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Special Issue: Sexuality and Aging: Research Article

Sexual Activity and Satisfaction in Older Adult Dyads: The Role of Perceptions of Aging

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Abstract

Background and Objectives: This study assessed the associations between perceptions of aging (POA) and sexual frequency and satisfaction in older adult dyads.
Research Design and Methods: Using dyadic data from up to 1,122 different-sex married and cohabiting couples ages 50-89 ($M_{\text{men}} =$ 66.63 [7.40]; $M_{\text{women}} =$ 64.43 [7.27]), we estimated 2 actor-partner interdependence models. We first examined the association between men's and women's POA and each partner's reports of frequency of partnered sexual activity (e.g., intercourse, oral sex, kissing, petting, and fondling). Then, we tested the link between POA and each partner's sexual satisfaction.
Results: Actor effects were detected in both models. Both men's and women's positive POA were associated with their own reports of more frequent sexual activity and greater satisfaction with their sex lives.
Discussion and Implications: These findings provide insight into how positive views on aging relate to older couples' sexuality. Future research should consider how attitudes shape later-life sexuality over time.

Keywords: Ageism, Dyadic methods, Sexuality, Subjective aging, Views on aging

Life span psychological research acknowledges the importance of romantic relationships in later life as a developmental context (Hoppmann & Gerstorf, 2016). Both conceptual and empirical work suggests that long-term partners constitute one of the most important social contexts for older adults (Lang, 2001). Interrelations and similarities between romantic partners have been studied in several key aspects of aging, including physical health (Pauly et al., 2021), cognitive functioning (Caillot-Ranjeva et al., 2021), and belief systems such as views of aging (Drewelies et al., 2016; Mejía & Gonzales, 2017).

Research demonstrates that how older adults view aging and their own aging process is associated with a variety of health outcomes, including physical functioning (Tovel et al., 2019), preventative health behaviors (Levy & Myers, 2004), cognitive functioning (Levy et al., 2016), and longevity (Levy et al., 2002). One area of health and physical functioning that is important to both older adults and their partners is sexual activity (Lindau et al., 2007). Most adults over the age of 50 who are in a committed relationship are sexually active, and many remain sexually active into their oldest years (DeLamater, 2012; Kolodziejczak et al., 2019; Waite et al., 2009). Partially due to physical health changes

and the absence of a partner (Karraker et al., 2011; Waite & Das, 2010), some decline in sexual frequency in later life is normative, with the lowest rates reported by those in their eighties and beyond. In contrast, sexual satisfaction may remain stable with adults in their fifties equally likely to report feeling extremely satisfied with their sexual activities as those in their eighties and older (Schick et al., 2010).

Health is a strong predictor of sexual activity (DeLamater, 2012; Lindau & Gavrilova, 2010; Lindau et al., 2007), although not the only one. With a sample of 2,507 participants aged 44-72, Karraker et al. (2011) found that health explained about 10% of the variance in decline in sexual frequency for men but was not a significant predictor for women, indicating the need to examine additional factors which might contribute to older adults' sexuality. To date, however, much of the literature on sexual activity after age 50 has centered on predictors of sexual *dysfunction* (e.g., erectile dysfunction). Less is known about nonclinical correlates, and despite evidence documenting the association between perceptions of aging (POA) and a broad range of older adults' physical and cognitive health, we know of no research into how POA relates to sexual activity and satisfaction among older couples.

Regarding POA, evidence shows that one spouse's POA can contribute to the other's well-being (Momtaz et al., 2013), and one spouse's POA can influence the other's over time (Cohn-Schwartz et al., 2021). Taken together, it may be that individuals' POA affects their own and their partner's sex lives. Thus, the purpose of this study is to examine the relation between POA and sexual frequency and satisfaction among older couples within a dyadic framework.

Theoretical Foundations

The present study is guided by two theories: stereotype embodiment (Levy, 2009) and interdependence (Rusbult & Van Lange, 2003). The former describes individuals' formation and manifestation of POA, while the latter describes how these internal beliefs may affect one's partner.

Stereotype Embodiment Theory

According to stereotype embodiment theory, POA are developed from societal and interpersonal constructions of aging encountered across the life course (Levy, 2009). Ageist stereotypes may be transmitted through interpersonal exchanges (Rippon et al., 2015), structural policies and systems (Ayalon & Tesch-Römer, 2018), medical encounters (Gott et al., 2004), and mass and social media (Levy et al., 2014). Such stereotypes often portray older adults as asexual. At times, older women are depicted as *cougars*, predatory creatures preying on younger men, who are notable because of their unique sexual desire, a foil to the stereotypical older woman whose sexuality is invisible (Montemurro & Siefken, 2014). Older men are permitted a longer sex life than women (Roy & Ayalon, 2020) yet risk being stereotyped a "dirty old man" if they exhibit sexual desire too far into later life (Sandberg, 2016). Collectively, media representations may serve as socialization agents, reinforcers, and triggers for negative POA, reminding older adults that they are not supposed to be sexually active, desiring, or desirable.

Empirical findings support these notions. Syme and Cohn (2016) found that participants ages 18-85 reported moderate permissiveness regarding older adult sexuality, with no difference by participants' age. Another study, however, found that college students considered the idea of older adults engaging in sexual acts more surprising and disgusting, as well as less appropriate and acceptable than they did for younger adults (Waterman, 2012). Older adults report awareness of these stereotypes and may themselves reinforce ageist stereotypes (Nimrod & Berdychevsky, 2018). When triggered implicitly, holding negative POA may thus result in undesirable outcomes (Levy, 2009).

Interdependence Theory

Interdependence theory posits that many processes cannot be viewed as entirely individual, as they are both intrapersonal and interpersonal (Rusbult & Van Lange, 2003). For many older adults, most of whom are married (Margolis & Verdery, 2017), the closest and most interdependent relationship is with a spouse. Unique features of late-life relationships may make this interdependence especially salient (Hoppmann & Gerstorf, 2016). Notwithstanding an increase in divorce and remarriage in later life (i.e., "the gray divorce"; Brown & Lin, 2012), greater longevity means married older adults might remain married longer than previous cohorts (Agree & Hughes, 2012), and retirement may also increase time spent together (Stancanelli & Van Soest, 2016).

Committed romantic partners consider themselves an intertwined unit (Agnew et al., 1998) and look to one another for cues on how to appraise a given situation (Rusbult & Van Langue, 2003). Spouses also report similar levels of subjective well-being and self-rated health (Bookwala & Schulz, 2000). Thus, it stands to reason that spouses' internal beliefs are interlinked (Drewelies et al., 2020; Walker & Luszcz, 2009). Studies that adopt couple-level approach support these notions, finding that spouses score similarly on measures of POA and that spouses' POA are interrelated (Cohn-Schwartz et al., 2021; Kim et al., 2018; Mejía & Gonzales, 2017; Momtaz et al., 2013). Moreover, evidence suggests that older spouses craft their POA jointly as they age together (Mejía et al., 2020). Therefore, a dyadic approach to the relationship between POA and sexuality is needed not only because most later-life sexual activity occurs within a committed partnership (Lindau et al., 2007) but also because partners' experiences of aging are intertwined.

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Perceptions of Aging and Sexuality Among Older Men and Women

Given that physical health explains some, but not all, of the variance in older adults' sexual activity, other factors must play a role in shaping older adults' sexuality. It may be that, in the absence of physical limitations, aging itself is a lesser impediment to sexual activity than the meaning ascribed to aging and sexual expression (DeLamater & Koepsel, 2015). Ageism is stratified by social location, including gender identity, and POA may be constructed differently for men and women (Kim et al., 2021). Thus, the relation between aging beliefs and sexuality may be particularly salient for older women. As Slevin (2010) found through interviews with adults aged 60–89, "while men and women both fear getting old, women have a special fear of *looking* old" (p. 1015). Indeed, women report using antiaging products to appear more sexually attractive to men, indicating that youth and desirability are inherently linked within womanhood (Calasanti et al., 2018).

Although the double-jeopardy of embodying two oppressed identities disadvantages older women (Sontag, 1979), older men also report insecurities (Slevin, 2010). Social constructions of masculinity dictate that men be virile and desiring. Calasanti et al. (2018) found that men aged 42–61 equated youthfulness with strength and performance, including virility. Respondents valued appearing physically strong as an indicator of health and ability, which they perceived as distancing themselves from muscle loss common in older adulthood (Walston, 2012). In summary, ageist stereotypes of sexuality are gendered but are negative and harmful for both women and men.

In Western societies, older adulthood is stereotyped as a period of celibacy (DeLamater, 2012). To the extent that older adults conflate youthfulness and sexuality, POA may be linked to their sexual outcomes. Consequently, POA become a self-fulfilling prophecy (Levy, 2009), such that older adults who have internalized the stereotype of later-life celibacy may experience less frequent and satisfying sexual activity, whereas those who evaluate aging more positively may experience more positive sex lives. Altogether, individuals' sexual engagement may depend upon the degree to which they have internalized ageist stereotypes and what they perceive or expect from their own aging process.

The Present Study

The present study extends prior research by examining the association between POA and sexual frequency and satisfaction among older intimate partners. Considering the theoretical framework and empirical evidence, we tested the following hypotheses: (a) men's and women's more positive POA will be associated with higher levels of their own (actor effect) and their partner's (partner effect) reported frequency of partnered sexual activities; and (b) men's and women's more positive POA will be associated with higher sexual satisfaction in themselves (actor effect) and their partner (partner effect).

Several physical and psychosocial resources are related to sexuality. Better health, higher relationship quality, higher socioeconomic position, and more frequent alcohol consumption are associated with more frequent and/or satisfying sexual activities (Bell et al., 2017; DeLamater, 2012; Lindau & Gavrilova, 2010). Age, depressive symptoms, sexual dysfunction, and having a child in the home have been inversely related to sexual activity (Bell et al., 2017; DeLamater, 2012; Fraser et al., 2004). These were thus included as covariates in the current report. We also controlled for race/ethnicity, which has shown an inconclusive relation to later-life sexuality (Bell et al., 2017).

Method

Participants

Data were drawn from the English Longitudinal Study of Ageing (ELSA; Banks et al., 2019), a nationally representative biennial survey of community-dwelling older adults and their partners in England. We obtained a special license to access anonymized sexuality data through the UK Data Service.

Inclusion criteria for this study were married or cohabiting adults and their partners aged ≥50 who completed supplemental questionnaires related to psychosocial constructs and sexuality (NatCen Social Research, 2019) at Wave 8 (2016-2017) and reported any sexual activity in the past 12 months. Spouses self-reported their sex as male or female. We excluded 30 same-sex couples because spouses' sex is of interest, and the actor-partner interdependence framework (APIM; Kenny et al., 2006) does not allow for simultaneous modeling of distinguishable and indistinguishable dyads (i.e., whether one can differentiate between dyad members on a meaningful variable such as sex). Participants were excluded if they were missing more than one of the four items in the POA scale ($n = 36$), resulting in a sample of $n = 1{,}592$ dyads before dropping couples with missing outcome data. Because sexual frequency and satisfaction were modeled separately, those who responded to at least one measure were included, and small differences in sample size between models are present ($N_{\text{satisfaction}} = 1{,}120$ dyads; $\mathrm{N}_{\text{frequency}} = 1{,}122$ dyads). Most (93%) of these couples were married. Compared to individuals missing all sexuality items ($N = 908$), our samples were younger ($d = 0.62$), more educated ($d = 0.40$), and wealthier ($d = 0.32$), and reported better health ($d = 0.43$) and fewer depressive symptoms ($d = 0.25$).

Measures

Sexual frequency

Inclusive definitions of sexual activity better capture the diversity of sexual activities in which older couples engage

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(Liu et al., 2019) and how they define sexual activity (Gott & Hinchliff, 2003). Therefore, the sexual frequency was assessed with two items that were asked of respondents who reported any sexual activity in the past 12 months: frequency of "sexual intercourse (vaginal, anal, or oral sex)" and "other sexual activities (kissing, fondling, and petting)" in the last year (1 = *not at all*, 6 = *once a day or more*). Items were averaged to create a measure of sexual frequency.

Sexual satisfaction

Respondents reported their degree of satisfaction with their overall sex lives in the last year (1 = *very dissatisfied*, 5 = *very satisfied*).

Perceptions of aging

Four items were averaged to create the POA scale, following past work showing that of the 12 items available, only these load strongly onto a single factor with good reliability, whereas other factors showed low loadings, poor internal consistency, or both (Gale & Cooper, 2018). Based on respondents' qualitative responses assessing the experience of aging at Wave 2 (Demakakos et al., 2006), items broadly assess POA (e.g., "Old age is a time of ill-health."), as well as self-POA (e.g., "I expect to become more lonely with age."). Responses range from 1 (*strongly agree*) to 5 (*strongly disagree*). Higher scores indicate a more positive POA. Cronbach's α was 0.75 for men and 0.76 for women.

Covariates

Sociodemographic covariates were race (0 = *White*, 1 = *non-White*), age (in years), education (in years), and household wealth. To reduce skewness and kurtosis, we retained zero values and took the natural log of all positive values. Because some households reported more debt than assets (i.e., negative wealth), we took the natural log of the absolute value of these values, then multiplied the transformed score by −1, thereby maintaining the meaning of debt. Self-rated health (1 = *poor*, 5 = *excellent*) may be a better indicator of sexual function than specific conditions (DeLamater, 2012). Depressive symptoms were measured with an eight-item Center for Epidemiologic Studies Depression (CES-D) Scale (α = 0.98; Radloff, 1977), with higher scores representing more symptoms (Jackson et al., 2019). Alcohol consumption in the past year was coded as none/rarely (never to once or twice a week), regularly (once every couple of months to twice a week), or frequently (3 days a week to almost daily). Sexual dysfunction was operationalized as the frequency of erectile dysfunction for men (1 = *always able to get and keep an erection,* 4 = *never able to get and keep an erection*) and vaginal dryness for women (1 = *almost never/never*, 5 = *almost always/always*), the most common physical obstacles to sexual activity (Lindau et al., 2007). Relationship quality was included with three items for strain (e.g., "How much do they criticize you?" α = 0.71 for men and women) and four items for support (e.g., "How much can you rely on them if you have a serious problem?" $\alpha_{\text{men}} = 0.66$; $\alpha_{\text{women}} = 0.59$) from spouse. Higher scores indicate more support or strain (1 = *Not at all*; 4 = *A lot*). Finally, we controlled for a coresiding child (0 = *absent*; 1 = *present*).

Analytic Plan

We computed separate models examining the association between (a) POA and sexual frequency and (b) POA and sexual satisfaction using structural equation modeling in Mplus version 8.7 (Muthén & Muthén, 1998–2017) with maximum likelihood to account for the minimal missing observations ($n = 98$ men's frequency; $n = 4$ women's frequency; $n = 5$ men's satisfaction; $n = 9$ women's satisfaction). Models were computed as APIMs (see Figures 1 and 2).

Standards for acceptable model fit values were considered ≥0.95 for comparative fit index (CFI), ≤0.06 for root mean square error of approximation (RMSEA), ≤0.08 for standardized root mean square residual (SRMR), and a nonsignificant chi-square test (x^2), although these are guidelines and chi-squares are expected to be significant in large samples (Hu & Bentler, 1999).

Results

Descriptive statistics are presented in Table 1. Men were older, more sexually satisfied, more likely to be White, and reported more frequent alcohol consumption and spousal support than their partners. Women reported better health, more depressive symptoms, and spousal strain than their partners. There were no significant differences between partners on POA, education, or reports of sexual frequency. Twenty-two percent lived with a child. Bivariate correlations of the frequency sample are presented in Table 2.

We first examined whether each partner's POA were associated with their and their partners' reported frequency of sexual activity (see Table 3). The model fit the data well (x^2 [18] = 40.71, $p = .002$, CFI = 0.96, RMSEA = 0.03, SRMR = 0.03). Partners' POA were significantly correlated ($r = 0.17$, $p < .001$). In partial accordance with Hypothesis 1, men's and women's POA were positively and significantly

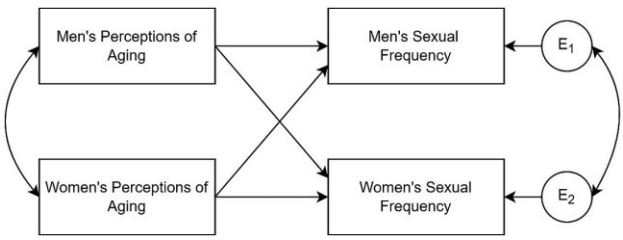

Figure 1. Actor-partner interdependence model representing perceptions of aging and reported frequency of sexual activities.

associated with their own sexual frequency but not their partners' reports.

We then estimated the association between each partner's POA and their own and their partner's sexual satisfaction (see Table 3). The model showed good fit to the data (x^2 (18) = 33.92, p = .01, CFI = 0.97, RMSEA = 0.03, SRMR = 0.02). Partners' POA were significantly correlated (r = 0.17, p < .001). Partially supporting Hypothesis 2, POA were positively associated with one's own sexual satisfaction (actor effect) but not one's partner's (partner effect).

Discussion

The objective of this study was to examine dyadic associations among POA and both sexual frequency and satisfaction among older couples. Informed by stereotype embodiment theory and interdependence theory, we implemented a dyadic framework to examine the association between POA and couples' sexual frequency and satisfaction.

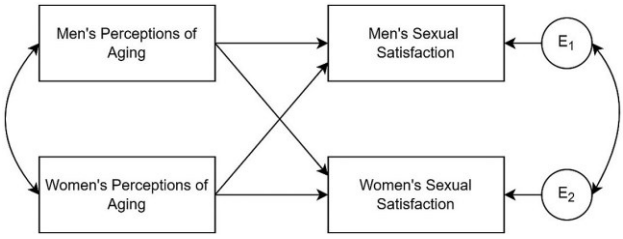

Figure 2. Actor-partner interdependence model representing perceptions of aging and sexual satisfaction.

Consistent with past work suggesting that partners often report similar views on aging (Cohn-Schwartz et al., 2021; Kim et al., 2018; Mejía & Gonzales, 2017; Momtaz et al., 2013), partners' reports of POA were positively correlated. Whether this similarity is due to selection effects preceding partnership or whether partners become increasingly similar with age was beyond the scope of this study, yet other researchers have found that couples married the longest report the greatest concordance in aging beliefs (Mejía et al., 2020). These findings, and ours, support interdependence and stereotype embodiment theories as adults' experiences of aging are socially constructed and related to their partners' appraisal of and satisfaction with growing older (Levy, 2009; Rusbult & Van Lange, 2003).

We found partial support for Hypotheses 1 and 2 as both men's and women's more positive POA were associated with their own reports of more frequent and satisfying sexual encounters. Our finding aligns with qualitative work in which some older participants report higher quality sex with age (Vares et al., 2007). It may be that those who have internalized fewer ageist messages experience more satisfying sexual encounters. Conversely, those who anticipate the inevitability of negative aging outcomes such as physical decline may experience anticipatory inhibitions and less satisfaction in the present. It is also plausible that participants with more positive POA are more resilient to youthful beauty ideals and feel more satisfied with their sex lives because they are less self-conscious about aging than participants with more negative POA. It might also be that as older adults who view aging positively engage in sexual

Table 1. Sample Descriptive Statistics

	Men		Women				
Variable	*M* (*SD*)	%	*M* (*SD*)	%	*M* (*SD*)	t/χ^2	*d*, 95% CIs
Sexual satisfaction (1–5)[a]	3.64 (1.13)		3.85 (1.14)			5.07***	0.15 (0.09, 0.21)
Sexual frequency (1–6)	3.22 (1.20)		3.12 (1.20)			1.00	0.03 (–0.03, –0.09)
Perceptions of aging (1–6)	2.88 (0.82)		2.84 (.83)			1.13	0.03 (–0.03, 0.09)
Age (years)	66.63 (7.40)		64.43 (7.27)			15.84***	0.47 (0.41, 0.53)
Education (years)	16.87 (1.65)		16.83 (1.65)			0.82	0.03 (–0.03, 0.08)
Race (% White)		98		98		0.04	
Self-rated health (1–5)	3.41 (1.05)		3.51 (1.03)			–2.99**	–0.09 (–0.15, –0.03)
Alcohol							
Never/rarely		10		19		41.10***	
Regularly		43		48		4.25*	
Frequently		47		33		44.46***	
Depressive symptoms (1–8)	0.67 (1.16)		1.14 (1.63)			–8.99***	–0.27 (–0.32, –0.21)
Household wealth					£575,633.20 (£687,541.53)		
Spousal support (1–4)	3.75 (0.40)		3.63 (0.53)			–2.04*	–0.06 (–0.12, –0.00)
Spousal strain (1–4)	2.19 (0.33)		2.22 (0.38)			7.56***	0.23 (0.17, 0.28)
Erectile dysfunction (1–4)	2.14 (1.04)						
Vaginal dryness (1–5)			2.40 (1.48)				

Notes: Data presented from the sexual frequency subsample. No significant differences in sample characteristics exist in the sexual frequency subsample. SD = standard deviation; CI = confidence interval.

*p < .05; ** p < .01; *** p <.001.

[a]Mean and SD computed from the satisfaction sample (N = 1,120 couples).

Table 2. Bivariate Correlations of All Continuous Variables Under Study

Variable	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20
1. Sexual frequency (M)																				
2. Sexual frequency (W)	0.59***																			
3. Sexual satisfaction (M)	0.00	0.03																		
4. Sexual satisfaction (W)	−0.04	−0.04	0.17***																	
5. Perceptions of aging (M)	0.13***	0.08*	0.02	0.01																
6. Perceptions of aging (W)	0.04	0.12***	0.04	0.02	0.18***															
7. Age (M)	−0.13***	−0.10**	0.08*	0.06*	0.04	0.04														
8. Age (W)	−0.14***	−0.13***	0.01	0.07*	0.04	0.06*	0.79***													
9. Education (M)	0.05	0.06	−0.05	−0.03	0.09**	−0.08*	−0.14***	−0.09**												
10. Education (W)	0.05	0.06	−0.05	−0.06	0.09**	−0.12***	−0.15***	−0.19***	0.48***											
11. Health (M)	0.14***	0.13***	−0.05	−0.03	0.23***	0.10**	−0.16***	−0.12***	0.17***	0.14***										
12. Health (W)	0.09**	0.12***	−0.04	−0.07*	0.09**	0.21***	−0.12***	−0.16***	0.14***	0.19***	0.35***									
13. CES-D (M)	−0.07*	−0.20***	−0.01	0.05	−0.23***	−0.11***	0.00	−0.02	−0.04	−0.06	−0.35***	−0.13***								
14. CES-D (W)	−0.07*	−0.18***	0.03	0.03	−0.07*	−0.23***	0.03	0.04	0.07*	−0.11***	−0.16***	−0.38***	0.24***							
15. Spousal support (M)	0.13***	0.14***	0.01	−0.11***	0.16***	0.09**	0.03	0.03	0.01	0.02	0.12***	0.12***	−0.18***	−0.15***						
16. Spousal support (W)	0.16***	0.20***	0.03	−0.04	0.10**	0.15***	−0.03	0.00	0.04	0.00	0.12***	0.09**	−0.17***	−0.24***	0.34***					
17. Spousal strain (M)	−0.13***	−0.11***	0.02	0.06*	−0.16***	−0.09**	0.03	−0.01	−0.03	0.02	−0.14***	−0.05	0.12***	0.06	−0.29***	−0.20***				
18. Spousal strain (W)	−0.08**	−0.15***	−0.02	0.04	−0.10**	−0.11***	0.05	0.06	−0.04	−0.04	−0.11**	−0.11***	0.11***	0.16***	−0.20***	−0.35***	0.20***			
19. Sexual dysfunction (M)	−0.33***	−0.17***	0.01	0.06*	−0.13***	−0.01	0.41***	0.30***	−0.08**	−0.05	−0.25***	−0.11***	0.14***	0.05	−0.04	−0.09**	0.08*	0.06		
20. Sexual dysfunction (W)	−0.08**	−0.10**	−0.06	−0.02	−0.02	−0.10**	0.09**	0.07*	0.03	0.04	−0.14***	−0.03	0.00	0.03	−0.05	−0.02	−0.03	0.03	0.01	
21. Wealth	0.09**	0.07*	−0.02	−0.04	0.01	−0.03	0.00	−0.02	0.25***	0.26***	0.13***	0.13***	−0.02	−0.08*	0.05	0.06	0.02	−0.03	−0.08*	0.06

Notes: All correlations were conducted with the frequency sample (N = 1,022) except for those involving the sexual satisfaction variables (N = 1,020); Correlations are significant in both samples; M = men; W = women; CES-D = Center for Epidemiological Studies Depression Scale.

*$p < .05$

** $p < .01$

*** $p < .001$.

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Table 3. Actor-Partner Interdependence Model Results Showing Associations Between Perceptions of Aging and Sexual Frequency and Satisfaction

	Couples' sexual frequency (N = 1,122)[a]				Sexual satisfaction (N = 1,120)[a]			
	Men		Women		Men		Women	
Variable	*B*	*SE*	*B*	*SE*	*B*	*SE*	*B*	*SE*
Intercept	3.60***	0.67	3.40***	0.63	2.49***	0.64	3.12***	0.64
Perceptions of aging (M)	0.13**	0.05	0.04	0.04	0.17***	0.04	0.01	0.04
Perceptions of aging (W)	0.00	0.04	0.09*	0.04	−0.03	0.04	0.12***	0.04
Age (M)	−0.01	0.01			0.02**	0.01		
Age (W)			−0.01*	0.01			0.01*	0.01
Education (M)	0.00	0.02			−0.03	0.02		
Education (W)			0.04	0.02			−0.05*	.02
Race (M)[b]	0.22	0.26			0.58*	0.24		
Race (W)[b]			0.37	0.22			0.32	0.23
Self-rated health (M)	0.04	0.03			0.08**	0.03		
Self-rated health (W)			0.01	0.03			0.08*	0.03
Alcohol consumption[c]								
Regularly (M)	−0.14	0.11			−0.12	0.11		
Regularly (W)			−0.12	0.08			−0.02	0.08
Frequently (M)	−0.10	0.12			−0.20	0.11		
Frequently (W)			−0.24**	0.09			−0.22*	0.09
CES-D (M)	0.02	0.03			0.03	0.03		
CES-D (W)			−0.07**	0.02			−0.06**	0.02
Household wealth	0.02	0.01	0.01	0.01	−0.02*	0.01	0.00	0.01
Coresiding child	−0.03	0.09	−0.17	0.09	0.09	0.08	0.00	0.08
Spousal support (M)	0.18*	0.08			0.54***	0.08		
Spousal support (W)			0.18**	0.06			0.44***	0.06
Spousal strain (M)	−0.20*	0.09			−0.37***	0.09		
Spousal strain (W)			−0.26**	0.08			−0.36**	0.09
Sexual dysfunction (M)	−0.23***	0.04	−0.19***	0.04	−0.37***	0.03	−0.12***	0.03
Sexual dysfunction (W)	−0.06**	0.02	−0.06**	0.02	−0.08***	0.02	−0.12***	0.02
Residual variances	1.32***	0.06	1.27***	0.05	0.99***	0.04	1.05***	0.05

Notes: B = unstandardized coefficient; M = men; W = women; CES-D = Center for Epidemiological Studies Depression Scale; *SE* = standard error.
[a]Maximum likelihood was used to account for missing observations. [b]White = reference group. [c]Never = reference group.
*p < .05; **p < .01; ***p < .001.

activity, their positive POA are reinforced, resulting in a cyclical association between POA and sexual frequency.

While the significant correlations between partners' POA indicate that how older adults feel about aging is related to their partners' aging beliefs, the nonsignificant partner effects suggest that, in this context, one's own POA may be more important for reported sexual frequency or satisfaction than one's partner's POA. Such results mirror past work documenting actor-only effects between spouses' views on aging and their mental and physical health (Cohn-Schwartz et al., 2021). It is possible that associations between views on aging and outcomes such as sexuality or physical health only manifest when the difference between two partners is significant (e.g., one partner compensating for another partner's lack of positive POA) or when partners are aware of one another's views. Future studies should further examine this finding to fully understand the association.

Strengths of this study include our theoretical grounding, large sample size, and broad operationalization of sexual activity (Gott & Hinchliff, 2003). Furthermore, we employed dyadic methods to simultaneously analyze reports from both partners. We also controlled for each spouse's reports of sexual dysfunction; thus, we found that POA are related to sexual outcomes over and above the variance explained by either partner's sexual dysfunction. Still, this study has several potential limitations. First, the cross-sectional nature precludes causal inferences. As more ELSA waves are released, longitudinal data will be useful in understanding how POA relates to changes in sexual activity and vice versa. Second, other variables unavailable in

ELSA may elucidate nuances in the association between POA and sexuality, such as sexual self-efficacy (Carlson & Soller, 2019), partner communication, and body image (Montemurro & Gillen, 2013). Third, our sample was limited to different-sex couples, and the results may not be generalizable to same-sex couples or single older adults. For instance, because older adults and lesbians in long-term relationships are both stereotyped as asexual, women in same-gender relationships may have unique feelings regarding aging and sexual activity (Paine et al., 2019). Among single adults, who engage in sex less frequently than their partnered counterparts (Lindau & Gavrilova, 2010), the negative POA may inhibit the pursual of sexual encounters. Similarly, our sample was majority married with few cohabiting couples, and findings may not generalize to couples with other relationship statuses (e.g., living-apart-together and dating). Moreover, participants who completed the sexuality items represented a more advantaged group than those with missing data and, thus, our results may differ among less privileged couples. Finally, past work suggests that POA is a multidimensional construct (Meisner, 2012; Turner et al., 2021), yet our measure is unidimensional due to the scale's psychometric properties (Gale & Cooper, 2018). Future work should examine how perceptions of growth and loss relate to sexuality among more diverse samples.

Taken together, these findings support interdependence (Rusbult & Van Lange, 2003) and stereotype embodiment theories (Levy, 2009). In this sample, adults who perceived aging more positively enjoyed more frequent and satisfying sexual encounters with their partners. To the best of our knowledge, this study was the first to examine the association between POA and sexual frequency and satisfaction with a large sample of older dyads. Adding to the views on aging literature, these results demonstrate that POA are related not only to experiences and behaviors at the individual level but also within couples.

These findings have important implications for practitioners who work with older adults. Evidence shows that physicians are often reluctant to discuss sexual issues with older patients (Gott et al., 2004), which reinforces ageist beliefs that sexual activity is only for young adults. Sex therapists should recognize that promoting positive POA may promote more fulfilling sex lives for their older clients. Furthermore, interventions have been shown to reduce older adults' negative POA (Brothers & Diehl, 2017). Such programs might benefit older adults' sexuality, particularly if interventions focus on dismantling the stereotype of celibacy in older adulthood. Because partnered sexual activity is beneficial for health, well-being, and relationship functioning (DeLamater, 2012), maximizing the possibility for a healthy sex life into older ages is essential. Future work on POA could help us understand the mechanisms through which perceptions benefit older adults' sexual frequency and satisfaction.

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Conflict of Interest

None declared.

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