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MENOPAUSE AND SEXUAL ACTIVITY

PRZEKWITANIE A AKTYWNOŚĆ SEKSUALNA

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Summary

Sexual activity is a natural and important part of a healthy lifestyle, no matter what is age. Although the amount of sexual activity generally declines with age, sexual interest and ability can remain fairly constant. While the need for and interest in sex varies widely in people, most people experience sexual desire throughout life.

KEY WORDS: sexuology, menopause.

Streszczenie

Przekwitanie jest okresem przejściowym w życiu człowieka między okresem reprodukcyjnym a okresem starzenia się. Zazwyczaj starsi ludzie rzadko wypowiadają się na temat swojego życia seksualnego – nawet pytani o tę sferę przez lekarzy. W tej grupie wiekowej są jednak ludzie, którzy według siebie są atrakcyjni seksualnie, ludzie mający poczucie, że doświadczanie uczucia i zmysłowej przyjemności to cenna część starszego wieku.

SŁOWA KLUCZOWE: seksuologia, przekwitanie.

A diversity of complex controlling factors as well as an abundance of ways in which human sexuality is expressed remains an important methodological problem which impedes a scientific description of the phenomenon in question. Sexual activity is a natural and important part of a healthy lifestyle, no matter what one's age is. Although the amount of sexual activity generally declines with age, sexual interest and ability can remain fairly constant.

While the need for and interest in sex varies widely in people, most people experience sexual desire throughout life.

An extensive survey on sexuality from USA and Canada, showed that a vast majority of people at the age of 65 said that sex was important. Our clinical observations are the same. While one quarter of respondents from Canada and USA reported that they had not been sexually active the year before the survey, majority of those between 65 and 74 considered themselves sexually active. Maintaining a level of sexual activity makes the biological changes associated with aging less pronounced, with less impact on overall sexuality.

Many older couples say that they enjoy sex more now than when they were younger. They have more privacy, life has fewer stresses and for heterosexual couples the risk of unwanted pregnancies disappears.

Aging brings about a number of physical and psychological changes that can have an impact on sexual performance and pleasure. An important predictor of how active sex life people will have in later years is their overall physical health [1, 2, 3].

The Benefits of Maintaining Sexual Activity – There are many benefits in maintaining a healthy sexual activity (sex) level in later years. Some benefits include:

Sex burns fat and causes the brain to release endorphins, natural chemicals that act as painkillers and reduce anxiety.

In men, sex stimulates the release of growth hormones and testosterone, which strengthen bones and muscles.

Sex also seems to prompt the release of substances that bolster the immune system.

Some studies suggest that sex (performed about three times a week) can slow aging and prevent wrinkles around the eyes from appearing.

The physical exertion associated with sex is about the same as walking up two flights of stairs. If your heart is up to that much exercise, it's probably up to sex.

Continuing to have sex will preserve your sexual vigour beyond middle age. Sexually active people have higher levels of naturally produced sex hormones [1, 2].

Aging and women sexual activity

For women, vaginal discomfort, dryness or pain during intercourse may occur, due to decreased lubrication, the result of hormonal changes related to menopause. Treatments and ways to adapt are available. Sensitivity to breast stimulation may also occur. Men may notice that achieving an erection may take longer and that it may not be as large or firm as before. Orgasms may be less intense than in their youth. These changes are normal and a result of a decrease in hormones. Again, treatment and ways to adapt are ava-

ilable. While the normal changes of aging can affect sexual response and desire, other factors can also increase the challenge. They include:

- smoking
- excess alcohol (more than two drinks a day)
- obesity
- lack of self-confidence
- depression
- performance anxiety.

Lack of sexual desire beyond the normal changes of aging can sometimes be related to an underlying health problem. Diabetes, high blood pressure and prostate problems can affect sexual desire and performance. Heart disease, osteoporosis, arthritis, incontinence and emphysema can also affect physical ability and enjoyment of sexual activity. Prescription drugs to treat conditions such as depression and high blood pressure can suppress desire and performance.

Anatomic and physiologic changes that accompany aging in women include reduced vaginal size, thinning and decreased elasticity of the vaginal walls, a change in the vaginal pH from acidic to alkaline, shrinkage of the labia majora and thinning of the labia minora, decreased clitoral sensitivity and size, reduced perineal muscle tone, possible uterine or bladder prolapse, and a thinner orgasmic platform. Breast atrophy, decreased breast engorgement during arousal, and sensory changes in the nipple and areola are also noted. These anatomic changes predispose women to more frequent episodes of vulvovaginitis and urinary tract infections, which, along with decreased vaginal lubrication, may cause dyspareunia.

Aging and women sexual activity

As they age, women require more time to become sexually aroused, take longer to lubricate, produce less vaginal lubrication, have less intense orgasms, and need more clitoral stimulation to become orgasmic. The ability to have orgasms does not change significantly with aging, but older women are less likely to be multiorgasmic. Women who are coitally active after menopause have less vulvar and vaginal atrophy and higher titers of androgen than abstinent women [2, 3].

Aging and men sexual activity

Men also experience physiologic changes and a decrease in sexual desire and frequency as they age. There is a decrease in the number of nocturnal and morning erections. Men may require more intense penile stimulation for arousal (erection) and ejaculation. Erections tend to be less rigid, sometimes making intercourse difficult. Penile detumescence is more rapid, and the refractory phase is much longer in the older male [3, 4].

Aging and sexual activity

Illnesses that accompany aging may also have an impact on sexual function in men and women. Arteriosclerosis may decrease vaginal blood flow and cause decreased arousal, vaginal lubrication, and orgasmic intensity. Chronic obstructive pulmonary disease may cause lowered testosterone levels, impairing sexual desire.

Erectile Dysfunction

Obstetrician-gynecologists may be called upon to counsel women about their male partner's sexual health. Therefore, they should be familiar with the male sexual-response cycle and the common causes and treatment of sexual dysfunction in men. Erectile dysfunction is the inability to develop an erection or to maintain a rigid erection long enough for completion of intercourse. The term erectile dysfunction is preferable to impotence. Erectile dysfunction is common and is age dependent, increasing as men age [3, 5, 6]. The prevalence of erectile dysfunction in men age 40–70 years is about 50%. Similar to the female sexual dysfunctions, erectile dysfunction can be lifelong or acquired, generalized or situational. The other male sexual dysfunctions commonly encountered (ie, hypoactive sexual desire, delayed or absent orgasm, and premature ejaculation) can contribute to the development of erectile dysfunction [6].

Erectile dysfunction that occurs suddenly and intermittently is often associated with psychologic causes such as depression and anxiety, whereas erectile dysfunction that is gradual, persistent, and progressive is usually organic in etiology. Most men with erectile dysfunction are now thought to have an organic cause for their condition, especially circulatory insufficiency, with psychologic issues as important contributing factors. Common causes of erectlie dysfunction include surgery (prostatectomy), aging, cigarette smoking, and chronic medical conditions such as multiple sclerosis, diabetes mellitus, hypertension, atherosclerosis, and heart disease. Erectile dysfunction is also associated with medications like antihypertensives (especially thiazide diuretics) and psychotrophics [3, 7]. The use of recreational drugs and alcohol also contributes to erectile dysfunction. Endocrine causes of erectile dysfunction include bilateral testicular atrophy, hypothyroidism, and prolactinomas.

Aging and sexual activity in women and men

Pain from an arthritic hip may make it difficult to find a comfortable position for intercourse. Several psychosocial factors may contribute to an older woman's decision to stop sexual activity. Older women may lack a sexual partner, or their partner may develop erectile dysfunction.

Couples may find that they can no longer function sexually as they did in the past and are unable to make the transition to a new (noncoital) way of lovemaking. Other factors include privacy issues (such as living in a nursing home or with children), reluctance to masturbate, and the negative attitudes of society toward sexuality in older women.

Aging and sexual activity

Management of sexual difficulties in older women should include local or systemic estrogen supplementation to alleviate vaginal dryness, urinary tract symptoms, and dyspareunia. Other suggestions might include taking a warm bath before lovemaking to loosen stiff joints, making

love in the morning when the couple is less fatigued, and experimenting with sexual stimulation to orgasm without having intercourse. The sexual expectations of the patient and her partner and their current level of sexual functioning should also be evaluated. Myths they may believe about sexuality in the elderly should be dispelled. However, aging patients may have difficulty changing their sexual expectations and ways of making love because they may not easily adapt to change and may resist reevaluating long-held sexual beliefs, attitudes, behavior, and gender roles [4].

Medical Problems

Both acute illness (myocardial infarction) and chronic illness (renal disease or arthritis) can create depression, a distorted body image, and physical discomfort and can disturb the hormonal, vascular, and neurologic integrity needed for sexual functioning. Neurologic disorders that impair sexual functioning include multiple sclerosis, alcoholic neuropathy and spinal cord injury. Endocrine and metabolic disorders such as diabetes mellitus, hyperprolactinemia, testosterone deficiency, estrogen deficiency, and hypothyroidism can affect sexual response.

Drugs

A variety of prescription and nonprescription medications and illicit drugs can alter the sexual response in men and women. These include antihypertensives, thiazide diuretics, antidepressants (especially the serotonin reuptake inhibitors), antipsychotics, antihistamines, barbiturates, narcotics, benzodiazepines, oral contraceptives, and recreational drugs like cocaine and marijuana. Alcohol also can affect sexual response.

STI

While there are many benefits to sexual activity, it is important to remember that sexually transmitted infections (STIs), for example, chlamydia, ghonorrhea, HIV and genital herpes do not respect age. Seniors who have lost a partner, perhaps after many years together, become vulnerable to STIs when they seek new companionship.

Aging and the cessation of ovarian function accompanying menopause can significantly affect the sexual-response cycle of women. Sexual desire and frequency of intercourse decrease as women age, although women remain interested in sex and continue to have the potential for sexual pleasure for their entire lives. The need for closeness, love, and intimacy does not change with advancing age. The way women function sexually as they grow older is largely dependent on partner availability and how frequently they had sex and how much they enjoyed sex when they were younger [2, 4, 5].

Sexual Dysfunction

The sexual dysfunctions include sexual desire disorders (eg, hypoactive or inhibited sexual desire and sexual aversion), sexual arousal disorders, orgasmic disorders, sexual pain disorders (eg, vaginismus and dyspareunia), and sexual disorders due to general medical conditions and substance abuse. Each disorder can be further classified as lifelong or acquired (ie, after a period of normal sexual functioning), generalized (ie, not limited to a specific partner or situation), or situational [5].

In evaluating patients with sexual dysfunction, it is important to obtain the following information:

1) a specific description of the dysfunction and an analysis of current sexual functioning,
2) when the dysfunction began and how it has progressed over time,
3) any precipitating factors,
4) the patient's theory about what caused the dysfunction,
5) what effect the dysfunction has had on her relationship,
6) past treatment and outcome,
7) the patient's expectations and goals for treatment.

The patient's understanding of sexual physiology and sexual behavior should be assessed, and any myths or misinformation should be addressed [6, 7, 8].

Ageless intimacies

As important as robust health is for older people, an often undervalued point involves their capacity for intimacy.

One such non-goal-oriented model for sex has been developed in Far East: tantric sex. Here the emphasis is not on speeding up sex but rather on slowing things down in order to savor each moment fully.

Lovers are encouraged to focus on their own touches and imagine how it would feel to be receiving them. Orgasm is not emphasized. In fact, sensual arousal without orgasm is especialy cherished. Since building up to orgasm is not the objective, sex that does not end in orgasm is not seen as failure. Instead, it may be as a loving gesture – one that older friends can share with each other. Seen from tantric point of view, the quality of sex may actually improve with age [7, 8].

Many young, sexually active people do not experience (do not fully know) the whole range of sensations that love between two elderly people gives.

Luckily, the ability to share feelings, show affection and love is not determined by the amount of muscles we have or perfect body fitness.

This ability does not shrink with age [7, 8].

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