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How Do Older Adults Perceive Sexual Unwellness? A Cross-National Qualitative Study with Mexican and Portuguese Older Adults

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Abstract: Objectives: Perspectives on sexual unwellness (SU), referring to difficulties in achieving sexual satisfaction and maintaining sexual relationships, may vary across different cultural contexts. Understanding how cultural factors such as social norms, religion, family values, and help-seeking behaviors influence SU is crucial. This cross-cultural study aims to explore Mexican and Portuguese older adults' perspectives on SU in the context of aging in different cultures. Methods: A total of 166 heterosexual older participants living in the community (range = 65 to 98 years of age; mean = 71.54 ± 5.0 years of age) took part. Semi-structured interviews were conducted, and interview data were content analyzed. Results: Six SU themes emerged: poor sexual experiences; feeling alone; religious values; medication; not feeling attractive; and feeling pain or physical restrictions. Cross-cultural differences were evident in this study. Older Portuguese participants most often spoke of 'poor sexual experiences' (25.5%), 'religious values' (18.2%), 'medication' (17.3%), 'feeling alone' (15.5%), and 'not feeling attractive' (15.5%). Older Mexican participants identified most with 'feeling alone' (13.7%), followed by 'poor sexual experiences' (7.4%) and 'feeling pain or physical restrictions' (5.6%). Conclusions: A diversity of experiences of older adults in relation to SU was highlighted in this study. Moreover, cross-cultural research on the construct of SU is essential to understanding the cultural differences in the conceptualization of the construct and how these themes may influence sexual life in old age. Research into older adults' SU is still scarce; hence, these findings are pertinent for outlining guidelines and health interventions by considering elements that affect SU and by focusing on the sexuality of older people with a deep cultural and ethnic sensitivity.

Keywords: cross-cultural; older adults; qualitative study; sexual unwellness

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1. Introduction

Sexuality is relevant for older adults across different cultures (Træen and Villar 2020). Interest in sex is related to a number of key psychosocial factors, including perceived relationship quality, well-being, openness to experience, a positive mindset, presence of family members in one's social network, financial stability, marriage, depression, and anxiety (Træen and Villar 2020; von Humboldt et al. 2021a, 2023b). Moreover, cultural influences, including the stigma surrounding sexual activity in later life, and health factors, such as the side effects of medications or surgical procedures, may also significantly

influence sexual well-being (SWB) and sexual experience in older age (von Humboldt et al. 2021a, 2023b).

SWB is related to overall satisfaction with life, sexual health, and well-being, and it can positively contribute to aging well (Træen and Villar 2020). It has been defined as a subjective emotional and cognitive assessment of individual quality of sexuality (von Humboldt and Leal 2015, 2017; von Humboldt et al. 2013c, 2014, 2020, 2023d), and it has been used as an umbrella construct that integrates several positive elements of sexuality. However, this concept has not been sufficiently explored in the literature (Berdychevsky and Nimrod 2017; Iveniuk and Waite 2018; Træen et al. 2017b; von Humboldt and Leal 2015; von Humboldt et al. 2023d; World Health Organization [WHO] 2020). Interestingly, older sexually active populations report a strong emotional connection with partners and sexual activity as an expression of their love and commitment (Hinchliff et al. 2020; Sørensen et al. 2017; Træen et al. 2017a; von Humboldt et al. 2023c). In this context, understanding SWB in later life is critically important for resource planning, knowledge, and planning public health services tailored to older adults (von Humboldt and Leal 2015, 2017; von Humboldt et al. 2013c, 2014, 2015, 2020, 2021a).

Prevalence in relation to aging differs worldwide. In 2020, 18% of Europe's general population was 65 years and older; in Latin America, this proportion was 8% (Fernando Álvarez et al. 2020). In 2019, older people made up 7.4% of Mexico's general population, and this proportion is expected to increase to 10.2% by 2030 (United Nations 2019). In Portugal, these proportions are 22.4% and 27%, respectively (United Nations 2019). Further, Portugal is one of the 'oldest' countries worldwide (Carrilho 2015). On the other hand, in 2015, although the average age in Mexico's general population was 27.9 years, this is expected to increase to 42 years of age by 2050 (Angel et al. 2016).

In this culturally nuanced context, different large-scale studies have been carried out examining older adults' sexuality in these populations, highlighting older adults' desire to engage in sexual activities (Hinchliff et al. 2020). Literature has indicated that older adults remain sexually active, engage in sexual activities, and are involved in a diverse range of activities (Cameron and Santos-Iglesias 2024; Træen et al. 2017b). For example, nearly one-quarter of older women report having had vaginal sex with a male partner; 37.2% of older men engaged in vaginal intercourse (Hinchliff et al. 2020; Mercer et al. 2013). In Træen and colleagues' study of older people in Norway, Denmark, Belgium, and Portugal, 40–60% of responders reported being sexually satisfied (Traeen et al. 2018). Portuguese men and Danish women were also most sexually satisfied. Despite these studies, research into sexual well-being and sexual unwellness (SU) remains very scarce (Traeen et al. 2018).

SU can negatively affect aging well and is conceptualized as dissatisfaction, displeasure, and/or suffering derived from sexual experiences, albeit in relation to sexual identity, function, and/or behavior (Sørensen et al. 2017; von Humboldt et al. 2017). Sexual difficulties, some of which are more likely to occur in older age, including erection and ejaculation problems, decreased sexual desire, and dyspareunia, can contribute to SU (Træen et al. 2017a). These difficulties can negatively impact relationships and psychological well-being and can be a source of distress and unwellness (Hinchliff et al. 2020).

Other factors also negatively affect the sexual behavior of older adults, such as lack of sexual reciprocity, depression, repetitive sexual intercourse, anxiety, and chronic illnesses, among others (Inelmen et al. 2012). Moreover, physiological factors can also constitute barriers to sexual expression in later life (Ambrosini et al. 2018). Men can experience decreases in testosterone levels, erectile dysfunction and malfunction, atrophy of sexual organs, inability to maintain arousal, and decreases in sexual desire (Jones 2008). Women are affected by decreased estrogen secretion after menopause; decreased lubrication, breast size and elasticity; contraction of the cervix; and vaginal atrophy (Baspure 2019). However, interestingly, sexual problems are accepted as a natural part of growing older. This seems to modulate the impact of sexual problems on older adults' perception of well-being, and some older adults report lower levels of unwellness and distress about untoward changes in their sex lives (Sinković and Towler 2019).

The few studies in this area indicate that SU is related to a negative feeling associated with sexual function and sexuality, such as frustration, anxiety, worry, and discomfort (Hayes 2008; Stephenson and Meston 2010; Santos-Iglesias et al. 2018). Further, SU has been related to older people's lack of sexual satisfaction and an incapacity to maintain sexual relationships due to physical and mental health concerns (Syme et al. 2015; von Humboldt et al. 2017). Despite the existing studies, it is still not entirely clear who is more or less likely to be sexually unwell. By exploring individual differences in relation to SU, we can further understand the factors that could enhance SU (Juang and Knight 2018).

SU was significantly correlated with seeking professional help independently of gender (Hinchliff et al. 2020). Older adults often experience barriers to seeking and receiving help for sexual problems, which can be related to stereotypes of asexuality of older age, shame, or economic issues (Hinchliff et al. 2020; Træen et al. 2017a). Although some older individuals seek professional help, a large part do not follow the same path. There is little information about how older people seek help and what the main sources of help are (Hinchliff et al. 2020). SU is related to less seeking out of professional help; however, primary care physicians are the main helpers. Some older adults opt to look for informal sources, such as partners, friends, or websites (Hinchliff et al. 2020; Foucault 1978; Simon and Gagnon 1987; Gagnon and Simon 1973; Park and Burgess 1925). In a different study (Juang and Knight 2018), female older adults and people without partners were the least sexually distressed. These important differences were partly owing to attitudes towards the importance of sex (Juang and Knight 2018).

Although SU in old age has been poorly investigated, several dimensions seem to be related to this concept, i.e., social, cultural, biological, and psychological factors (Chung 2019; Sørensen et al. 2017). SU appears to peak at midlife and decrease with age, with both such patterns being highly related to one's partner (Seftel 2017), since SU is associated with lower relationship satisfaction (Vannier and Rosen 2017).

Furthermore, previous studies indicate that SU is associated with higher levels of vaginal sexual symptoms, concerns about body image, concerns about sexual pain, and dissatisfaction with intimate relationships (Bakker et al. 2017). In four European countries, older people between 60 and 75 years of age stressed that being in good health was a key determinant of sexual interest and pleasure (Traeen et al. 2018). Additionally, there was a high prevalence of sexual problems, and interestingly, most men and women with sexual problems experienced little to mild distress about their problems (Graham et al. 2020; Hald et al. 2019; von Humboldt et al. 2013a). In this study, cross-cultural differences were also clear regarding unwellness related to sexual problems, with Portuguese individuals demonstrating a higher level of unwellness compared to individuals from northern Europe.

Research has reiterated that sexuality is grounded in the social theory argument, since sexual behavior and experience are strongly shaped by cultural, social, and historical contexts rather than being purely biological drives (Foucault 1978; Simon and Gagnon 1987). Indeed, literature indicates that cultural norms, historical contexts, and social roles regulate sexuality, and emphasize the fact that sexual meanings and practices are contingent upon specific cultural and historical circumstances. This approach aligns with the idea that sexual identities and experiences are constructed through a complex interplay of social expectations, cultural scripts, and historical developments (Gagnon and Simon 1973). Furthermore, sexuality is not commonly perceived as static, but instead, it can be perceived as shifting, learned and modified throughout the life cycle. This perspective highlights that SWB and SU, like many other facets of life, evolve with age and changing life circumstances. By focusing on how sexuality is learned and adapted over time, this study contributes to a nuanced understanding of SWB as a dynamic and evolving aspect of human life shaped by both individual experiences and broader social frameworks (Park and Burgess 1925).

In relation to this, some studies (e.g., García Villanueva et al. 2020) particularly focus on the scarce knowledge about sexuality in Mexican society, and sexuality at senior age is often particularly denied and repudiated. Social stereotypes of sexuality centered on reproduction and denigrating the old age stage seem to still be present in Mexican culture,

still remaining a taboo theme (García Villanueva et al. 2020; Romero 2004). In Portugal, there are also a several social stereotypes about senior sexuality, sharing with Mexico the values of sexuality centered on performance and youth. However, in recent years, there has been a great growth in the literature and visibility of this theme in European countries, which may be influencing social perception and current stereotypes and creating some divergences between these two countries (Carvalheira 2018).

Træen et al. (2017a) draw attention to the lack of systematic research on socio-cultural factors that influence older people's sexual satisfaction. More cross-cultural research is needed to better understand older people's perceptions about SU so that their social and health-related needs can be met and so that all such findings are reflected in the literature (Sinković and Towler 2019). Moreover, Sinković and Towler (2019) call for qualitative explorations, particularly in relation to male sexual desire and pleasure, the impact of health problems on the sexuality of older women, sexual risk in older adults, and culture-specific influences on outcomes, such as help-seeking behavior and sexual satisfaction. The quality of qualitative research reports on sexual aging can be improved through a good description of the data, and online supplementary materials should be used for a detailed description of methodological procedures, including ethical issues (Sinković and Towler 2019). Few cross-cultural studies, particularly qualitative studies, explore SU in old age. Hence, the main aim of our study was to shed light on older adults' perspectives on SU across two different cultures.

2. Methods

2.1. Recruitment and Sampling

In this study, a phenomenological approach was employed to explore older adults' perspectives on SU across two distinct cultures: Mexico and Portugal. By integrating both descriptive and interpretative phenomenological methods (Alhazmi and Kaufmann 2022), we delve into how individuals experience and interpret their own SU, capturing the nuanced and multidimensional aspects of older adults' experiences.

Between February and April 2018, contacts were made with community centers, senior universities, and life-long learning centers. Thus, this qualitative study was initiated by recruiting participants from all such locations. The recruitment phase started by telephone and through personal contact with potential participants. The researchers collected contact information from consenting participants and scheduled an interview with them. Inclusion criteria for this study were: (1) age 65 and older; (2) agrees to participate in the study; (3) accepts to participate in mini mental state examination [MMSE] screening (assuming that the results are within the established parameters); and (4) not undergoing any medical or psychotherapeutic treatment related to sexual or psychiatric problems. Monetary compensation was not offered to study participants. At the beginning of the semi-structured interviews and after explaining the study and its objectives, all participants gave their consent. On average, each interview took 35 min. The purpose of these interviews was to collect data about what contributes to SU in older age. The interviews were recorded, transcribed, and subjected to content analysis. The ISPA—Instituto Universitário Ethics and Coordination Committee and the Research and Ethics Committee from the Health Science Division of the University of Guadalajara approved this study.

One hundred and sixty-six older adults (average age = 71.54 years) took part. One hundred and eight participants were female, 98 were married or partnered, and 54 lived alone. As for education, 47 participants had a bachelor's degree or higher. Most participants had incomes above 25,000 euros. Portuguese participants (n = 86) lived in Lisbon and Algarve. Mexican participants (n = 80) lived in Guadalajara. All participants identified themselves as binary and heterosexual (see Table 1).

Table 1. Sample socio-demographic and health characteristics.

Characteristics	Portuguese (n = 86)	Mexican (n = 80)	Total (n = 166)
Age, mean ± SD	71.8 ± 3.6	71.28 ± 6.41	71.54 ± 5.0
Gender, n (%)			
Women	56 (65.0)	52 (65.0)	108 (65.0)
Men	30 (35.0)	28 (35.0)	58 (35.0)
Living Status, n (%)			
Alone	22 (26.1)	32 (40.0)	54 (32.6)
With sons	3 (2.9)	22 (27.5)	25 (15.0)
With a partner	61 (71.0)	26 (32.5)	87 (52.4)
Education n (%)			
Illiterate	0 (0.0)	3 (3.8)	3 (0.1)
Primary school	30 (34.2)	37 (46.1)	67 (40.2)
Middle school	25 (29.4)	24 (30.1)	49 (29.5)
≥High school	31 (36.4)	16 (20.0)	47 (28.2)
Marital Status n (%)			
Married or cohabiting	59 (69.1)	39 (48.8)	98 (59.0)
Having a spouse or other intimate relationship	27 (30.9)	41 (51.2)	68 (41.0)
Professional Status n (%)			
Active	18 (21.3)	24 (30.0)	42 (25.3)
Inactive	68 (78.7)	56 (70.0)	124 (74.7)
Family Annual Income n (%)			
≤25,000 €	34 (40.1)	80 (100)	114 (68.7)
>25,000 €	52 (59.9)	0 (0)	52 (31.3)
Perceived Health n (%)			
Good	56 (65.1)	67 (83.8)	123 (74.1)
Poor	30 (20.9)	13 (16.3)	43 (25.9)

2.2. Data Analysis

After sharing the contents and objectives of the study with participants, the interview protocol followed five main steps: clarification of questions and signing informed consent; semi-structured interview; full transcribing; in-depth reading; and content analysis (Erlingsson and Brysiewicz 2017; Elo et al. 2014). Since the main objective of this study was to explore older adults' perspectives on SU across cultures, interviews focused on two main topics: predictors of SU and predictors of sexual well-being. Data collection uniformity was ensured through the provision of a short interview guide and a proposed structure for each semi-structured interview. In addition, interviewers were trained through mock interviews to better facilitate participants' sharing and expression of sexual experiences. The interview guide was composed of two questions focused on two domains: SU (e.g., "I would like to understand what, from your point of view, may currently most contribute to your sexual unwellness?") and sexual well-being (e.g., "I would like to understand what, from your point of view, may currently most contribute to your sexual well-being?").

After applying the interview protocol and transcribing it, a brief reading was carried out to verify the coherence of the speech and so that the researchers became familiar with the contents of the interviews. After this brief reading, two experienced researchers began to analyze the interviews (see Figure 1).

The process of coding the interviews was initiated, with the data being classified for an *a posteriori* analysis. Each category was assigned a numeric code to create a code list (Sampaio and Lycarião 2018; Singh 2007). This code list was elaborated upon based on the different comments that participants made about SU. The researchers reviewed all of the coding until they reached a consensus and divergences in coding could be resolved. In order to make replicability possible, coding followed important rules (e.g., mutually exclusive codes; codes applied consistently; and coding process implemented by more than one coder). Two researchers imposed the suggested coding structure upon interview texts

from a random sample of participants (Saldaña 2009).Assessments have emerged regarding internal consistency from this manual coding, and changes in the coding structure have been carried out. Further, agreement was assessed regarding codifications made for each interviewer, and across different categories, using CohCohs Kappa test. Cohen's Kappa (k = 0.80–0.98) was strong across all emergent categories.

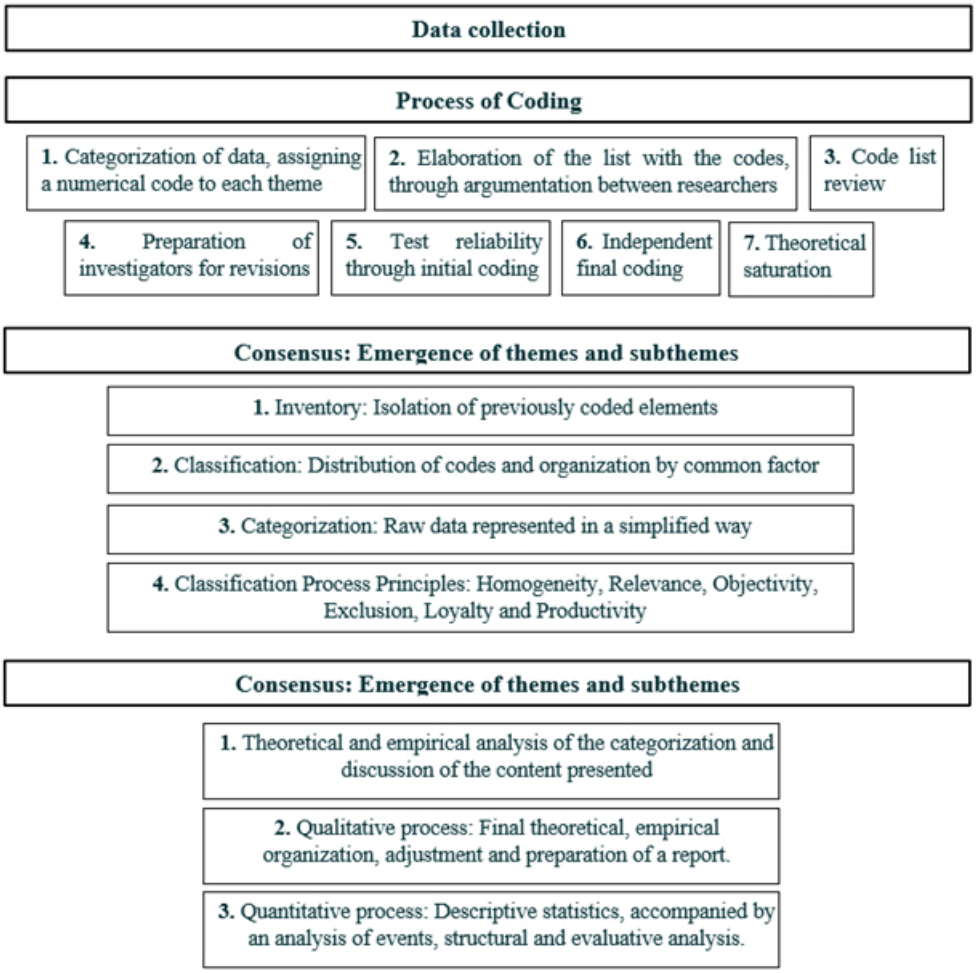


Figure 1. Adapted process of content analysis.

To develop the content analysis process, it was necessary to develop a descriptive structure of the results. The whole analytical process was thus qualitative in nature, with this also including a process whereby averages, medians, and percentages were estimated (Bengtsson 2016; Elo et al. 2014; Erlingsson and Brysiewicz 2017; Mayring 2000).

3. Results

Through this study, it became evident that SU was a culturally distinct construct that was conceptualized in different ways by our older Portuguese and Mexican participants. Six main themes of mutual exclusivity emerged, namely poor sexual experiences; feeling alone; religious values; medication; not feeling attractive; and feeling pain or physical restrictions. The information shared by each participant belongs to the above themes. The themes are described below, and additional verbatim quotes are shown in Table 2.

Table 2. Examples of older participants' verbatim quotes.

Theme	Participants' Quote
1: Poor sexual experiences	*"Sexual activity has become more of a reminder of what we once had rather than something we enjoy now. We rarely engage in it because, honestly, neither of us feels up to it." (Frank, 79 years old)*
2: Feeling alone	*"My partner isn't around anymore, and that left me feeling incredibly lonely. I miss the closeness and intimacy we once shared." (Barbara, 81 years old)*
3: Religious values	*"I am a Catholic and due to my beliefs, I choose to abstain from sex, as I believe it should be reserved for marriage. Since my husband passed away, I have chosen not to engage in intimacy at all." (Grace, 82 years old)*
4: Medication	*"Medication for my health issues has greatly diminished my sex drive. The side effects make it challenging to engage in intimate activities, so I've largely stopped being interested in sex." (Marilyn, 70 years old)*
5: Not feeling attractive	*"Since I don't feel attractive, I struggle with the idea of being intimate. My self-image has taken a hit, and it's hard to feel interested in sex." (Helen, 79 years old)*
6: Feeling pain or physical restrictions	*"I find it difficult to engage in sex. The discomfort and pain makes intimacy challenging and often unenjoyable, so I've stopped trying." (Arthur, 81 years old)*

3.1. Theme 1: Poor Sexual Experiences

Seventy-seven older adults found non-pleasurable and non-satisfactory sexual experiences to be contributing most to SU, particularly for older Portuguese participants (*nPort* = 67). Only 10 Mexican participants mentioned this.

Some participants believed that poor sexual experiences resulted in less interest in the sexual function, hence less sexual activity. In general, Portuguese participants showed more diversity of poor sexual experiences than Mexican older adults. Portuguese participants indicated that they felt less availability for sexual intercourse, fear of not being able to perform, less desire, and few seductive contexts. Mexicans' poor sexual experiences were related to the influence of traditional social norms and expectations on their intimacy and to daily living shared with several members of the family. These seemed to negatively affect their sexual experiences. Carla explained: *"Nobody teaches us how to have the best experiences, and even if we have someone, we are ashamed to ask, because this is our intimate life. So, I think many of us go through unsatisfactory sexual experiences until we get to the best of times. However, many may give up halfway and end up being no longer sexually active."* (Carla, female, 89 years old). In the same sense, Esther expressed that *"when I was young it was almost daily, now I'm fed up, I'm not interested"* (Esther, female, 72 years old).

Not feeling sexual drive is a factor that negatively influences the sexual activity of older adults. As Tim reported, "*I have had several sexual experiences throughout my life. But it was less and less pleasurable. The pleasure is not the same. I lost interest because I could no longer feel the adrenaline at 100%"*(Tim, 92 years old).

In the same way, Rita verbalized *"I don't feel that satisfaction anymore like before. Unfortunately, we both lost interest in sexual activity, so now it's just kisses and romantic hugs. It's not the same but we are happy."* (Rita, 84 years old). While Sara said *"The emotional instability give me sexual unwellness, I don´t see the interest, I don´t feel like doing it"* (Sara, female, 80 years old).

3.2. Theme 2: Feeling Alone

The second theme most mentioned by the older adults in this study was feeling alone (*n* = 61). Mexican participants mentioned this the most (*n* = 36), followed by Portuguese participants (*n* = 25). Feeling alone was very frequently verbalized by both groups. Mexicans felt that feeling alone contributed to their SU, mainly due to widowhood and restrictive social expectations and relationship difficulties. Romantic experiences with

sexual intercourse seemed to be desirably kept as private, hence romantic encounters were not stimulated or facilitated. Some participants indicated that it was easier to choose paid sexual intercourse than to engage in dating others. Portuguese participants felt lonely mainly due to widowhood, relationship issues, and to difficulties in displacing and to geographical isolation, hence they felt less social opportunities to socialize with others and to share their couple experiences with friends and family.

Indeed, the participants in this study expressed significant losses related to aging in terms of family or social relationships. Hugo explained, *"I was married, once. I don't intend to do it again to be honest and that's why I've been alone ever since. She was the love of my life. It was some time ago and it was from there that I left my sexual life behind"* (Hugo, male, 68 years old). In the same sense, Maria verbalized *"in old age you cannot give what you would want, everything changes due to age, the curve of desire decreases"* (Maria, female, 74 years old).

On the other hand, some older participants perceived their loneliness to be an important aspect for their SU and as an opportunity to explore the world, albeit in the absence of romantic relationships and sex. *"We are all aware that one day we will leave this world and we will leave someone behind. My husband passed away some time ago, it is sad but it is life. I try to see this as an opportunity, an opportunity to do the last things I want in this life for myself and not as a couple. I have had enough sexual adventures, they only conduct to more loneliness!"* verbalized Filipa (Filipa, female, 73 years old).

Within this theme, independence and difficulties in displacing were also addressed: *"I was always an independent person, and I never liked to depend on anyone. So, I don't really feel alone, but yes, my sexual activity was affected after I lost my partner"*, declares Gina (female, 78 years old).

Some others expressed relationship problems: *"it makes you feel bad, when you want to be with that person and rejects, and abandons you, since my husband left me I haven't had any sexual relationship, nor interest"*(Celina, female, 65 years old), *"I don´t want anything since my husband´s infidelity"* Laura added (female, 71 years old). Juan also verbalized *"my wife no longer wants to have sex, she is that cold"* (Juan, male, 69 years old).

Finally, some participants indicated that they would like to have a sexual life, but did not have a sexual partner: *"I feel unwellness because I do not have the closeness of my wife, I feel bad because I don´t have a partner"*, said Victor (male, 67 years old). Moreover, Esther expressed *"I can´t do anything, I feel desire, but I don´t have a husband"* (female, 76 years old).

3.3. Theme 3: Religious Values

The third most common theme was religious values (n = 54); however, Mexican participants did not mention this. Religion and spiritual beliefs have been an important topic for people in older age. Interestingly, Portuguese participants were the only participants to verbalize this theme. Although many did not integrate religious communities, these older adults expressed that religious values were important for them and that sexual pleasure, desire, and eroticism were negatively experienced with guilt and shame in their religious cultural context.

For those who belonged to religious communities, religious matters were construed as a way of joining a community, as well as a source of strength, in which sexual activities were not always positively perceived. Mara verbalized, *"I already felt part of a community and I feel that society does not accept us as before. They even think that because I'm older I can't be sexually active. Society has changed, it is normal, but religion has not. I still feel the same here"* (Mara, female, 69 years old).

Some older participants felt that sexual activities were incongruent with their religious beliefs and were therefore less likely to perceive their sexual behaviors and feelings as acceptable and as matching their moral standards, so many abdicated their sex lives. Helena explained, *"I have a commitment to the church, and I think my sexual activity goes against that. I think in a way I am afraid of moral judgment. So, my sex life is ruled out"* (Helena, female, 65 years old). In a similar vein, Diana reported, *"I have always believed that God viewed sex in a negative way, so having a Catholic religion, I do not attach much importance to my sexual activity.*

For me, the church means a lot, because it was implemented in my life since I was a child, so I think I gave up on sex life some time ago." (Diana, female, 87 years old).

Participants also reported feelings of shame and guilt. As Ana shared, "*My faith has always told me that sexual activity should be reserved for procreation inside marriage. Now, I feel guilty and ashamed for having sexual fantasies*"(Ana, female, 71 years old). As Maria also explained, "*My religion teaches us that sexual pleasure is sinful after a certain age. This belief makes me feel like there's something wrong with me when I feel sexual desire for any man*" (Maria, female, 68 years old).

Moreover, despite the evolution of social norms, some older adults still experience significant stigma related to sexuality. For example, Carlos mentioned, "*I grew up with the idea that old age means giving up on sex."* (Carlos, male, 80 years old). Sophia also verbalized, "*I always had a strong desire to explore an intimate relationship with multiple partners, but my religious beliefs and fear of societal judgment make me suppress these feelings"* (Sophia, female, 72 years old).

3.4. Theme 4: Medication

The fourth most common theme was medication (n = 32), and this was relevant to Portuguese participants alone.

These participants indicated that several drugs, such as antihypertensives, anticholinergics, antidepressants, blood pressure drugs, antipsychotics, acid-blocking drugs, and some tranquilizers, and some surgeries negatively affected their sexual experiences. Moreover, they indicated that they felt more side effects in their sexual function, than when they were younger. Some medication, especially in relation to comorbidities, can affect an older person's ability to have and to enjoy sex. *"I had surgery to remove part of the breast due to breast cancer. Everything went well, I took several medications, which made me lose my sexual interest,"* tells Kim (female, 70 years old).

Aging may be associated with different types of problems, such as heart problems. Dean explained "*I take medication because I have heart problems, and I often have problems with erections. Also, I already had a heart attack and so I am afraid that having sex will cause another attack.*" (Dean, male, 71 years old). Indeed, some drugs can cause sexual problems. Ana pointed out the following: "*Some time ago I started taking medicine and I felt difficulty with arousal and orgasm. So I think that it has contributed to a reduced sexual activity*" (Ana, female, 68 years old).

Furthermore, medication can provoke SU. Gina reported: "*I started taking a medication, but because of it I started to get depressed and it made me lose the desire to have sex*" (Gina, female, 71 years old).

3.5. Theme 5: Not Feeling Attractive

Not feeling attractive was the next theme, with this being most relevant to Portuguese participants ($nPort$ = 25). One Mexican participant mentioned this. Not feeling attractive was most relevant to female participants (87%).

Not feeling attractive was mainly an issue for Portuguese participants. Conversely, Mexican participants did not feel that unattractiveness was relevant to their SU. Portuguese participants, and, in particular, Portuguese older women, felt that their aging body was an obstacle for the sexual well-being. These indicated that feeling that the body lost its younger shape, that it became more flaccid, and with wrinkles, which detracted them from enjoying their sexual experiences. Moreover, they expressed strong feelings of sadness and hopelessness concerning negative changes in their body.

Comparing past and present, physical appearance may significantly affect self-esteem and older adults' perceptions of attractiveness. Lara explained *"It is strange to say this, but I am afraid to see myself in the mirror, to look at the body. I was a model before, and now I've aged (it's normal), but I don't feel like an attractive person, so my self-esteem has gone down. It influenced my sex life, without a doubt"* (Lara, female, 74 years old).

For men, masculinity remained important and was a synonym for attractiveness. "*I no longer have those abs or that physique as before. I feel insecure sometimes, so having sex with insecurities is not the best combination*," revealed Diego. (Diego, male, 67 years old). Additionally, Pedro said "*I don´t feel comfortable, I feel I lack virility*" (Pedro, male, 82 years old).

Moreover, beauty can be seen from different perspectives and for the older population, beauty was defined in terms of life experiences. Samantha explained *"Nowadays we associate old age with bring unattractive. But this is subjective! I was beautiful and today I continue because in advanced life what defines us as attractive or not, is not exactly a perfect body, or skin without wrinkles, but rather the experiences we carry: emotional, sexual and other experiences"* (Samantha, female, 85 years old).

3.6. Theme 6: Feeling Pain or Physical Restrictions

The last theme most mentioned was feeling pain or physical restrictions for Mexican (n = 7) and Portuguese (n = 6) participants.

Indeed, the last theme was relevant for both Mexican and Portuguese participants. Mexican participants indicated that physical restrictions due to poor lifestyle behaviors (e.g., smoking, eating, and sedentary living) negatively affected their sex life. In a different perspective, Portuguese reported that heart diseases, pain during penetrative sex, and chronic pain due to medical conditions negatively influenced their SU.

Age is not a reason to change the sexual practices you have had throughout your life, but it may be necessary to make some adjustments to accommodate the physical changes of aging. Brian verbalized, *"I haven't stopped being sexually active, but I'm not as active as I used to be. We both agreed that our body was not the same, that pain is always there and that is why we decreased in frequency"* (Brian, 72 years old).

With some medical conditions and age, muscles generally lose strength, flexibility, and endurance, and these factors affect coordination, stability, and balance. *"I am more physical vulnerable and that is why I have to be more careful with all the activities of my life. Sexual activity was one of those that was affected,"* reported Bianca (female, 69 years old).

Feeling pain was verbalized as uncomfortable and demotivating, especially during sexual activity. For example, with the vagina being more fragile, penetration is more painful. Vivian explained, *"My sexual activity has decreased because I didn't feel so comfortable, I felt pain. This is a negative point, obviously."* (Vivian, female, 65 years old).

Additionally, restrictions due to diseases and poor lifestyle behaviors can be a source of SU: *"having a disease of a physical problem does not let you enjoy sex"* (Omar, male, 78 years old), while Margarita verbalized that *"not sleeping well, having a poor diet and not eating well, contributes to SU"* (Margarita, female, 87 years old).

4. Discussion

The objective of this study was to explore older adults' perspectives on SU across Mexican and Portuguese cultures. We met this objective, since content analysis revealed six key themes: poor sexual experiences; feeling alone; religious values; medication; not feeling attractive; and feeling pain or physical restrictions. The findings are particularly noteworthy and highlight issues related to SU. Any such issues can be experienced at other life stages and thus have broader relevance across the life course. What we learn from older people can inform all-age research. Moreover, we are all aging.

'Poor sexual experiences' was mentioned most and particularly among older Portuguese adults. These results may be associated with the fact that we also found in this study a greater proportion of Portuguese with more education than Mexicans. Since a higher training level is associated with greater criticism and greater demand, this also seems to play out in the sexual sphere (Bouman 2013). Some older adults indicate a general decline in the quality of sexual experiences with age (Hinchliff et al. 2018). However, Allen and Desille (2017) found that greater openness and less agreeableness were related to higher levels of sexual satisfaction and more frequent sexual activity, among other attitudes. For

some sexually active older people, more frequent experiences, higher levels of extraversion, and lesser neuroticism can afford greater sexual satisfaction (Allen and Desille 2017).

Many women reported that sex became more pleasurable after age 50. They speak of a strong desire to maintain sexual pleasure and intimacy as 'a person' who is also aging (Allen and Desille 2017). It is important for health professionals to implement sexual health in their routine care for older patients. Doing so can help prevent sexually transmitted diseases, increase adherence to medications, and improve quality of life in older age (Freak-Poli 2020).

'Feeling alone' was most relevant to older Mexicans, which may be associated with having fewer partners than older Portuguese people typically do. Individuals in late adulthood can be especially vulnerable to loneliness if they do not have a partner and/or a support network nearby (Hsieh and Liu 2021; von Humboldt et al. 2022b). Over the past decade, intimate relationships in later life have increasingly captured researchers' attention. Advanced life is associated with less sexual activity and sexual thinking but not with differences in intimacy (Kolodziejczak et al. 2019). Kolodziejczak et al. (2019) found that older people who reported more loneliness also reported less sexual activity and less intimacy but not fewer sexual thoughts. Sexual expression can also be negatively influenced by the loss or death of partners (von Humboldt et al. 2021b).

'Religious values' were relevant to older Portuguese participants alone. In a religious dimension, sexually active older adults could be conceived of as sinners (Tôrres 2006; Uchôa et al. 2016). Religion is a highly relevant socio-cultural impetus for Portuguese people. This may be due to ancient Judeo-Christian values in European cultures, with these being more historically situated than in Latin America per se. In this sense, Uchôa et al. (2016) found that 15.5% of older Brazilian people consider religion to be one of the factors that restricts their sexuality. The repression of sexuality in later life comes mainly from family, religion, and society (Souza et al. 2015). In having long-dwelled in communities that espouse Judeo-Christian values, Portuguese and Mexican participants in this study were likely to have lived out their sex lives accordingly. In this cultural context, sexual expression can be defined more by the reproductive dimension than by pleasure, satisfaction, and eroticism (von Humboldt et al. 2020). Iveniuk et al. (2016) argue that religion shapes the quality of older people's sexual lives. Religious values vary in relation to biological sex, and religion influences sexual expression differently. In 2011, almost 80% of Portugal's general population is Roman Catholic, with a mere 14.1% having no organized religion or being indifferent, agnostic, or atheist. The prevalence of Protestants and evangelists has grown, perhaps largely due to Brazilians immigrating to Portugal (Manuel and Glatzer 2019). In Mexico, despite the steady decline in Catholicism since the 1950s, 8 in 10 Mexican people identify as Catholic, and Protestants, evangelists and non-affiliates seem more plentiful (de la Torre et al. 2017; INEGI 2010).

Medication was most relevant to Portuguese participants in relation to SU. Sexual dysfunction is a common and distressing side effect of many medications (Smith 2007). The first available drug to treat sexual dysfunction was for male erectile dysfunction. Even today, men are more likely than women to take drugs for sexual dysfunction, which can increase the number of complaints (Carpenter et al. 2009; Richters et al. 2014). However, in particular, Portuguese seniors may have given more importance to the effects of medication in the SU than Mexicans due to their higher annual incomes and concomitant purchasing power.

On the other hand, among adults over 85, disability rates are relatively high (Jaul and Barron 2017). Older people with disabilities often struggle with chronic pain, depression, and complex medication regimens (Connolly et al. 2017). Further, older adults have assigned growing importance to sex over time (A. Graf and Patrick 2014). One possible outfall is that older people stop taking or lessen their intake of prescribed medications to preserve sexual function. Medications are common at this stage of life and have different collateral effects due to increased sexual dysfunction (Freak-Poli 2020). Antidepressants can, for example, deter sexual function (Clayton et al. 2014). Drugs also have sexual side effects. Hypertension medications can cause erection problems, many of which are prescribed

for people aged 50 and over (Hinchliff et al. 2018). The prevalence of drug-related sexual problems is often higher in later life due to age-related sensitivities to side effects (Bouman 2013). Older men are often affected by multiple chronic diseases and drug regimens and are thus privy to worsening sexual function (Bruzziches et al. 2013).

'Not feeling attractive' was most relevant to older Portuguese participants. The study by von Humboldt et al. (2020) indicated that attractiveness was a relevant theme for sexual expression in old age. Although attractiveness is a personally relevant topic for a good number of people, attractiveness is generally wrongly considered to be unimportant in later life (von Humboldt et al. 2020).

There are many psychological or social factors that influence sexuality, including a poor body image, feeling less attractive (due to surgeries or simply body changes), feeling less feminine or less masculine, and fear of rejection, all of which affect older adults' sexual experiences (McNicoll 2008). Feeling attractive can also be related to availability and space for intimacy and with feeling loved and desired (Hillman 2012). Unlike Portuguese seniors, Mexican seniors largely lived alone or with their sons. This living arrangement is likely to hinder expressions of affection and intimacy and thus influence SU.

Træen et al. (2017a) found that sexual experiences can be affected by psychological and interpersonal factors such as common biological changes, with these dampening older people's sex lives. In addition, while the greater emphasis in society on attractiveness among women per se is considered a central factor in their bodily satisfaction, few studies have been published on body image and sexual health in older women and even less among older men (Træen et al. 2017a). Marshall et al. (2014) found a positive relationship between sexual satisfaction and the degree of fitness among older men *and* women.

In a focus group study, 13 older women reported that they perceived their bodies more negatively when naked than when dressed (Liechty 2012). The aging process itself poses challenge for body image, especially for women who define themselves largely based on physical appearance (Ferraro et al. 2008; von Humboldt et al. 2018). Nowadays, sexual or sexualized images are often associated with young and energetic people. These images may not only affect the younger population, but also the beliefs of older people, and suggest that sex is only for younger adults. Both men and women who are aging may feel that they are no longer physically or sexually attractive, and this can hamper their sexual desire (Træen et al. 2017a; Erens et al. 2019).

Feeling pain or physical restrictions was mentioned with similar frequency among Portuguese and Mexican participants as contributing to SU. Difficulties associated with reduced vaginal lubrication and thinning of vaginal tissues after menopause can make sexual penetration painful (Bouman 2013). Additionally, lower sexual function can be associated with menopausal symptoms as well as with advancing age (Ornat et al. 2013). Although some women report heightened sexual desire and improved body confidence during menopause, others experience significant distress due to physical and sexual changes. This distress is not solely attributed to the biological aspects of menopause but is also influenced by the interaction of these changes with individual psychological and relational factors (Ussher et al. 2015).

Health problems can influence whether individuals have an intimate partner (Erens et al. 2019; Rodrigues et al. 2018). Pain and physical restrictions can be in-common factors across cultures in later life. Aging brings natural biophysiological and psychobiological changes that may negatively impact the (in)dependence of seniors and sexual functioning (Bouman 2013; Erens et al. 2019; von Humboldt et al. 2013b). Untoward physical and mental health may decrease sexual desire, hinder sexual positions, increase anxiety (e.g., sexual activity can trigger another heart attack), and affect sexual well-being (Bouman 2013; von Humboldt et al. 2022a).

When both partners may experience sexual difficulties, this can further enhance sexual frustration. In other cases, sexual difficulty for one partner makes it easier to accept that sex is no longer a fundamental factor in that relationship (Hinchliff et al. 2018).

Given that sex can be a quality-of-life issue in later life and that older people may experience sexual difficulties but not receive appropriate care, SU research is essential research (Hinchliff et al. 2018). Older individuals do not necessarily address their sexual concerns spontaneously; therefore, it would also be beneficial to have educational and intervention programs about SU (von Humboldt et al. 2017). From a cross-cultural perspective, this study highlights differences in the way older adults perceive SU. Poor sexual experiences most resonated with older Portuguese participants. Mexican participants identified with feeling alone.

The findings of this study should be interpreted with several limitations in mind. First, the studied sample captures perspectives on SU among two ethnic groups. This does not make our findings generalizable to others. More cross-cultural studies about SU are needed. Most participants also had a high level of education and were sexually active, which likely having influenced their decision to participate. Furthermore, participants' responses may have been biased due to social expectations. Aging as it relates to sexuality is a particularly sensitive area to study, especially regarding intimacy and sexuality desire. This could limit what researchers learn from cross-cultural comparisons (Bouman 2013; Erens et al. 2019; von Humboldt and Leal 2014).

Another limitation of this study is the fact that a good number of participants had experienced significant age-related losses, and this may have evoked more negative life experiences in relation to SU. Clearly, future interventions with older groups need to address individual beliefs as well as structural and social factors. Furthermore, this study does not comprise the experiences of people with different sexual orientation and gender identity. Future studies should include older LGBTQIA+ adults experiences.

The current study brings value to the literature. The study has a well-defined sample from a sociodemographic point of view, as it contains high- and low-income participants. In addition, making international comparison increases literacy, particularly given the paucity of studies about SU in later life. Furthermore, cross-cultural dimensions provide a more holistic conceptualization of SU and a better understanding of key thematic influences in older people's sexual lives.

In addition to the biological and psychological factors influencing sexual wellness in older adults, it is essential to consider societal stigma and double-standards. Stigma related to later-life sexuality often deters older adults from seeking help for sexual concerns (Syme and Cohn 2016). This can be rooted in feelings of shame, lack of knowledge, and deeply ingrained beliefs that sex when you are 'old' is inappropriate (Syme and Cohn 2016). Such stigma not only affects individuals' willingness to address sexual issues but also limits access to sexual healthcare and support services.

Societal myths about aging and sexuality can expose older people to others' harsh judgments, particularly among women. Research tells us that older adult men generally exhibit more positive attitudes toward sexual expression than women, which is befitting of sex-specific perceptions in society at large (Waite et al. 2009). Additionally, societal norms and conservative attitudes towards sexuality in older age, particularly regarding sex outside marriage, further perpetuate stigma and reinforce double standards (Hillman 2012). More and more, sexuality plays a bigger role in older age. While older men and women remain actively engaged in sexual activities, they also experience great suffering from reduced sexual activity and physical tenderness as they age.

In this study, 'poor sexual experiences', 'feeling alone', and 'religious values' were the three most important themes that contributed to SU. On the other hand, themes such as 'medication', 'not feeling attractive', and 'feeling pain or physical restrictions' have also been shown to influence SU in older life but with less impact than those previously mentioned. Sexuality is a factor of great importance to active aging. Considering sexuality as a lifelong experience and gaining a deeper understanding of sexual health should be a priority for people at any age. Older people should be encouraged to seek help. Policies that support and promote intimate relationships and sexual health in later life are essential (Freak-Poli 2020).

It may be possible to evoke positive changes in cultural attitudes through open discussions about sexuality in later life. It is wrong to assume that older adults have no interest in sex or are not affected by the absence of a sexual partner (Freak-Poli 2020). Older adults' sexual experiences are shaped by many factors, such as religion, age, gender, health, disability, location, sexual identity, migration history, socioeconomic status, and ethnicity (Gewirtz-Meydan et al. 2018; von Humboldt et al. 2022c, 2023a).

This study provides rich information to health professionals and older people about their sexual behavior and sexual issues and links both to the aging process. Indeed, health and mental health practitioners may benefit of this study by considering in their practice elements that affect SU and by focusing on the sexuality of older people with a deep cultural and ethnic sensitivity. Additionally, future studies that compare the contributors to SU in old age and consider cross-cultural differences (e.g., equality, intimacy, and religiosity) in an in-depth way could therefore have relevant practical implications.

Moreover, this study underscores how SU among older adults is influenced by a complex interplay of cultural norms, historical contexts, and social expectations and stereotypes. While the challenges faced by older adults are significant, they also reflect broader cultural patterns that strongly modulate sexual expression across the life cycle. Understanding SU is not limited to older populations and is relevant to broader social, historical, and cultural discussions on sexuality and aging. This study enriches current understandings of how cultural attitudes and societal norms influence SWB. This study contributes to sociocultural and theoretical discourse around sexual health in later life by making practical recommendations based on the views of older people themselves.

Older adults' sexual well-being may be negatively affected by different factors. Cultural differences influence people's sexual needs and expression in later life. The findings of this study underscore the need to study multiple aspects of SU, such as poor sexual experiences, loneliness, medication, religious values, not feeling attractive, and feeling pain or physical restrictions. These SU themes were important factors seemingly influencing sexual activity in later life and could be key intervention foci.

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