Older women's sexuality

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ABSTRACT

- In consultations with older women, doctors should ask about sexual problems. A holistic approach is needed to examine the many different factors that can affect sexuality.
- Hormonal changes associated with ageing have an impact on women's sexuality. Doctors need to have a clear idea of the place of hormonal treatment for different sexual problems.
- Physical changes associated with ageing, including illness and disability, may interfere with sexual expression. Diseases of the endocrine, vascular and nervous systems will most commonly affect sexual function.
- A broad range of psychosocial factors associated with ageing may influence sexuality.

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SEXUAL PROBLEMS are relatively common in women, occurring in up to 43% of younger women[1] and increasing with age.[2] These result from an interaction of biological, psychological and social factors.[3] As the population in the Western world ages, there is more attention focused on quality-of-life issues as they affect older people. (In Australia, older people are defined as those aged over 65 years.[4]) The proportion of older people who remain sexually active varies considerably with age, sex, marital status and general health. Estimates indicate that about 55% of married women over 60 years and up to 24% of married women over 76 years are sexually active.[5] In Australia, 12.4% of the population in 2001 was aged over 65 years, a proportion that is projected to rise to 21.3% by 2031.[6] As physicians, we are increasingly likely to see more sexual problems in older women as this present generation remains healthier and independent for longer.

Sexual intimacy is an important aspect of human relationships, and sexual problems should be addressed as part of a holistic health assessment. However, doctors are often uncomfortable talking about sexuality, and the topic is often ignored in consultations with older patients.[7] While many doctors report that they would be willing to discuss sexuality if patients broached the subject, studies indicate that most older women patients will be hesitant to do so. As these women grew up in a generation in which sex and sexuality were rarely discussed, the onus of initiating discussion of sexual issues often rests with the doctor.

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Physical causes of sexual problems

Physical problems associated with hormonal changes and acute and chronic illness become more prevalent later in life. These inevitably affect a woman's physical wellbeing and may alter her sexual response or ability to physically engage in intercourse.[8] Physical causes of sexual problems in older women include:[9]

- hormonal changes (Box 1);
- vascular disorders (eg, high blood pressure, high cholesterol levels, heart disease);
- diminished pelvic blood flow, secondary to ageing, trauma or surgery;
- atherosclerotic disease causing vaginal wall and clitoral smooth muscle fibrosis;
- neurological disorders (eg, spinal cord injuries, diseases of the central or peripheral nervous system);
- side effects of drugs such as antidepressants, β-blockers, antipsychotics, anticholinergics;
- effects of alcohol or recreational drugs; and

1: Effects of oestrogen and testosterone deficiency in older women[10,11]

- Genital area: decreased lubrication, atrophic skin changes, shrinkage and atrophy of the clitoris and vagina, diminished sensation, urogenital prolapse, urinary incontinence;
- Olfactory epithelium: reduced sensitivity to smell;
- Skin: reduced sensitivity to touch;
- Muscle and bone: loss of muscle bulk and bone mass;
- Brain: loss of sense of wellbeing, cognitive slowing, loss of concentration.

- illness and disability (primary effects of illness and secondary effects of treatment).

Management of sexual problems

When older women present with sexual problems, clinicians should take a detailed sexual and drug history and do a careful vulval and pelvic examination to identify any localised treatable conditions (Box 2). Underlying conditions and risk factors (see above) should be sought and treated, and any drugs likely to interfere with sexual function should be withdrawn. Drug therapy with substances such as sildenafil citrate or prostaglandins may potentially provide a means of enhancing sexual excitement by increasing clitoral vasocongestion and generalised vasodilation. (The use of drugs for this purpose is currently at an experimental stage.) The treatment of sexual problems of hormonal origin is discussed in more detail below.

Hormonal treatment

Topical therapy

Local urogenital symptoms are a common cause of sexual problems in older women. It may be more appropriate in this age group to use topical oestrogen therapy in the form of vaginal pessaries or creams that are not systemically absorbed. A Danish study found that the most common sexual dysfunction in older women was vaginal dryness, which was present in a third of women.[12] Topical oestrogens plus the use of vaginal lubricants relieve dryness associated with vaginal atrophy, which is a common cause of dyspareunia. Topical use of oestrogens may also help to alleviate other urogenital problems, including prolapse of the uterus, cervix, vagina, bladder and rectum, and incontinence. Such problems can have physical and emotional effects on older women's sexual wellbeing.[13]

Hormone replacement therapy

Long-term use of oral, continuous, combined hormonal preparations may be inadvisable in view of the increased risk of breast cancer.[14] However, short-term use (less than 5 years) may alleviate some of the symptoms of oestrogen deficiency. Doses can be titrated according to symptom relief.

The use of tibolone, a synthetic corticosteroid, may also be considered. Studies in postmenopausal women have shown that it can enhance libido and mood and reduce vaginal dryness and consequent dyspareunia.[15]

Testosterone cotherapy

Testosterone replacement therapy in selected older women may also be considered after appropriate counselling about risks and side effects. Clinical experience has shown that testosterone therapy is helpful for some women who have diminished libido and persistent fatigue with no clear cause.[16] It is usual to use oestrogen with androgen as cotherapy.[17] If testosterone is administered, it is important that the patient knows that female hormone therapy is not one of the approved uses of the drug in Australia.

Psychosocial factors affecting sexuality

The presence or absence of a partner affects the sexual practices of older women. With life expectancy of women exceeding that of men, many older women will eventually live alone and may have limited opportunities for intimate relationships. In a US study, 55.8% of married women over 60 years were reported to be sexually active, compared with 5.3% of unmarried women.[18]

Should an older woman choose not to conform to societal norms in expressing her sexuality, she may have to battle with family and friends who find her behaviour confronting. However, some women report experiencing greater sexual freedom as they become older.

Acknowledging the sexuality of older women is often difficult in a society that promotes positive messages about youth and sexuality as a societal norm, but is silent on the

2: Case study — sexual assessment in an older woman

"Marge" is a 66-year-old woman, widowed for the past 4 years, who moved to a self-contained hostel unit 6 months ago because of her worsening osteoarthritis. She has met "Ben", a 69-year-old widower who would like to marry her. Marge comes to see you, her general practitioner, about resuming an "intimate relationship". She mentions that her children do not like Ben.

History. Take a general medical history, including details of medications, gynaecological history (eg, age at menopause), any urogenital problems, and past sexual history. Taking the history in an empathic way will provide opportunities to explore psychosocial issues, such as:

- Marge's feelings about restarting a sexual relationship. Is she apprehensive?
- Any unresolved issues about her relationship with her previous husband. Is she ready for a new relationship? Is she guilty about "moving on"?
- Marge's difficulties with loss of mobility due to osteoarthritis. Does it affect her self image? Will it affect her ability to participate in intercourse?
- Marge's difficulties with her children. Does she feel guilty? Is it difficult for her to marry Ben without the support of her family?
- What Ben can offer Marge.

Examination. Inspect the vulva and vagina to assess vaginal atrophy. Take a Pap smear, if appropriate, and assess any urogenital problems.

Treatment. Offer hormone replacement therapy, either topical or systemic, if necessary. Discuss the impact of any medications on sexual function, and provide treatment for any concurrent urogenital problems. Provide the opportunity for Marge to discuss any psychosocial issues further.

subject of sexuality in older people. However, there are some signs that attitudes are changing — for example, the *Aged Care Act 1997* (Cwlth) has recently been amended to allow the right to privacy for older people in institutionalised care.

As they reach an advanced stage of life, many women grapple with losses that affect their self esteem. These include loss of employment, loss of status, loss of mobility, and loss of partners, friends and family. Any or all of these factors can have a negative influence on sexuality.

For an older woman who has a partner, the frequency of sexual activity will also be affected by the partner's health status. About 57% of men at age 60 have erectile dysfunction, a problem that increases with age.[19] This often has an impact on their partner's expression of sexuality. However, a loving and caring partner will positively encourage the continuation of a sexual relationship.

Factors that have been shown to encourage continuing sexual activity for older women include having a positive attitude towards sexuality, an active sex life in the younger and middle years, good health, an interested and interesting partner, and a willingness to experiment sexually.

Conclusion

Doctors can play an important role in facilitating discussion and management of sexual problems in older women. This requires a positive, proactive, holistic approach that addresses psychological and social issues as well as providing appropriate medical care.

Competing interests

None identified.

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