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Perimenopausal issues in sexuality

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ABSTRACT *The perimenopause, with its attendant physiological and psychological changes, has influences on a woman's sexuality. These may be positive, e.g. bringing a release from fears of pregnancy leading to an increased sexual enjoyment. More often though the perimenopause brings negative physical effects, such as erratic heavy periods, hot flushes and vaginal dryness and also negative psychological effects such as depression and low libido. Other negative factors may include psychosocial changes such as coping with ageing parents and teenagers, and increased vulnerability to disease of the reproductive organs, which obviously affects sexuality. Thus the perimenopause is a time of high risk for sexual problems of all kinds. As perimenopausal women may be reluctant to complain about sexual difficulties, it is helpful for health professionals to be aware of this and ask them about their sexual lives. Sexual problems will thus be identified early at a stage when they are easier to treat.*

Introduction

Sexual problems are common. Masters and Johnson in one of their surveys found that 50% of the population would suffer from a sexual problem at some time in their lives. The likelihood of a woman suffering from such a problem is obviously increased if her reproductive anatomy or physiology is disturbed in some way. This can occur with the natural physiological changes of the menopause, which can have profound psychosexual effects. Also, some women view the menopause as being the onset of old age, with concurrent negative attitudes towards their sexuality (Adler *et al.*,2000). This, along with social and relationship difficulties at this time in their lives, means that the menopause is a high-risk time for sexual problems.

Physiological effects of the menopause

The ovary contains a limited number of primitive ova at birth. The ageing process makes these follicles increasingly resistant to gonadotrophic stimulation, to the point when ovarian activity and menstruation cease. This last menstruation is preceded by a gradual slowing down of ovarian responsiveness over many years and also continues afterwards until a stable post-menopausal state is reached. The entire

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period is known as the perimenopause. The post-menopausal ovary virtually stops producing oestrogen but still produces a certain amount of androstenedione and testosterone. These, along with adrenal androgens, provide oestrogen by peripheral aromatization.

The characteristic symptoms of the menopause are hot flushes and night sweats. Vaginal dryness is an important feature as far as sexual functioning goes, but only affects about 10% of women (Chakravarti *et al.*, 1979). It may simply be the result of sexual arousal problems. It should be seen separately from vaginal atrophy, which does not tend to lead to complaints of dyspareunia (Laan & Vanlunsen, 1997). In addition it has been found that sexual activity protects against vaginal atrophy (Leiblum *et al.*, 1983). Perhaps emotional changes at this time have more effect on a couple's sex life (Stoppe *et al.*, 2000). In general, a woman's sex drive declines at the menopause if she thinks it should; for example, if for her sex is tightly linked to reproduction or if sex is unsatisfactory anyway and the menopause is the ideal time to give up the whole 'nasty business'. Conversely, women for whom the fear of pregnancy has blighted their sexual relations may welcome the onset of natural infertility. This may completely alter their attitude towards sex so that, rather than being fearful they can relax totally perhaps for the first time in their adult lives. This of course leads to an increase in their libido. A few women, however, do suffer a profound loss of libido when there is no particular reason to and this may not respond to conventional HRT (Sherwin & Gelfand, 1987; Shifren *et al.*, 2000). It may be associated with a distaste of touch of any kind and these women may find even non-sexual contact, like cuddling grandchildren, impossible, which is often very distressing. These women seem to be highly dependent on the ovarian rather than adrenal androgens, so when the ovaries shut down, circulating androgen levels fall. This problem may be resolved by using a more androgenic HRT like tibolone, or may require use of actual testosterone supplements like oral testosterone undecanoate, testosterone implants or patches.

A menopausal woman may become acutely aware of the ageing process as lowered hormone levels alter the subcutaneous fat content and moisture content of the skin. This along with heavy or unpredictable periods, dry vagina and hot flushes may make her feel sexually unattractive and she may worry that her partner will lose interest in her. Her partner, who is also likely to be middle-aged, may be struggling with his own mid-life crisis and may be unable to offer her the support she needs.

Disease processes

I mention the following conditions as they are more commonly found in middle-aged women or their treatment may induce the menopause.

Malignancy

I think that the feeling in general with gynaecological malignancy is that most women who suffer from it are elderly and will not be having a sex life, so their sexual

functioning after treatment is not a high priority. It is important to remember that many couples are sexually active into their seventies and beyond. Also, although vulval carcinoma is more likely in the elderly, endometrial and cervical cancer can occur in much younger women. Such women not only have to endure major surgery and radiotherapy but also may be plunged into an induced menopause with all its related symptoms. All of these can greatly affect their sexual functioning.

Women suffering from breast cancer have to endure mutilating surgery to the breast. These days this is limited to lumpectomy where possible and breast reconstruction, if the woman wishes. The breast in Western society is clearly not just a milk-producing organ, but is a source of sexual pleasure and a symbol of femininity. Its loss or deformity is therefore highly likely to affect a woman's sense of herself as a sexual being (Schover, 1994). In addition, further radiotherapy, chemotherapy or hormonal therapy may be required. The tumour may be oestrogen dependent, so induction of the menopause is often an important part of treatment. Therefore, in addition to their anxieties about having a fatal condition and their perceived deformity, such women suffer from menopausal symptoms. It would be surprising if they did not suffer from sexual problems as a consequence.

Women who suffer breast or gynaecological malignancy initially may be too worried about the possibility of death to worry about sex, but as they recover and readjust they are often in need of the comfort and reassurance that a good sex life can bring. They may feel reticent about raising the subject of sex with their doctor, as they often feel mutilated, no longer feminine and therefore not deserving of a sex life. I feel, therefore, that it is essential that their doctor raise the possibility of them becoming sexual again (Ara, 1999). The woman's partner must not be forgotten in this situation. He will have anxieties about the loss of his wife. He may also be anxious about resuming a sexual relationship for fear of damaging her further in some way. Sexual dysfunction should be recognized as a couple-oriented phenomenon. A woman's anxiety about her appearance, post-operative depression, or dyspareunia may be perceived by her partner as a sexual rejection, which may initiate a cycle of decreasing contact or even sexual problems in the partner. When a surgical procedure which may affect a woman's sexual functioning is contemplated, her partner should be involved in any counselling. With a bit of imagination and understanding from her partner, even a woman who has had a radical procedure like a clitoridectomy can become sexual again. If the couple is keen to resume a sex life it is worth exploring all options for sexual pleasure. Many couples in our society have a fairly narrow range of sexual activity, which may be limited to intercourse. They may see other activities as somewhat 'kinky' and need permission from a professional to try them out. Unfortunately not all health professionals feel able or willing to discuss sexual matters and their response to a woman who is struggling with feelings of unattractiveness may compound her anxieties and low self-esteem.

Case study. Mrs W a 38-year-old married woman developed an anal carcinoma. This was treated initially with surgery to remove the anus, rectum and posterior half of the vagina. She then had pelvic radiotherapy. The combination of treatment left her

with a colostomy, a greatly narrowed vagina and also plunged her into the menopause. Not surprisingly, as a result she suffered severe sexual difficulties. She described feeling that her entire body below the waist was alien to her. She and her husband had very real practical difficulties with penetration and she also was highly embarrassed by her colostomy. She mentioned her sexual problems to her surgeon who advised her that she was lucky to be alive and should be content with that. Fortunately she was a very assertive woman who was not willing to give up her sex life and she found her own way to the sexual problems clinic. There we addressed her sadness at the loss of her attractive, feminine self and looked at ways of exploring a different but hopefully still rewarding sex life.

Hysterectomy

This is a very common operation in middle-aged women and usually relieves rather than causes sexual problems (Ara, 1999; Rhodes *et al.*, 1999). Women who have had very heavy periods or pelvic pain clearly will find sexual activity easier when the uterus is removed. Some women, however, may be anxious about the effects of hysterectomy on their sexual functioning. Their male partner too may worry about the possibility of damaging her internally with intercourse after surgery. They should both be reassured that very little will change for them sexually after surgery. Those who have had a total hysterectomy will find the vagina is a little shorter but this may be stretched to an extent by gentle intercourse. Most women find pressure against the cervix during deep penetration quite unpleasant so the absence of the cervix is not a problem. The few women who do enjoy cervical contact may be best served by a sub-total hysterectomy in which the cervix is preserved. Women should be reassured that given that most of their sexual sensation arises from the clitoris, vulva and lower third of the vagina, their orgasmic capacity should not change after the operation.

Case study. Mr A attended the GP surgery to discuss anal intercourse. His wife had had a hysterectomy six months previously and, although she seemed to have made a good recovery, she had only allowed him to have anal intercourse with her since. He was puzzled by this, but happy to comply with her wishes. They had never discussed sexual matters so it didn't cross his mind to ask her the reasons behind this change in behaviour. I talked with him about the safety aspects of anal intercourse, namely, use of adequate lubrication and hygiene measures, but also asked him to ask his wife to come and talk to me, in case she was suffering any adverse post-operative effects. She duly did but was very surprised to be asked about her sexual activity. As far as she was concerned, she'd had "everything taken away" so was unable to have vaginal intercourse!

Sexual problems

Lack of sexual desire may be organic or psychological.

Organic causes—perimenopausal hormone effects

A lack of oestregen, which impairs physiological genital arousal, will also impair the perception of sexual arousal. Low testosterone will cause low libido.

Organic causes—other hormone effects

Hypo- and hyper-thyroidism may cause low libido. Hyperprolactinaemia causes low libido as a result of secondary hypogonadism.

Depression. Oestrogen has a mood elevating quality so its relative lack in menopausal women may lead to depression, which in turn causes low libido. More commonly, depression in this age group is the result of psychosocial factors.

Drugs

Women going through the menopause may suffer a variety of psychological symptoms such as anxiety, lack of confidence and low mood. Unfortunately, drug treatment for these conditions with tranquillisers or anti-depressants may cause low libido as an unwanted side-effect.

Psychological causes

Sexual satisfaction in women, unlike in men is often as much influenced by non-sexual as it is by sexual interaction with their partner Therefore non-sexual relationship conflicts often lead to a loss of sexual desire. Most menopausal women with low sex drive have psychological problems, either personal, or relationship based, and require detailed psychosexual or relationship counselling (Hite, 1979).

Relationship issues. These, as with any relationship, are likely to be poor communication and resentment. In the more mature couple, these may have been ongoing for years, even decades, with entrenched positions over regular domestic disputes leading to sexual withdrawal. Along with this emotional loss of attraction for their partner, may go loss of physical attraction as people in a relationship which is years long no longer try so hard to make themselves as attractive to their partner as they once did.

Teenage children. More specific problems may arise with teenage children. A nubile daughter can be a threat to a menopausal mother whose lack of self-confidence about her looks is thrown into sharp relief by her daughter's emerging sexual attractiveness. The daughter may test out her own sexuality on her father with flirtatious behaviour, thus ensuring his attention is turned to her and away from his wife.

Case study. Mrs R. attended the GP surgery complaining of headaches. No abnormality was found on examination and when asked if there was any particular stress in her life, she burst into tears. Her husband had stopped making love to her three years before and she thought it was because she was no longer attractive to him. She was aged 53 and had gone through the menopause two years previously. It was suggested that her husband attended with her on her next appointment. He duly came along and with great embarrassment revealed that he had been suffering erectile failure for three years. This had started suddenly one night when he became aware that his daughter, whose bedroom was next door to her parents, was probably able to hear them making love. From that time on he had been unable to achieve an erection and eventually stopped approaching his wife sexually.

Ageing parents. Elderly parents are often the responsibility of a middle-aged wife. She may spend time doing their domestic chores along with her own and this, combined with coping perhaps with a full-time job, leaves a woman with little energy for her own sexual relationship. Her husband too may work long hours and they may therefore have very little free time together. This makes a meaningful sexual relationship very difficult to achieve.

The death of parents leaves an individual feeling vulnerable, as they no longer have a buffer generation between themselves and death. The menopausal woman may also fear that her useful life is over and that the only milestone left to look forward to is her own death. The combination of these two life events, which is not uncommon in middle age, is a potent cause of anxiety and depression.

Vaginismus. Vaginismus may occur after painful intercourse for any reason and in the menopausal woman may be initiated by: (1) vaginal dryness resulting from lowered oestrogen levels; (2) vaginal infections—the vaginal mucosa becomes atrophic during the perimenopause and less able to fend off minor infections, which can cause dyspareunia.

Vaginismus can be treated, as in any age group, by instruction in control of the pelvic floor along with insertion of objects of increasing size, either fingers or dilators. This increases the woman's confidence that she is able to allow penetration without pain. In addition, simple lubricants like KY jelly or local or systemic oestrogen will be required to ensure the problem does not recur. If intercourse has not been attempted for some years after the menopause there may be a degree of vaginal stenosis which will require gentle stretching with vaginal dilators.

Anorgasmia. I see the occasional middle-aged or older woman who is starting out in a new relationship, perhaps after the end of a marriage through divorce or bereavement. She may never have achieved an orgasm in her previous relationship and that may not have been a problem for her. Her new partner, however, may question her enjoyment, leading her to feel that there is perhaps more to sex than she had previously considered. These women are encouraged to masturbate—often a new experience for them—as there is no doubt that it is easier to teach your partner how to help you to achieve an orgasm if you are able to do it for yourself. Many

women still believe that if they can't have an orgasm during intercourse there is something wrong with them. They are often greatly reassured by the findings of the *Hite Report* (Hite, 1979) which showed that only 33% of women regularly achieve an orgasm through intercourse alone. The majority will require some other form of stimulation to the clitoris, either before during or after intercourse.

Male sexual problems

One change in sexual functioning that men notice as they age is that they have fewer spontaneous erections. By mid-life a man will need direct touching of the penis to achieve an erection. This can cause problems in couples whose only sexual contact is intercourse in that he may find his erection is less reliable. HRT prescribed to his wife can add to his difficulties. If she starts HRT her vagina becomes well lubricated. This may be more comfortable for her but may not give him enough friction to maintain his erection. Also, she may feel much better in general on HRT and may find a new lease of sex life. A man already lacking in confidence in his sexual prowess may, when faced with this newly sexually demanding woman, may retreat into complete erectile failure.

Future treatment of menopausal female sexual problems

Viagra?

So far, studies looking at treatment with Viagra of every female sexual problem have had mixed results (Berman *et al.*, 2001; Kaplan *et al.*, 1999). Viagra's current use is in erectile failure and it works by increasing blood flow into the penis. This is translated in women to increased genital blood flow with erection of the clitoris and vaginal lubrication. If a man is asked about his sexual arousal, he will discuss his erection. A woman's reported sexual arousal correlates best with how mentally exciting she finds certain sexual stimulation and correlates poorly with objective genital blood flow, which is something she may have little awareness of. Studies of women shown erotic movies in a laboratory while their genital blood flow was measured found that there was poor correlation between subjective ratings of arousal and genital response (Steinman *et al.*,1981). Women who report low arousal are actually referring to psychic arousal and Viagra will do nothing for this. In the few who definitely have poor genital blood flow it will work quite well.

Conclusion

Perimenopausal women are more vulnerable to sexual problems because of the various physiological, psychosocial and disease processes occurring at this time in their lives. As these women may be reluctant to complain about sexual difficulties it is helpful for health professionals working in this field to ask them about their sex lives. Hopefully, as a result, sexual problems will be identified at an early stage when they are easier to treat.

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