Menopause and Sexual Function

The menopause transition and postmenopause can be associated with bothersome changes in sexual function. Although some people experience a stronger sense of sexual confidence and freedom after menopause, others find that symptoms negatively affect their relationships and well-being. The most reported sexual concerns during this time include

- Low sex drive
- Decreased lubrication
- Vaginal dryness
- Pain with sex
- Difficulty having an orgasm
- Decreased sexual satisfaction

Causes of Sexual Dysfunction During and After the Menopause Transition

Sexual dysfunction during and after the menopause transition is often due to multiple factors, including biological, psychological, sociocultural, and interpersonal.

- **Biological Factors:** Poor health and underlying medical conditions, as well as some medications and hormone changes can have a negative effect on sexual function. Menopause is marked by a loss of sex hormones (estrogen and progesterone). The loss of estrogen in particular results in changes to the vagina, vulva, and bladder, referred to as genitourinary syndrome of menopause (GSM). These changes may contribute to pain and bleeding with sexual activity, decreased sensation, and problems reaching orgasm, often leading to decreased sexual desire and interest.
- **Psychological Factors:** Mental health issues such as depression, anxiety, or substance abuse and negative self-image are risk factors for sexual dysfunction. Similarly, a history of mental, physical, or sexual abuse, along with a history of adverse childhood events influence sexual function.
- **Sociocultural Factors:** Negative or restrictive beliefs about sexuality based on cultural upbringing or religion may result in decreased sexual desire or the inability to enjoy sexual experiences.
- **Interpersonal Factors:** Relationship issues (eg, infidelity, unresolved conflict, difference in libido, poor communication) play a significant role in sexual dissatisfaction and low desire. In addition, lack of a partner or poor partner health and life stressors (eg, caregiving, financial strain) may further contribute to issues with sexual desire and function.

Treatment of Sexual Dysfunction at Midlife and Beyond

- **Psychological Interventions**: A critical component to treatment is education on the female sexual response with a focus on addressing negative thoughts, reducing stress and self-doubt, and providing simple ways to be more relaxed, present, and engaged in intimacy. A variety of psychotherapy approaches including sex therapy, individual and

couples therapy, mindfulness-based interventions, and cognitive-behavioral therapy have been found to be effective.

- **Physical Therapies:** Therapeutic techniques geared toward addressing pain with sexual activity and tight or weak pelvic floor muscles can be helpful. Pelvic floor muscle training, electrical stimulation, therapeutic ultrasonography, and soft-tissue mobilization are among the techniques used.
- **Vaginal Moisturizers and Lubricants:** Vaginal moisturizers help to maintain vaginal moisture and can be used regularly, at least two to three times per week. A lubricant is used for sexual activity and can be applied to the vulva or vagina, penis, or device to increase comfort and pleasure. Lubricants and moisturizers can be used alone or in combination with prescription therapies for GSM.
- **Pharmacotherapies:** Prescription therapies are geared towards management of GSM and decreased sexual desire.
    - ***GSM*:** A variety of low-dose vaginal estrogen options, prasterone vaginal insert, and oral ospemifene are used to restore vaginal tissue and treat vaginal dryness and pain with sex caused by loss of estrogen.
    - ***Decreased sexual desire*:** Flibanserin and bremelanotide are government approved for treatment of low sexual desire in premenopausal women in the United States However, in Canada, flibanserin is government approved for women aged 60 years and younger. Off-label use of topical (eg, cream) testosterone approved for use in men has been shown to improve desire and arousal in some postmenopausal women when used in doses that approximate testosterone levels found in premenopausal women. There are no government approved testosterone options for women except for those in Australia, and long-term safety data are lacking.

It is important to recognize that sexual function may change as women age but is still a vital component of well-being. Successful treatment depends on identifying and addressing individual factors because the cause is often multifactorial and may require an integrative approach to management. With the right care, sexual well-being can be restored.

Resources: Please visit The Menopause Society's website (menopause.org) where you can find additional information on important menopause-related topics, including hot flashes, midlife weight gain, sleep dysfunction, mood changes, and hormone therapy. You can also search for a menopause-certified specialist in your area.

The Menopause Society™

This *MenoNote* provides current general information but not specific medical advice. It is not intended to substitute for the judgment of a person's healthcare professional. Additional information can be found at **www.menopause.org**. The Menopause Society is committed to leading the conversation about improving women's health and healthcare experiences during the menopause transition and beyond. The Society develops evidence-based position statements and consensus recommendations to ensure that healthcare professionals and the public have access to the most up-to-date information.

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