Understanding the sexual concerns of older women presenting for care to women's health clinics: a cross-sectional study

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Abstract

Objective: To compare the prevalence of female sexual dysfunction (FSD) and distress between sexually active midlife women (50-64 y) and older women (65+ y) presenting for care at women's health clinics at a tertiary care center.

Methods: This cross-sectional study included women aged 50 and above who received care at Mayo Clinic women's health clinics in Rochester, MN; Scottsdale, AZ; and Jacksonville, FL, between May 1, 2015, and August 31, 2022. Sexual function and distress were compared between midlife and older women using the Female Sexual Function Index (FSFI), Female Sexual Distress Scale-Revised (FSDS-R), and self-reported sexual health concerns.

Results: Among 3,465 sexually active women, older women were less likely to report loss of sexual desire (33.4% vs. 47.6%; $P < 0.001$) and reduced genital sensation (13.0% vs. 16.9%; $P = 0.024$) compared with midlife women. There were no significant differences for vaginal dryness, painful intercourse, or arousal/orgasm difficulties. FSFI scores were higher in older women for desire (3.0 vs. 2.4; $P < 0.001$) and lubrication (3.9 vs. 3.6; $P < 0.001$). While total FSFI scores were similar between older and midlife women (21.2 vs. 22.2; $P = 0.11$), sexually related distress was lower in older women compared with midlife women (13.0 vs. 15.0; $P = 0.015$). The prevalence of FSD (defined as FSFI score ≤ 26.55 and FSDS-R score ≥ 11) was similar between groups (51.8% vs. 56.2%; $P = 0.056$).

Conclusions: Older women experienced FSD at similar rates as midlife women but reported less sexual distress, potentially reflecting lower expectations regarding sexual function. Addressing sexual health concerns in older women may enhance quality of life.

Key Words: Female sexual health, Female sexual function, Female sexual dysfunction, Menopause, Aging, Older women.

(*Menopause* 2025;32:000–000)

The aging population is rapidly expanding, with adults aged 65 years and older becoming the fastest-growing demographic. By 2030, all US baby boomers will be aged 65 or older, representing 20% of the population.[1-3] Although sexual activity declines with age, sexual health remains relevant throughout life and does not cease with the end of reproductive years, as demonstrated by the Study of Women's Health Across the Nation, where over

Received for publication March 18, 2025; accepted May 16, 2025.

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Funding/support: None reported.

Financial disclosures/conflicts of interest: C.S.: consultant for Bayer Pharmaceuticals. S.K.:Advisory Board/Consultant Fee: Alloy, Astellas Pharma, Bayer, Daré Bioscience, Freya, Futura Medical, Madorra, Materna, Gideon Richter (formerly Mithra) Technologies Inc., Perrigo, Pfizer Inc., Reunion Neurscience ReJoy, Sprout Pharmaceuticals Inc., Strategic Science & Technologies, Ms. Medicine, Vella Biosciences. Shares/Restricted Stock Units: Alloy, J3 Bioscience. Board of Directors: J3Bioscience. E.K.: consultant for Astellas Pharmaceuticals, Estetrol SRL, Exeltis, Fresenius Kabi, and Womaness. Received research funding from Estetrol SRL. J.M.K.: consulting for Bayer and Elsevier. CME and non-CME honorarium for AiCME, City of Mesa, Paradise Valley Country Club, EPG Health, Vindico Medical Education, Arizona Public Services, WebMD, and Evolve Medical Education LLC. S.S.F.: CME presentations for Medscape, PriMed; consulting for Women's Health Platform Inc., CME lectures for MedAll, AiCME and consulting for Weight Watchers. The remaining authors have nothing to disclose.

Presentation at Conferences: The work was presented as an e-poster with a moderated oral presentation at the ISSWSH conference on Saturday, March 1, 2025.

J.K., C.S., and S.K.: conceptualization, methodology, writing—original draft, writing—review and editing. K.C.C. and S.W.: methodology, formal analysis, writing—review and editing. E.K.: writing—review and editing. J.M.K.: writing—review and editing. S.S.F.: conceptualization, methodology, writing—original draft, writing—review and editing, funding acquisition.

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eISSN: 1530-0374
DOI: 10.1097/GME.0000000000002617

75% of middle-aged women reported that sex was important to them.[4] Other studies have similarly shown that 37% of women over age 65 and 10% over age 85 remain sexually active.[5-8] In the National Social Life, Health & Aging Project, most older adults, including women, were found to engage in intimate relationships and consider sexuality an important part of life.[9,10]

Problems with sexual health are common, affecting 22%-43% of women globally.[11-13] Female sexual dysfunction (FSD) is defined in the DSM-5 as a clinically significant disturbance in sexual response or pleasure that persists for at least six months, causes personal distress, and cannot be attributed to other factors. Personal distress is a hallmark of FSD and a necessary component that distinguishes sexual dysfunction from a sexual health concern.[14,15] Sexual health encompasses physical, emotional, and relational aspects, and sexual satisfaction is associated with better quality of life.[9,11,16,17] Yet, female sexual dysfunction (FSD) remains underrecognized and undertreated, especially in later life.

Despite the growing population of older women, data on sexual health and FSD in women aged 65 and older remain sparse. Most research focuses on middle-aged populations or combines data from men and women.[18] This study aimed to examine sexual health concerns, sexual function, and related distress in sexually active women aged 65 years and older who received care in women's health clinics at a tertiary care center. We further sought to compare findings with those of women aged 50-64.

METHODS

Study design and participants

This cross-sectional analysis was completed using questionnaire data from the Data Registry on Experiences of Aging, Menopause and Sexuality (DREAMS).[19] Women aged 50 years and older who were seen at one of 3 women's health clinics for menopause or sexual health concerns at Mayo Clinic in Rochester, MN, Scottsdale, AZ, and Jacksonville, FL between May 1, 2015, and August 31, 2022, were included if they consented to the use of their medical records for research and completed both the Female Sexual Function Index (FSFI) and the Female Sexual Distress Scale-Revised (FSDS-R). Participants self-reported menopause status as premenopause (having regular periods), perimenopause (changes in periods, but have not gone 12 months in a row without a period), postmenopause (after menopause), or unsure. The study was approved by the Mayo Clinic Institutional Review Board.

Measures

Sexual health concerns

Participants reported sexual health concerns on clinical intake questionnaires, selecting all that applied from the following options: vaginal dryness, painful intercourse, pelvic pain, genital pain, loss of sexual desire, reduced genital sensation, and problems with arousal or orgasm. The total number of reported concerns (0-7) was calculated, and participants were categorized as having no concerns (0), 1-2 concerns, or ≥ 3 concerns.

Female sexual function index

The FSFI is a validated 19-item self-report questionnaire assessing six domains (desire, arousal, lubrication, orgasm, sexual satisfaction, pain), with scores ranging from 2 to 36. The FSFI is validated specifically for women who reported being sexually active within the past 4 weeks. A lower score is associated with worse sexual function, and a total score of ≤ 26.55 indicating significant sexual problems.[20,21]

Female sexual distress scale-revised

The FSDS-R is a 13-item validated self-report measure focused on distress related to sexual function over the past 30 days. Total scores range from 0 to 52, with higher scores associated with more sexual distress, and a total score ≥ 11 associated with clinically significant sexual distress.[22]

FSD was defined by a composite of FSFI score $\leq$ 26.55 *and* FSDS-R score $\geq$ 11.[23]

Mood and anxiety

Depression was assessed using the Patient Health Questionnaire-9 (PHQ-9), a 9-item validated tool based on DSM-IV criteria.[24] A score of ≥ 5 indicates depression. Anxiety was evaluated with the Generalized Anxiety Disorder-7 (GAD-7), a 7-item self-reported questionnaire. A score of ≥ 5 indicates anxiety.[25]

Demographic and clinical variables

The analysis included age, body mass index (BMI), race/ethnicity, menopause status, relationship status, education level, employment status, current hormone therapy (HT) use, current selective serotonin reuptake inhibitor (SSRI)/serotonin and norepinephrine reuptake inhibitor (SNRI) and gabapentinoid use, current smoking status, and current alcohol use. These variables were obtained from questionnaires administered during the clinical visit and from the electronic health record.

Statistical analysis

Among women who reported being sexually active in the past 4 weeks, χ^2 tests for categorical data and Wilcoxon rank sum tests for continuous score measures were used to make comparisons between midlife (50-65) and older (65+) women. Similar methods were used to compare sexually active and inactive women among midlife and older women. For each sexual health complaint, we created a logistic regression model that included sexual activity, age group, and their interaction. Interaction terms were assessed to test if the association between sexual activity and each sexual complaint was different between midlife and older women. All analyses were performed using SAS version 9.4 software (SAS Institute Inc., Cary, NC) and R version 4.2.2 (R Core Team, R Foundation for Statistical Computing, Vienna, Austria).

RESULTS

Study population

The study included 4,900 women aged 50 years and above, with 3,465 (71%) identifying as sexually active and 1,435 (29%) as not sexually active in the past 4 weeks. Based on self-reported menopause status, 47.3% of participants identified as postmenopausal, 14.3% as perimenopausal, 2.9% as premenopausal, and 35.5% were unsure. For the primary outcome, women who were sexually active in the past 4 weeks were included, and their detailed demographic characteristics are summarized in Table 1. In the sexually active group, 2,911 were aged 50-64 years (midlife group) and 554 were 65 years and above (older group). Median ages were 55.4 years (IQR: 52.7-59.1) for midlife and 69.3 years (IQR: 66.9-72.2) for older women, with the oldest participant aged 95 years.

Current systemic HT use was reported by 23% of participants and was higher among women without sexual health concerns (32%) compared with those with 1-2 (20%) or ≥ 3 concerns (18%; $P < 0.001$). Local vaginal HT use increased with the number of sexual health concerns, from 9.0% in women without concerns to 20.1% in those with ≥ 3 ($P < 0.001$).

Comparison by age group in sexually active women

Anxiety prevalence was similar between older and midlife women (23.5% vs. 27.5%; $P = 0.06$), but depressive symptoms were less common in older women (24.3% vs. 33.0%; $P < 0.001$).

The use of SSRIs/SNRIs (11.7% in older women vs. 14.0% in midlife women; $P = 0.23$) and gabapentinoids (4.1% vs. 2.8%; $P = 0.16$) was comparable between the groups. Local vaginal HT use was higher in older women (21.4% vs. 12.5%, $P < 0.001$), while systemic HT use was similar (26.2% vs. 22.3%; $P = 0.09$).

Sexual health concerns in sexually active women

Rates of reported sexual health concerns on the intake form were similar between older and midlife women (median: 2.0, IQR: 0-3, $P = 0.09$). No differences were observed between the age groups in terms of vaginal dryness (52.5% in older women, vs. 51.2% in midlife women; $P = 0.57$), painful intercourse (30.7% vs. 32.6%; $P = 0.38$), or arousal and orgasm concerns (20.8% vs. 24.0%; $P = 0.09$). Concerns about genital pain were more prevalent in older women (8.1% vs. 5.8%; $P = 0.04$), whereas pelvic pain concerns were higher in midlife women (6.7% vs. 4.5%; $P = 0.05$). Concerns about loss of sexual desire and reduced genital sensation were less frequently reported by older women than midlife women (33.4% vs. 47.6%, $P < 0.001$; and 13.0% vs. 16.9%, $P = 0.02$, respectively).

FSFI and FSDS-R scores in sexually active women

Total FSFI scores were similar between older and midlife women (21.2 vs. 22.2, $P = 0.11$). A majority of older women (71.8%) and midlife women (70.9%) had FSFI scores ≤ 26.55, identifying sexual problems ($P = 0.66$). Median FSFI domain scores showed that older women had higher desire scores (3.0 vs. 2.4; $P < 0.001$) but lower scores for lubrication (3.6 vs. 3.9; $P < 0.001$) and pain (4.0 vs. 4.8; $P < 0.001$). No differences in FSFI domain scores for arousal (3.6 vs. 3.6, $P = 0.89$), orgasm (4.0 vs. 4.0, $P = 0.93$), or satisfaction (4.4 vs. 4.4, $P = 0.346$) were identified between age groups.

FSDS-R total scores were significantly lower (better) in older women compared with midlife women (13.0 vs. 15.0; $P = 0.02$). A smaller proportion of older women had FSDS-R scores ≥ 11, indicating significant sexually related distress (57.0% vs. 61.9%; $P = 0.030$). The prevalence of FSD was similar between older and midlife women (51.8% vs. 56.2%; $P = 0.06$).

Comparison between sexually active and not sexually active women

Table 2 summarizes the comparison of HT use and sexual complaints between age groups, by women who were sexually active and not sexually active in the past 4 weeks. Of the 3,996 women in the 50-64 age group, 73% were sexually active compared with 61% in the 65+ age group ($P < 0.001$). The use of systemic HT differed between sexually active and inactive women in each age group, with sexually active women being more likely to use HT. However, there was no interaction between age groups by sexual activity for systemic HT. The use of local vaginal HT did not differ by sexual activity in either age group.

Among women aged 65 and older, those who reported sexual activity in the last 4 weeks had higher rates of concerns about vaginal dryness (52.5% vs. 39.7%; $P < 0.001$), painful intercourse (30.7% vs. 22.0%; $P = 0.004$), and arousal and orgasm problems (20.8% vs. 15.4%; $P = 0.045$) versus sexually inactive women. Sexually inactive women reported more pelvic pain (8.0% vs. 4.5%; $P = 0.030$) compared with sexually active women. No significant differences were noted for genital pain ($P = 0.70$), loss of sexual desire ($P = 0.65$), or reduced genital sensation ($P = 0.49$).

Among women aged 50-64, those who reported sexual activity in the last 4 weeks had higher rates of concerns about vaginal dryness (51.2% vs. 45.3%; $P < 0.001$), reduced genital sensation (16.9% vs. 13.5%; $P = 0.009$), and arousal and orgasm problems (24.0% vs. 18.2%; $P < 0.001$) versus sexually inactive women. In contrast, sexually inactive women reported more genital pain (8.3% vs. 5.8%; $P = 0.004$) and loss of sexual desire (51.3% vs. 47.6%; $P = 0.038$) versus sexually active women. There were no significant differences for painful intercourse ($P = 0.97$) or pelvic pain ($P = 0.13$) between sexually active and inactive women aged 50-64.

Painful intercourse was the only complaint with a significant difference between sexually active and not sexually active women between age groups (interaction P-value = 0.011).

DISCUSSION

This study found that in sexually active women, while the prevalence of FSD was comparable between

TABLE 1. Comparing ages 50-64 versus 65+ among sexually active participants

	50-64 (N = 2,911), n (%)	65+ (N = 554), n (%)	Total (N = 3,465), n (%)	*P*
Sexual health concern(s)				
Vaginal dryness	1,491 (51.2)	291 (52.5)	1,782 (51.4)	0.57
Painful intercourse	949 (32.6)	170 (30.7)	1,119 (32.3)	0.38
Pelvic pain	196 (6.7)	25 (4.5)	221 (6.4)	0.050
Genital pain	169 (5.8)	45 (8.1)	214 (6.2)	0.038
Loss of sexual desire	1,387 (47.6)	185 (33.4)	1,572 (45.4)	< 0.001
Reduced genital sensation	491 (16.9)	72 (13.0)	563 (16.2)	0.024
Arousal orgasm problems	700 (24.0)	115 (20.8)	815 (23.5)	0.094
Age, median (IQR)	55.4 (52.7-59.1)	69.3 (66.9-72.2)	56.7 (53.2-62.1)	< 0.001
Race/ethnicity				0.40
American Indian/Alaskan Native	6 (0.2)	1 (0.2)	7 (0.2)	
Asian	33 (1.1)	5 (0.9)	38 (1.1)	
Black or African American	27 (0.9)	3 (0.5)	30 (0.9)	
Native Hawaiian/Pacific Islander	1 (0.0)	0 (0.0)	1 (0.0)	
White	2,722 (93.6)	532 (96.0)	3,254 (94.0)	
Other[a]	39 (1.3)	3 (0.5)	42 (1.2)	
Unknown/choose not to disclose	83 (2.9)	10 (1.8)	93 (2.7)	
Relationship status[b]				< 0.001
Divorced	142 (4.9)	25 (4.5)	167 (4.8)	
Married	2,562 (88.2)	478 (86.4)	3,040 (87.9)	
Partnered	20 (0.7)	5 (0.9)	25 (0.7)	
Separated	11 (0.4)	0 (0.0)	11 (0.3)	
Single	144 (5.0)	20 (3.6)	164 (4.7)	
Widowed	25 (0.9)	25 (4.5)	50 (1.4)	
Self-reported menopause status[c]				< 0.001
Premenopausal	58 (4.2)	1 (0.4)	59 (3.6)	
Perimenopausal	257 (18.7)	0 (0.0)	257 (15.7)	
Postmenopausal	611 (44.6)	164 (60.1)	775 (47.2)	
Not sure	443 (32.4)	108 (39.6)	551 (33.6)	
BMI[d], mean (SD)	26.1 (5.2)	26.1 (4.8)	26.1 (5.1)	0.94
Education[e]				< 0.001
High school graduate/GED or less	190 (7.8)	58 (12.3)	248 (8.5)	
Some college or 2 2-year degree	673 (27.6)	137 (29.0)	810 (27.8)	
4-year college graduate	849 (34.8)	119 (25.2)	968 (33.3)	
Postgraduate studies	726 (29.8)	158 (33.5)	884 (30.4)	
Employment[f]				< 0.001
Employed	1,084 (52.1)	65 (15.9)	1,149 (46.2)	
Full-time homemaker	299 (14.4)	35 (8.6)	334 (13.4)	
Retired	240 (11.5)	250 (61.3)	490 (19.7)	
Self-employed	281 (13.5)	42 (10.3)	323 (13.0)	
Unemployed	80 (3.8)	8 (2.0)	88 (3.5)	
Work disabled	46 (2.2)	3 (0.7)	49 (2.0)	
Other	49 (2.4)	5 (1.2)	54 (2.2)	
Smoking status[g]				< 0.001
Current smoker	76 (3.7)	13 (3.3)	89 (3.7)	
Former smoker	465 (22.8)	138 (35.4)	603 (24.8)	
Never smoked	1,500 (73.5)	239 (61.3)	1,739 (71.5)	
Alcohol use[h]				< 0.001
4 or more times a week	413 (15.9)	128 (25.1)	541 (17.4)	
2-3 times a week	664 (25.5)	101 (19.8)	765 (24.6)	
2-4 times a month	579 (22.3)	82 (16.1)	661 (21.3)	
Monthly or less	515 (19.8)	94 (18.5)	609 (19.6)	
Never	430 (16.5)	104 (20.4)	534 (17.2)	
GAD-7 ≥ 5[i]	725 (27.5)	115 (23.5)	840 (26.9)	0.062
PHQ-9 ≥ 5[j]	897 (33.0)	124 (24.3)	1,021 (31.7)	< 0.001
Systemic HT[k]	452 (22.3)	103 (26.2)	555 (22.9)	0.088
Local vaginal HT[k]	253 (12.5)	84 (21.4)	337 (13.9)	< 0.001
SSRI/SNRI[k]	284 (14.0)	46 (11.7)	330 (13.6)	0.23
Gabapentinoid[k]	56 (2.8)	16 (4.1)	72 (3.0)	0.16
FSFI domain scores, median (IQR)				
Arousal	3.6 (2.4-4.8)	3.6 (2.4-5.1)	3.6 (2.4-4.8)	0.89
Desire	2.4 (1.8-3.6)	3.0 (2.4-3.6)	2.4 (1.8-3.6)	< 0.001
Lubrication	3.9 (2.1-5.2)	3.6 (1.8-4.8)	3.6 (2.1-5.1)	< 0.001
Orgasm	4.0 (2.4-5.6)	4.0 (2.4-5.6)	4.0 (2.4-5.6)	0.93
Pain	4.8 (2.4-6.0)	4.0 (1.3-6.0)	4.4 (2.0-6.0)	< 0.001
Satisfaction	4.4 (2.8-5.2)	4.4 (2.8-5.6)	4.4 (2.8-5.2)	0.35
FSFI—total, median (IQR)	22.2 (16.4-27.5)	21.2 (15.9-27.0)	22.1 (16.3-27.4)	0.11

TABLE 1. (*continued*)

	50-64 (N = 2,911), n (%)	65+ (N = 554), n (%)	Total (N = 3,465), n (%)	*P*
FSFI ≤26.55	2064 (70.9)	398 (71.8)	2462 (71.1)	0.66
FSDS-R total score, median (IQR)	15 (6-25)	13 (4-24)	14 (5-25)	0.015
FSDS-R total score ≥ 11	1803 (61.9)	316 (57.0)	2119 (61.2)	0.030
Female sexual dysfunction (FSFI ≤ 26.55 and FSDS ≥ 11)	1636 (56.2)	287 (51.8)	1923 (55.5)	0.056

FSDS-R, Female Sexual Distress Scale-Revised; FSFI, Female Sexual Function Index; GAD-7, Generalized Anxiety Disorder-7; GED, Graduate Equivalency Degree; HT, hormone therapy; PHQ-9, Patient Health Questionnaire-9; SSRI, selective serotonin reuptake inhibitor; SNRI, serotonin and norepinephrine reuptake inhibitor.

[a]"Other" was a self-selected option without further classification.

[b]Missing in 8 (7 aged 50-64 and 1 aged 65+).

[c]Missing in 1,823 (1,542 aged 50-64 and 281 aged 65+).

[d]Missing in 171 (136 aged 50-64 and 35 aged 65+).

[e]Missing in 555 (473 aged 50-64 and 82 aged 65+).

[f]Missing in 978 (832 aged 50-64 and 146 aged 65+).

[g]Missing in 1034 (870 aged 50-64 and 164 aged 65+).

[h]Missing in 355 (310 aged 50-64 and 45 aged 65+).

[i]Missing in 342 (278 aged 50-64 and 64 aged 65+).

[j]Missing in 240 (196 aged 50-64 and 44 aged 65+).

[k]Missing in 1041 (880 aged 50-64 and 161 aged 65+).

older women (65 y and above) and midlife women (50-64 y), older women reported lower levels of distress related to sexual problems. While others have suggested a lower FSFI cutoff of <21 to define sexual dysfunction in postmenopausal women,[26] we have used the accepted FSFI cutoff of ≤26.55 (which has been validated in postmenopausal as well as premenopausal women)[27] along with an FSDS-R score of ≥11 to define FSD in this cohort of women seeking care for menopause or sexual health concerns.

Our findings align with the Prevalence of Female Sexual Problems Associated with Distress and Determinants of Treatment Seeking (PRESIDE) study, which examined over 31,000 women aged 18-102 years, finding that sexual health concerns increased with age affecting 44.6% of middle-aged women (45-64 y old) and 80.1% of those 65 or older.[12] Similar to the current study, while sexual health concerns increased with age, distress related to these problems was highest in middle-aged women (14.8%) and lowest in women 65 years or older (8.9%).[12]

The high rates of FSD are not completely unexpected since multiple physical, social, and psychological factors contribute to FSD in older women. These include age-related changes including decreased vaginal lubrication, reduced libido, diminished sexual responsiveness and activity, and an increased prevalence of urogynecological conditions such as pelvic organ prolapse and fecal or urinary incontinence.[28-32] Older women accumulate chronic medical conditions as they age, such as diabetes, hypertension, cardiovascular disease, depression, arthritis, and cancer, which can negatively impact sexual function.[12,33-38] Medications commonly used to treat these conditions, such as antihypertensives, antidepressants, antiepileptics, anti-Parkinson drugs, and antipsychotics, can also contribute to sexual dysfunction.[38] Further, partner-related factors, such as the presence (or absence) of a partner and their own medical, psychological, or sexual health issues, also influence sexual activity and function.[13,39,40]

Our study found that vaginal dryness was the most commonly reported sexual health concern for all women (~50%), underscoring the persistence of this issue beyond midlife. While GSM is typically associated with menopause and midlife, its symptoms—such as vaginal dryness, dyspareunia, and urinary complaints—continue to affect many older women and can significantly impair quality of life.[12,41-45] Notably, older women who were sexually active were more likely to report painful intercourse, most likely due to progression of GSM. Furthermore, some women who indicated no sexual activity in the prior four weeks still reported concerns about pain during sexual activity on their intake forms, suggesting that GSM-related discomfort might contribute to discontinuation of sexual activity over time. This raises the hypothesis that symptoms of GSM worsen with time when untreated. It is important to note that sexual problems rarely occur in isolation, and concerns such as pain, desire, and arousal difficulties often co-occur and overlap.[46] In this study, low sexual desire was more prevalent in midlife women than older women, consistent with PRESIDE, which showed that ~15% of US women 45-64 years and 9% of women 65 years and older experienced low sexual desire coupled with distress.[12]

Despite reporting sexual health concerns, older women had significantly lower rates of depressive symptoms compared with midlife women. This aligns with research showing that aging is often linked to increased emotional resilience, life satisfaction, emotional stability, and overall emotional well-being.[47-49] This relationship could explain why older women experienced less distress related to sexual problems than younger women. This increase in life satisfaction, often observed in older adults, could contribute to a greater sense of contentment and less negative emotional impact associated with sexual health problems. Alternatively, older women may have lower expectations regarding their sexual function and, as a result, lower distress due to sexual problems.

Several potential barriers may impede the effective management of sexual health concerns in older women.

TABLE 2. Comparing ages 50-64 versus 65+ by those sexually active vs not sexually active in the past 4 weeks

	Age 50-64			Age 65+			
Sexual complaint(s)	**Not sexually active (N = 1,085), n (%)**	**Sexually active (N = 2,911), n (%)**	***P***	**Not sexually active (N = 350), n (%)**	**Sexually active (N = 554), n (%)**	***P***	**Interaction *P*[a]**
Vaginal dryness	491 (45.3)	1,491 (51.2)	< 0.001	139 (39.7)	291 (52.5)	< 0.001	0.073
Painful intercourse	353 (32.5)	949 (32.6)	0.97	77 (22.0)	170 (30.7)	0.004	0.011
Pelvic pain	88 (8.1)	196 (6.7)	0.13	28 (8.0)	25 (4.5)	0.030	0.19
Genital pain	90 (8.3)	169 (5.8)	0.004	31 (8.9)	45 (8.1)	0.70	0.30
Loss of sexual desire	557 (51.3)	1,387 (47.6)	0.038	122 (34.9)	185 (33.4)	0.65	0.61
Reduced genital sensation	146 (13.5)	491 (16.9)	0.009	40 (11.4)	72 (13.0)	0.49	0.61
Arousal orgasm problems	197 (18.2)	700 (24.0)	< 0.001	54 (15.4)	115 (20.8)	0.045	0.98
Systemic HT[b]	138 (17.6)	452 (22.3)	0.007	47 (19.0)	103 (26.2)	0.037	0.59
Local vaginal HT[b]	80 (10.2)	253 (12.5)	0.10	40 (16.2)	84 (21.4)	0.11	0.64

HT, hormone therapy.
[a]Testing if there is a difference in the association of sexual complaints and being sexually active between women aged 50-64 and women 65+.
[b]Missing in 1,181 women aged 50-64 (301 not sexually active and 880 sexually active) and 264 women aged 65+ (103 not sexually active and 161 sexually active).

Social and cultural stigma surrounding aging and sexuality perpetuates misconceptions, such as the belief that older women are not sexually active or that symptoms such as vaginal dryness and pain with sexual activity are inevitable parts of aging, leading to embarrassment and underreporting of concerns.[46,50-54] Women may feel uncomfortable discussing sexual health concerns and may be unaware of effective treatments, such as vaginal hormonal treatments.[51]

Clinicians also face challenges, including inadequate training in sexual health, personal discomfort in discussing sexual health concerns, and assumptions that sexual function is less relevant after the reproductive years and particularly with advanced age.[55-59] Yet sexual functioning has been linked with global quality of life and health-related quality of life in midlife and older women.[60] Misconceptions about the safety of low dose vaginal hormone treatments persist among both patients and clinicians, compounded by the boxed warning on all estrogen products, including low-dose vaginal therapies. This warning likely contributes to unfounded fears about the safety of low-dose vaginal estrogen therapies for management of GSM.[46,61,62] Addressing these barriers requires improved clinician education and greater awareness of age-specific physiological and social challenges.[28] Sexual health must be recognized as an integral aspect of overall well-being, requiring enhanced provider training, open communication, and a focus on equitable care. Clinicians should screen for FSD and address sexual health concerns in all patients, including those of advanced age.[63] Future research should prioritize identifying and addressing systemic and cultural barriers to care while advocating for sexual health equity.

Strengths and limitations

This study has several strengths, including a large, geographically diverse sample from 3 US locations and the use of validated tools (FSFI and FSDS-R) for reliable assessment of sexual function and distress. However, several limitations must be considered. The cohort consisted of women actively seeking care for menopause or sexual health concerns, which introduces selection bias and explains the high prevalence of FSD in the cohort. It is important to note that this study captures a unique population of women who actively sought care for sexual health or menopause-related concerns, suggesting that despite lower distress levels, many older women still consider their sexual health concerns to be significant enough to warrant medical attention. This included women as old as 95 years who presented for care, demonstrating the importance of addressing sexual health across the lifespan.

Limitations also include recall bias from patient-reported outcome measures, high rates of missing data, and the inability to account for all confounding variables. Furthermore, the study population was primarily composed of White, educated, partnered, and insured participants with access to specialized care at a tertiary care center, which limits the generalizability of the findings. The high percentage of older women using HT in this study, which is much higher than the estimated 4% usage rate in the general population of women aged 65 and above, further limits generalizability.[64] In addition, the FSFI is only validated in women who were sexually active within the past 4 weeks, potentially excluding those women who were not sexually active because of sexual dysfunction. Another limitation is that not all women in the study were postmenopausal. While all participants were aged 50 years or older, menopausal status varied, particularly in the midlife group, where some women were perimenopausal. This variation may have contributed to differences in sexual function observed between the age groups.

CONCLUSION

Older women continue to be sexually active, yet their sexual health is often understudied and untreated. This

study demonstrates that the rate of sexual problems is similar in older women compared with midlife women presenting to women's health clinics, further highlighting the need to screen and treat this concern in older women. Interestingly, older women report lower levels of distress related to sexual problems, possibly reflecting greater acceptance of age-related changes. Raising awareness and destigmatizing sexual health can help older women recognize their sexual health concerns as valid, challenging misconceptions about sexuality and aging, and ultimately enhancing their quality of life.

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