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Terri D. Fisher, Clive M. Davis, William L. Yarber, Sandra L. Davis

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Charles B. White
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Aging Sexual Knowledge and Attitudes Scale

CHARLES B. WHITE,1 Trinity University

The Aging Sexual Knowledge and Attitudes Scale (ASKAS) is designed to measure two realms of sexuality: (a) knowledge about changes (and nonchanges) in sexual response to advanced age in males and females and (b) general attitudes about sexual activity in the aged. The items are largely specific to the elderly rather than a general sexual knowledge-attitudes scale. The ASKAS was developed for use in assessing the impact of group or individual interventions on behalf of sexual functioning in the aged utilizing, for example, a pretest-posttest procedure. Further, the measure may form the basis for group and individual discussion about sexual attitudes and/or sexual knowledge. The scale is also appropriate for use in educational programs for those working with the aged.

The actual numerical scores may be conveniently used for research purposes, but the individual items are also useful to assess the extent of an individual’s knowledge upon which to base clinical interventions, as well as identifying attitudinal obstacles to sexual intimacy in old age.

Description, Response Mode, and Timing

The ASKAS consists of 61 items, 35 true/false/don’t know in format and 26 items responded to on a 7-point Likert-type scale as to degree of agreement or disagreement with the particular item. The 35 true/false questions assess knowledge about sexual changes and nonchanges which are or are not age related. The 26 agree/disagree items assess attitudes toward sexual behavior in the aged. The items are counterbalanced. The instrument takes 20–40 minutes to complete.

Scoring

The ASKAS may be given in an interview of paper-and-pencil format and may be group administered or individually administered. The nature of the scoring and items are readily adaptable to computer scoring systems.

Scoring is such that a low knowledge score indicates high knowledge and a low attitude score indicates a more permissive attitude. The rationale for the low knowledge score reflecting high knowledge is that don’t know was given a value of 3, indicating low knowledge. In the Knowledge section, Questions 1 through 35, the following scoring applies: true = 1, false = 2, and don’t know = 3. Items 1, 10, 14, 17, 20, 30, and 31 are reversed scored. In the Exhibit, the correct answers are in parentheses for Items 1 through 35. The attitude questions, 36 through 61, are each scored according to the value selected by the respondent with the exception of Items 44, 47, 48, 50–56, and 59 in which the scoring is reversed.

Reliability

The reliability of the ASKAS has been examined in several different studies, and in varying ways, summarized in Table 1. As can be seen, reliabilities are very positive and at acceptable levels.

Validity

Presented in Table 2 are the means and standard deviations of ASKAS scores from several studies. These means are not meant to be viewed as normative, but rather illustrative of group variation in ASKAS performance.

The validity of the ASKAS has been examined in a sexual education program for older persons, by individuals working with older persons, and by adult family members of aged persons in which each group received the psychological-educational intervention separately (White & Catania, 1981). Each experimental group had a comparable

### TABLE 1

<table>
<thead>
<tr>
<th>Type of reliability</th>
<th>Reliability coefficient</th>
<th>Sample size</th>
<th>Type of sample</th>
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<td>163</td>
<td>Nursing home staff</td>
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<tr>
<td>Split-half</td>
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<td>279</td>
<td>Nursing home residents</td>
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<td>163</td>
<td>Nursing home staff</td>
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<td>Alpha</td>
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<td>30</td>
<td>Families of older adults</td>
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<td>15</td>
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<tr>
<td>Test-retest</td>
<td>.90</td>
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<td>Staff of nursing home and families of the older adults</td>
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<tr>
<td>Attitudes</td>
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<tr>
<td>Split-half</td>
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<tr>
<td>Test-retest</td>
<td>.72</td>
<td>30</td>
<td>Staff of nursing home and families of the aged</td>
</tr>
</tbody>
</table>

1 These correlations have been corrected for test length.

1 Address correspondence to Charles B. White, Trinity University, 1 Stadium Drive, San Antonio, TX 78212; e-mail: cwhite@Trinity.Edu
nonintervention control group. In all cases, the educational intervention resulted in significant increases in knowledge and significant changes in the direction of a more permissive attitude, both relative to their own pretest scores and relative to the appropriate control group, whereas the control group posttest scores were not significantly changed relative to their pretest scores. There was a 4–6 week period between pre- and posttests.

Hammond (1979) utilized the ASKAS in a sexual education program for professionals working with the aged. She reported significant changes from pre- to posttest toward increased knowledge and more permissive attitudes in the interception group, as in the White and Catania (1981) research, whereas the control group scores were unchanged from pre- to posttest.

White (1982a), in a study of nursing home residents in 15 nursing homes, reported that both ASKAS attitude and knowledge scores were associated with whether an individual was sexually active or not such that more activity was associated with greater knowledge and with more permissive attitudes.

A factor analysis of the ASKAS results (White, 1982b) from the studies in Table 2 resulted in a two-factor solution, with each item loading most heavily on its hypothesized membership in either the attitude or knowledge section of the measure.

Other Information
The ASKAS may be utilized without permission. It is only requested that all findings be shared with the test author.

References


Exhibit

**Aging Sexual Knowledge and Attitudes Scale**

*Knowledge Questions (Correct answer shown in parentheses.)*

1. Sexual activity in aged persons is often dangerous to their health. (F)  
   - True  
   - False  
   - Don’t know

2. Males over the age of 65 typically take longer to attain an erection of their penis than do younger males. (T)

3. Males over the age of 65 usually experience a reduction in intensity of orgasm relative to younger males. (T)

4. The firmness of erection in aged males is often less than that of younger persons. (T)

5. The older female (65+ years of age) has reduced vaginal lubrication secretion relative to younger females. (T)

6. The aged female takes longer to achieve adequate vaginal lubrication relative to younger females. (T)

7. The older female may experience painful intercourse due to reduced elasticity of the vagina and reduced vaginal lubrication. (T)

8. Sexuality is typically a life-long need. (T)

9. Sexual behavior in older people (65+) increases the risk of heart attack. (F)

10. Most males over the age of 65 are unable to engage in sexual intercourse. (F)

11. The relatively most sexually active younger people tend to become the relatively most sexually active older people. (T)

12. There is evidence that sexual activity in older persons has beneficial physical effects on the participants. (T)

13. Sexual activity may be psychologically beneficial to older person participants. (T)

14. Most older females are sexually unresponsive. (F)
15. The sex urge typically increases with age in males over 65. (F)
16. Prescription drugs may alter a person’s sex drive. (T)
17. Females, after menopause, often have a physiologically induced need for sexual activity. (F)
18. Basically, changes with advanced age (65+) in sexuality involve a slowing of response time rather than a reduction of interest in sex. (T)
19. Older males typically experience a reduced need to ejaculate and hence may maintain an erection of the penis for a longer time than younger males. (T)
20. Older males and females cannot act as sex partners as both need younger partners for stimulation. (F)
21. The most common determinant of the frequency of sexual activity in older couples is the interest or lack of interest of the husband in a sexual relationship with his wife. (T)
22. Barbiturates, tranquilizers, and alcohol may lower the sexual arousal levels of aged persons and interfere with sexual responsiveness. (T)
23. Sexual disinterest in aged persons may be a reflection of a psychological state of depression. (T)
24. There is a decrease in frequency of sexual activity with older age in males. (T)
25. There is a greater decrease in male sexuality with age than there is in female sexuality. (T)
26. Heavy consumption of cigarettes may diminish sexual desire. (T)
27. An important factor in the maintenance of sexual responsiveness in the aging male is the consistency of sexual activity throughout his life. (T)
28. Fear of the inability to perform sexually may bring about an inability to perform sexually in older males. (T)
29. The ending of sexual activity in old age is most likely and primarily due to social and psychological causes rather than biological and physical causes. (T)
30. Excessive masturbation may bring about an early onset of mental confusion and dementia in the aged. (F)
31. There is an inevitable loss of sexual satisfaction in post-menopausal women. (F)
32. Secondary impotence (or non-physiologically caused) increases in males over the age of 60 relative to young males. (T)
33. Impotence in aged males may literally be effectively treated and cured in many instances. (T)
34. In the absence of severe physical disability, males and females may maintain sexual interest and activity well into their 80s and 90s. (T)
35. Masturbation in older males and females has beneficial effects on the maintenance of sexual responsiveness. (T)

Attitude Questions (7-point Likert-type scale, where disagree = 1, agree = 7)
36. Aged people have little interest in sexuality. (Aged = 65+ years of age.)
37. An aged person who shows sexual interest brings disgrace to himself/herself.
38. Institutions, such as nursing homes, ought not to encourage or support sexual activity of any sort in its residents.
39. Male and female residents of nursing homes ought to live on separate floors or separate wings of the nursing home.
40. Nursing homes have no obligation to provide adequate privacy for residents who desire to be alone, either by themselves or as a couple.
41. As one becomes older (say past 65) interest in sexuality inevitably disappears.

For Items 42, 43, and 44:
If a relative of mine, living in a nursing home, was to have a sexual relationship with another resident I would:
42. Complain to the management.
43. Move my relative from this institution.
44. Stay out of it as it is not my concern.
45. If I knew that a particular nursing home permitted and supported sexual activity in residents who desired such, I would not place a relative in that nursing home.
46. It is immoral for older persons to engage in recreational sex.
47. I would like to know more about the changes in sexual functioning in older years.
48. I feel I know all I need to know about sexuality in the aged.
49. I would complain to the management if I knew of sexual activity between any residents of a nursing home.
50. I would support sex education courses for aged residents of nursing homes.
51. I would support sex education courses for the staff of nursing homes.
52. Masturbation is an acceptable sexual activity for older males.
53. Masturbation is an acceptable sexual activity for older females.
54. Institutions, such as the nursing home, ought to provide large enough beds for couples who desire such to sleep together.
55. Staff of nursing homes ought to be trained or educated with regard to sexuality in the aged and/or disabled.
56. Residents of nursing homes ought not to engage in sexual activity of any sort.
57. Institutions, such as nursing homes, should provide opportunities for the social interaction of men and women.
58. Masturbation is harmful and ought to be avoided.

59. Institutions, such as nursing homes, should provide privacy such as to allow residents to engage in sexual behavior without fear of intrusion of observation.

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

61. Sexual relations outside the context of marriage are always wrong.

*These options are repeated for Items 2–35.
Indicates that the scoring should be reversed such that 2 = 1, and 1 = 2 (i.e., a low score indicates high knowledge).
Reverse scoring on these items. A low score indicates a permissive attitude.

Sex Anxiety Inventory

LOUIS H. JANDA, Old Dominion University

The Sex Anxiety Inventory (SAI) measures anxiety regarding sexual matters, defined as a generalized expectancy for nonspecific external punishment for the violation of, or the anticipation of violating, perceived normative standards of acceptable sexual behavior. A major goal was to be able to distinguish sexual anxiety from sexual guilt, which Mosher (1965) defined as “a generalized expectancy for self-mediated punishment for violating, anticipating the violation of, or failure to attain internalized standards of proper behavior” (p. 162).

Description

The 25 items on the scale are in a forced-choice format, with one alternative representing an anxiety response and the other a nonanxiety response. The form of the scale used by its developers includes 15 filler items. Items were included on the final version of the scale if they met the following criteria: (a) The correlation between the item and the total score of the SAI was significant at the .05 level (two-tailed), (b) the item-total correlation exceeded the correlation between that item and the score on the Sex Guilt subscale of the Mosher Forced-Choice Guilt Inventory, (c) the item-total correlation exceeded the correlation between that item and the score on the Crowne and Marlowe (1964) Social Desirability Scale, and (d) there was no significant difference between the item-total correlations for males and females. Of the 25 items that appear on the scale, only 4 were significantly correlated with social desirability, 2 in the positive direction and 2 in the negative direction. The scale was developed with a college student population.

Response Mode and Timing

The respondents circle the letter of the alternative that comes closest to describing their feelings. The scale rarely requires more than 15 minutes for completion.

Scoring

For Items 2, 3, 5, 6, 8, 11, 12, 13, 14, 15, 17, 22, 24, and 25, alternative “a” is the anxiety response. For the remaining items, alternative “b” is the anxiety response. Each anxiety response is scored as 1 point, resulting in a possible range of scores from 0 to 25.

Reliability

Janda and O’Grady (1980) reported that the internal consistency of the scale (using the Kuder-Richardson formula) was .86. Test-retest reliability, with a time interval of 10 to 14 days, was .85 for males and .84 for females.

Validity

Concurrent validity of the scale has been demonstrated by using it to predict self-reported sexual experiences of both men and women (Janda & O’Grady, 1980). Vanwesenbeeck (2001) reported that women high in sex anxiety were less likely to watch Dutch sexually explicit television for leisure than low-anxious women.

Other Information

A copy of the scale, complete with filler items, can be obtained at no cost from the author.

1 Address correspondence to Louis H. Janda, Department of Psychology, Old Dominion University, Norfolk, VA 23508; e-mail: ljanda@odu.edu