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Sexuality in the elderly

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SEXUALITY IN THE ELDERLY

ABSTRACT

Quality of sexual life in the elderly is analyzed from five perspectives:

- sex identity crisis: role of the involution of sensory organs and secondary sex characters in the gradual biological fading of the sexual self-perception;
- biological modifications of the sexual function: libido, quality of central and peripheral – genital and non genital – arousal, intensity of orgasm and post-intercourse and/or post-orgasmic memories; role of HRT and, specifically, ART (androgen replacement therapy) in selectively improving libido and arousal;
- couple dynamics and role of partner's problems or help in modulating the optimal adjustment to the many changes that aging plus menopause may cause to the couple;
- elderly single-women issues about sexuality;
- love in the elderly

Guidelines for treatment include appropriate HRT (ERT, progestin and/or ART) and improvement in doctor's attitudes to cure and care, through careful listening of women's needs, fears, frustrations and hopes in aging and a thorough understanding that sexual issues are an important part of the clinical consultation, even in the late postmenopausal years.

INTRODUCTION

A satisfying sexuality is an intrinsic part of the quality of life [1, 2]. Sexuality means a well adjusted sexual identity, a satisfying sexual function, and possibly an emotionally gratifying, loving and rewarding couple relationship [1–5], either hetero- or homosexual. It also means coping with sexual issues when single. All these aspects are quite neglected during the medical consultation, particularly if it involves old people.

The long lasting effects of the sexual hormones deprivation on sexuality in the postmenopausal woman will be briefly analyzed from the following points of view:

- female sex identity;
- female sexual function;
- couple relationship;
- single women sexual issues;
- love in the elderly.

FEMALE SEX IDENTITY

Perception of femininity may be affected by the estrogenic deprivation in many ways:

a) Involution of secondary sex characters [1, 2, 5–14]

- Lack of estrogens reduces breast dimensions (unless the woman is gaining weight) by selective involution of the mammary glands.
- Loss of the pubic hair reveals the sexual identity crisis in the sexual intimacy. It is a major factor in reducing self-confi-

dence and self-esteem in the sexual approach, inducing a sort of shyness and even a feeling of sexual "unworthiness".

- Modification of the body build [15, 16]. Increase in the body weight and modifications in the body shape definitely affect female sexuality, because of the gap between social beauty ideals and the disappointing reality the woman sees in the mirror.
- Wrinkles and skin aging adds a further burden to the challenge of adjusting female sex identity to the aging process [12].

The vulnerability to these physical and symbolic wounds is maximal in women who used to rely on physical beauty and seductiveness for their emotional equilibrium [5], is minimal in those who built-up self-perception and self-esteem linked to less age-vulnerable values.

b) Involution of sensory organs

Our body scheme and the emotional perception of our physical image are the result of the integration between information coming from the sensory organs and the lifelong experience of "who" we are through the emotional messages that go back and forth in interpersonal relationships and loving or rejecting dynamics.

New studies indicate that the function of sensory organs is reduced by an average 35–38 % [1, 2, 7–12]: this figure seems to be specifically linked to the loss of the trophic effects of estrogens [17].

The fading of sexual signals, consequent to the involution of secondary sex characters and sensory organs function, reduces the biological basis of libido [1], contributing to the decrease of intensity and importance of the sexual function.

The decrease in active sexual life may be worsened by a strong female sex identity crisis, secondary to the estrogen and androgen deprivation; because of the increase of male sexual problems [18]; because of the real loss of the partner and previous and/or acquired singlehood.

Involution of sensory organs, secondary to the loss of estrogens was analyzed elsewhere [1, 5]. It may be useful to report in short the most striking data:

Skin aging

This process recognizes two main causes: intrinsic aging, due to genetic factors, and photo-aging, due to solar irradiation [12, 13]. Because of the estrogen loss, menopause may contribute to a specific part of the skin intrinsic aging [19–24]. The involution of skin sebaceous and sweat glands causes loss of the “scent of woman” so typical of fertile age and so important for the erotic cloud of pheromones that subtly surrounds the body, contributing to personal and partner’s libido, and “smell identity” so important in the deep “recognizing” of loving ones [1, 9]. The hormone-dependent skin aging involves also the thin nerves that run through the dermal structures, contributing to the so-called “touch-impaired disorders”, leading to aversion of physical contacts [24].

Mucosal aging

It is part of the intrinsic skin aging and leads to:

- eye dryness, that may cause different ophthalmic complaints in 35 % of postmenopausal women not on HRT [8];
- mouth dryness, with tooth [10, 11] and taste involution, that may reduce pleasure in eating, the joy of kisses and oral intimacy;
- vaginal dryness with secondary arousal difficulties, dyspareunia, till secondary vaginism and post-coital cystitis, that may ultimately lead to a secondary loss of libido and/or frank sexual aversion [1, 4, 5].

This hormone-dependent part of a striking aging process improves dramatically on HRT [5, 10–14, 19–23] and may add a strong concrete help to the woman self-perception, facilitating a sweeter and better adjustment to the aging process and to a more joyful feminine perception even in the elderly woman [12].

Smell aging [1, 5, 9]

The involution of the olfactory epithelium is a perfect example of hormone dependent neuroplasticity [1, 5, 9]. Its function is a key biologic contributor of libido through the role of smell and perfumes in rhinencephalic and limbic circuits linked to sexual drive [1, 5].

Proprioceptive aging

Self perception is also dependent on the muscle tone and the proprioceptive information conveyed to the brain, contributing to the so called “sixth sense” [25]. Aging is characterized by a de-

crease in muscle mass, strength, flexibility, an increase of rigidity and a general loss of the “kinetic melody”, the lightness and elegance with which we inhabit the space while moving. This loss translates aging in an immediate physical limitation, a process that may be acutely worsened in women suffering from Female Androgen Deficiency Syndrome (FADS) [14].

FEMALE SEXUAL FUNCTION

Coital sex seems to become less frequent and welcomed in the postmenopausal women, while love, affection, attention, holding and reciprocal tender caring remain extremely important for all of them [3, 5].

The reduction of sexual activity recognizes female and male causes [18]. The effect of endocrine-dependent aging of female sexual function may be summarized in the following complaints women often report to the listening gynecologist:

Libido reduction

Graziottin [1, 5] discussed extensively elsewhere the biological roots of libido. In short, estrogens seem to have an INDIRECT effect on libido, through their positive action on secondary sex characters, female sex identity and self perception, genital and pelvic floor trophism, physical quality of arousal, general well-being [1, 3–5, 7–17, 27–33]. Androgens have a DIRECT effect, as they specifically increase sexual motivation [1].

Arousal difficulties

They may be (a) central, (b) non-genital peripheral and (c) genital [4, 5].

- a) Biological *central* arousal difficulties may be secondary to estrogen and androgen loss [2]. Reduced frequency of erotic dreams, of fantasies, of sexual day dreams and of spontaneous mental arousal are the clinical consequences of central arousal difficulties [5].
- b) Problems in *non-genital peripheral* arousal may be better exemplified by "touch-impaired" disorders. According to Sarrel and Whitehead [24], 35.71 % patients of their series described a change in touch perception suggestive of peripheral neuropathy that may lead to avoidance of skin contact during foreplay, so interfering with sexual arousal.
- c) Reduction in *genital* arousal leads to vaginal dryness, one of the most frequent complaints reported in the clinical consultation [5, 24, 27, 28]. This symptom is more intense in thin women and may be totally absent even in very old patients, if they are overweight, thanks to the estrogen aromatization in the adipose tissue and/or still having sexual activity. Levin [4] hypothesized that estrogens could be the "permitting" factor for the action of Vaso Intestinal Peptide (VIP), the most important neurotransmitter that "translates" sexual drive in vaginal lubrication: the lack of estrogens is the first cause of arousal difficulties.

A second biologic cause of arousal difficulties is vaginism, either primary or, more frequently, secondary to vaginal dryness and dyspareunia with secondary defensive spasm of pubococcygeal muscle: it may account for half the cases of postmenopausal dyspareunia [24].

The third most frequent cause of genital arousal difficulties is urinary incontinence, whose prevalence dramatically increases in the elderly, with the contribute of estrogen loss. Women suffering from stress or urge incontinence secondary to detrusorial instability may suffer from occasional loss of urine during sex and may become inhibited for fear that it would recur. Appropriate diagnosis and treatment of incontinence may contribute to a renewed self-confidence [24].

Orgasmic difficulties

They may be the end point of a number of biological, as well as motivational-affective and cognitive factors [1, 5, 24, 30]. From the biological point of view, the diagnostic flow chart should look for loss of sexual hormones, with secondary libido and arousal problems, vaginal and vulvar trophism (included clitoris!) and pelvic floor status. Hypertonic conditions may cause dyspareunia, vaginismus and post-coital cystitis [5], thus impairing the formation of the so called "orgasmic platform" [3] for the negative association of fear, anxiety and pain [5]. Hypotonic conditions, leading to vaginal hypo-anesthesia, deserve as well a rehabilitative approach with Kegel exercises [3, 5].

Post-coital or post-orgasmic memories

This phase may explain the positive or negative feedback mechanisms that modulate the circuit of sexual function. Negative feelings may restrain the sexual circuit, when pain or disappointment are the final feeling after sex.

THE COUPLE RELATIONSHIP

The aging process affects the individual and the couple, as a dyadic sexual unit. Biological modifications, secondary to hormonal loss as well as to aging, may have a deep impact on the bases of reciprocal physical attraction and affective bonding [2, 3, 5]. Male independent sexual problems may as well affect the possibility of a satisfying sexuality in the elderly [18]. Only thirty per cent of men over 70 still enjoy a full erectile competence and a satisfying sexual life. Beside physical erectile competence, the REAL desiderability of an aging partner (for overweight, lack of attention to good hygiene, self care and cure, to the quality of courting and foreplay, for general health and specific sexual problems, for lack of intimacy) [1, 5] may further contribute to this fading of sexual life that worsen over the years. In positive, a new partner may contribute to the increase of libido, satisfaction, orgasm in postmenopausal women, better if the woman is given full biological equilibrium thanks to HRT.

SINGLE WOMEN ISSUES

Single women are the leading group in the elderly cohorts [6]. Sexual drives may be spontaneously fading, or be actively removed in the unconscious and/or sublimated in caring family or social activities. The daily life could be more painful, even from the sexual point of view, if the woman is still feeling the need to partake a sexual intimacy and possibly a loving relationship with another human being. When a partner is not physically or emotionally available, autoerotism may be the unique choice to satisfy the need and calm down a sexual arousal that in some cases is reported as painful. Autoerotism, in women educated in a religious or inhibited style, may provoke strong guilty feelings, somatizations like vulvar pruritus and/or vulvodynia, feelings of loneliness, of abandonment, of loss, that may painfully stress the single condition. Other negative feelings may be induced by the fear that masturbation may damage health and/or mental equilibrium [26]. Only a minority of elderly women seem to enjoy autoerotism with a feeling of empowerment and joy.

A third possibility is the "life surprise", the gift of having new loves and partners even in old age. This rejuvenating experience, emotionally rewarding, may raise new sexual problems, particularly if one or both partners had remained alone for years. Also in these cases a caring doctor could be precious in treating the problems that could

prevent a satisfying intimacy. Provided that he/she had overcome the many prejudices many doctors have towards love and sex in the elderly.

LOVE IN THE ELDERLY

"Late loving bloomers" are not infrequent in old age and "come out" if we are willing to listen to. Thanks to a more open social attitude to love in the elderly, and the strong help from medical support, even through HRT, for women, and uroandrogenic therapies, for men [18], many more postmenopausal women and old people will consent themselves the new wave of emotions that love and sex may carry, independently of age. The love potential does not get old.

CONCLUSION

A well balanced hormonal status, that may modulate the impact of the intrinsic aging on self perception and sexual function, is a prerequisite for physical femininity. Nevertheless, feminine self-perception is strongly context-dependent. Vulnerability to sex identity crisis during and after the menopausal transition may be further modulated by psychosocial factors [1, 5, 12, 15, 25]. This may explain the wide range of findings in the scientific literature, on one side suggesting the potential negative effect of menopause on female sexual function [1, 3, 5, 27–33], on the other questioning the prevalence of female sexual dysfunctions in

the postmenopause and the specific role of hormonal loss, as many other psychosocial factors seem to have a causal and confounding role [27, 28, 30–31, 33–36]. Methodological biases seem to be the major cause for these conflicting results [5, 34]. More research is necessary to properly understand the role of biological factors versus the psychosocial ones that affects sexuality in the postmenopause.

In the daily practice, the best way to deal with sexual issues in the peri- and post menopause requires a careful improvement of the gynecologist's medical skill in this area through an appropriate learning and updating, desirably under the patronage of scientific societies.

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