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LINKING SOCIAL SUPPORT AND SEXUAL INTEREST AMONG OLDER  
ADULTS IN INTIMATE ROMANTIC RELATIONSHIPS

by

JENNIFER LEIGH GRIFFITH

Under the Direction of Dr. Elisabeth Burgess

ABSTRACT

This study examines social support and sexual interest among coupled persons aged 57 to 85 in North America. Using quantitative data from the 2006 National, Social Life, Health, and Aging Project ( $n = 3,005$ ), the dependent variable is sexual interest and the independent variable is social support received from an intimate partner. Using survey and quantitative interview data, I analyze social support older couples receive from their partner, sexual interest, health status, marital status, and gender. In my analysis, I predict that higher levels of social support will positively affect levels of sexual interest, with health, relationship status, and gender mediating the outcomes. This study has gerontological significance because sexuality can impact overall well-being among older adults, and my findings could further our understanding of sexuality among this population.

INDEX WORDS: Aging, sexuality, health, relationships, social support



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by

JENNIFER LEIGH GRIFFITH

A Thesis Submitted in Partial Fulfillment of the Requirements for the Degree of

Master of Arts  
in the College of Arts and Sciences  
Georgia State University

2008



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Jennifer Leigh Griffith  
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ADULTS IN INTIMATE ROMANTIC RELATIONSHIPS

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## Chapter 1

### Introduction

“What then does it really mean for a woman to grow old? For me, first of all, to be old is to be myself. No matter how patriarchy may classify and categorize me as invisible and powerless, I exist. I am an ongoing person, a sexual being, a person who struggles, for whom there are important issues to explore, new things to learn, challenges to meet, beginnings to make, risks to take, endings to ponder” (Garner 1999,3).

In the preceding quote, Garner (1999) states that as an older woman she is subject to discrimination based on her age and gender and, she acknowledges her sexual self as well. Yet, prejudices and stereotypes are frequently used when describing sex and sexuality in older adulthood, and thus, it is important to examine how culture has shaped and constructed our views of sexuality and gender. Many contemporary researchers reject essentialist models of sexuality, which rely on biological interpretations of sexual behavior. Instead, sexuality is seen as continually being shaped by society and history. Feminist gerontology starts from a place of understanding that sex and age are more rooted in social structure than biology (Browne 1998). Intertwined with assumptions about sex and gender are stereotypes of older adults. Ageism, or prejudice against individuals because of age, is still a rather invisible form of discrimination (Calasanti and Slevin 2001).

Despite common ageist assumptions that older individuals are asexual, recent research indicates that sex remains important for older adults (Lindau, Schumm, Laumann, Levinson, Muirheartaigh, and Waite 2007). In a sample of 3,005 partnered older adults, 84% of men and 62% of women aged 57-64 report sexual activity in previous 12 months, 67% of men and 40% of women aged 65-74, 39% of men and 17% of women aged 75-85. The reasons for not having sex varied among participants by gender, with women’s sexual problems being lack of desire (43%), issues with vaginal lubrication (39%), and inability to climax (34%). In older adulthood sexuality



and health are closely related, specifically being sexually active is positively associated with self-rated health. These findings highlight the need for broader interpretations of sex, where vaginal intercourse is not the only form of sexual behavior included in our definitions (Gott and Hinchliff 2003). For example, older adults may include masturbation, noncoital sex, touching, holding hands, hugging, and kissing in their definitions of sex (Ginsberg, Pomerantz, and Kramer-Feeley 2005; Zeiss and Kasl-Godley 2001). If broader definitions of “sex” were widely accepted, then this could recast what older adults categorize as sexual problems. For example, vaginal lubrication and inability to climax may not be as important sexual problems.

Among married older adults, partners who report higher levels of social support have fewer depressive symptoms and better manage stress (Dehle, Larsen, and Landers 2001). As previously established being sexually active is positively correlated with health (Lindau et al. 2007). While smaller scale studies have been conducted looking at the relationship between relationship quality and sexual interest, with health as a mediating factor (Gott and Hinchliff 2003), no literature exists using a nationally representative sample of older adults. This research will be able to look at the breadth of older adults interested in sex, receiving adequate social support, and what the factors are related to health status, relationship status, and gender.

Research showing older adults are interested in sex throughout all phases of older adulthood dispels the myth that old age is equated with a celibate lifestyle. Showing that sexual interest does not deteriorate with age, even though sexual activity may decrease, reveals complex issues that need to be examined. Older adults may be very interested in sex but factors, such as their health declining or their partner’s negatively affects their ability to engage in sexual behaviors (Gott and Hinchliff 2003). Also, their relationship status greatly affects their ability to access a sexual partner. For example, someone who is widowed may desire sex but is not able to



have sex because of lack of access to a partner (Gott and Hinchliff 2003). Also, the widow may deny interest in sex because they know they cannot have it, so they've decided it is not important in their lives.

This study uses quantitative data from the National Social Life, Health, and Aging Project (NSHAP) (Lindau et al. 2007) to examine the relationship between social support and sexual interest for older adults in romantic relationships. Specifically, I conducted logistic regressions to verify whether an increase in social support among older adults leads to an increase in sexual interest. Also, I compared older adults who are younger with older adults more advanced in age to find out who reports higher levels of sexual interest. Thirdly, I analyzed whether women report higher levels of sexual interest than men. Additionally, I researched whether health status will negatively affect sexual interest among older adults.

NSHAP was created in order to capture the many factors affecting the health of older adults. The aim of NSHAP is to provide accurate information about the physical health, sensory function, health behaviors, and social connectedness of older Americans to policy makers, health providers, and individuals (Lindau et al. 2007). For purposes of this study, "sex" is not defined but rather open for interpretation. In addition to sexual interest, NSHAP researched social support among partnered older adults. Questions about social support received from a partner include spending time together, sharing problems, balancing responsibilities, and managing problems. High levels of social support in a romantic relationship affect several facets of life including: lower levels of illness and medical intervention (Casel 1976), less psychiatric symptoms (Lin, Simeone, Ensel, and Kuo 1979), and better physical health outcomes (Schiaffino and Revenson 1995).



## **Demographics of Aging Population**

The American population is changing dramatically and will continue to evolve into an older population. Over the next 50 years, the population of older adults aged 65 and older is predicted to double. By 2050 the older adult population will reach 82.0 million, a significant increase from 31.1 million in 1990 (Census 2000a). Furthermore, the “oldest old,” persons aged 85 and over, are projected to rapidly increase in size. Between 2000 and 2050, the oldest old are expected to reach 19 million, representing nearly 24% of the older adult population. When compared to three million Americans, or 10% of older adults, in 1994, this means the oldest old population will quadruple in upcoming years (Census 2000a). More services will need to be available in order to accommodate this growing population.

Gender is another important variable when looking at statistics about the aging population, because a majority of older adults are women. In 2000, the ratio was 100 women for every 81 men, and the gender ratio only increases among the oldest old. By the time older adults reach their mid-eighties, there are nearly 100 women to every 50 men (Census 2000). Nearly half of all adult women will be at least 50 years of age by 2010 (Allen 1993). Since gender will only continue to play an increasing role among older adults, it is critical for researchers to analyze issues with an emphasis on gender.

Romantic relationships in older adulthood frequently shift due to life events such as a partner leaving to go into a nursing home, partners dying, and people dating and remarrying (Census 2003). The chances of remarriage for a women is unlikely in comparison to a man, since 42% of older women are married while 72% of men are married (AoA 2007). Additionally, a relationship shift where a partner dies, women are most likely to be widowed, since 42% of women are widows in comparison to 13% of men (AoA 2007). Among all older adults 65 to 74,



75 percent are married, 8 percent widowed, 8 percent divorced, 1 percent separated, and 4 percent never married, with all percentages decreasing as age increases (with the exception of widowed) (Census 2003).

Statistics on cohabitating and dating older adults is limited, and this may be due to a societal belief in the asexuality and monogamy of older adults, even after a spouse has died. King and Scott (2005) used data from the 2000 Census Public Use Microdata Samples to determine that over 1.2 million persons over age 50 cohabitate. Cohabitation is defined as “the act of living together and having a sexual relationship (especially without being married)” (Farlex 2008, 1). While exact numbers of dating older adults have not been calculated (Bulcroft and O’Connor 1986), AARP and knowledge networks conducted a study on 3,500 single or un-partnered older adults, showing that 36 percent are interested in dating or starting a relationship (Yin 2004).

### **Conceptual Framework**

Gender is a fundamental part of my study, and I use feminist gerontology perspective in order to enhance my research. Feminist gerontology starts from a place of understanding that sex and age are more rooted in social structure than biology (Browne 1998). From an early age, women, and especially women born in earlier cohorts, were taught to turn to men for major decisions such as finances. Being socialized to put others needs before your own can affect the ways women interpret social support received from their partner. Also, growing up in a time where women were taught to be sexually reserved may affect their views on sexuality (Garner 1999). Furthermore, many other hurdles such as unequal pay, sexual harassment, unpaid caregiving, and unmet health and social needs can lead to cumulative disadvantages in older adulthood (Browne 1998), thus feminist gerontology perspective helps illuminate these gender disparities that exist throughout the life course.



Gender has been a largely invisible concept within gerontology and later life sociology despite the fact that gender plays a major role in older adulthood (Kosberg & Kaye, 1997). Since age and gender are both fundamental components of social life, these concepts make a relevant theoretical model. Over the life course, gender functions differently depending on the way gender roles and identity are constructed for a specific age group. Gender roles and identities of the older adults in this study will most likely be affected by family practices, patriarchal structures, labor market and state (Arber and Ginn 1995).

Sex norms are age-graded. Standards of age-appropriate sexual behavior frequently render older adults invisible or deviant. While a sex act may be viewed as appropriate for younger adults, older adults who engage in the same sex act are stigmatized. Older men are perceived as dirty and perverse for engaging in sex acts, while older women are denied sexual agency (Calasanti and Slevin 2001). This misperception of older adults, specifically older women, as asexual is not only false but it can be debilitating to older adults' perceptions of themselves as sexual beings (Calasanti and Slevin 2001). Furthermore, a societal belief in the asexuality of older adults could affect the way health practitioners, family members, and friends interact with them. For example, health care practitioners may choose not to test an older adult for STDs and HIV/AIDS because of perceived asexuality (NIA, 2004). If and when older adult sexuality is acknowledged, the assumption is that sexuality occurs within a marital relationship (Calasanti and Slevin 2001).



## Chapter 2

### Literature Review

In order to provide a foundation for my research, the literature review provides previous research on social support and sexual interest in older adulthood, in addition to health, gender, relationship status, and age.

#### **Gender factors**

In older adulthood, women outnumber men and typically live longer than men (Estes 2001). Among older adults aged 80 to 84, there are 56 men to every 100 women. Among older adults aged 95 and older, there are 35 men to every 100 women (Estes, Linkins, Lynch, Newcomer, Rice, and Rummeisberg 1998). Among women gender plays an important role in older adulthood, and many experiences as a man or woman affect the life course of an individual. A gender gap can lead to a partner gap, meaning more men than women have partners (Jacoby 1999). For older women, the loss of a partner can lead to the end of their sexual lives, because of the unlikelihood of finding another partner (Jacoby 1999). In 1999, four out of five women 75 and older were without partners. While older men do not reap the consequences of the partner gap, they face many other obstacles in older adulthood.

Older men can often mourn the loss of being “breadwinner” in the family upon entering retirement, and this affects the way they think and feel about themselves. Some older men miss the traditional gender roles, which the husband and wife performed pre-retirement. Furthermore, the loss of power and sexual prowess can affect older men’s sense of manliness. (Calasanti and Slevin 2001).

In older adulthood, societal perspectives on masculinity shift which can lead to lower status and invisibility for older men (Calasanti 2004). Health problems associated with males reveal



ways in which masculinity can be problematic and lead to cumulative disadvantages over the life course. Men are more likely to smoke, drink, not see a doctor regularly, and take physical risks (Courtenay 2000b). Also, men perform their manliness and display their power in way that leads to negative health outcomes (Courtenay 2000a). For example, traditionally male-dominated sports often involve physical strength and aggression, which men can come to believe are essential traits of manliness (Calasanti 2004). Unfortunately, many male-dominated sports such as rugby and football can lead to injury and misuse of the body, which can greatly affect health in older adulthood.

Some older men may feel emasculated if their health declines and in turn have less interest in sex. Researchers discovered various diagnoses that lead to a decrease in sexual interest, for example DeLamater and Sill (2005) found that men who were diagnosed with an enlarged prostate had low levels of sexual interest. Among older men, Bertero (2001) found significant differences in their sexual interest since the diagnosis and treatment of prostate cancer. DeLamater and Sill (2005) also found that hypertension and low levels of sexual interest are slightly yet significantly correlated, which Steinke (2005) found can be caused by the disease itself or antihypertension medications. DeLamater and Sill (2005) also found that the relationship between high blood pressure and low levels of sexual interest is very strong. Overall, it appears that disease, medication, and treatments all can affect sexual interest among older men.

In addition to health affecting sexual interest, gender and physical attractiveness also can affect sexual interest. Over one thousand married couples aged 55 and older were telephone interviewed in 1980 and 1983 about their sexual relationship and physical attractiveness to their spouse. Men's sexual interest waned over time as the wife's physical attractiveness declined.



While women also reported a decline in physical attractiveness towards their husbands, this did not affect their sexual interest in their spouse. As the wife continued to physically change, the husband mentioned a continued loss in sexual interest. (Margolin and White 1987).

In a study examining community dwelling older adults aged 80-102, women and men were compared on levels of sexual interest over time. For men, sexual interest appears to slightly decrease with age, but for women the trend is opposite, with sexual interest increasing with age when comparing those 66 to 71 to those ages 80 to 90 (Bretschneider and McCoy 1988). A similar finding by McIntosh shows women aged 60 to 94 (among a sample of 100 community-dwelling women) still have sexual interest in older adulthood despite a societal intolerance for older adults' sexuality (McIntosh 1981).

Araujo, Mohr, and McKinlay (2004) further confirm that men's sexual interest decreases from one decade to the next, using longitudinal data from the Massachusetts Male Aging Study. Researchers followed 1,085 men aged 40 to 70 for a 9-year-period, measuring sexual intercourse, erection frequency, sexual desire, ejaculation with masturbation, satisfaction with sex, and difficulty with orgasm. One of the findings was 60-year-old men had lower levels of sexual interest when compared with 50-year-old men. This finding is in accordance Bretschneider and McCoy (1988).

Through my research, I will add to the literature by determining the impact gender has on the relationship between social support from one's partner and sexual interest.

### **Health factors**

There is a growing concern that as the older adult population increases the cost of health care will also increase. In the 1980s, when older adults only made up 12% of the population, they accounted for 33% of health expenditures (Waldo, Sonnefeld, McKusick, and Arnett 1989). As



the older adult population grows, health expenditures will only continue to increase, therefore researchers, health care practitioners, and policymakers need to do everything within their power to help curb this upshot.

Researchers established that social support affects health. After controlling for baseline health status, those with low levels of quantity and sometimes low quality of social relationships are linked to increased risk of death (House, Landis, and Umberson 1994). When assessing why social support plays such a major role in health, two broad categories have been established: the direct effect hypothesis and the buffering hypothesis. The direct effect hypothesis describes social support as a mechanism which promotes good health regardless of stress level, while the buffering hypothesis suggests that social support guards individuals from the negative physiological and psychological effects of stress (Cohen and Wills 1985).

Sexual interest is also affected by health problems. A study based on the National Social Life, Health, and Aging Project found that lack of sexual interest is more prevalent for older adults with poor self-rated health among 3,005 North American older adults aged 57 to 85. Among older adults who are sexual active, 28% of men aged 57-64 reported lack of sexual interest as a sexual problem in comparison to 44% of women aged 57-64, 29% of men aged 65-74 reported lack of sexual interest as a sexual problem in comparison to 38% of women aged 65-74, and 24% of men aged 75-85 reported lack of sexual interest as a sexual problem, in comparison to 49% of women aged 75-85. Furthermore, as self-rated health declines, more respondents reported lack of sexual interest. Moreover, women were more likely than men to report lack of sexual interest as a reason for sexual inactivity, and this finding was especially pronounced for among those not in a relationship (51% of women, 24% of men) (Lindau et al. 2007).



### **Relationship status factors**

Relationship status influences sexual interest, according to a study by Gott and Hinchliff (2003). Using quantitative and qualitative data, Gott and Hinchliff (2003) found differences in the level of importance older adults placed on sex, according to relationship status. Of the forty-four older adults aged 50-92, those who placed little importance on sex were mostly not presently partnered or not having sex with their partner at this time. The women who were widowed placed a low value on sex because: they felt no one could ever replace their partner, they did not want to have to form a new sexual relationship, or they have adapted to no sex. The participants who rated sex as 'very' or 'extremely important' all had a sexual partner (with one exception), and they felt their high sexual interest came from high levels of social support and sexual attraction (Gott and Hinchliff 2003).

In a global study of 27,500 men and women aged 40-89 from 29 countries, which included the United States, people in relationships with high levels of social support were found to have positive sexual interest (Laumann, Paik, Glasser, Kang, Wang, Levison, Moreira, Nicolosi, and Gingell 2006).

### **Dating**

It is unknown the amount of older adults dating, but it certainly does occur. Dating does not replace the role of former spouses nor change the importance of other people in the older adult's social network. Dating provides companionship, social support, sexual relations, and opportunity to share oneself (Bulcroft and O'Connor 1986). Furthermore, dating among older adults usually involves serious, monogamous, and steady relationships (Bulcroft and Bulcroft 1991). Social support is rated as being an important aspect of dating, according to 35 community-dwelling older adults aged 60 and older who were currently dating at the time of the



study or had been in the past year. Men and women report that having a person as a confidant is an important benefit to dating in older adulthood (Bulcroft and O'Connor 1986).

Companionship with a person and other practical concerns are seen as more essential needs among dating older adults (Bulcroft and O'Connor 1986).

### Cohabiting

Research on cohabitation among older adults did not begin until the 1980s. Cohabitation is rapidly increasing among the older adult population, especially in light of high rates of divorce (Bumpass 2000). It is important to take into consideration that cohort differences will exist when examining cohabitation among older adults (with the exception of longitudinal studies) since people born in different historical periods are likely to have varying attitudes, experiences, and behaviors (King and Scott 2005).

Among cohabitators, age is related to less relationship instability and more frequent interaction with one's partner (Brown 2003). Finding a partner to cohabitate with is difficult for older women because of lack of available partners (Hatch 1995). Reasons for cohabitation among older adults include: taxes, Social Security, pensions, inheritance, and the views of adult children (Espionza 2002; Kemp and Kemp 2002).

Cohabitators aged 50 and older think that cohabitating is more sexually satisfying than dating when compared to cohabitators in their 20s. However, further analysis reveals that men and previously married older adults, both whom make-up the largest proportion of the oldest group of cohabitators, are the significant group who feel that cohabitating is more sexually satisfying than dating. Also, when compared to younger cohabitators, those over age 50 report more social support from their partner, specifically higher levels of fairness, more time spent with their



partner, and fewer disagreements. When looking along gender lines, men are more likely to consider their relationship fair in comparison with their women partners (King and Scott 2005).

According to the 1998 Health and Retirement Study, self-reported health is worse for cohabitators in comparison to married persons (Brown, Bulanda, and Lee 2005).

### Married Lives

The majority of older men are married but the minority of older women are married (AoA, 2007). In 2006, 72% of older men and 42% of older women were married. According to the Census (2000), 65% of women aged 55-64 and 75% of men aged 55-64 are married. Though, among older adults aged 65-84, the gender disparities widen with 45% of women married and 74% of men. For older adults aged 85 and older, the largest gender gap exists with 53% of men and 12% of women married. According to accounts from older adults in long-term marriages, it is crucial that spouses provide adequate social support, for example giving one another the freedom and space to pursue their individual interests (Thomas 2005). Social support manifests in a variety of ways among married couples, and a study by Dehle and Landers (2005) reveals gender differences with personality traits and social support in marriage. The study examines 66 college students with a mean age of 27 for women and 26 for men. Couples filled out multiple questionnaires regarding their individual personalities and marriage. Also, couples participated in an interactive task lasting ten minutes each. Using the Support Recipient Satisfaction Scale, couples rated the amount of informational support, emotional support, tangible support, and esteem support received. Men who were less conscientious tended to receive more informational support from their wives, such as advice and situation appraisal in addition to esteem support, such as compliments and validation of abilities. A women's level of conscientiousness did not affect the level of support received from a spouse, although married



women with high levels of conscientiousness and emotional stability tended to be more satisfied with support received from their spouse.

Many women are socialized to view themselves as “nurturing,” “kind,” and “giving” can lead to them giving more social support in a relationship. For example, according to Dehle and Landers (2005), women give more social support to husbands with low conscientiousness, while men do not give social support to their wives with low conscientiousness and emotional stability. Gender is a powerful institution, which takes affect in all facets of life, including intimate relationships, which can often posit men in a position of power over women (Lorber and Martin 2005).

Differences can exist with the amount of social support one wants to receive from their partner and the actual amount received. Dehle, Larsen et al. (2001) studied 212 married undergraduate students using the Support in Intimate Relationships Rating Scale in order to assess supportive behaviors and perceived adequacy of support in marriage. Before going to bed every night for one week, participants rated their actual and preferred social support from their partner. The results showed that subjects who received less support than desired reported more stress and depressive symptoms. Furthermore, these subjects scored lower on marital adjustment and had higher negative marriage quality. Moreover, relationship and individual functioning related to the subjects perception of social support from their partner.

Among married older adults, one of the main sources of marital dissatisfaction is sexual relations (Herman 1994). Hinchliff and Gott (2004) used data from 21 men and 23 women aged 50-92 in the UK. The subjects completed two quality of life measures in addition to in-depth semi-structured interviews. Using mixed methods allowed the researchers to pay add breadth and depth to their work. When asked how important sex was to their lives, participants who had



little to no sexual interest (6 women and 3 men) either: did not have a sexual partner, had psychological or physical barriers to having sex with their partner, didn't want anyone else after their partner died, or not able to find a sexual partner. For the 15 subjects who rated sex as moderately important, they mainly attributed the decline to personal health problems or their partner's health problems. Eleven subjects, who all except one had partners, rated the importance of sex as very or extremely important, and they mostly felt that their attraction and close, positive relationship with their partner led to sex being important (Gott and Hinchliff 2003).

The first objective of this study is to explore the correlation between social support received from a partner and sexual interest among North American older adults. The second objective is to analyze how individual level factors mediate the relationship between social support received from a partner and sexual interest among North American older adults. Studies involving younger adults have examined the relationship between social support received from a partner and sexuality, but no studies to date have used older adult participants. While studies have examined the relationship between gender and sexual interest among older adults, the literature is outdated and uses small populations. My findings will be the first nationally representative quantitative study examining gender and sexual interest among older adults. Literature does exist about dating and cohabitating older adults, but they are small samples. My research will be a nationally representative sample. Also, no previous research has compared cohabitating and dating older adults on levels of sexual interest. While many studies have looked at health and sexual interest in terms of individual diseases and the impact on sexual behavior, no studies have looked at self-rated health and relative health with sexual interest.



## **Chapter 3**

### **Methods**

#### **Significance**

This research is gerontologically significant because sexuality affects overall well-being in older adulthood, and it is imperative that researchers continue to study this area (Arber and Ginn 1995). Also, using a feminist gerontology perspective, differing perceptions of social support received from an intimate partner could help address gender inequalities within intimate older adult relationships-especially highlighting inequalities in the everyday lives of older women.

Moreover, it is understood that older adults who have sexual relations benefit from this source of pleasure and this preserves physical well-being and reduces physical problems (Lindau et al. 2007). Improvement in the sexual well-being of older adults could possibly reduce the amount of health care given to this population (Trudel, Turgeon, and Piche 2000). It would be beneficial for health care practitioners and mental health practitioners to collaborate on ways to improve the sexual well being of older adults, specifically through more holistic practices and comprehensive training. Finally, government health initiatives need to address sexual health in later life, instead of solely focusing on younger adults. Not focusing on the sexual health of older adults but putting money towards the sexual health of younger adults could be viewed as an ageist attitude.

#### **Research Objectives and Hypothesis**

For this study, the objectives are: 1) to explore a correlation between social support received from a partner and sexual interest among North American older adults, and 2) to



analyze how individual level factors mediate the relationship between social support received from a partner and sexual interest among North American older adults.

Using the findings in the literature and the stated research objectives, four sets of hypothesis are presented for evaluation in this study:

**Hypothesis 1: Among older adults, age and gender influence levels of sexual interest.**

**1A) Older adults who are younger will report higher levels of sexual interest in comparison to those who are older.**

Gott and Hinchliff (2003) found that sexual interest was rated as less important for those in their 70s and 80s when compared to those in their 50s and 60s. Although, it is important to note that this difference could be due to cohort differences rather than age differences.

**1B) Women will report higher levels of sexual interest than men.**

In a study with community-dwelling older adults, men's sexual interest was found to decrease over time while women's sexual interest increased (Bretschneider and McCoy 1988). Araujo, Mohr, and McKinlay (2004) found that with each passing decade, men's sexual interest decreased. Furthermore, men's sexual interest waned over time as the wife's physical attractiveness declined. While women reported a decline in physical attractiveness towards their husbands, this did not affect their sexual interest in their spouse. As the wife continued to physically change, the husband mentioned a continued loss in sexual interest (Margolin and White 1987).

**Hypothesis 2: Dating older adults will report lower levels of sexual interest than cohabitating older adults.**

Cohabitators aged 50 and older think that cohabitating is more sexually satisfying than dating when compared to cohabitators in their 20s (King and Scott 2005). However, further analysis



reveals that men and previously married older adults, both whom make-up the largest proportion of the oldest group of cohabitators, are the significant group who feels that cohabitating is more sexually satisfying than dating (King and Scott 2005). While sexual interest is present among dating older adults, it was not the primary motive for dating. Compared to earlier stages of life, sexual interest is lower due to other competing priorities (Bulcroft and O'Connor 1986).

**Hypothesis 3: Health status will negatively affect sexual interest among North American older adults.**

For some married older adults, spousal health problems were shown to affect the ability to have sex, although sexual interest remained high (Gott and Hinchliff 2003). On the other hand, other married older adults had less sexual interest over time due to their partner's failing health (Gott and Hinchliff 2003). In a study that conducted research across many different cultures, self-rated health and sexual interest were shown to be correlated regardless of culture or gender (Laumann et al. 2006). This is particularly important for older women who are more likely to end their years with chronic illness than men and thus may experience a greater loss of sexual interest (Browne 1998).

**Hypothesis 4: Higher levels of social support received from a partner will positively affect levels of sexual interest among older adults.**

In a study using younger adults, when less social support than desired is received from a partner this led to negative marital outcomes, specifically related to relationship and individual functioning (Dehle, Larsen, and Landers 2001). While sexual interest was not included among relationship and individual functioning variables, the implications may have a similar affect for sexual interest. Women's perceived levels of social support may be more positively correlated



with sexual interest than men because women are socialized to connect sexuality with love and emotion (Cancian 1986).

### **Study Limitations**

The first limitation to this study includes the use of secondary data. When choosing which variables to include in my analysis, I am limited by the choices of those who created the study. Also, since I was not present when researchers collected the data, I cannot account for various biases or problems that might occur. While a representative sample of quantitative data allows the researcher to make generalizations, qualitative data could add depth to understanding of the data (Whitley 2002).

Looking at cross-sectional data lends itself to cohort effects, meaning that participants born at different times may have different worldviews because of historical events and social change. While researchers are able to compare and contrast differences between age groups on specific characteristics, they are not able to observe change over time. Furthermore, cross-sectional data limits the data analysis because researchers are not able to determine whether differences found among age groups are because of differences in life experiences or chronological ages. Longitudinal data is more ideal for researching sexual interest and social support, because it helps avoid cohort effects (Whitley 2002).

Using structured interviews also has limitations, because the researcher is not able to adjust the questions or control the order of the questions. Close-ended questions can be particularly limiting, because the respondent may not find their answer within the choices given. Interviewer bias, or respondents being influenced by the interviewer, could affect research outcomes. In addition to using structured interviews, NSHAP used mail questionnaires, which can be problematic because respondents are not able to ask for clarification on questions.



Furthermore, mail-in questionnaires require respondents to adequately read and write (Whitley 2002).

In regards to study questions regarding sexual interest, asking subjects directly about whether they lack sexual interest may elicit an inaccurate response. Instead, more subtle and indirect questions could be added. Furthermore, older women might hesitate to say they have high levels of sexual interest, because women are socialized to be more sexually prudent than men (Browne 1998). During data analysis, the social support questions may produce an inaccurate response, because being socialized to put others needs before your own can affect the ways women interpret social support received from their partner (Browne 1998). Additionally, the research questions about social support may not reliably measure social support received from a partner. Specifically, subjects may receive their social support from friends and family members, which may skew the results for social support received from a partner.

My dependent variable did not include two important questions about sexual interest, because they were not available at the time of data analysis. The two missing questions asked about the importance of sex in the respondent's life and how often the respondent thinks about sex, and these questions would have made a stronger argument for the relationship between social support and sexual interest. Sexual interest cannot be fully determined by whether respondents have a period of several months or more when they lacked sexual interest. This one research question is linked closely with behavior but does not address the attitudes and desires of the respondent. While the respondent may lack interest in physically having sex, they still may frequently think about sex.

Another limitation could be that dating older adults have not been in relationships long enough to come to a point where they are reporting a period of several months or more where



they lack sexual interest. Therefore, the finding that dating older adults have higher levels of sexual interest than married and cohabitating older adults may be invalid.

For the social support questions, the emotional social support questions (whether the respondent is able to open up to their partner and whether the partner criticizes the respondent) evoke a more positive response. On the other hand, the functional support questions (whether the respondent is able to rely on their partner and whether their partner makes too many demands) are more negative. While a partner making demands is not necessarily negative, the question asks whether your partner makes *too* many demands. This added word could change how the respondent answers the question and casts a partner making demands in a negative light.

### **Setting and Sample**

The data used in this study come from The 2006 National Social Life, Health, and Aging Project (NSHAP). The National Opinion Research Center and Principal Investigators at the University of Chicago surveyed 3,005 North American, community-dwelling older adults aged 57 to 85 years at the time of the interview. NSHAP conducted a nationally representative study consisting of surveys and in-home interviews. The research team collected information on social networks, social and cultural activity, physical and mental health, well-being, illness, medications, sexual and intimate partnerships, and patient-physician communications. Additionally, non-medically trained interviewers collected biomeasures using methods designed to be non-invasive and safe for both the respondent and interviewer. At the end of each 120 minute in-person, in-home interview, the interviewers gave respondents a paper-and-pencil questionnaire which took 30 minutes to complete. Approximately 84 percent of respondents returned the pre-stamped questionnaires (Lindau et al. 2007).



The National Opinion Research Center and Principal Investigators at the University of Chicago created NSHAP in order to capture the many factors which affect the health of older adults. The aim of NSHAP is to provide accurate information about the physical health, sensory function, health behaviors, and social connectedness of older Americans to policy makers, health providers, and individuals (Lindau et al. 2007).

For purposes of this study, I will use data pertaining to physical health, sexual and intimate partnerships, and social support. Alternate forms ensured respondents answered consistently on similar questions. This allowed researchers to demonstrate reliability without measuring subjects over time. NSHAP used valid measures, which ensured accuracy of measurement (Whitley 2002).

For purposes of this study, “sex” is not defined but rather open for interpretation. Specifically, questions regarding sexual interest ask participants whether they lacked interest in having sex, without defining “sex.” Sex can include phone sex, cybersex, oral sex, and vaginal or anal intercourse (Calasanti and Slevin 2001). Older adults may be more likely to include masturbation, noncoital sex, touching, holding hands, hugging, and kissing in their definitions of sex (Ginsberg, Pomerantz, and Kramer-Feeley 2005; Zeiss and Kasl-Godley 2001).

*Dependent variable-* For this study, sexual interest is the dependent variable. Sexual interest consists of one question asking the participants: if they had a period of several months of more when they lacked sexual interest. Dichotomous variables were used to determine if the participant lacked interest in having sex over the past 12 months, where no=0 and yes=1 (see Table 3.1). I initially planned on using two additional questions related to sexual interest, but the data was not ready in time for analysis. Since the only sexual interest question I had contained dichotomous variables, I was not able to create an index or scale for sexual interest.



*Independent variable-* The independent variable is support from partner. For measuring social support, respondents were asked four questions, starting with: (1) How often can you open up to (NAME) if you need to talk about your worries, (2) How often can you rely on (NAME) for help if you have a problem, (3) How often does (NAME) make too many demands on you, and (4) How often does (NAME) criticize you. The four questions were originally categorized by 1=hardly ever (or never), 2=some of the time, 3=often. I recoded all 4 social support questions into dichotomous variables in order to better examine differences. For social support questions 1 and 2, hardly ever (or never), some of the time=1 and often=0. For social support questions 3 and 4, hardly ever (or never)=1 and some of the time, often=0. For categorization and coding of all variables, see Table 3.1. I considered combining the social support questions and creating a scale or index, but I thought the results would be more meaningful having the questions separate. Once I did initial analysis of the social support questions, I realized that some social support questions were more significant than others, and I wanted to talk about each question individually. Among the four social support questions, there are two different conceptual categories: emotional and functional support received from a partner. The questions regarding how often the respondent is able to open up to their partner and how often the respondent's partner criticizes them both relate to emotional social support received from a partner. These questions ask about whether the respondent feels comfortable talking to their partner when they are worried and whether they feel their partner puts them down. On the other hand, questions about (1) whether the respondent is able to rely on their partner and (2) whether the respondent's partner makes too many demands relate more to functional social support received from a partner. The first functional support question relates to whether the respondent is able to rely on their partner with: chores around the home, providing money, or being available



if your car breaks down. The second functional support question relates to whether the respondent feels their partner expects to have dinner ready at a certain time every night or to have the house constantly be clean. While the emotional social support questions evoke a more positive response, the functional support questions are more negative. While a partner making demands is not necessarily negative, the question asks whether your partner makes *too* many demands. This added word could change how the respondent answers the question and makes a partner making demands sound negative.

*Demographic variables-* For the demographic variables, age of participants was measured by year of birth. To compare age differences among the sample, age was recoded into three categories (57 to 64 years, 65 to 74 years, and 75 to 85 years). Gender is coded as dichotomous variables, with 1=male and 2=female, but I recoded gender as a dummy variable with 1=male and 0=female. For purposes of this study, only white, black, and Hispanic (non-black and non-white) categories are used, and the “other” racial categories were set to missing since there were so few participants in this category. Racial categories were recoded into three separate dummy variables. For white, 1=white and 0=black and Hispanic. For black, 1=black and 0=white and Hispanic. For Hispanic, 1=Hispanic and 0=black and white. Participants’ household income was measured in dollars on a continuous scale. Self-rated physical health rated on a 5-point scale ranging from poor to excellent, but I recoded it as a dummy variable with 0=poor, fair, and good and 1=very good and excellent. Health is also assessed through participant’s ratings of their health relative to others their age. Relative health was measured on a five point scale where 1=much worse and 5=much better, but I recoded it into a dummy variable with 0=much worse, somewhat worse, and about the same and 1=somewhat better and much better. For self-rated health and relative health, I recoded the answer categories in order to



have meaningful numbers. For self-rated health, since 1,282 older adults had very good or excellent health, I combined the 1,712 older adults with poor, fair, and good health so I could get more significant results during data analysis. For relative health, since 1562 older adults rated themselves in somewhat better or much better health than their peers, I combined the 908 older adults who rated themselves in much worse, somewhat worse, or about the same health level as their peers so I could get more significant results during data analysis.

A full marital and cohabitating history was conducted for each subject, including information about sex and sexual activity. For this study, only subjects who are currently married, living with a partner, or have a “romantic, intimate, or sexual partner” are included. Whether participants are unmarried with a romantic, intimate, or sexual partner is coded as dichotomous variables, with no=0 and yes=1, but I recoded it into a dummy variable so 1=dating and 0=other.



## Measures

*Table 3.1. Categories and codes of variables*

Variable	Variable codes
<b><i>Demographic variables</i></b>	
Age	57 to 64 years, 65 to 74 years, and 75 to 85 years
Race/ethnicity	white, black, Hispanic, non-black
Household income	dollars earned
Gender	male, female
Marital status	married, living with a partner
Dating	no, yes
<b><i>Support from partner</i></b>	
How often can you open up to (NAME) if you need to talk about your worries?	hardly ever (or never), some of the time, often
How often can you rely on (NAME) for help if you have a problem?	hardly ever (or never), some of the time, often
How often does (NAME) make too many demands on you?	hardly ever (or never), some of the time, often
How often does (NAME) criticize you?	hardly ever (or never), some of the time, often
<b><i>Sexual Interest</i></b>	
During the past 12 months, has there been a period of several months or more when you lacked interest in having sex?	no, yes
<b><i>Health</i></b>	
Self-rated health	poor, fair, good, very good, excellent
Relative health	much worse, somewhat worse, about the same, somewhat better, much better



## **Data Analysis**

Older adults were separated into the categories: 1) dating, 2) married, and 3) living with a partner. For the question “during the past 12 months, has there been a period of several months or more when you lacked interest in having sex,” logistic regression was used because the dependent variable consists of dichotomous variables. The models included three separate age groups (57 to 64 year, 65 to 74 years, and 75 to 85 years) with self-rated health (excellent or very good, good, and fair or poor), relative health (much worse or somewhat worse, about the same, and somewhat better and much better), gender, household income, race/ethnicity, and relationship status as covariates. The models also included social support received from a partner, which consists of four independent variables: ability to open up to partner, able to rely on partner, whether partner makes too many demands, and whether partner criticizes you. Data analysis was conducted using SPSS 15.0 statistical software.

In order to compare how significance and direction may change as variables are added, I conducted four logistic regression models. Logistic regression is best suited for my research because it allows me to make predictions using a dichotomous independent variable. Also, logistic regression allows me to test my hypotheses through evaluating the performance of the models. Model One includes the covariates with sexual interest as the dependent variable. Model Two includes cohabitating and married older adults, with dating older adults as the reference category. Model Three only analyzes the four social support questions, which offers a comparison with model four. Model Four includes covariates, cohabitating and dating older adults, and social support questions, with sexual interest as the dependent variable.



## **Chapter 4**

### **Findings**

#### **Demographic Overview**

Initial analysis of the data (see Table 4.1) showed a fairly even gender distribution among the sample, with 48% male participants and 52% female. Age distribution was spread relatively evenly between categories, with 34% of participants aged 57-64 years, 36% aged 65-74 years, and 30% aged 75-85 years. NSHAP oversampled Latino participants, which made the sample more representative of the American population, with 72% White, 17% Black, and 10% Latino, non-black. Among coupled older adults, 90% reported being married, 3% reported living with a partner, and 8% reported being in a dating relationship. Respondents rated themselves rather highly in health, with 57% in poor, fair, or good health, and 43% in very good or excellent health. When asked about their health relative to their age-related peers, 37% of respondents rated themselves either about the same, somewhat better, or much better, and 63% of respondents rated themselves much worse or somewhat worse.

The social support questions were separated into four independent variables. Seventy-five percent of older adults open up to their partner often, while 25% hardly ever (or never) or some of the time open up to their partner. Eighty-seven percent of older adults rely on their partner often, while 13% hardly ever (or never) or some of the time rely on their partner. Sixty-one percent of older adults report their partner hardly ever (or never) makes too many demands, while 39% report their partner some of the time or often makes too many demands. Finally, 55% of older adults report their partner hardly ever (or never) criticizes them, while 50% report their partner some of the time or often criticizes them.



The dependent measures sexual interest. Thirty-two percent of participants reported a lack of sexual interest for a period of several months or more, while 68% reported they did not experience such a lack of interest.



Table 4.1 Profile of North American older adults (Valid N=1,070)

Independent Variables		Frequency	Percentage
<b><u>Covariates</u></b>			
<b>Gender</b>			
Male		1455	48.4%
Female		1550	51.6%
<b>Age</b>			
57- 64		1020	33.9%
65-74		1092	36.3%
75- 85		893	29.7%
<b>Race/Ethnicity</b>			
White		2110	72.2%
Black		509	17.4%
Hispanic, non-black		304	10.4%
<b>Self-Rated Health</b>			
Poor, Fair, Good		1712	57.2%
Very Good and Excellent		1281	42.8%
<b>Relative Health</b>			
Much worse, somewhat worse, about the same		908	36.8%
Somewhat better, much better		1562	63.2%
<b>Relationship Status</b>			
Married		1801	89.5%
Cohabiting		60	3.0%
Dating		152	7.6%
<b>Social Support</b>			
<i>Open up to partner</i>			
Often		1514	75.2%
Hardly ever (or never), some of the time		498	24.8%
<i>Rely on partner</i>			
Often		1741	86.7%
Hardly ever (or never), some of the time		266	13.3%
<i>Partner makes too many demands</i>			
Hardly ever (or never)		1218	60.6%
Some of the time, often		793	39.4%
<i>Partner criticize</i>			
Hardly ever (or never)		1106	55.1%
Some of the time, often		903	44.9%
<b>Dependent Variable</b>		<b>Frequency</b>	<b>Percentage</b>
<b>Lacked interest in sex</b>			
<i>Yes</i>		444	32.0%
<i>No</i>		943	68.0%



## Findings

In order to understand the various factors influencing sexual interest, I conducted four logistic regression analyses. The models include: (1) sexual interest and covariates, (2) sexual interest and cohabitating and married variables, (3) sexual interest and social support variables, (4) sexual interest and dating, cohabitating, social support, and covariates. The Valid N for the logistic regression models is 1,070. Model 1 only has the dependent variable and covariates so I can have a comparison of how the significance changes in comparison to Model 4, which adds in relationship status and social support variables. Model 2 only has the dependent variable and relationship status variables so I can have a comparison of how the significance changes in comparison to Model 4, which adds in social support variables and covariates. Model 3 only has the dependent variable and social support variables so I can have a comparison of how the significance changes in comparison to Model 4, which adds in relationship status variables and covariates. Model 4 is the most important model, because it has covariates, independent variables, and the dependent variable in the model. The results of all regressions are shown in Table 4.2. The results of the logistic regression models will be reported according to the hypothesis they relate to.

### Hypothesis 1A: Age and Sexual interest

Hypothesis 1A states that older adults who are younger will report higher levels of sexual interest in comparison to those who are older. According to Model 1 and Model 4, there is no significant difference in sexual interest between younger older adults and those more advanced in age. This result does not support Hypothesis 1A, stating that older adults who are younger will report higher levels of sexual interest in comparison to those who are older.



### Hypothesis 1B: Gender and Sexual Interest

Hypothesis 1B states that women will report higher levels of sexual interest than men. Model 1 and Model 4 show that men are significantly less likely than women to report a period of several months or more when they lacked sexual interest ( $p \leq .001$ ), with men being the reference category. This result rejects Hypothesis 1B, stating that women will report higher levels of sexual interest than men.

### Hypothesis 2: Relationship Status and Sexual Interest

Hypothesis 2 states that dating older adults will report higher levels of sexual interest than cohabitating older adults. Model 2 shows that cohabitating older adults are significantly more likely to lack sexual interest when compared with dating older adults ( $p \leq .05$ ), which does not support Hypothesis 2. In contrast to Model 2, Model 4 shows there is no significant difference in sexual interest between cohabitating and dating older adults, which does not support Hypothesis 2.

### Hypothesis 3: Health Status and Sexual Interest

Hypothesis 3 states that health status will negatively affect sexual interest among North American older adults. According to Model 1, older adults reporting very good or excellent self-rated health are significantly less likely to report a lack in sexual interest when compared with those who report poor, fair, or good self-rated health ( $p \leq .05$ ). For relative health, older adults who report somewhat better or much better health in relation to their peers are significantly less likely to express a period of several months or more when they lacked sexual interest than those who report much worse, somewhat worse, or about the same ( $p \leq .05$ ), according to Model 1. The self-rated health and relative health results support Hypothesis 3 stating that health status will negatively affect sexual interest among North American older adults.



In consistence with Model 1, Model 4 shows that older adults in reporting good health have higher levels of sexual interest than those in poorer health ( $p \leq .05$ ), which supports Hypothesis 4. Unlike Model 1, Model 4 shows no significant difference in sexual interest between older adults in better health than their peers and those in poorer health than their peers.

#### Hypothesis 4: Social Support and Sexual Interest

Hypothesis 4 states that higher levels of social support received from a partner will positively affect levels of sexual interest among older adults. In Model 3, there was no significant difference in sexual interest between coupled older adults who report they can open up to their partner hardly ever (or never) or some of the time when compared with those who report they can open up to their partner often. Also, there is no significant difference in sexual interest between coupled older adults who report they can rely on their partner hardly ever (or never) or some of the time when compared with those who report they can rely on their partner often. Additionally, there is no significant difference in sexual interest between coupled older adults who report their partner hardly ever (or never) makes too many demands and those who report some of the time or often. Moreover, coupled older adults who report their partner hardly ever (or never) criticizes them is significantly less likely to have a period of several months or more when they lacked sexual interest than those who report some of the time or often ( $p \leq .001$ ). Among the four social support variables, only respondents who report their partner rarely criticizes them have higher levels of sexual interest among older adults, which supports Hypothesis 4.

In contrast to Model 3, Model 4 shows coupled older adults who open up to their partner hardly ever (or never) or some of the time are significantly more likely to lack sexual interest when compared with those who open up to their partner often ( $p \leq .05$ ). There was no significant



difference between coupled older adults who report their partner hardly ever (or never) makes too many demands and those who report some of the time or often in Model 4. Also, Model 4 shows that there is no significant difference in sexual interest between coupled older adults who can rely on their partner hardly ever (or never) or some of the time when compared with those who can rely on their partner often. Similar to Model 3, coupled older adults who report their partner hardly ever (or never) criticizes them is significantly less likely to lack sexual interest than those who report some of the time or often ( $p \leq .001$ ) (see Table 4.2).

The pseudo r-squared for each model explains the percentage of variance in the dependent variable the model accounts for. Each model accounts for a very small percentage of the variance in sexual interest. Model 1, which only includes the demographic variables, only explains 5.3% of the variance in sexual interest. Model 2, which includes the relationship status variables, only accounts for 2% of the variance in sexual interest. Model 3, which includes the four social support variables, only explains 1.7% of the variance in sexual interest. Finally, Model 4, which includes the demographic variables, relationship status variables, and social support variables, accounts for 8.3% of the variance in sexual interest.

### Interaction Variables

In order to test the significance of gender within my models, I computed interaction variables. Then, I placed each interaction variable into a separate logistic regression model with covariates, relationship status variables, and social support variables, with sexual interest as the dependent variable. Only partner makes too many demands and gender had a significant relationship, and the results are displayed in Model 5 (see Table 4.2). Model 5 includes covariates, relationship status variables, social support variables, and gender X partner makes too



many demands. There is no significant relationship between both relative health or self-rated health with gender when sexual interest is the dependent variable.

Additionally, there is no significant relationship between open up to partner, partner criticize, or rely on partner with gender when sexual interest is the dependent variable. Neither younger older adults nor those more advanced in age had a significant relationship with gender, when sexual interest is the dependent variable. Finally, married, cohabitating, and dating older adults all had no significant relationship with gender when sexual interest is the dependent variable.







## **Chapter 5**

### **Discussion/Conclusions**

#### **Discussion**

The purpose of this study is to explore the relationship between social support received from a partner and sexual interest among North American older adults. In this chapter, the various factors affecting sexual interest among older adults will be discussed, including health, age, gender, relationship status, and social support. The discussion of my findings is based on the results of logistic regression Model 4. Policy implications and future research are also included.

#### **Age and Sexual Interest**

My first hypothesis (1A) examines the relationship between age and sexual interest. Specifically, as older adults advance in age sexual interest decreases. When older adults aged 50-60 were compared with those aged 70-80, sexual interest was rated as less important for older adults more advanced in age (Gott and Hinchliff 2003). Additionally, DeLamater and Sill (2005) found that among a sample of 704 women and 620 men, five percent have low levels of sexual desire among persons aged 45 to 49 but among persons aged 80 to 84 more than 59 percent have low levels of sexual desire. According to my analysis, my hypothesis is not supported, because younger older adults did not have significantly higher levels of sexual interest when compared with those more advanced in age. Even though older adults may be more likely not to engage in sex when compared with younger adults, this does not mean they lack interest in sex. There are many other factors that affect sexual interest, including gender, health status, and relationship status, which may explain the insignificant finding mentioned above.



### Gender and Sexual Interest

In contrast to my first hypothesis (1B), men are significantly less likely than women to report a period of several months or more when they lacked sexual interest. This finding may be because a national study is able to look at older adults in all regions of North America and from various backgrounds. Female older adults may be more likely to lack sexual interest since they grew up in a time where women were taught to be sexually reserved (Garner 1999). My hypothesis that women will report higher levels of sexual interest than men is based on research by Bretschneider and McCoy (1988) showing that over time men's sexual interest decreased while women's increased. The results of this study showed women 80 to 90 years of age have increased sexual interest when compared with those aged 66 to 71. This study had a sample of 202, health, upper middle-class older adults in retirement facilities and is twenty years old, which may account for their findings being contradictory to my findings.

### Relationship Status and Sexual Interest

In contrast with my second hypothesis, there is no significant difference in sexual interest among cohabitating and dating older adults. Little research has been done on dating and cohabitating older adults, and this may be due to the belief that older adults are asexual and monogamous, even after a partner dies. The exact numbers of dating older adults is not known (Bulcroft and O'Connor 1986), but AARP and knowledge networks conducted a study on 3,500 single or un-partnered older adults, showing that 36 percent are interested in dating or starting a relationship (Yin 2004). Furthermore, according to King and Scott (2005), when compared with cohabitators in their 20s, older adult cohabitators find cohabitating more sexually satisfying than dating, and I based my hypothesis on these findings. The reason for the contrast in findings could be due to the small sample size in previous research and comparison of younger and older



cohabitators. Additionally, previous research did not involve interviewing or surveying dating older adults; it only includes currently cohabitating older adults views on dating. These accounts may not be true reflections of dating versus cohabitating relationships among older adults.

#### Health Status and Sexual Interest

In support of my third hypothesis, older adults with very good self-rated health are significantly less likely to report a lack in sexual interest when compared with those with poorer self-rated health. There is no significant difference in sexual interest between older adults in better health than their peers and those in poorer health. The National Social Life, Health, and Aging Project found that among 3,005 North American older adults, as self-rated health declines so does sexual desire (Lindau et al. 2007). Some older men may feel emasculated if their health declines and in turn have less interest in sex, and various researchers have discovered specific health problems and there link to sexual interest in older adulthood. DeLamater and Sill (2005) found that men who were diagnosed with an enlarged prostate had low levels of sexual interest. Additionally, Bertero (2001) found significant sexual interest differences among older men since the diagnosis and treatment of prostate cancer. DeLamater and Sill (2005) also found that hypertension and low levels of sexual interest are related, in addition to the relationship between high blood pressure and low levels of sexual interest. Gott and Hinchliff (2003) found that among older adults who rated sex as moderately important, they mainly attributed the decline to personal health problems or their partner's health problems. These findings support that a decline in health status is correlated with less sexual interest.

#### Social Support and Sexual Interest

As I predicted in my fourth hypothesis, social support is significantly correlated with sexual interest, though some aspects of social support are more significant than others.



Specifically, coupled older adults who infrequently open up to their partner are significantly more likely to lack sexual interest when compared with those who frequently open up to their partner. This result relates to Gott and Hinchliff (2003) finding that older adults in close, positive relationships are more likely to place importance on sex. Furthermore, coupled older adults who report their partner infrequently makes too many demands are less likely to lack sexual interest, than those who report their partner frequently makes too many demands, though this result is not significant. Coupled older adults who cannot rely on their partner are more likely to lack sexual interest when compared with those can rely on their partner. Moreover, coupled older adults who report their partner rarely criticizes them are significantly less likely to lack sexual interest than those who report their partner frequently criticizes them. These findings support research on younger adults showing that less social support than desired led to negative marital outcomes (Dehle, Larsen, and Landers 2001), which includes sexual interest. Additionally, a global study by Laumann et al. (2006) of 27,500 men and women aged 40-89 from 29 countries revealed that people in relationships with high levels of social support have positive sexual interest, which also supports my findings.

### Interaction Variables

I only discuss the implications of the finding gender and partner makes too many demands, because it is the only interaction variable that has a significant relationship with sexual interest. The contrasting ways in which men and women spousal care givers deal with the functional and emotional demands of their spouse can help illuminate my interaction variable finding. According to previous literature, care work within family relationships is highly gendered (Calasanti 2003). For example, women are less likely to consider domestic labor *real* work, since they automatically assume it is their responsibility (Davidson, Arber, and Ginn



2000). On the contrary, men are more likely to count all of their care tasks, which give researchers the impression that men do more domestic labor than women (even though this is not true). Additionally, women and men handle caregiving stress differently, with women tending to report more depression, anxiety, physical strain, poorer health, and lower life satisfaction than their husbands (Yee and Schulz 2000). Researchers suggest that these different caregiving styles have to do with men being able to detach from the emotional aspects of care work and focus on the task at hand, while women feel emotionally attached (Russell 2001).

The interaction between gender partner makes too many demands significantly impacts sexual interest. For example, if a female is caregiving for her sick husband, then research suggests he feels emasculated about his poor health, which in turn affects sexual interest. Researchers discovered various diagnoses that lead to a decrease in sexual interest, for example DeLamater and Sill (2005) found that men who were diagnosed with an enlarged prostate had low levels of sexual interest. Among older men, Bertero (2001) found significant differences in their sexual interest since the diagnosis and treatment of prostate cancer. DeLamater and Sill (2005) also found that hypertension and low levels of sexual interest are slightly yet significantly correlated, which Steinke (2005) found can be caused by the disease itself or antihypertension medications. DeLamater and Sill (2005) also found that the relationship between high blood pressure and low levels of sexual interest is very strong. Overall, it appears that disease, medication, and treatments all can affect sexual interest among older men.

Additionally, if a man was caregiving for his wife, then the care work may interfere with traditional cultural constructs of masculinity, which may affect the couple's sexual relationship (Calasanti 2003). Overall, women do more spousal care work than men and suffer more chronic



illnesses (Calasanti and Slevin 2001). Women are also less likely to receive informal care than men, which increases their caregiver burden (Katz, Kabeto, and Langa 2000).

### Discussion Summary

The results of this study support the notion that social support is an important factor influencing sexual interest among partnered older adults. Overall, positive emotional social support received from a partner is more significantly correlated with increased sexual interest when compared with positive functional social support received from a partner. For example, partnered older adults who frequently open up to their partner and infrequently are criticized by their partner and are significantly less likely to lack sexual interest. This finding is in line with qualitative research by Hinchliff and Gott (2004) showing that among couples in long-term marriages, sexual interest remained high because of being able to trust one's partner and feeling valued by them. Others have argued that when older adults feel loved and needed by their partner, they are more likely to be sexually intimate (Riley 1999). It is clear that positive emotional social support received from a partner significantly increases sexual interest among older adults.

While positive functional support was not significantly correlated with increased sexual interest, they still had a relationship. Functional support involves being able to rely on one's partner and one's partner not making too many demands. Though functional support may somewhat affect sexual interest, it does not play a major role in sexual interest for older adults. Just because an older adult does not frequently rely on their partner, this does not indicate that their relationship is not supportive and therefore may lack sexual interest. Older adults may choose to rely on their children instead of their partner for activities such as: buying groceries, taking out the trash, or even supplying money. Additionally, it may be rather common for



couples to feel that their partner makes too many demands, but this does not mean they are not in a supportive relationship and therefore lack sexual interest.

It is important to note that the findings and discussion are based on logistic regression Model 4, which has a pseudo r-squared of 8.3%, which means that the model only explains a small percentage of the variance in sexual interest. Other factors not included in my study significantly impact sexual interest among North America older adults, such as sexual history, living situation, and relationship history.

## **Conclusions**

Sexuality in older adulthood is relatively unexplored and often misunderstood despite the impact it has on overall well-being (Lindau et al. 2007). Health care and mental health practitioners can use research on the sexual health of older adults in order to have more holistic practices and specialized training, since sexual interest has a significant relationship with self-rated health and social support received from a partner. Since a societal belief in the asexuality of older adults could affect the way health practitioners interact with older adults, education about sexuality in older adulthood needs to be required for all health care professionals. As older adults advance in age, health care and mental health care professionals may consider talking to their patients about new sexual options with their partner. While this topic may be hard for health care professionals to discuss, more attention needs to be paid to reframing sexuality for older adults. Instead of suggesting products to increase virility to patients reporting sexual concerns with their partner, health care professional may ask questions about whether the couple feels comfortable opening up to each other and whether they feel criticized by each other, because if the couple is not able to open up to each other, then they may not be able to talk about



sexual concerns. If sexual communication is lacking, health care professionals may need to find ways to increase discussion about sex among older adult couples.

While this study only researched community-dwelling older adults, eventually some of the respondents will be institutionalized. Sexual expression within institutionalized settings is sometimes not viewed as acceptable by staff members (Szasz 1983). Employees in institutions serving older populations need similar training about sexuality in older adulthood, ensuring workers understand older adults are sexual beings and should be allowed to express their sexuality.

Broader interpretations of sex, where vaginal intercourse is not the only form of sexual behavior included in our definitions, need to be adapted for older adults (Gott and Hinchliff 2003). For example, older adults may include masturbation, noncoital sex, touching, holding hands, hugging, and kissing in their definitions of sex (Ginsberg, Pomerantz, and Kramer-Feeley 2005; Zeiss and Kasl-Godley 2001). If broader definitions of “sex” were widely accepted, then this could recast what older adults categorize as sexual problems.

Showing that older adults remain interested in sex as they advance in age dispels the myth that old age is equated with a celibate lifestyle. This research contributes to gerontological literature by proving that sexual interest does not stop in older adulthood, even though sexual activity may decrease. Older adults can still have high levels of sexual interest but factors, such as their health declining or their partner’s negatively affects their ability to engage in sexual behaviors (Gott and Hinchliff 2003). Also, their relationship status greatly affects their ability to have sex. However, older adults who do have a sexual partner benefit from this source of pleasure, therefore preserving physical well-being and reducing physical problems. This link



between sexual well-being and reduced physical problems is believed to eventually reduce the amount of health care given to this population (Trudel, Turgeon, and Piche (200).

My research also adds to existing literature about the relationship between sexual interest and social support among partnered older adults. Research showing variations in social support and sexual interest among partnered older adults could help address gender inequalities within intimate relationships. The results of the interaction model of gender and partner makes to any demands with sexual interest highlight how although both men and women are engaged in care work, they handle the emotional strain differently (Calasanti 2003). As a result, men may feel that the role of caregiver does not fit with the traditional masculinity, which may affect his sexual interest. Also, when men are the care recipients, they can feel emasculated which results in a decrease in sexual interest. Feminist gerontology perspective highlights how hegemonic masculinity can be harmful to men in older adulthood (Calasanti 2003).

Women do more spousal care work than men and also suffer more chronic illness (Calasanti and Slevin 2001). Dehle, Larsen and Landers (2001) found that older adults who received less support than desired reported more stress and depressive symptoms, which can affect sexual interest. There are various explanations for why women do more spousal care work than men, which include socialization and a natural connection to others Calasanti and Slevin 2001). Both of these explanations fall short, because men can also learn caregiving skills and perform them as well, though women learn these skills more often (Risman 1987). Examining care work through a power relations lens reveals how care work is gender divided, devalued as unpaid work, and separates women from the work force (Stoller 1993). A feminist gerontology perspective highlights inequalities within the lives of female spousal caregivers, specifically



increased caregiver burden, additional emotional attachment, more chronic illnesses, and removal from the work force.

### **Policy Implications**

Based on the findings and discussion, I will discuss important policy implications to address sexuality in older adulthood. As shown, health status continues to play an important role in sexual interest among older adults. Since my findings show that higher self-rated health is significantly positively correlated with sexual interest, it is important to ensure older adults have access to affordable health care (Ponce, Hays, and Cunningham 2006). Health services beyond medical institutions need to be readily available for older adults, such as medication management, exercise classes, and nutrition education, since all of these can affect self-rated health status.

Additionally, mental health services also need to be available for older adults to utilize, since my findings show that emotional social support significantly affects sexual interest. As relationship statuses change, health problems increase, friends and partners die, and living arrangements fluctuate older adults need to have an objective third party to talk to (Kuiken 2004). Also, coupled older adults may need counseling on sexual health concerns and relationship problems. Policies need to be created to include mental health services in the continuum of care, so older adults do not have to pay out-of-pocket for these services.

Government policies should address the growing need for services to older adults who desire to age in place. Though my sample consists of community-dwelling older adults, some of the participants may eventually move into an institution. Since emotional social support received from a partner is significantly correlated with sexual interest, there is potential for intimate relationships among older adults to become strained when one or both partners are living in an



institution (Russell, Cutrona, de la Mora, and Wallace 1997). Moreover, current institutions need policies addressing sexuality in these spaces, specifically giving rights to allow residents to develop intimate relationships and to increase resident rights to privacy.

### **Future Research**

There needs to be more presence in gerontological literature about the living situations and sexual practices of older adults in relationships other than marriage. Future research needs to address dating and cohabitating older adults, specifically, the reasons that dating older adults and cohabitating older adults have no significant difference in levels of sexual interest. Possibly, dating relationships have not developed enough to the point where they are reporting a period of several months or more where they lack sexual interest. Also, research needs to explore the growing number of cohabitating older adults and their relationship stability and sexual interest. As older adults become more aware of the financial benefits of cohabitation, specifically surviving partners being able to keep their husband or wife's social security check if they cohabitate rather than remarry, then there may be a greater number of people choosing cohabitation.

Sexual interest among different racial and ethnic groups also needs to be examined. In my analysis, there are no statistical differences in sexual interest among racial and ethnic groups. There could possibly be hesitation by different racial groups to report a lack of sexual interest because of the cultural constructs of masculinity. Laumann, Paik, and Rosen (1999) analyzed data from the National Health and Social Life Survey, which included 1410 men and 1748 women aged 18 through 59, and found Black women reported lower sexual desire and pleasure than White women. Hispanic women reported fewer sexual problems than White women, which the researchers speculated might be a cultural affect. Qualitative data on Hispanic, Black, and



White older adults should explore possible explanations for ethnic and racial differences in sexual problems. It may possibly be that different ethnic groups classify sexual problems differently, so what one ethnic group finds problematic another does not.

The relationship between socioeconomic status and sexual interest needs to be examined further. In my analysis, there was no relationship between household income and sexual interest, and the variables affecting this outcome need exploration. Among younger adults, a reduction in household income is associated with sexual dysfunction for women and erectile dysfunction in men (Laumann et al. 1999), but it is not known what the affect of deteriorating household income has on older adult couples. DeLamater and Sill (2005) showed that household income is negatively associated with sexual desire for both men and women, but the other factors affecting this result have not been explored.

Future research should address other variables relating to sexual interest, specifically questions about the importance of sex in the respondent's life and how often the respondent thinks about sex. Sexual interest cannot be determined solely by whether respondents have a period of several months or more when they lacked sexual interest. This one research question is linked closely with behavior but does not address the attitudes and desires of the respondent. While the respondent may lack interest in physically having sex, they may be frequently thinking about sex. Additionally, since my study only explained a small percentage of the variance in sexual interest, other factors not included in my study could significantly impact sexual interest among North America older adults, such as sexual history, living situation, and relationship history.

The notion of emotional social support received from a partner as it relates to sexual interest needs to be further analyzed. Qualitative research should explore the reasons why sexual



interest among coupled older adults is more correlated with emotional social support rather than functional. It would be helpful to know who else provides functional social support for older adults in order to discover why functional social support received from a partner does not significantly impact sexual interest. Additionally, more comprehensive social support questions need to be developed, because the relationship between gender and social support may be more significant with sexual interest if social support had more valid measures.



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