1974	low psycho-social activity level; pessimism regarding health	
Halbfinger	1976	frustration; hopelessness; few supports for friendship	
B. Negative Impact on Health:			
Lawton and Yaffe	1967	become ill; are hospitalized; restricted activity	
Tobin	1968	become ill; are hospitalized; restricted activity	
Rahe	1969	overall health becomes poor	
C. Negative Impact on Mortality:			
Costello and Tanaka	1961	high mortality in first year	
Killian and Aldrich	1964	transfer increases mortality rate	
Jasnau	1967	high mortality if involuntary, unprepared, dreaded change	
Tobin	1968	high mortality in first year	
D. Miscellaneous Negative Impact:			
Turner, Tobin, and Lieberman	1972	rigid expectation of behavior creates negative impact	
II. <u>Conclusions Suggest Ways to Reduce Negative Impact or Achieve Positive Impact.</u>			
Donahue, Hunter, and Coons	1953	satisfaction; social relations through activity	
Bennett and Nahemow	1965	socialization; community involvement	
Anderson	1967	increase quantity and quality of interaction	
Donahue, Coons, and Gotterman	1969	supportive milieu to motivate residents	
Silverstone and Wynter	1975	opportunity for sexual interaction	
Halbfinger	1976	activity which resembles pre-institution activity	
Mercer	1978	activity which allows control and choice	

TABLE II
CHANGES WITH AGE IN SEXUAL RESPONSE PATTERNS*

	<i>Younger Women</i>	<i>Older Women</i>		<i>Younger Men</i>	<i>Older Men</i>
Breasts	Nipple erection Increase in size, areolar engorgement, flush prior to orgasm	Same Intensity of reactions diminishes	Breasts	Nipple erection	Diminishes
Sex Flush	Vasocongestive skin response to tension	Diminishes	Myotonia	Increased muscular tension; involuntary muscular contractions	Responses may diminish
Myotonia	Muscular tension increases	Response diminishes	Rectum	Rectal sphincter contractions during orgasm	Decrease in frequency
Urinary System	Minimal distention of external urinary meatus during orgasm	Meatus gapes with orgasm of high intensity or with successive orgasms	Penis	Erection develops within 3-5 seconds of stimulation; full erection early in cycle	Erection takes 2-3 times longer over 50; full erection not attained until immediately prior to orgasm
Rectum	Rectal sphincter contractions with orgasm	Decrease		Ejaculatory control varies	Maintain erection longer without ejaculation
Clitoris	High degree of responsiveness	Same		May attain and partially lose full erection, several times during cycle	When erection partially lost, difficulty in returning to full erection
Major Labia	Flatten, separate, and elevate with increased sexual tension	Response diminishes		Color change of glans penis	Diminished or absent
Minor Labia	Vasocongestive thickening; color change from cardinal-red to burgundy-wine before orgasm	Color change and thickening diminish		Forceful ejaculation; expulsive contractions during orgasm	Force diminishes; sensual experience may be reduced
Bartholin's Glands	Small amount of mucoid secretion during plateau	Response diminishes		Refractory phase variable	Prolonged refractory phase after orgasm before next erection; rapid penile detumescence
Vagina	Walls well-corrugated, thickened, reddish-purple appearance; vaginal lubrication within 10-30 seconds of stimulation	Walls tissue-paper-thin, noncorrugated, pinkish; vagina shortens and expansive ability decreases; lubrication may take 1-3 minutes or more	Ejaculation	Two-stage, well-differentiated process	Single-stage expulsion of seminal fluid
	Orgasmic platform (swelling of outer vagina) develops during plateau, constricting vagina	Engorgement reduced but constriction response continues.		Prostatic contractions	Not clinically obvious
	Contractions (5-6) of platform during orgasm	Number of contractions decreases		Awareness of fluid emission and pressure	May experience seepage rather than expulsion; fewer and less motile sperm than younger men
	During resolution, slow collapse of expanded portion of vagina	Rapid collapse	Scrotum	Scrotal folding patterns obliterated with sexual tension	Response diminishes
Uterus	Uterine elevation during excitement and plateau	Reaction delayed and elevation not as marked	Testes	Testicular elevation in late excitement or early plateau; increase in size	Diminished response
	Expulsive contractions (3-5) with orgasm	Decrease in number		Testicular descent during resolution	Rapid descent

*(from Masters and Johnson, 1966)

IMPACT OF PHYSICAL CHANGES ON SEXUAL FUNCTIONING

The sexual behavior of men and women over the age of sixty years has often been misunderstood, stereotyped, and/or ignored. Although there is not very much information about the sexual behavior of older adults, the research from the last 25 years indicate that people over sixty do have sexual desires, express themselves in sexual activities and are influenced in those activities by their personal health, social conditions, and type of previous sexual activity in younger years. Kinsey (1948, 1953) indicated people over the age of sixty are capable of continued sexual activity. Masters and Johnson (1966) also found that older men and women are still physically capable of intercourse and sexual desire. Verwoerdt, et. al. (1969) concluded that many physical and psychological factors alter patterns of sexual activity during the aging process, however. Specifically, 1) elderly men differ markedly from elderly women in reported sexual behavior; 2) sexual activity of elderly women is greatly dependent on whether or not there is a socially-approved partner available; 3) declining sexual activity and interest were common, but patterns of stable as well as increasing activity also occurred.

Pfeiffer and Davis (1972) identified the determinants of sexual behavior in middle and old age. Most notably, high sexual activity in middle years positively correlated with continued sexual activity throughout life. Variables that influence the sexual behavior of men are past sexual experience, age, health factors, and social class. Those factors which influence women are marital status, age, and degree

of enjoyment derived from prior sexual experience. The availability of a socially-approved partner for a woman is an important determinant of her sexual activity (Verwoerdt, et. al., 1969). Note that sexual activity was determined by frequency of intercourse and interest in sex. Questions that dealt with other forms of sexual activity were not included in these surveys. Pfeiffer determined that approximately 80 per cent of the group are still sexually active. For men aged 78 or older 1 of 4 is still regularly sexually active. DeNicola and Peruzza (1974) found that marital status and health are also important determinants of sexual activity into old age. In both of these studies, sexual satisfaction was not limited to frequency of intercourse in the elderly persons questioned. According to West (1975), aged persons' sexual activity included fondling, carressing, and oral contact. It was stated that these activities often would not lead to orgasm, but still provided pleasure and release from tension. In a study (DeNicola and Peruzza, 1974) which did not distinguish between males and females, it was found that previous satisfaction in younger years tended to determine satisfaction after age sixty. He noted that some men would prefer oral-genital sex but would often not ask their wives to participate. Dean (1974) believes that the aged need not feel that sexual activity be confined to intercourse.

Elderly people who have sexual desire should be able to achieve fulfillment through any modified physical activity, reflective of their abilities and circumstances that would satisfy both partners.

DEBILITATING PHYSICAL CONDITIONS AFFECTING SEXUAL BEHAVIORS

There are a variety of physical conditions which adversely affect the sexual functioning of many elderly persons. These conditions are often compounded by a number of misconceptions that can lead to either physical and/or psychological sexual dysfunction.

Heart attack can lead to impotency for both physical and psychological reasons. The fear of inducing another coronary and risking death is the most common and understandable reason for avoiding sex. Yet the incidence of death during intercourse is estimated at less than one per cent of sudden coronary deaths. Studies have indicated that the sex act, on the average, takes ten to fifteen minutes, and utilizes the oxygen equivalent of climbing one or two flights of stairs. Most physicians recommend a recuperative period of eight to fourteen weeks following an attack to allow for adequate healing before resuming sexual activity.

Episodes of congestive heart failure are also commonly called heart attacks. They can be treated with digitalis, diuretics, and diet; and sexual relations are again possible. The recovery period is generally two to three weeks. Moderate exercise is recommended to reduce the possibilities of another attack. Sexual activity provides this exercise as well as producing exhilaration, release of tension, and a sense of well-being.

Strokes (cardiovascular accidents) do not directly impact on sexuality or sexual activity. However, when paralysis has occurred, it may be necessary to choose appropriate sexual positions to compensate for the diminished mobility (Butler and Lewis, 1976).

Vascular diseases can impair the sexual response to the extent that it impacts upon vascular engorgement and muscular contractions. This can occur with thrombosis of veins or arteries of the penis, leukemia, and sickle cell disorders, among other things. The condition impairs erection only; ejaculation and libido remain intact. This occurs because of the interference with penile blood supply, and can generally be surgically corrected (Kaplan, 1974).

Hypertension (high blood pressure) does not directly affect erection. However, many forms of anti-hypertension medication can cause impotency by impairing the neurovascular reflexes. When the medication is discontinued, or changed, the potency returns.

Diabetes is common in later life. It is one of the few illnesses which can directly cause chronic impotency in men. Impotency occurs two to five times as often in diabetics as in the general population. In diabetes there can be depression of the central nervous system, general debility, lower androgen levels, and depression, all of which may decrease libido and impair arousal (Kaplan, 1974). When the disease has been poorly regulated, there is a good possibility that proper regulation will increase potency. However, when impotency occurs in well controlled diabetes, it may be permanent (Butler and Lewis, 1976).

The form of arthritis that most often affects the aged is Osteoarthritis. It is usually mild, not inflammatory and rarely interferes with sex. Rheumatoid arthritis may cause pain during sexual activity, although there is evidence that suggests regular sexual activity helps to relieve the arthritic condition. This is due to adrenal gland production of the hormone cortisone and the physical activity involved.

Backache is common among older people. This is often caused by a sudden use of back muscles in a generally inactive person. Sexual activity itself is often an excellent form of exercise therapy for the back, stomach, and pelvic muscles and can do much to reduce back pain when undertaken regularly (Butler and Lewis, 1976).

Anemia has been found to some degree in one out of four people over sixty. It is a common cause of fatigue and consequent reduction of sexual activity. Since anemia is a symptom of a number of diseases, comprehensive medical treatment is necessary and follow-up is important. Often improved diet and vitamins are all that is necessary to restore both energy and sexual activity (Butler and Lewis, 1976).

Any condition which either causes pain on intercourse or interferes with intromission or stimulation may affect the sexual response adversely. Kaplan (1974) reports that estimates regarding the number of sexually dysfunctional patients who demonstrate some organic component range from 3 to 20 percent. Obviously, physical factors may play a role in sexual complaints, and decreased sexual activity. Knowledge of precipitating factors, and regular treatment can aid the aging person in maintaining sexual activity. Also, influential in the maintenance of sexual activity are the attitudinal beliefs coherent in both individuals and society as a whole.

ATTITUDES TOWARD SEXUALITY IN AGED PERSONS

There is a degree of self-fulfilling prophecy in the attitudes of society that contribute to age-role expectations of non-sexuality among the aged. Neugarten (1965) stated that there is an age-role identity

as well as a sex-role identity. At each age people are expected to behave in "appropriate" ways. The expectation of society toward the aging individual was to conform to social image and dress, not seek pleasure in sex, avoid scandal or ridicule, and believe in the myth of lost sexuality with age (Glover, 1975). Grown children who were cautioned about sex and were taught to regard it as dirty, reverse the process when they become parents and condemn sex in their elders (Dean, 1966). Cleveland (1976) delineated attitudes toward aging sexuality that she referred to as the 'traditional' norms of behavior:

Sex is for procreation and aging couples are not childbearing couples. Sexual tension and need for sexual outlet are highest during youth and radically decline with old age; therefore, aging married couples physiologically don't need sex. Body organs are at peak health during youth and healthy sex is satisfying sex; because people are less healthy in later life, sex will be less satisfying. Sexual tension is built on physical attractiveness; to be old is to be ugly and ugly people can't inspire sexual tension in others. Romantic love can occur among the young and sex without romantic love is not quite normal. (p. 234)

Spinazzola (1975) stated that the general public feels that older people do not have sexual desires or a need for sexual expression and if they do, it is improper for them to do anything about it. As a side-light of a more comprehensive study, Golge and Kogan (1959) found that a group of students answering a sentence completion test question "Sex for most old people....", 92.9% replied that for most old people sex was negligible or unimportant; while in the group that answered the question "Sex for most people....", only 4.9% of the respondents regarded sex as negligible or unimportant. Feigenbaum (1967) mentioned the lack of factual data regarding the sexual habits and attitudes of the aged. He added that the elderly are both confused and interested in

obtaining information regarding the sexual norms of the geriatric population. Long (1976) stated that the belief that sex is somehow "dirty" and not to be enjoyed or needed is often Biblically founded. Winter (1973) observed that women sometimes lose their desire for sex after menopause because sex is linked in their minds with the Biblical injunction to "be fruitful and multiply". Christenson and Gagnon (1965) reported that church attendance has an inverse relationship to coital and masturbatory activity for the married and unmarried.

Pfeiffer (1974) wrote that our cultural attitudinal taboo is related on a more unconscious level to feelings regarding sexual expression in our parent generation. It is noted that aging patients, to a significant degree, evoke the unconscious reminder of our own parents and, as such, we may wish to avoid dealing with the sexuality of elderly people.

LaTorre and Kear (1977) assessed attitudes toward sexual behavior in the aged residents of a nursing home. Contrary to their hypothesis, while staff members were no more negative towards sex in the aged than towards sex in younger people, student respondents working in the nursing home were less negative than the permanent staff members toward sex in general. Merritt, et. al. (1975) reported both greater and less education to be associated with negative sexual attitudes.

Snyder and Spreitzer (1976) investigated attitudes of the aged toward premarital sexual relations, extramarital sexual relations, and homosexuality. Their findings indicate that older people tend to hold disapproving attitudes toward these non-traditional sexual behaviors; however, there is still variation of activities among older people.

It could, therefore, be hypothesized that the societal prejudices and oppression experienced by homosexual individuals of all ages is experienced even more severely by older homosexuals and may have a negative effect on life satisfaction. Generalizations must be qualified in terms of levels of health, education, social class, occupation, church attendance, and marital status. The pattern of homogeneity within the variations should not be assumed.

Traditional cultural attitudes imply a continual decline in sexual interactions until disuse and disinterest bring about a full cessation of sexual activity. Sanders (1976) states "...the impact of societal attitudes influences the aging to repress and deny their sexual feelings" (p. 505). Many authors (Masters and Johnson, 1966; Pfeiffer, 1974; Sanders, 1976) have written that the denial of sexuality in older years damages the aging individuals sex-life potential, self-image, and self-esteem. It has been stated (Masters and Johnson, 1966) that "ignorance is one of the greatest deterrents to effective sexual functioning in all ages, but its been most damaging to the aging" (p. 316). Older people want and need information about sexuality and the sexual norms of their peers. They often tend to withdraw from social interaction because they simply do not know what is normative for their age group (Burnside, 1976; Sanders, 1976).

It is apparent that in spite of negative attitudes towards sexuality in older persons, sexual activity does occur, but the importance of this activity upon life satisfaction has not yet been determined. An examination of the concept of life satisfaction is needed before its relationship to sexual activity can be explored.

CHAPTER IV

THE CONCEPT OF LIFE SATISFACTION

DEFINITIONS OF HAPPINESS

The concept of life satisfaction assumes "happiness" exists and is a basic value of life. Although the concept itself is elusive and difficult to define precisely, the goal of this study is to create an operational definition of life satisfaction. Philosophers, beginning with Plato and Aristotle and continuing through the present day have engaged in controversy over understanding the concept of happiness. This chapter highlights the notable theories of happiness as they relate to the concept of life satisfaction employed in this research.

Happiness, as defined by Aristotle, is the highest good and is relative to each individual. Man is motivated above all else to pursue those activities which are pleasurable and expected to bring happiness. Intimately intertwined with Aristotilian logic is Plato's conception of happiness which emphasizes virtue. Virtue necessarily results in happiness. Similar to Platonism, the essence of Stoicism also centers around the concept of virtue although the degrees between virtue and vice are eliminated: man is either all good or all bad. These theories incorporate the notion that happiness is attainable, and specify, to some degree, what an individual must be, have, or do to be happy. Thus, a person may examine himself relative to these ideals and take an active stance towards attaining happiness.

Kant highlights the dualism between virtue and happiness: human beings have a natural desire for pleasure, and at the same time, are functioning within the constraints of moral reasoning. Thus, the activity from which one derives pleasure may conflict with the activity which morality dictates. Kant believes that because of this permanent conflict, happiness cannot be attained. Hegel, however, diverges from Kant's belief by asserting that this conflict can be resolved through learning and happiness then becomes attainable.

Hedonists maintain that the individual pursues pleasure and avoids pain. A derivative of hedonism is the Utilitarian concept which states that moral action is the greatest happiness of the greatest number. The motivation for action becomes dualistic: while the individual seeks personal pleasure, he is also concerned with the happiness of the greater community. Within the framework of self-realization, happiness is seen to be both moral attainment and fulfillment of individual potential. Rather than seen in opposition, reason and desire are fused: every desire has its rationale, every reason which leads to action must have a desire. Inherent in self-realization theory is the concept of self-preservation. Nothing can be attained unless the self is preserved.

IMPACT OF PHILOSOPHICAL ANTECEDENTS ON PSYCHOLOGICAL THEORIES

The impact of the philosophical antecedents of the concept of life satisfaction can be found in several current psychological theories. The influence of Hedonism and the pleasure-pain principle is found in the thinking of Freud, Erikson, and Skinner. Freud claims that happiness comes from the satisfaction of pent-up needs which have reached

great intensity. (Kretch and Crutchfield, 1966) The external society places demands on the individual and man must repress inner drives to function within the constraints of society. In view of that, s/he will never attain true happiness. Nevertheless, man is internally motivated to avoid pain and pursue pleasure. Erikson, a strong proponent of Freudian thought, believes that happiness is attainable even in the face of the necessity of cultural repression. His view of the function of achieving "integrity" in old age can be thought of as a part of life satisfaction (Kretch and Crutchfield, 1966). In examining B.F. Skinner's contributions, while he is not concerned with the inner beliefs or subjective values of observed subjects, the influence of the pleasure principle is clear. Skinner observes that while pain is a temporary deterrent to activity, unless extreme, it will not result in avoidance of the activity itself. Rather, a more predictable human response is to engage in those activities which result in positive environmental reinforcement, i.e., pleasure (Skinner, 1953).

Personality theories have emerged which emphasized more positive satisfying aspects of life and were based on the earlier concepts of self-realization. Maslow has perhaps most adequately expanded upon the construct of self-realization, defined as the basic tendency toward making actual what is potential within the self. He emphasizes gratification, joy, curiosity, and creativity. Personality development, when not disrupted by dysfunctional interactions and occurrences, is seen as a gradual process of the "unfolding" of essential needs and attributes of human nature. Individuals pass through a sequential series of stages seeking higher and higher levels of organization.

Crucial to the construct is the idea that the lower needs must be adequately satisfied if the developmental process is to proceed toward the maximum emergence of the personality. (Kretch and Crutchfield, 1966) Thus, inherent in the concept of full personality development is the basic idea of life satisfaction on a variety of levels.

While all of these perspectives on life satisfaction have been used at one time or another to define happiness, the most useful definition with an aging population is one which is consistent with known factors regarding aging, reflective of the existing culture, and takes into account variability inherent in the over 65 population. The phenomenological approach, exemplified by Maslow, perhaps best fits since it reflects a more flexible definition of life satisfaction.

CHAPTER V

THE HYPOTHESIS

Research is a forerunner of social change. Recognizing the elderly are an increasing population within our society and that many of these individuals either are or will be institutionalized, this study addresses the issues of sexuality and life satisfaction among institutionalized aged.

Sexuality is a basic drive throughout life; however, it often has remained unacknowledged in the lives of older persons. It is known that many factors contribute to an individual's overall life satisfaction, including sexuality. Yet to date, there has been little objective evidence linking the concept of life satisfaction to sexual activity among an elderly population.

Basically, the question this study seeks to address is whether sexual activity makes any difference in the overall life satisfaction of the institutionalized aged. Because life satisfaction can be assessed phenomenologically, while sexual activity can be linked to a hedonistic position, the underlying philosophical issue being addressed is to what extent hedonism is reflected in a phenomenological approach to life.

The evidence accumulated thus far shows that sexual behaviors occur in spite of negative stereotypes about sex in the aging population and continue to provide avenues for comfort and contact for participants.

Because sexual activity occurs even in the face of opposing social forces, it is hypothesized that among the institutionalized aged, there is a strong and positive relationship between sexual activity and overall life satisfaction.

*they should be allow
to have sex p. 62*

CHAPTER VI

OPERATIONALIZING THE CONCEPTS

THE LIFE SATISFACTION SCALE

Prior to 1961, the goal of research measuring the psychological well-being of the elderly was to create an operational definition of "successful" aging. Two conceptual approaches emerged:

- 1) external frame of reference: emphasis was primarily on measuring the overt behavior of the individual, and utilized social criteria of success or competence (Cavan, Burgess, Havighurst, and Goldhammer, 1949; Havighurst and Albrecht, 1953). This way of measuring reflects the theoretical perspective of both Aristotle and Plato and advocates a definitive version of happiness. Activity and involvement were the measured variables. Basic to the study was the value premise that the greater the extent of social participation, and the less the individual varied from the pattern of activity that characterized him in middle age, the greater was his well-being. The implicit assumption was that only those elderly who continue to function along societally acceptable positive characteristics of middle-age could have a high level of psychological well-being in old age. A weakness of this approach was the inherent bias against those who became chronically ill, homebound, and/or had drastically reduced incomes, categories into which the vast majority of the elderly fall.

2) internal frame of reference: emphasis was primarily on the individual's own evaluation of his/her past and present life satisfaction, and/or happiness as the measured variables (Havighurst, 1957). Using this frame of reference, the assumption is that the individual is the only proper judge of his/her well-being. This reflects the phenomenological approach to life satisfaction. Further, value judgements made by the investigator were minimized; and it was not appropriate to measure well-being in old age by the same activity and social participation standards that apply to middle-age.

In 1961, Neugarten, Havighurst, and Tobin sought to create and validate an instrument which measured successful aging. The Life Satisfaction Rating (LSR) was designed to:

- 1) reflect the individual's personal frame of reference
- 2) obtain a measure independent of other psychological and social variables.

One hundred seventy-seven men and women, ages 50-90 were interviewed. From this data emerged a fivefold construct of "Life Satisfaction" which included: zest, resolution and fortitude, congruence between desired and achieved goals, self-concept, and mood tone. An individual is regarded as being at the positive end of the continuum of well-being to the extent that he/she 1) takes pleasure from the round of activities that constitute everyday life; 2) accepts resolutely what life has been without blaming self or others for failures or disappointments; 3) feels successful in achieving major goals; 4) holds a positive image of self; and 5) maintains happy and optimistic attitudes and mood.

The LSR proved to be statistically reliable and valid as follows: interjudge reliability, $r = .78$, Sherman-Brown coefficient of attenuation = .87; the correlation between the LSR and the LSR-CL (The LSR scored by clinical psychologists after interviews) = .64 (for ages 70+ = .70; for ages 50-69 = .53). Nevertheless, the lengthy interview, especially when administered to a large group of people, was problematic. In response, Neugarten, Havighurst, and Tobin (1961) created a short, self-report instrument called the Life Satisfaction Index-A (LSIA). It was constructed by selecting items from existing scales and by creating new items which were representative of the five previously described components of life satisfaction. It used as its validating criterion the LSR. While considerable effort went into refining the LSIA, the authors cautioned that correlations between the scales were only moderately successful, and it was recommended for use only with certain groups of persons over 65, where correlations were the highest.

Wood, Wylie, and Sheafor (1969) attempted to improve the validity of the LSIA as a measure of life satisfaction. Individual item analysis suggested omission of seven of the original twenty items. The result was the Life Satisfaction Index-Z (LSIZ), a thirteen item subset of the LSIA. Statistical analysis of the LSIZ yielded the following data: test reliability of .79 using the Kuder-Richardson 20 formula which computes an average of all conceivable split halves; and construct validity of .57 of LSIZ correlated with the LSR. These results indicated that the LSIZ was a useful self-report instrument in cases where reasonable approximation of the level of psychological well-being will suffice (Wood, et. al., 1969).

In conclusion, the LSIZ contains the following significant components:

- 1) it includes the multi-dimensional aspect to the construct of life satisfaction
- 2) it reflects many of the positive aspects of thought on the subject of happiness that have filtered down through the centuries
- 3) the items elicit an internal frame of reference
- 4) the instrument allows for differentiation of life satisfaction from middle-aged activity level
- 5) there are adequate reliability and validity statistics for the instrument
- 6) it is self-reporting (free of investigator bias)
- 7) length of the instrument allows for presentation on a single page with adequate spacing for those with visual difficulties.

For these reasons, the LSIZ has been chosen to measure life satisfaction of the elderly population in this study (See Appendix A).

DEFINITION OF SEXUAL ACTIVITY

A sexual activity questionnaire (See Appendix B) was developed to measure sexual behaviors and non-sexual touching both with and without partners. For purposes of this study, sexuality has been broadly defined. There has been a recent emphasis on viewing sexuality as composed of several kinds of behaviors on a continuum (Podell and Perkins, 1957; Kinsey, 1953). Thus questions include a range of behaviors that extend from touching to intercourse. It was also necessary that the

wording of the questions asked be acceptable to the age cohort being studied. As in the Kinsey research, the questions have been stated to assume that the respondent has engaged in the specific behavior. For example, rather than asking, "Have you ever sexually touched another person?" the question is phrased, "How many times have you touched another person sexually?". Kinsey's belief was that people who had not engaged in the behavior could answer "none" while those who had engaged in the behavior would be more likely to answer affirmatively. As Kinsey (1948) states,

Since it becomes apparent from the form of our question that we would not be surprised if he had such experiences, there seems less reason for denying it. (p. 53)

This phraseology sets up a receptive atmosphere for acknowledgment of having engaged in specific sexual behaviors and is believed by Kinsey to be more effective in obtaining accurate information about sexuality.

Most studies that examined the sexual behavior of the elderly did so using narrow definitions of sexuality, such as Verwoerd's (1969) exclusive focus on sexual intercourse. The expanded definition used in this study specifically includes non-genital touching, masturbation, sexual touching, penile-vaginal intercourse, orgasmic response, gender of sexual partner, and past frequency of sexual activity. The reasons for including questions on these behaviors are discussed in the following section.

DEVELOPMENT OF THE QUESTIONNAIRE

Non-Genital Physical Contact

Research substantiates the importance of physical contact. Physical touching, holding, and rocking has been shown to be necessary to the development, health, and even survival of infants (Spitz, 1945).

The non-genital physical contact questions are an essential dimension to an expanded definition of sexuality. Few sexual behavior inventories include items such as touching, hugging, cuddling, or kissing. Current sex therapy (Masters and Johnson, 1970; Kaplan, 1974) stresses the importance of such behaviors and extensively utilizes non-genital contact between partners as part of the treatment techniques used for resolving sexual problems. Expanding the definition of sexuality also enables an examination of a wider spectrum of behaviors that could occur in either non-sexual or non-marital relationships for the aged with less risk of societal disapproval.

Non-genital forms of contact may be of increased value to aged people for several reasons. Genital contact may have ceased due to negative attitudes toward such activity for the aged or for the reasons of disease. However, non-genital contact can continue despite debilitated health of oneself or one's partner. Touching, hugging, and kissing can occur between spouses, as well as with friends and relatives.

Masturbation

Masturbation/sexual arousal with or without orgasmic release is available by self-stimulation. It is, however, contingent upon an individual's attitude toward masturbation, the physical capacity to

stimulate one's genitals, and the privacy to do so. Data on masturbation/sexual arousal and aging individuals is somewhat scarce. Kinsey's original volumes include data for single men up to the age of 50 and married men up to the age of 60. He found that more single than married men continue to masturbate in later years. Kinsey (1953) stated that masturbation may provide a better measure of sexual interest in heterosexual females than heterosexual activities because partner sexual activity is often male-initiated. Masturbation may provide the only opportunity for sexual arousal and/or orgasm for aging individuals without partners. Significantly more women, 65%, than men, 29%, are unmarried in this age cohort. (Kalish, 1975) Furthermore, women are less likely to be sexually involved outside of a socially sanctioned relationship, i.e., marriage (Pfeiffer and Davis, 1972). This is consistent with the previous findings of Christenson and Gagnon (1965) who found a higher frequency of masturbation among postmarital than married females. Although masturbation is sometimes seen as a substitute for interpersonal sexual relations, it is also considered to be a viable sexual option with inherent value, i.e., different from, but not less than, coitus (Barbach, 1975; Dodson, 1974). DeNicola and Peruzza (1974) determined that women in particular reported satisfaction from masturbation.

Sexual Touching

The two items pertaining to sexual touching are an important dimension when broadening the definition of the parameters of sexual behavior. The items on this questionnaire have been phrased to elicit a subjective definition of what the respondent considers to be sexual touching.

Kinsey (1948, 1953) did include questions pertaining to manual stimulation of partners' genitals and breasts and found these activities to be a significant source of sexual arousal in his study.

Penile-Vaginal Intercourse

Penile-vaginal intercourse is a frequently employed category used in sexuality and aging research to measure the extent of sexual involvement. For this questionnaire, it is one of many behaviors used to measure sexual contact.

Orgasm

Orgasm is the physiological consequences of a high level of sexual arousal. The orgasmic response consists primarily of a series of involuntary contractions of the pelvic floor muscles. The physiological capacity for orgasm remains throughout the aging years.

Orgasm is one measurement of the intensity of arousal from sexual activity; however, its significance for the aging individual is unknown.

Gender of Sex Partner

The question regarding the gender of the respondent's sexual partner was included because without specific knowledge of sexual orientation, all of the respondents would be assumed heterosexual.

Past Frequency of Sexual Activity

Research (Kinsey, 1948, 1953; Pfeiffer and Davis, 1972) found a positive correlation between levels of sexual activity in younger and later years. Masters and Johnson (1966) have said that continuation of sexual activity helps maintain sexual functioning, particularly for women.

Other Important Factors

The importance of past patterns of behavior as it impacts on current functioning is also recognized. It seems reasonable to assume that life satisfaction may be affected by individual expectations based upon these past experiences. The focus of this study is on what norms exist for this age group. Questions were included that would provide general demographic data giving a profile of the respondent in terms of marital status, age, educational background, and other factors.

The question addressing the recency of change in residence was included because that event is often associated with heightened life stress. For the elderly, a shift in living situation might impose an even greater hardship than is incurred by a younger person, as it could signify an end to, or a movement away from, an autonomous living situation. The support system of friends and relatives could also be lost during this change, with an obvious potential decrease in general life satisfaction. It was estimated that six months would allow the individual time to resolve most of the initial turmoil associated with the move; consequently, this item was used to screen out respondents living in the residence less than six months.

The educational level of the respondent was addressed because numerous studies have shown correlations between this variable and sexual behavior: Kinsey (1948) reported individuals with less education had correspondingly negative attitudes regarding sexuality. Other studies reported a gender difference: Pfeiffer and Davis (1972) found this variable to be one of the most important factors influencing the sexual behavior of men. Pfeiffer and David (1972) found a correlation

between educational level and female sexual behavior. That is, as education increases for females, attitudes become more positive and sexual activity increases correspondingly.

Church attendance was related to female sexual interest and sexual behavior in a number of studies. Christenson and Gagnon (1965) found that church attendance has an inverse relationship to coital masturbatory activity for both the married and the unmarried. Winter (1973) found a lessening of sexual desire after menopause which he claims resulted from the linkage of sexuality to the church edict, "be fruitful and multiply".

The area of physical health has also been shown to be an important determinant of both sexual activity and life satisfaction. Pfeiffer and Davis (1972) found the health of the respondent to be an important variable in terms of sexual behavior. This was confirmed by the West, DeNicola and Peruzza (1974) study which concluded that health is an important factor for the extension of sexual behavior into old age. Kalish (1975) found health to be linked with both morale and sexual functioning, and cites diabetes, strokes, arthritis, and rheumatism and the fear of heart attacks as deterrents to sexual functioning.

One frequently noted variable related to sexual functioning is the age of the individual. Kinsey (1948) indicated that 96% of men 51-55 years old and 94% of those 56-60 in their sample, reported engaging in intercourse. Similar percentages were reported by men who were no longer married. Pfeiffer (1972) noted that with increasing age there is commonly a decrease in sexual activity and interest. Christenson and Gagnon (1972) in their study of women, found that at age 50,

marital coitus was the chief sexual activity of 87% of women still engaging in coitus. By age 60, the participation had dropped to 70% and by age 65, only 50% were still experiencing coitus. In addition to a decrease in sexual activity, the factor of age was also noted by Merrit, et. al. (1975) to be related to negative sexual attitudes.

Many researchers have noted that males and females markedly differ in reported sexual behavior. Verwoerdt, et. al. (1969) and Pfeiffer and Davis (1972) found that sexual behavior is discontinued at a younger age by women than men and that women have a corresponding decrease in interest at a younger age than their male counterpart. Since women tend to marry men older than themselves, it seems reasonable to speculate that some of this may be attributable to the age of the husband. Christenson and Gagnon (1965) found that women who married men at least four year older than themselves had a lower rate of coital activity and orgasmic response. They found that 20% of women married to older men had no orgasms, whereas only 3-4% of women who were married to the same age or younger men were non-orgasmic. They concluded that the male determined the rate of coital activity.

Marital status of the aging person is significant, not only in terms of the availability of a sexual partner, but also in terms of interpersonal relationships. The elderly experience a high rate of widowhood, with 31% of women and 8% of men over the age 65 in that category. Only 1% of the widows over age 65 remarry, and many women never seek another partner after the death of their spouse. It is often difficult for these individuals to fill their sexual as well as emotional needs. Kalish (1975), West (1975), and DeNicola and Peruzza

(1974) agreed that widowhood was an important variable in life satisfaction.

In terms of sexual behavior, both Verwoerdt, et. al. (1969) and Pfeiffer (1972) found the availability of a sexual partner to be an important determinant of sexual activity. Christenson and Gagnon (1972) found differing levels of sexual activity between married and post-married women. Coital frequency levels were 50-66% greater for married females.

Inclusion of a question dealing with prior levels of sexual enjoyment reflects the findings of several researchers. Newman and Nichols (1960) found a strong sexual urge earlier in life tended to correlate with a continuation of similar feelings into old age. Verwoerdt, et. al. (1969) observed that with women, the enjoyment of sexual relations in younger years, rather than frequency or interest levels, seemed to be of particular importance in determining the extent of present sexual interest and frequency of intercourse. DeNicola and Peruzza (1974) also noted that sexual satisfaction prior to age 60 tended to determine satisfaction after age 60.

CHAPTER VII

THE PILOT STUDY

The initial draft of the questionnaire contained 26 questions. The first 8 elicited demographic data. The remaining 18 were content questions relating to a variety of sexual behaviors and attitudes toward those behaviors. This draft was utilized for a pilot study. (See Appendix B)

ADMINISTRATION OF THE QUESTIONNAIRE

Once the questionnaire was completed, it was then administered to a small sample of persons age 60 and over as this was the cohort to be addressed in the sample for this study. The research group arbitrarily initiated contact with 11 individuals to whom the researcher was a close friend or relative in 4 cases, and was a casual friend or neighbor in the remaining 7 instances.

SUBJECTS

The 11 individuals were comprised of 3 males and 8 females ranging in age from 60 to 75. Six of those were widowed and five were married. Eight of the eleven persons contacted agreed to complete the questionnaire and six questionnaires were eventually received. In general the questionnaires were filled out, but in one case only the first page of demographic information was completed, and in another case many sexually explicit items were omitted.

INITIAL CONTACT AND SUBJECT REACTION

All potential respondents were informed of the general nature of the study and were told that their answers would be held in strict confidence. In addition, time was allocated for "debriefing" with the older person, either after the questionnaire was completed or at another time arranged by the older person.

Two individuals flatly refused to participate, citing such feelings as their right to privacy and the impropriety of such questions.

INTERVIEWER REACTION

In nearly all cases the individuals administering the questionnaire experienced feelings of embarrassment and attributed such feelings to the highly personal nature of the questions combined with a lack of specific format for soliciting potential responses.

WRITTEN RESPONSES

One respondent indicated that the questions were "stupid" and provided no information related to sexually explicit items. In addition, the questions pertaining to oral-genital and anal contact were indicated to have been the experience of only one respondent.

CONCLUSION: THE REVISED QUESTIONNAIRE

Based on the results of the pilot study, the questions related to oral-genital and anal contact were omitted. The original rationale for including these three items was to expand the definition of

sexuality beyond physical contact, sexual touching, coitus, and orgasm. It was also thought that anal intercourse would be an important measurement of sexual involvement of male homosexual respondents. Also, oral-genital contact is placed in a high position in sexual behavior hierarchies (Podell and Perkins, 1957) and could, therefore, be possibly considered a discriminating index of sexual involvement.

However, these items were removed from the final questionnaire because of highly negative reactions or non-response from participants in the pilot study. In addition, minor changes were made to help clarify some ambiguity that appeared to be present on a few items.

The revised questionnaire contained 22 items. (See Appendix C) The first 8 elicited demographic information. The remaining 14 were content questions relating to a variety of sexual behaviors and attitudes toward those behaviors.

CHAPTER VIII

WEIGHTING THE QUESTIONS

The following paragraphs outline the weighting of the items pertaining to the parameters of sexual behavior, items 1 through 10 (See Appendix C) and provide the basis for the assigned scores. The questions are grouped into these three categories based on a hierarchy of explicitness of sexual behaviors and the frequency with which they are likely to occur.

Category I - 0 to 4 Points

Responses to items 1 to 4 pertaining to being touched, touching another person, hugging, and kissing were scored from 1 to 4 points as follows: never = 0, less than once a week = 1, once a week = 2, more than once a week = 3, daily = 4. Category I items are the least sexually explicit. Each of them could occur with friends, relatives, and institutional staff as well as sexual partners. These behaviors can be done with or without the intent of sexual arousal. The philosophical bias of these researchers is that such behaviors are important to well-being, whether or not sexual intent or sexual arousal is involved.

In attempting to establish a continuum of point values for all the items 1 through 10 in this section, and given the likelihood that Category I behaviors were likely to occur more often than Category II and III behaviors, each item was weighted less than those in other categories.

Category II - 0 to 8 Points

Responses to items 5 to 7 pertaining to cuddling in bed, sexually touching another person, and being sexually touched were scored from 0 to 8 points as follows: never = 0, less than once a week = 2, once a week = 4, more than once a week = 6, daily = 8. Category II items are more sexually explicit than Category I items. Cuddling in bed could be affectionate and not sexual, but opportunity for explicit sexual contact is likely to be more available to someone who cuddles in bed with another person. Also, the work "cuddling" as opposed to "sleeping" or "sharing a bed with" implies overt, purposeful contact. The sexual intent of "sexual touching" is implicit in the items asking about such behaviors. People who engage in Category II behaviors are likely to do so with fewer people than with Category I behaviors. This will likely result in Category II behaviors occurring less frequently, and therefore Category II behaviors are weighted more heavily than are Category I behaviors.

Category III - 0 to 16 Points

Responses to items 8 to 10 pertaining to sexual intercourse, touching oneself for sexual pleasure, and orgasm were scored as follows: never = 0, less than once a week = 4, once a week = 8, more than once a week = 12, daily = 16. Category III items are the most sexually explicit behaviors. They relate most directly to sexual arousal and genital contact. Intercourse, self-stimulation, and orgasm are apt to be likely to occur less often than the behaviors in Categories I and II. Therefore, they are weighted more heavily in order to maintain the

continuum of behaviors. For example, if a subject touches another person daily, the score is equivalent to having intercourse less than once a week: both items are weighted at 4 points. The limited research that does exist about sexual behavior of aged populations reveals that the frequency of intercourse declines with age. The average frequency of subjects in one study was one time per month by the age of 65 and the frequency approached zero by age 80 (Verwoerd et. al., 1969). An analysis of the 1940's and 1950's Kinsey data found that 27% of married and 43% of unmarried women in the sample engaged in masturbation by age 60, but the report did not specify frequency of the activity. This same study reported that by age 60 about 18% of the women in the sample still experienced orgasm during sexual dreams, but the study did not specify the frequency (Christenson and Gagnon, 1965). Masters and Johnson's laboratory results corroborate these findings about orgasm by establishing that the physiological capacity for orgasm extends through old age.

In conclusion, because so little research has been done on the frequency of the variety of behaviors used in this study, a highly scientific analysis of the weighting is impossible. These researchers have attempted, therefore, to apply the available research and common sense to establish the weighting of scores in the three categories.

CHAPTER IX

THE STUDY

SEARCH FOR SUBJECTS

Based on the literature review and questionnaire development, the group concluded that subjects suitable for our study would be:

- over the age of 60
- ambulatory
- cognitively oriented in person, place, and time.

In addition, a suitable sample would also be composed of:

- an equal number of males and females,
- as broad a distribution in marital status as possible,
- members from a total resident population greater than 10.

The group decided to conduct the research study at a single institution to decrease the number of extraneous variables and to simplify data collection. The State of Oregon Health Licensing Board Listings were used as a source for a list of retirement homes for the aged in Multnomah County. Contact with 33 of these homes was made, 31 initially by telephone and two through personal or work contact by research group members.

Of the 33 homes, 6 (18%) responded "yes" to initial requests to participate in the study. The six "yes" responses were further reviewed by the group, but it was decided these retirement homes did not meet one or more of the previously stated criteria.

Seven (21%) responded "maybe" to initial requests. Of the seven "maybe" responses, all became "no" responses after further contact. The owners of three homes refused after they saw the questionnaire on sexual activity; they stated that the questionnaire was inappropriate and/or too personal. On second contact, one owner refused and gave no reason. The remaining three original "maybe" responses were determined by the group to be unsuitable based on the previously stated criteria.

Seventeen (52%) responded "no". The owners of nine of these homes judged their residents to be inappropriate due to psychiatric and/or health problems. The remaining eight owners had the opinion that the survey was too offensive and would upset the residents. In addition, some owners stated that the residents did not engage in sexual activity! Two (6%) did not return the telephone call. Table III presents a detailed account of agency responses.

During the exploration of homes in the Portland area, a University staff member offered to make contact with his sister who owns a home in Seattle, Washington. The group realized that this facility did not meet all previously established criteria. However, having found no suitable and willing retirement home among the 33 homes contacted in the Portland area, and realizing the impact of time constraints, the group decided to contact the Restorative Care Center in Seattle, Washington. Use of this institution and a specific date for the study were then confirmed with the owner.*

*NOTE: Upon arrival at the Restorative Care Center on the prearranged date, the questionnaire was presented for approval to the head administrator, the assistant administrator, and the social worker. Only the

TABLE III
SEARCH FOR SUBJECTS

I. "Yes" Responses from Agency Owners:

Agency Number: Reason Not Pursued by Research Group:

- 1.....Residents all female; incapacitated.
- 2.....Residents senile.
- 3.....Residents too physically incapacitated.
- 4.....Agency population too small (9).
- 5.....Agency population too small; too many men.
- 6.....Agency population too small.

II. "Maybe" Responses from Agency Owners:

Agency Number: Reason Not Used for the Study:

- 1.....Did not meet group criteria.
- 2.....Did not meet group criteria. (mostly female, over age 89)
- 3.....Did not meet group criteria. (too physically incapacitated)
- 4.....Owner said "no" after seeing the questionnaire.
- 5.....Owner said "no" after seeing the questionnaire.
- 6.....Owner changed mind stating no reason.
- 7.....Owner said "no" after seeing the questionnaire.

III. "No" Responses from Agency Owners:

Agency Number: Reasons Stated by Agency Owner:

- 1....."Population not appropriate for the study."
- 2.....(no reason stated)
- 3....."Residents would be upset by questionnaire."
- 4....."Population too small; all male; mental problems."
- 5.....(no reason stated)
- 6....."Population too small and inappropriate for the study."
- 7....."Population too incapacitated for the study."
- 8....."Sex questionnaire would be too offensive to residents."
- 9....."Residents would not approve of the study."
- 10....."Not interested; find another agency."
- 11....."Population too small and most are confused."
- 12....."Study would upset the residents; most residents inappropriate."
- 13....."Few residents would understand the questionnaire."
- 14....."My ladies are too educated for your study; too religious too."
- 15....."Residents are too old for your study; most psychiatric patients."
- 16....."Most of the residents are too impaired."
- 17....."Residents are too confused to answer the questionnaire."

head administrator approved use of the sexual activity questionnaire; even she stated she would have preferred the questionnaire to be worded in a "more delicate" manner.

SETTING

The Restorative Care Center provides services for all ages in rehabilitation, extended-skilled care, intermediate care and day care. Services are available for rehabilitative patients, post-operative convalescents, short-term medical patients, long-term chronically ill persons, and out-patients.

Professional staff includes: medical director, physician, nurses, dietician, pharmacist, physical therapist, occupational therapist, speech worker, and social worker. Activities include recreation, crafts, planned civic and community activities with speakers, and special programs for families. The facility offers a chapel, barber and beauty shop, hobby area, gift shop, lounges, day rooms, elevators, electronic call system, access to bus lines, meeting room, cafeterias and dining areas, inside and outside recreational area, and rooms designed for one, two or four beds. Capacity of this center is 250 patients.

This facility is licensed by the State of Washington as a Nursing Home and is certified to care for medicare, medicaid, and veterans. Nationally it is accredited by the Joint Commission of Accreditation of Hospitals and is a member of American Nursing Home Association and Washington State Health Facilities Association.

SUBJECTS

The measures of life satisfaction and sexual activity were administered to 23 of the 250 residents of the Restorative Care Center. The subjects were pre-screened by the staff social worker prior to her seeing the questionnaire. On the basis of her subjective judgement regarding their suitability for the study, she made judgements regarding willingness, interest, and ability to participate in the study. No resident was excluded on the basis of physical limitation.

23 questionnaires were returned:

-9 were unsuitable for data analysis (See Appendix D)

-14 were completed by nine females and five males and were suitable for data analysis. Table IV presents demographic characteristics of these 14 respondents.

EQUIPMENT

The instruments used were: 1) an informed consent form (See Appendix E), 2) a cover sheet that gathered demographic information, 3) the LSIZ questionnaire which measured life satisfaction, and 4) a questionnaire on sexual activity developed by this group for the research project. The latter two instruments were sequenced alternately to control for possible order effects.

TABLE IV

DEMOGRAPHIC CHARACTERISTICS OF RESPONDENTS

	Number of Residents
LENGTH OF STAY AT RESIDENCE:	
Over six months.....	13
Less than six months.....	1
HIGHEST LEVEL OF EDUCATION:	
College graduate.....	1
College attendance.....	2
High school graduate.....	6
Between grades 6 and 11.....	4
Between grades 1 and 6.....	1
CHURCH ATTENDANCE IN PAST 5 YEARS:	
One or more times per week.....	5
2 or 3 times per month.....	5
3 to 12 times per year.....	2
Never.....	2
SELF-EVALUATED HEALTH:	
Excellent.....	1
Good.....	4
Fair.....	8
Poor.....	1
AGE:	
78 years and over.....	11
72-77 years.....	2
66-71 years.....	1
SEX:	
Female.....	9
Male.....	5
MARITAL STATUS:	
Widowed.....	8
Divorced.....	2
Married.....	4
DIVORCED, WIDOWED WITHIN PAST YEAR:	
Yes.....	1
No.....	13

PROCEDURE

Residents were notified of the project two weeks in advance by the social worker of the agency. The morning of the research, announcements were made in the two main activity areas and dining rooms by the social worker and the three researchers. At this time, residents were reminded that the research would be conducted that afternoon and were invited to participate in the project. However, attention was focused on eliciting the participation of the residents pre-selected by the agency social worker as more appropriate for our research purposes.

The research was conducted in a conference room located in an ambulatory wing of the facility accessible from the main activities and dining areas by a long sloping ramp. Subjects in wheelchairs could not reach the room without assistance on the ramp.

The conference room contained two long tables, one small table, and several chairs. The room was carpeted, well-lighted, and well-ventilated.

Twelve subjects were present when the research presentation began. A short introduction was given that included identification of the researchers and purpose of the research project. Informed consent forms were distributed and were accompanied by an explanation of why they were necessary. After they were collected, instructions were given on how to mark the questionnaires.

It was explained that the answers on the questionnaires would remain confidential, and that the subjects were free to withdraw from the research at any time. Researchers were available to answer questions

and give assistance during the time questionnaires were being administered. Subjects were told that one of the three researchers would also be available following completion of the questionnaire to discuss any personal issues that might have been raised by the content of the research. The questionnaires were distributed and it became apparent from the respondents' reactions that individual instructions were necessary. (See Appendix D) The researchers circulated around the room giving the subjects individual assistance.

Additional subjects began to arrive singly and in small groups. Many were in wheelchairs. This necessitated moving people to accommodate the wheelchairs in the already crowded room. The same procedure was followed on an individual basis as new subjects arrived.

Many of the participants required assistance in reading, and in some instances, marking the questionnaires. (See Appendix D) The research was completed in two hours. The questionnaires were placed in a closed box when completed by the respondents.

RESULTS

Scores on the life satisfaction inventory and the sexual activity questionnaire were tested for correlation ratio ($F=1.67$, $df=5,8$, $p>.05$) and linear correlation ($F=2.45$, $df=1,12$, $p>.05$). Since the correlation ratio and the linear correlation were not significant, Eta was used to investigate the relationship between life satisfaction and sexual activity. Results showed that $\eta = .52$, and was not significant as found by the F test of curvilinearity ($F=1.39$, $df=4,8$, $p>.05$). A scatter-plot of the data revealed scores polarized at the ends of the sexual behavior

continuum. Scores on both life satisfaction inventory, and the sexual activity questionnaire were transformed by multiplying by 100, dividing in half at the median and analyzed by means of $2 \times 2 \chi^2$. Results showed $\chi^2 = .16$, $df = 1$, $p > .05$.

Because polarized scores might have reflected differing responses, a post hoc analysis of questions 1 - 6 on the sexual activity questionnaire and the life satisfaction inventory was performed. Results showed that F tests for correlation ratio ($F=1.43$, $df=5,8$) and for linear correlation ($F=2.74$, $df=1,11$) were not significant. Data were then analyzed by means of Eta, $\eta = .69$ which also was not significant ($F=1.08$, $df = 4,8$, $p > .05$).

Using the Spearman Rank-Order Correlation Coefficient, sexual activity scores were compared separately with church attendance, and educational level of achievement. For sexual activity and church attendance, $\rho = 1.5$, $p > .05$, for sexual activity and educational level of subjects $\rho = .12$, $p > .05$.

The results of the analyses of data showed no significant relationships between life satisfaction and sexual activity, and no significant relationships between life satisfaction and educational level, health, or church attendance. The results also indicated the lack of significant relationship between sexual activity and educational level or church attendance.

CHAPTER X

DISCUSSION

The data from this research study do not support the hypothesis of a positive relationship between life satisfaction and sexual activity among the institutionalized aged. The researchers believe that results were biased due to sample, instrument, and methodology problems.

Due to the previously outlined difficulties in securing a sample congruent with the established criteria, the group elected to study an available sample that was more limited in cognitive and physical characteristics than established by previous criteria. The research was conducted in a nursing home rather than in a home for the aged which resulted in unanticipated difficulties concerning the respondents' reading, understanding, and answering the questionnaires. These difficulties are detailed in the appendix (See Appendix D).

The methodological problems concern method of presentation of the introductory instructions, non-standardized assistance for questionnaire completion and inappropriate control for privacy. Contrary to the researchers' expectations, most of the subjects did not adequately comprehend the instructions that were presented by large group format. The researchers then chose to assist the subjects on a one-to-one basis and adapted the instructions according to the individual's needs. Consequently, instructions and assistance in completing the questionnaire were non-standardized. Additionally, the research group did not provide

a setting with adequate privacy to insure confidentiality and uninfluenced responses.

Results from the pilot study, refusals by agencies to participate after seeing the questionnaire, and difficulty in questionnaire completion point to several problems with the instruments. Many of the subjects directly expressed difficulty interpreting the items on both questionnaires. Some pilot study participants, agencies, and subjects objected to the sexual content of the sexual behavior inventory questions. Inexperience of the researchers in dealing with this age cohort and in designing the sexual behavior questionnaire many only in part explain these difficulties. Negative attitudes toward sexuality must also be considered as a contributing factor.

The researchers conducted post hoc analysis of some of the data in an attempt to determine if correlations previously established in the literature were upheld in this study. The literature suggested specific relationships between the following pairs of variables: sexual activity and church attendance, sexual activity and educational level, and life satisfaction and health. This study did not yield such correlations. While the literature did not discuss life satisfaction and church attendance, or life satisfaction and educational level, the researchers attempted to see if this study revealed such correlations. No significant relationships were found.

The researchers believe that despite the lack of statistical results, valuable information regarding research in the area of sexuality has been acquired. A pervasive theme throughout the development and implementation of this study was the discomfort about the subject

matter of sexuality. Discomfort was documented in the review of the literature and observed in the reactions of the agency directors, the reactions of subjects of the pilot study and final study, and the discussions of the research group. The negative societal attitudes towards sexual expression of older people, as documented in the review of the literature may contribute to the restrictive institutional practices and policies concerning sexual access and activities of residents. The resistance of agencies to participate in this study involving sexuality was highlighted by the refusal of one agency, despite the considerable efforts of the group to involve and prepare the agency. Furthermore, even several of the staff in the agency that participated in the study did not want to do so because of the sexual subject matter. In the pilot study, refusals to participate and failures to return the questionnaire were also indicative of discomfort in responding to a sexuality questionnaire. Some pilot study subjects voiced strong disapproval of the sexual content of the questions. In the final study some subjects expressed similar reactions. Group members also acknowledged occasional feelings of personal discomfort with the topic of sexuality, especially when administering the sexual activity questionnaire.

CHAPTER XI

CONCLUSION

The hypothesis of this study was not supported. The data are inconclusive due to the difficulties previously described. The current task of the researchers is to use the problems encountered during the research to suggest several areas for revision which may lead to more conclusive results. The researchers recommend revisions in the areas of groundwork, sample, methodology, and instrument design.

The researchers' lack of thorough familiarity with this age cohort contributed to difficulty in questionnaire design and administration. Preliminary first-hand experiences with older persons and additional, on-going consultations with experts in the field of sexuality and aging, in addition to the literature review actually conducted, would more thoroughly prepare the researchers for the study. The researchers consider the use of an appropriate home for the aged to be crucial to the research effort. With a heightened sensitivity to the concerns of the elderly regarding sexuality, and with a greater facility in communicating clearly and concisely with the elderly, the researchers may have encountered greater success in contracting with an appropriate agency. Once the initial agency contact is made, further groundwork for successful research could be laid through extensive communication and cooperation between researchers and agency personnel with the goal of creating

an appropriate instrument by which to measure sexual activity of the sample. The researchers and agency personnel need to work hand-in-hand to educate each other to the needs of the sample and the study. Sexuality education for agency staff is recommended as a part of this process in order to reduce some of the expected resistance. Experts could be used to provide sex education necessary to prepare agency staff. Through the model of mutual participation and education, the researchers should be able to create a research design and method of administration more suitable than those used in the present study.

The research group, in retrospect, realized the need for a well-conceived and administered pilot study. The pilot study would have provided the researchers additional information about appropriate methodology and the age cohort in question. For both the pilot and the final studies, the researchers recommend ample time allocation for visiting the facility and planning the questionnaire-administration phases. Planning should include steps to ensure an adequate test-taking environment with the provision for privacy and ample time for questionnaire completion. In addition, the researchers recommend that the sexual behavior inventory questionnaire be administered by a one-to-one interview format.

Although subjects voiced difficulty in understanding the LSIZ, reliability and validity for this instrument have been established. The researchers recommend retaining the LSIZ but modifying some aspects of the sexual behavior inventory. In response to complaints from some of the subjects, the following modifications of the sexual behavior inventory are suggested. The introductory description of the questions

as "sexual behaviors" should be removed, clarifying that touching can occur between the subject and friends, family, spouses, and staff. The word "pleasurably" should be removed from the touching questions. Examples of touching (such as hand-holding, an arm around another person, and a pat on the back) should be given. Incorporating other sexual behavior inventories used with this age cohort may be helpful in improving the present inventory.

In conclusion, the researchers believe that many of the difficulties encountered during the study stem from overall societal resistance to dealing with sexuality especially with the age cohort studied. It is anticipated that any research in the area of sexuality and the aged would encounter attitudinal obstacles. The suggestions enumerated represent an attempt, garnered from the researchers' experience in this study, to deal more sensitively and effectively with these problems. We maintain that further research in the field of aging and sexuality is needed.

It is desirable for social workers to consider all aspects of individuals' needs and issues concerning sexuality. Results from this study indicate the large barriers that exist in addressing these needs of older persons. Without first understanding both personal and societal resistance to considering sexual issues, a social worker cannot intervene effectively. Because social workers will be among the key professionals in contact with the ever-growing members of older people, it is imperative that these barriers be removed so that those who do achieve greater life satisfaction by realizing their sexuality will be enabled to do so.

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APPENDIX A

LSIZ QUESTIONNAIRE

HERE ARE SOME STATEMENTS ABOUT LIFE IN GENERAL THAT PEOPLE FEEL DIFFER-
 ENTLY ABOUT. WOULD YOU READ EACH STATEMENT ON THE LIST, AND IF YOU AGREE
 WITH IT, PUT A CHECK MARK IN THE SPACE UNDER "AGREE". IF YOU DO NOT AGREE
 WITH A STATEMENT, PUT A CHECK MARK IN THE SPACE UNDER "DISAGREE". IF YOU ARE
 NOT SURE ONE WAY OR THE OTHER, PUT A CHECK MARK IN THE SPACE UNDER "?". PLEASE
 BE SURE TO MAKE A CHECK MARK FOR EVERY STATEMENT ON THE LIST.

	AGREE	DISAGREE	?
A. As I grow older, things seem better than I thought they would be.			
B. I have gotten more of the breaks in life than most of the people I know.			
C. This is the dreariest time of my life.			
D. I am just as happy as when I was younger.			
E. These are the best years of my life.			
F. Most of the things I do are boring or monotonous.			
G. The things I do are as interesting to me as they ever were.			
H. As I look back on my life, I am fairly well satisfied.			
I. I have made plans for things I'll be doing a month or a year from now.			
J. When I think back over my life, I didn't get most of the important things I wanted.			
K. Compared to other people, I get down in the dumps too often.			
L. I've gotten pretty much what I expected out of life.			
M. In spite of what people say, the lot of the average man is getting worse, not better.			

APPENDIX B

PRE-TEST SEXUALITY QUESTIONNAIRE

DURING THE LAST FOUR WEEKS:

HOW OFTEN HAVE YOU BEEN PLEASUREABLY TOUCHED BY ANOTHER PERSON?

never	less than once a week	once a week	more than once a week	daily
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HOW OFTEN HAVE YOU TOUCHED ANOTHER PERSON FOR PLEASURE?

never	less than once a week	once a week	more than once a week	daily
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HOW MANY TIMES HAVE YOU AND ANOTHER PERSON HUGGED?

never	less than once a week	once a week	more than once a week	daily
-------	--------------------------	-------------	--------------------------	-------

HOW MANY TIMES HAVE YOU AND ANOTHER PERSON KISSED?

never	less than once a week	once a week	more than once a week	daily
-------	--------------------------	-------------	--------------------------	-------

HOW MANY TIMES HAVE YOU AND ANOTHER PERSON CUDDLED IN BED?

never	less than once a week	once a week	more than once a week	daily
-------	--------------------------	-------------	--------------------------	-------

HOW MANY TIMES HAVE YOU SEXUALLY TOUCHED ANOTHER PERSON?

never	less than once a week	once a week	more than once a week	daily
-------	--------------------------	-------------	--------------------------	-------

HOW MANY TIMES HAS ANOTHER PERSON SEXUALLY TOUCHED YOU?

never	less than once a week	once a week	more than once a week	daily
-------	--------------------------	-------------	--------------------------	-------

DURING THE LAST FOUR WEEKS:

HOW MANY TIMES HAVE YOU EXPERIENCED SEXUAL INTERCOURSE?

never	less than once a week	once a week	more than once a week	daily
-------	--------------------------	-------------	--------------------------	-------

HOW MANY TIMES HAVE YOU TOUCHED YOURSELF FOR SEXUAL PLEASURE?

never	less than once a week	once a week	more than once a week	daily
-------	--------------------------	-------------	--------------------------	-------

HOW MANY TIMES HAVE YOU EXPERIENCED SEXUAL CLIMAX (ORGASM)?

never	less than once a week	once a week	more than once a week	daily
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DO YOU CURRENTLY HAVE A SEXUAL PARTNER(S)?

yes no

IF SO, IS YOUR SEXUAL PARTNER(S)...

male female

REGARDING YOUR PRESENT AMOUNT OF SEXUAL ACTIVITY, HOW MUCH DO YOU DESIRE?

less same amount more

BETWEEN THE AGES OF 30 AND 50 HOW OFTEN DID YOU ENGAGE IN SEXUAL ACTIVITY?

never	less than once a week	once a week	more than once a week	daily
-------	--------------------------	-------------	--------------------------	-------

*15. BETWEEN THE AGES OF 30 AND 50, HOW MUCH DID YOU ENJOY SEXUAL
ACTIVITY?

not at all some alot

(*This question was accidentally omitted in the final study due to clerical error.)

APPENDIX D

PERSONAL VIGNETTES

Three general observations were made by the researchers regarding the characteristics of the participants in this study: the desire to be useful, to explain and/or justify answers, and slow response time.

1) The sample seemed to need to be needed and feel useful, and responded to participating in this survey as a way of contributing themselves in a worthwhile manner. When they had trouble understanding what was asked of them, or in understanding the questions, they seemed disappointed in themselves since they had a sense of obligation to do well in their part of the research. All of these participants took their roles seriously as part of the survey, and tried hard to fulfill them to the best of their ability and circumstance.

2) When participants had conversations with researchers while filling out the questionnaire, they explained and/or justified their answers to the researchers. They were often told that explanations were not necessary, but they often continued anyway.

3) Generally, all participants read the questionnaire more slowly than the researchers had anticipated.

There were additional unanticipated issues associated with conducting the study. The following observations were noted as problems in administration of the questionnaire to the whole group:

1) The room was too small to afford privacy which forced people to sit so close to one another that answers could be seen by fellow participants. Adequate allowance for wheelchairs was not made which further contributed to the crowded conditions in the room.

2) The close proximity of seating arrangements allowed people to visit with each other, and discuss the questionnaire during its administration.

3) Information and instructions were not received clearly when given to the group simultaneously. This necessitated giving instructions on an individual basis. It was found that directions were better received when eye contact was made, speech was slowed, and simple concrete language was used, eliminating abstract concepts and professional jargon.

Situations and circumstances varied with individual participants and necessarily affected their responses on the questionnaire. These problems were unanticipated by the researchers and included the following observations and interactions.

Four people had difficulty seeing well enough to read the questionnaire and required assistance. This meant that a researcher read the questions aloud to the individual participant, which was often accompanied by discussion or explanation. Also, one participant from a foreign country could not read the questionnaire because of her inability to read English and asked for assistance from a researcher.

One man had Parkinson's disease and because of palsy in his hands was unable to mark the questionnaire. He asked that a researcher mark the questionnaire for him as he pointed to the answer he selected.

Most participants had some loss of hearing and were unable to follow the directions given to the group as a whole, necessitating instructions being given on an individual basis.

The memory of personal losses was stimulated by the questions for some participants, resulting in further reminiscence and their need to share these reactions with researchers through extended conversations.

Consulting with the social worker of the agency upon completion of the research, it was learned some participants did not disclose information regarding their intimate relationships on the questionnaire. One lady in particular stated she did not think she could answer the questions and did not believe she had anything to contribute. She went on to describe her relationship with another patient as being only friends with an occasional kiss and disclaiming any kind of sexual relationship. She said, "He respects me and has not taken advantage of me." The social worker later reported that this same woman had come to her for sexual counseling in her relationship with this boyfriend.

One woman participant cried during the administration of the questionnaire and when asked by the researcher if she wanted to continue, insisted that she wanted to participate. When asked if the questions were bothering her, she said they did not bother her, that she had no relationships. She attributed her sadness to being unable to see the questions well enough to read them for herself and was embarrassed at her loss of eyesight. Later on, the social worker reported that this woman had often been observed reading books during her free time.

Some participants related to the researchers that the questions were too personal, were an invasion of their privacy and had no relevance to their current life situations. Two women, both widows in

wheelchairs, felt both of these conditions made their participation useless, and resented being asked about their sex life. They refused to complete the questionnaire.

One married couple participated in the study and the man was heard telling his wife that their answers needed to match. The woman later commented to a researcher that she had not had sex with her husband since they were first married because they had discovered early in their marriage that she was unable to bear children. She went on to say, "but he has been very good to me over the years".

The husband of this pair commented to another researcher, when handing in his questionnaire, "Now you can see what kind of a man I am", accompanied by a grin. The questionnaires did not match.

When researchers discussed and compared their experiences with participants, the following problems were noted pertaining to the questionnaires.

1) The cover sheet containing the demographic questions was noted to be difficult on question #2 for anyone whose education system was not applicable to the categories presented; for example, those educated in a foreign country or an alternative education program.

2) Question #5 was confusing for one participant who was in her nineties, since she felt there was no age category appropriate for her.

3) The questionnaire on life satisfaction (the LSIZ) was confusing on items J and M for many participants. Researchers were often asked to clarify the meaning of those two questions, since the wording seemed to confuse their intended response.

4) On the sexual activity questionnaire, there were problems with questions #1 and #2, specifically with the term "pleasureably touched". Some participants were only able to relate the term "pleasureably" to specific categories or incidents:

- A. Foreplay to sexual activity,
- B. Sexual activity,
- C. One woman reported the only time she was pleasureably touched was by her father when he ruffled her hair as a little girl.
- D. One woman wanted to know if holding a baby counted as touching.

5) The term "touching" was confusing and many did not consider any hand-to-body touching that was part of their caretaking, or as greetings from relatives and friends. Another participant commented that she could not answer #2 because she had no way of knowing if the other person enjoyed it when she touched them---interpreting the question differently than it was intended by its designers.

6) Questions #3 and #4 was responded to by one participant saying, "The only time I'm hugged or kissed is twice a month when my son comes to visit me." Many other participants answered with "never" interpreting the question as a sexual activity.

7) Question #11, using the term "sexual partner", was often interpreted by this group as an ongoing relationship, mate, or most often, as a marriage partner.

8) Questions #13 and #14 contained barriers in language. The questions were not simple and concrete enough for participants to answer. Many participants asked for clarifications from researchers regarding the meaning of these two question.

APPENDIX E

INFORMED CONSENT

I hereby agree to participate in the study on aging by the students in the School of Social Work of Portland State University. I have been informed that my participation is voluntary and confidential. I have also been informed that I can withdraw from this study at any time.

Signed _____

Date _____