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Sexual desire among Mexican-American older women: a qualitative study

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Abstract

Although researchers have related sexual desire in older women to quality-of-life variables such as overall physical health, well-being, and life satisfaction, little is known about the socio-cultural mechanisms that shape sexual desire in minority ethnic older women. We investigated this sexual variable among Mexican-American older women in a qualitative fashion. Date were collected from 25 community-dwelling women of Mexican descent (aged 59–89 years) using a semi-structured interview protocol and a grounded theory approach. We inquired about dimensions of sexual desire including sexual fantasies and the desire to engage in sexual activity within the context of several socio-cultural and health-related factors. Using content analysis, we were able to identify key themes differentiating among respondents' levels of sexual desire and fantasies. These included the availability of a suitable partner, cultural and religious norms pertinent to women's sexuality, stigma related to sexuality in older age, and health status. Traditional socio-cultural restrictions coupled with unmarried status and physical health problems emerged as critical issues associated with limited or no sexual fantasies and desire in our sample. Many respondents indicated that their sexual needs were unmet.

Keywords

sexual health; sexual desire; older women; minority ethnic groups; USA

Sexual desire is a core component of sexual health (Young et al. 2000), and a key sexual developmental task in later life has been identified as that of sustaining pleasure into older age (Levine 1991). As pointed out by Nusbaum, Singh, and Pyles (2004), it is common to assume that sexual interest wanes considerably as people grow older. In contrast, researchers have discovered that ageing does not necessarily precipitate decreased longing for sexual intimacy (National Council on the Aging 1998; Laumann, Paik, and Glasser 2002). In fact, older women's sexual satisfaction is highly related to overall well-being, life satisfaction, and physical health (Yee and Sundquist 2003). To better understand the sexual needs and behaviours of minority ethnic older women in particular, researchers must acknowledge that these women traditionally place a strong emphasis on cultural prescriptions and norms (Phinney and Flores 2002). However, to our knowledge, there is very little empirical evidence on culturally relevant mechanisms that shape sexual desire in these research populations.

Sexual health is of particular interest in Latino populations in particular, as they constitute the largest ethnic group after Anglo-Saxons in the USA (United States Census Bureau

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2003). Of the 38 million Latinos, approximately 24 million are of Mexican descent. Women, who comprise the majority of older adults in the U.S., represent over 58% of older Latinos (United States Census Bureau 2005), thus Mexican-American older women are a sizeable research population. To contribute to the scarce literature on this topic, in the current study we explored socio-cultural and health-related factors associated with sexual desire among community-dwelling Mexican-American older women. Due to space limitations, we do not discuss the comparative literature on sexual desire and fantasies in older women from other cultures.

In the Diagnostic and Statistical Manual of Mental Disorders-IV-TR (DSM-IV-TR; DSM-IV-TR; American Psychiatric Association 2000), sexual desire is defined as the first phase of the linear model of the human sexual response cycle (followed by arousal, orgasm, and resolution; Masters and Johnson 1966; revised by Kaplan 1969). It encompasses two distinct features: fantasies about sexual activity and desire to engage in sexual activity. According to the DSM-IV-TR, hypoactive sexual desire disorder is a persistent deficiency or absence of fantasies about sexual activity and desire to participate in sexual activity. It is the most common form of sexual dysfunction among women age 18 to 59, affecting approximately one-third of all women. Older women's sexual desire is not a frequently addressed topic within health care settings, as general practitioners typically deem women's sexual health in old age to be an illegitimate topic of discussion due, at least partially, to stereotypical views of sexuality and ageing (Gott, Hinchliff, and Galena 2004). Indeed, stereotypes of the older woman continue to persist: according to Spence (1992), with older women being expected to be sexually undesirable, to not desire sex, and to be incapable of having sex. However, although the frequency of women's sexual activity typically declines with advanced age, sexual interest and ability generally do not (Benbow and Jagus 2002).

Women's cessation of sexual activity in later life depends on a multitude of factors. These include: (a) outliving men (in almost every country in the world; Austad 2006), which typically results in the lack of access to a partner (Pennell Initiative for Women's Health 1998) and forces older women into sexual abstinence (Vincent 2002); (b) an emotionally distant relationship with an intimate partner (Johnson 1998); (c) misinformation, misconception, and prejudice (Butler and Lewis 1988); (d) the culturally induced belief that sexual activity is for the young (Lobsenz 1974); (e) boredom and fear of failure (Rubenstein 1978); (f) needs of family members that result in strained emotional energy within the older couple (Kingsburg 2000); (g) lack of privacy (Le Gall, Mullet, and Shafighi 2002); (h) reduced levels of oestrogen and other hormones (during and after menopause) resulting in lower levels of sexual desire (Benbow and Jagus 2002), as well as in decreased vaginal lubrication and related painful intercourse (Dennerstien 1996); (i) illness and medication use (Gefland 2000), which often disrupt women's sexual functioning at all ages (Laganà et al. 2001); (j) poor body image (Leiblum 1991); and (k) erectile dysfunction in a sexual partner (Kingsburg 2000), with over 50% of men experiencing it by age 50 at a rate increasing by nearly 10% every decade (American Psychiatric Association 2000).

In addition to the aforementioned factors, depression, social networks/resources, as well as religious and cultural norms are likely to play a role in the sexual lives of Mexican-American older women. Regarding depression, deficiencies in sexual desire are often related to severity of depressive symptomatology (Benbow and Jagus 2002). Concerning our target population, there is empirical evidence showing that low-income immigrant Mexican-American older women are at heightened risk for depression (Chiriboga et al. 2002), which could affect sexual desire adversely. To our knowledge, researchers have yet to explore dimensions of sexual desire in relation to depression in this ethnic population. With regard to social resources, Wegner (1997) found that having multiple social networks acts as a protective factor for older adults' diseases and fatal health outcomes, as well as loneliness

and depressive symptomatology, but no research has related social resources to Mexican-American older women's sexual desire.

As to sexuality in relation to religious and cultural norms, older men and women who are religious typically are more sexually conservative than young people and nonbelievers, regardless of educational level (Le Gall et al. 2002). Concerning women in particular, empirical evidence shows that those with the greatest sexual satisfaction did not attend church within the past year (Davidson, Darling, and Norton 1995). These findings draw attention to the fact that, because most religions disapprove of sexual intercourse outside of a marital relationship, the repressing effects of religion on sexual desire could be substantial especially if an older woman is not married. According to Pick, Givaudan, and Kline (2000), in traditionally patriarchal societies such as Mexico, church-based social norms typically discourage the dissemination of accurate sexual knowledge within families and educational structures. On the opposite side of this issue, the defence of sexual and reproductive rights in Mexico is being carried forward by groups such as the feminist movement (Lamas 2003). Also, since the 1980s, there has been a growth in programmes providing sexuality education and family planning in Mexican youth centres (e.g., Townsend et al. 1987). Nowadays, younger women of Mexican background tend to focus on mutually pleasurable sexual intimacy within modern marriage (Hirsch 2003). Mexican-American older women, however, did not have access to the same kind of sexuality education when they grew up. They were typically raised, in accordance with traditional Mexican cultural norms, to engage in sexual interactions within a marital relationship fulfilling a gendered set of marital obligations (Hirsch 1999). These rather outdated norms could discourage the sexual autonomy and agency to make informed decisions about sexuality of women from prior generations. Given this socio-cultural historical context, it is reasonable to posit that older women of Mexican descent may be at risk for poorer sexual health, having low or no sexual desire.

To investigate sexual desire among Mexican-American older women, we chose as the conceptual foundation of this study Engel's (1977; 1980) classic biopsychosocial theoretical model of medicine, in which health (including sexual health and desire) is viewed as being influenced by a variety of factors. Because we designed this study following a methodological commitment to grounded theory (Charmaz 2003), we did not formulate any specific hypotheses in advance, but allowed respondents to create valuable data through the construction of their own stories of sexual desire. Charmaz's theory is particularly salient to our study, due to the scarcity of in-depth literature in this area, offering a systematic approach that guided the research process in the identification of emerging subtle themes from our interviews.

Methods

Sample

Our sample included 25 community-dwelling women of Mexican descent. Research assistants recruited participants as volunteers at stores, churches, libraries, and senior centres in Los Angeles County. Recruitment occurred using purposive sampling, i.e., focusing recruitment efforts on one specific ethnic population within Mexican-American communities, and snowball sampling. The latter was implemented through participant referral of other potential respondents. Inclusion criteria were: being at least 55 years of age (in line with many of the aforementioned studies), of Mexican descent (immigrant or first generation), and fluent in English (to minimise confounding the findings with acculturation levels). Exclusion criteria were: living in an institutional setting, or not being able to provide informed consent. The socio-demographic characteristics of the sample are summarised in Table 1.

Procedures

The procedures used in this investigation are in line with the ethical standards of the CSUN Institutional Review Board (which fully approved this study) concerning research conducted on human subjects. In following Alvidrez and Arean's (2002) suggestions regarding the need for ethical awareness in investigations involving minority ethnic groups, we used research measures and procedures that would minimise respondents' discomfort. For instance, to increase this study's cultural sensitivity, we matched research assistants to respondents in terms of ethnic background and gender. A consent form was signed and dated by each participant before assessment began. The assessment session lasted from one to two hours. Respondents chose convenient locations at which to conduct the interviews, usually libraries, senior centres, or similar facilities.

Measures

Demographic list—This simple list was developed by the first author. It is a 10-item tool that allowed us to quantify participants' socio-demographic information regarding age, place of birth, educational level, employment status, income, and marital status.

A semi-structured interview—This protocol was created by the first author to elicit older women's attitudes, beliefs, perspectives, and behavioural practices concerning sexuality, as well as their psychosocial and physical health concerns. The content of this protocol was based on an extensive review of the pertinent literature, in an attempt to maximise its contextual reliability and validity. Some of the protocol questions and related answers are reported later in the results section. To minimise the possibility of offending or embarrassing older women, specific sexual questions were not asked on topics such as masturbation or interactional sexual activity.

Data analyses

Descriptive statistics were computed for the socio-demographic variables using SPSS. The second author transcribed all audiotapes, typing the content of each interview first into Word files. Then, files were entered into the computer software NVivo (Quantitative Solutions and Research International, Australia 2000). This is a qualitative software used for textual data/content analysis and theory construction, generally utilised to inform sociological and anthropological researchers' understanding of social life (Walsh 2003). First, the themes covering sexuality and related topics were identified using open coding. In the second phase of analysis, respondents were placed on two continua for axial coding purposes based on their sexual desire responses. Finally, selective coding of the themes was implemented in order to identify sub-themes particularly relevant to sexual desire. The coding system was established by the second author in the following manner. Upon selecting 10 interview protocols at random, she based the initial system on the content analysis of these protocols' responses, coding them as presence/absence based on criteria established for each theme (e.g., absence of sexual desire if a respondent stated that she did not experience any sexual desire). Subsequently, five interviews were coded collaboratively to verify overall thematic fit. Both authors discussed minor inconsistencies in their application of the coding system and refined the content of the coding manual. This procedure allowed for verification of coding agreement and achievement of consensus on the final version of the manual containing full descriptions of the criteria for the themes and sub-themes. Finally, the second author re-coded the 15 interviews and coded the remaining 10 interviews according to the final manual. Regarding missing data, none of the respondents failed to answer the questions on the themes identified. The same was true for most demographics; concerning income, three women declined to disclose information on this variable.

Results

Open and axial coding

Five major themes emerged from the interviews through open coding: 1) Sexual health issues (because none of the respondents mentioned masturbation, only sexual activity of an interactional nature is discussed herein); 2) Physical health issues; 3) Mental health issues; 4) Socio-cultural factors; and 5) Religiosity/spirituality in particular. Concerning axial coding, research participants were placed on two continuums based on their responses concerning: 1) presence or absence of desire to have sexual activity (X-axis); and 2) presence or absence of fantasies about sexual activity (Y-axis). Women who reported having *sexual fantasies and desire to have sexual activity* were placed within the upper right-hand quadrant (QI). Those with *sexual fantasies but no desire to have sexual activity* were placed within the upper left-hand quadrant (QII). Respondents with *neither sexual fantasies nor desire to have sexual activity* were placed within the lower left-hand quadrant (QIII). Finally, those who had *no sexual fantasies yet desired to have sexual activity* were placed within the lower right-hand quadrant (QIV). Figure 1 offers a graphic illustration of the positioning of each respondent within the quadrants.

Selective coding

Numerous issues/sub-themes emerged from the major themes, as women's answers to several questions varied as a function of their placement within the two axes. Seven women in QI expressed having fantasies about sexual activity and desire to have sexual activity. These women ranged in ages from 59 to 82 years (57% were divorced, 29% widowed, and one married). Some of them reported acceptance of a decrease in their sexual desire as a normal part of ageing. Conversely, others identified a variety of sub-themes such as a lack of a suitable partner, loyalty to a former husband, and/or cultural restrictions as the reasons for a lack of sexual activity. The woman who verbalised the strongest sexual desire also had the highest frequency of sexual activity. All of them stated that marriage was the appropriate context in which to have sex. Nearly all women (86%) were taking no medications; 57% of them had a single medical condition. All women in this quadrant reported having "good" to "excellent" health and being "somewhat" to "very" physically active on a daily basis. Regarding mental health, although 71% of them denied having mental health problems, the remaining 29% considered themselves depressed. They all felt that they had sufficient emotional support from their children, friends, and others who shared their faith. Regarding religiosity/spirituality, most of them self-identified as Catholic or Christian (86%). They reported engaging in several religious/spiritual practices per week such as attending church services or choir groups, as well as praying and reading the Bible and/or Christian-based educational books. God was mentioned as a resource to quell sexual deprivation. Due to space limitations, we have included only a portion of the interviews' questions and related answers/quotes, selecting those that seemed most interesting within each quadrant.

Interviewer (I): "Has your sexual health changed over time?"

Conception (age 67, divorced): "Yes, it has changed. I'm okay with it."

Guadalupe (age 65, widowed): "No. I want to be in a relationship, but there are no men my age around."

Lucia (age 59, divorced): "I would like to believe that it has not. I have been separated from my husband for fifteen years and have not had sex since."

I: "Would you like to be sexually active?"

Magdalena (age 82, widowed): "I would, but I can't because in my culture it's not acceptable."

Rita (age 66, divorced): “Yes, only if I was married.”

Lucia (age 59, divorced): “I might want to be if my husband returns.”

I: “To whom can you turn to if you feel sexually deprived?”

Rita (age 66, divorced): “God.”

Lucia (age 59, divorced): “(Laughter)…My husband, but he is too far away.”

Jezabel (age 70, married): “My husband; he is very active and age has not affected his sexual desires.”

Four women in QII expressed having sexual fantasies but no desire to engage in sexual activity. They ranged in age from 65 to 92 years and were either widowed (two of them), married, or divorced. Concerning sexual health changes, they reported being unaware of whether their sexual desire had changed over time, not thinking about this topic, and/or doing other things that they liked instead of focusing on their sexual needs. These women prioritised sex differently than those in QI, as they did not have any desire to have sex nor find a sexual partner. One widow shared that missing her husband and feeling autonomous (now that she was alone) were her reasons for not wanting to pursue a new relationship. As a group, they had between two and five medical conditions each (e.g., high cholesterol, high blood pressure, diabetes, and arthritis) and took between one and five medications daily. Most of them were unable to stand or walk for long periods of time due to fatigue; one had limited mobility and used a walker for transportation. The majority of them reported having no mental health problems (75%); one woman was being treated for clinical depression. Their social resources (e.g., family, friends, and “senior citizen” groups) were less diverse than those of the women in QI. All of them were either Catholic or Christian and engaged in daily prayer.

I: “Has your sexual health changed over time, and how do you feel about the changes?”

Helena (age 71, divorced): “I don’t know; I don’t think about it.”

Carolina (age 65, widowed): “A little, because I do other things that I like to do.”

Luisa (age 72, married): “Not really…doesn’t really matter much.”

I: “To whom can you turn to if you feel sexually deprived?”

Helena (age 71, divorced): “I don’t know.”

Luisa (age 72, married): “My husband.”

Carolina (age 65, widowed): “…my prayer to God.”

I: “Would you like to date?”

Helena (age 71, divorced): “No, I don’t want any problems; I live good the way I am.”

Carolina (age 65, widowed): “There’s no need…I feel healthy and can do a lot on my own…have friends who live close by and come to visit often, or I go to visit them. I miss my husband sometimes to talk to…His death really had an impact emotionally at the time but I learned to deal with it over the last few years with help from family and friends.”

Twelve women in QIII reported having neither sexual fantasies nor the desire to have sexual activity. Their age ranged from 61 to 89 years. Concerning marital status, 42% of them were widowed, 33% married, 17% divorced, and one was separated. These women either expressed an acceptance of their lack of sexual desire and activity as part of ageing, or the

following sub-themes emerged as reasons for not desiring or fantasising about sex: repulsion toward sexual activity in general, lack of a suitable sexual partner, marital discord, poor body image, or loyalty to a former husband. The majority of them had multiple diagnosed medical conditions such as arthritis, high blood pressure, high cholesterol, and/or diabetes. Almost all the women in this quadrant took several medications daily and stated that, due to ageing, it now took longer to perform physical activities and was hard to walk far distances. Regarding depression in particular, 17% of the respondents in this group stated that they had a diagnosis of depression. All of them reported having been abused by their husband at some point in their lives and/or having an inadequate social support system (limited to their children, grandchildren, family, friends, or a volunteer/church group). They were all Catholic or Christian and, very much like the previous groups, reported engaging in several religious/spiritual practices per week, with the addition of listening to Christian radio.

I: “Has your sexual health changed overtime?”

Liliana (age 67, divorced): “Yes, it is how life is.”

Isabel (age 89, married): “Yes, I hate to be involved in sexual activities.”

Fabiola (age 68, widowed): “Yes, I don’t have a partner.”

Alma (age 63, divorced): “Yes, it has changed. Now, I think I can control all sexual aspects better than when I was younger.”

I: “Would you like to be sexually active?”

Monica (age 74, divorced): “No, I don’t want anyone to touch my body fat.”

Adriana (age 70, married): “No, my husband and I sleep in different rooms; we do not sleep together anymore.”

Rosa (age 65, married): “No, I feel fine like this.”

I: “Would you like to date?”

Liliana (age 80, widowed): “Heavens, no!”

Gabriela (age 70, widowed): “No, I need to keep the memory of my Carlos alive for my grandchildren…and I don’t have the patience to date.”

Monica (age 74, divorced): “Yes, I wish I were dating.”

Two women were placed in QIV, as they had no sexual fantasies, yet reported a desire to engage in sexual activity. Flora was 65 years of age and the only woman in the sample who had never been married. Sonia was 68 and married. Both of them mentioned the existence of contingencies that elicited their desire for sexual activity, i.e., they desired sex only when initiated by the husband (for the married respondent) or wished to be younger in order to have sex. These women had fair physical health, as both of them had two medical conditions (high blood pressure and arthritis, as well as heart and thyroid problems, respectively); one took two medications, and the other three. They both reported feeling depressed and needing mental health assistance (but were not receiving psychological treatment at the time). Flora talked about the cultural stigma that she experienced due to having mental health problems and being an older woman. The married respondent disclosed that she was very distressed by her husband’s alcohol abuse and had no emotional support from others or available mental health services. Both women had more limited social resources than the rest of the sample. Regarding religiosity/spirituality, they were both Catholic and used prayer as their primary religious/spiritual practice, although daily practice was not endorsed.

I: “Has your sexual health changed over time?”

Flora (age 65, single): “Well, I can tell you that as one gets older, our needs for sex get smaller… I can’t believe that I am sharing this with you. Well, it does matter; this is what women should do, feel comfortable talking about sex.”

I: “Do you feel sexual desire?”

Sonia (age 68, married): “I don’t feel the desire, but…when I do it, I enjoy it.”

Flora (age 65, single): “I remember when I was younger and dating I did care for sex.

Now, the desire is no longer there. Maybe it’s because I am not concerned with having a boyfriend or a husband to be with.”

I: “Do you wish to date?”

Flora (age 65, single): “No …I wouldn’t date. I’ve had too many bad experiences with men. I live okay alone; why get into problems at my age? People don’t date anymore…never been married, thank God! I had, you know, lived with men, never a spouse. My dream was to marry a handsome man that would love me unconditionally. My first live-in partner was a drunk and was unemployed…After he beat me severely, and hardships, I moved out and became a single mother to my daughter…My second live-in man was also unsuccessful. This one didn’t drink, but refused to work at all. Once again, I became the head of the household to raise two daughters… and, so here you see me now with my daughters grown, living in a horrible apartment. And, I am an old woman who is alone and unable to work any longer.”

Discussion

In this qualitative study, we found that several factors were related to sexual desire among Mexican-American older women. Although almost half of the sample reported having neither sexual fantasies nor desire, many respondents expressed having such fantasies and/or desire, confirming prior findings on this topic (e.g., Benbow and Jagus 2002). However, a variety of socio-cultural issues reportedly restricted several women from acting upon their sexual urges, which were perceived as unacceptable in their culture. This finding suggests the potential influence of *vergüenza* (i.e., sexual shame; Lorenzo 2005) on many respondents’ sexual behaviours and thoughts. Answers to sexual questions did not differ by place of birth, which suggests a carry-over effect from Mexico to the USA concerning cultural sexual restrictions and related negative attitudes, especially towards women’s sexual expression in older age and outside of marriage. This result corroborates prior research showing that Chicanas and Mexican immigrants are often influenced by patriarchal cultural sanctions dictating that sexual activity for women must be focused on procreation and relegated to church-sanctified marriage (Alarcón, Castillo, and Moraga 1989; Zavella 1997).

Prior research indicates that access to a variety of social resources may act as a buffer against a range of diseases, depression, and loneliness (e.g., Wegner 1997), which could all negatively impact on older women’s sexual desire. In line with such empirical evidence, participants with higher levels of sexual desire and fantasies had the most diversified social networks/resources, interacting with children, grandchildren, and their family, and also engaging in church, volunteer, and exercise groups. If we consider marriage as an intimate social resource, 70% of the sample lacked such a resource. Many of the respondents with a history of intimate partner abuse had neither sexual desire nor fantasies; this suggests that the quality of current or prior relationships is related to whether older women exhibit sexual desire, corroborating prior research findings (e.g., Johnson 1998). Although almost half of the sample reported having sexual fantasies, many of these women had no desire to engage

in sexual activity, justifying this as being due, among other reasons, to the unavailability of an appropriate partner. This is in line with Diokno, Brown, and Herzog's (1990) finding that 55.8% of older married women are sexually active, compared to 5.3% of unmarried ones.

Almost all respondents valued religiosity/spirituality greatly and derived a variety of health benefits from its integration into their lives, e.g., emotional healing and support, a general sense of well-being, and entertainment. This is in line with existing empirical evidence on the benefits of religion/spirituality (e.g., Koenig and Larson 2001). Overall, our sample was highly religious, thus more likely to follow traditional Catholic guidelines regarding women's appropriate sexual behaviours. Many participants referred to God in particular as their source of strength to deal with sexual deprivation, which suggests that a strong relationship with God allowed them to sublimate sexual desires in the absence of a suitable partner. This finding corroborates available literature on this topic (e.g., Pennell Initiative for Women's Health 1998). When asked to whom they could turn if they felt sexually deprived, out of all the unmarried women, only one mentioned turning to a man as an option (most of them saw no option). This mirrors the notion that traditional Mexican values disapprove of women's sexual activity outside of marriage (e.g., Zavella 1997). In agreement with this cultural sanction, almost all non-married respondents felt that they were not in the position to legitimately satisfy their sexual desires. Overall, widows viewed their sex life as being over and did not want to find an intimate partner/husband. This is in line with the traditional view that re-marrying when no longer of childbearing age is not appropriate, as the Catholic church envisions sex as procreation-focused (Valerio-Jiménez 2009).

Our findings also revealed a relationship between older women's physical health and sexual desire: those who had sexual desire were the most physically active, reported the lowest number of medical conditions, and took few or no medications. Conversely, respondents with neither sexual fantasies nor desire were involved in little physical activity, had multiple medical conditions, and took several medications daily. These results support prior research findings indicating that physical health is positively related to older women's sexual desire (e.g., Johnson 1998; Amin, Kuhle, and Fitzpatrick 2003). Regarding mental health, over a quarter of the sample reported depressive symptoms, with depressive symptomatology being present in all four quadrants of analysis. Although prior research shows an inverse relationship between depression and sexual desire in older women (e.g., Benbow and Jagus 2002), our findings do not exactly support this, as there were marked differences between the quadrants' sexual findings (although both women in the 4th quadrant reported being depressed). Perhaps the influence of depression on sexual desire in our sample was less profound than that of other variables such as the availability of a suitable sexual partner, due (at least partially) to the emphasis placed within traditional Mexican culture on older women's sexual restrictions.

This research has several limitations, including the exclusive use of self-report data, a modest sample size, and a potential selection bias, as respondents agreed to discuss sexual issues, thus they might have been more open about sexuality than more traditional Mexican-American older women. Moreover, we used a cross-sectional design, thus our results do not imply causation; additionally, to limit the scope of this study, the interview protocols covered several, but not all factors that could be related to sexual desire and fantasies. For instance, acculturation was not measured, and neither were other variables often related to women's sexuality in later life, such as masturbation or sexual activity at a younger age (Yee and Sundquist 2003). Another limitation concerns the assumptions and interpretations that the present authors have made about the sexual culture of older Mexican-American women, as it is evident in the way in which some questions were formulated. As research is seldom free of cultural assumptions, in the current study we made many assumptions that

might have influenced our findings. Among them, as we were bound by space and time limitations, as well as by the intent not to offend respondents by being too explicit/graphic, we asked sexual questions in very broad terms. This could be interpreted as implying that there is a "universal way" of defining sexual health and that both interviewers and respondents were defining it in similar ways. Ideally, researchers should carefully define culturally-bound variables such as sexual health factors, and we recommend that this is done in future studies if at all possible. To provide an example of assumptions embedded within our questions, the way in which we asked whether respondents wanted to be sexually active did not take into account several culturally-relevant factors. Those include the fact that sexual intercourse (or other sexual interactions) could be (a) dictated by only one member of a couple, (b) accepted only in order to please one's sexual partner, and/or (c) provided as a service in exchange for personal financial support and protection, remaining married, and/or securing the stable support of one's children. These and other assumptions intrinsic in our sexuality and dating questions shaped the way in which our questions were formulated. There could certainly be alternative and equally viable ways to assess sexual and dating domains and to interpret the same questions.

Despite the above limitation, in this study we conducted critical groundwork research on an understudied ethnogeriatric topic. Efforts to corroborate and further explain its findings could lead to interesting future research. For instance, our results could be conceptualised and clarified within the context of the sexual trajectories of older women by asking more questions in prospective studies. In particular, to clarify our findings on sexual desire and related changes in older age, researchers should investigate factors such as whether (a) older women ever experienced sexual desire towards their husbands or achieved orgasms with them, (b) their sexual desire changed during the course of their marriage, (c) (if it did change) this was due, among other factors, to their husbands behaving in certain ways (e.g., drinking heavily or physically abusing them), (d) their own sexual pleasure is/was more or less important than pleasing their husbands or retaining them, and/or (e) some older women would report feeling relief because, due to their age, they no longer feel that they must pay sexual services to their husbands. Also, unexplored socio-cultural variables could be investigated, including the influence of *familismo* (the strong influence of family members on one's life) and *marianismo* (which involves women being chaste and submissive about sexuality) on older women's sexual desire.

It should be noted that several women verbalised distress about their men's substance and domestic abuse. To clarify these findings, researchers should examine whether those behaviours in an intimate partner have adverse health outcomes for older women and/or carry into the sexual sphere, perhaps precipitating often-traumatic events such as domestic rape. The results of future studies on the above-mentioned delicate issues could become the foundation of community-focused programs and educational interventions targeting the sexual empowerment of Mexican-American women of all ages. Because, at least at first, such programs could face opposition, as they go against traditional Mexican values, a culturally-sensitive approach to implementing them could involve the integration of values such as *respeto* (respect) and *familismo* with accurate sexually-related information. These initiatives could encourage, among other changes, more open communication with loved ones about sexual issues and concerns, i.e., *confianza* or intimacy, which is the modern marital ideal in Mexico (Hirsch 2003), as well as autonomous and well-informed sexual decisions (such as sound contraceptive choices) in women of Mexican descent.

Conclusions

Generally speaking, the present findings support the growing body of research against a model of older women's sexuality that depicts them as victims of their hormonal changes, as

a variety of socio-cultural issues and factors such as widowhood and physical limitations were related to sexual desire in our sample. Despite the fact that, as one woman stated during her interview, “it is difficult to discuss sexual desire”, our results show that many Mexican-American older women report having sexual desire and related needs. This is in line with prior empirical evidence indicating that older women may have just as many sexual concerns as younger women (Nusbaum et al. 2004). Higher reports of sexual desire were associated with better physical health and being married. Traditional socio-cultural restrictions limited acting upon sexual urges. Several women complained about their sexual needs not being met and reported distracting themselves with a variety of activities if their health permitted.

In the event that an older woman of Mexican descent were to view her sexual interest as problematically low, it is unlikely that she would bring up this topic with her medical providers. One of the possible reasons for this is that, when interacting with health care practitioners, members of the Mexican culture traditionally employ the cultural practice of *formalidad* (formality), a highly regarded value among Mexican individuals (Diaz-Guerrero 1994). As pointed out by Diaz-Guerrero, a key component of *formalidad* is using the “language of respect,” which reflects the hierarchical and formal nature of relationships with authority figures such as health professionals. In light of these factors, to bring up unmet sexual needs or concerns with a health care provider would likely induce *vergüenza* and possibly *culpa* (guilt) in a Mexican-American older woman. Nevertheless, beyond specific ethnic backgrounds, 58% to 73% of older women in the USA report being less embarrassed to raise sexual issues with their physician if the doctor is kind, understanding, and empathic, and possesses characteristics such as a professional demeanor and comfort with the topic of sexuality (Nusbaum et al. 2004). Thus, health care providers interested in maximizing older women’s sexual health should consider delicately assessing potential sexual concerns and making appropriate referrals to mental health professionals if needed. Undoubtedly, as suggested by Hartmann et al. (2004) and in line with our findings, evaluation and treatment of low sexual desire in older women require considering a full range of socio-cultural and contextual issues in addition to medical and psychological factors.

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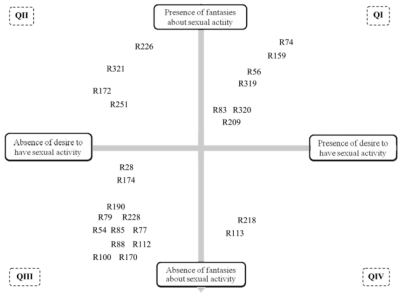

Figure 1.
Axial coding

Table 1

Sample descriptive statistics

Variable	Mean	%
Age	70.7	
Place of Birth		
U.S.		33
Mexico		67
Education Level		
Less than High School		49
Graduated High School		26
Some College		17
Bachelors		4
Masters		4
Employment Status		
Not employed		80
Part-time		8
Full-time		12
Income		
Declined to Answer		9
Less than $ 20,000		50
From $ 20,000 to $ 39,000		23
$ 40,000 plus		18
Marital status		
Married		30
Divorced		28
Separated		4
Widowed		38
Self described sexual orientation		
Heterosexual		100