Libido in Limbo:
Sexuality & the Mature Woman

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Although women of reproductive age often deplore their lack of sexual desire, this is generally blamed on an increasingly hectic life, which leaves little time or energy for intimacy with their partner and their sexuality. In comparison, women of menopausal age commonly describe a significant decline in desire, which is frequently accompanied by a dramatic reduction, or interruption, in sexual activity. In fact, 40% of menopausal women note a decrease in sexual interest, while 50% report minimal sexual activity.[1] Despite physiological mechanisms being poorly understood, the shift in hormonal production surrounding menopause may have marked effects on physical and emotional well-being. This may in turn alter sexual interest and response.

Forty per cent of menopausal women note a decrease in sexual interest, while 50% report minimal sexual activity.

Sexual dysfunction in mature women

Beyond hormonal alterations, psychosocial and medical factors may also influence sexual function. This can make it challenging for mature women and their doctor to identify possible causes, to select appropriate investigations and to choose suitable treatment options.

Initially, it is important to classify the problem(s). Many validated tools are available but they are usually too comprehensive to be practical in clinical practice.[2-4] Fortunately, classification of female sexual dysfunction has recently been established.[5]

Sexual desire disorder

Sexual desire disorder is the most commonly reported sexual dysfunction in the mature women. It is characterized by a decline in sexual interest, which may affect frequency of sexual activity.

Sexual arousal disorder

Sexual arousal disorder is a lack of emotional or physical response in the face of appropriate sexual stimulation.

Orgasmic disorder

Orgasmic disorder is the inability or difficulty in achieving orgasm despite adequate stimulus.

Sexual pain disorders

Sexual pain disorders include dyspareunia and vaginismus.

Once a presumptive diagnosis is established, the possible causative factors should be explored. At this point, it is essential to emphasize the complex and often multifaceted nature of sexual dysfunction. If hormonal evaluation is done, gonadotropins can be assessed; however, they are of limited use in establishing a diagnosis or guiding therapy. Serum estrogen varies widely and it is poorly predictive of symptoms or response to treatment. Free or bioavailable testosterone level, if low, may imply a causative association, but it is at best a very inconsistent association. Menopausal women with a normal testosterone level, may report profound decline in sexual interest and response; while women with a low level may have no sexual concerns.

Open communication is the key ingredient in the treatment of sexual dysfunction.

A decline in sexual interest & response

Both medical disorders and pharmacologic therapies should be evaluated. Thyroid dysfunction is a common condition in this age group and should be excluded before diagnosing the patient with a sexual dysfunction.

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This is important, especially if the patient shows symptoms such as:

- fatigue,
- low energy and
- unexplained weight gain.

Cardiovascular conditions, diabetes and depression should also be ruled out.

It is also important to note that commonly prescribed medications may have a negative impact on sexual function. The following are examples of this:

- Antidepressants such as selective serotonin reuptake inhibitors (SSRIs), may reduce sexual desire and response[6]
- Antihypertensive medications can affect physiological response to sexual stimulation
- Oral estrogenic compounds raise the hepatic production of sex-hormone binding globulin (SHBG), which may decrease the bioavailability of testosterone[7]

It is essential to evaluate the psychosocial environment. Self-image and emotional closeness to the partner are the most important factors affecting sexual desire.[3] The length of the relationship with the same partner may also affect the intensity of sexual desire. Women approaching menopause are sometimes confronted with significant changes in their health, their body image, their relationship issues, family circumstances and work-related matters and they may not intuitively link these factors to their sexuality.

Self-image and emotional closeness to the partner are the most important factors affecting sexual desire.

Open communication

Open communication is the key ingredient in the treatment of sexual dysfunction. Often, causes of sexual dysfunction are clearly identifiable and can be simply resolved. For example, dyspareunia, due to dryness, may be alleviated with the application of vaginal estrogenic compounds.

The type of medication and the route of administration may be altered to lessen side-effects. For example, bupropion has been shown to be effective in the treatment of depression, without consequences to sexual desire. In fact, animal and human studies suggest that bupropion may improve libido in non-depressed women.[8]

Systemic estrogen can be administered transdermally to normalize the sex hormone-binding globulin. If bioavailable testosterone is low, replacement may be considered. Presently, there are no available testosterone preparations designed for women in Canada. Treatment is off-label and must be modified for administration to women and requires close monitoring.

Finally, sexual or marital counseling may be beneficial to enhance communication and to explore psychosocial and relationship issues.

It is imperative that healthcare providers acknowledge sexual dysfunction as a problem, facilitate communication and guide medical management to promote healthy sexuality in the mature woman.

Sexual dysfunction is a common occurrence among menopausal women; however, many women suffer for years in silence before disclosing their concerns to their doctor. This can result in personal distress and it can profoundly affect the intimacy of their relationship. It is imperative that healthcare providers acknowledge this problem, facilitate communication and guide medical management to promote healthy sexuality in the mature woman.

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References

1. Kirchengast S, Hartmann B, Gruber D, et al: Decreased sexual interest and its relationship to body build in postmenopausal women. Maturitas 1996; 23(1):63-71.
2. Basson R: Introduction to special issue on women's sexuality and outline of assessment of sexual problems. Menopause 2004; 11(6):709-13.
3. Bancroft J, Loftus J, Long JS: Distress about sex: A national survey of women in heterosexual relationships. Archives of Sexual Behavior 2003; 32(3): 193-208.
4. Dennerstein L, Dudley EC, Hopper JL, et al: Sexuality, hormones and the menopausal transition. Maturitas 1997; 26(2):83-93.
5. Basson R, Berman J, Burnett A, et al: Report of the international consensus development conference on sexual dysfunction: Definitions and classifications. J Urol 2000; 163(3):888-93.
6. Rosen RC, Lane RM, Menza M: Effects of SSRI's on sexual function: A critical review. J Clin Psychopharmacol 1999; 19(1):67-85.
7. Lobo RA, Rosen RC, Yang H-M, et al: Comparative effects of oral esterified estrogens with and without methyltestosterone on endocrine profiles and dimensions of sexual function in postmenopausal women with hypoactive sexual desire. Fertil Steril 2003; 79(6):1341-52.
8. Segraves RT, Clayton A, Croft H, et al: Bupropion sustained release for the treatment of hypoactive sexual desire disorder in premenopausal women. J Clin Psychopharmacol 2004; 24(3):339-42.