Sexual Dysfunction in Older Women

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ABSTRACT

The geriatric patient population is anticipated to grow significantly in the coming decades. As individuals are living longer, healthier lives, there is interest in maintaining sexual health throughout the latter decades. The aging female faces many biologic and psychosocial factors which impact sexual functioning and satisfaction. Given this, it is not surprising that ~33% of older women will experience sexual dysfunction. As sexual dysfunction has been strongly associated with quality of life, physicians should be familiar with the assessment and treatment of sexual disorders in older women. This article reviews the effects of aging on the normal female sexual response cycle, as well as the various biologic and psychosocial factors affecting female sexuality in late life. The article then provides an overview of common female sexual disorders of desire, arousal, orgasm, and sexual pain. Finally, the authors discuss assessment and treatment of sexual dysfunction in the older woman.

INTRODUCTION

As individuals are living longer, healthier lives, there is a growing interest in maintaining one’s sexual health throughout the latter decades. Previous studies have reported that 70% of healthy 70-year-olds enjoy sex on a regular basis and that 80% of men and women 60–91 years of age are sexually active at least once per month. A recent study concluded that the majority of older adults are engaged in sexual activity and regard sex as an important part of life. However, many biologic and psychosocial factors related to aging impact the quality and quantity of sexual activity an older person experiences. The physical and mental health of the individual as well as their partner, the availability of a willing partner, and the previous level of sexual activity all play an important role in sexuality in aging.

Given the many factors related to aging which can impact sexual functioning, it comes as no surprise that the prevalence of sexual dysfunction increases with age. While the advertising market and popular media have paid much attention to sexual disorders among older men, these disorders are also common among older women. A recent national sample of sexual behaviors and problems in older community-dwelling individuals reported that women 57–64 years of age had the following sexual complaints: lack of interest in sex (44.2%), difficulty with lubrication (35.9%), inability to climax (34%), pain during intercourse (17.8%), and lack of pleasure during sex (24%). Despite the prevalence of sexual complaints, the same study found that women are less likely than men to discuss these matters with their physician.
themselves may fail to assess a patient’s sexual functioning due to personal discomfort, time constraints, placing sexuality low on the priority list, or out of fear of embarrassing the patient or being perceived as too intrusive.5

Given the anticipated increase in the geriatric population and the prevalence of sexual dysfunction with aging, physicians in both primary care and psychiatry should be familiar with common sexual disorders among older women. The purpose of this article is to review the diagnosis, evaluation, and treatment of sexual disorders among older women. The authors begin with a review of the normal sexual response and aging, followed by a discussion of biologic and psychosocial factors associated with changes in sexual functioning in aging. Finally, the article reviews common sexual disorders and their treatments.

NORMAL SEXUAL RESPONSE AND AGING

Before one can accurately diagnose and effectively treat sexual disorders in the older woman, one must understand the effects of aging on the normal sexual response cycle. The normal adult sexual response cycle, as originally described by Masters and Johnson,6 is comprised of four stages: arousal, plateau, orgasm, and resolution. A fifth stage, desire, has been added to include the psychological and physiologic part of sexual functioning which underlies response.7 Any of these stages may be impacted by age-related changes in sexual functioning.

Due to the significant changes in sex steroids that occur during reproductive life events, women are particularly vulnerable to sexual dysfunction during these times.8 Menopause, cessation of menses for >12 months, constitutes the major reproductive life event of the older woman. Perimenopause is defined as the transitional period from the reproductive years to reproductive quiescence.9 Perimenopause and menopause are associated with a decline in ovarian function, resulting in reduction and eventual cessation of estrogen production. Estrogen decline impacts sexual functioning in several ways. The urogenital tissue atrophies and vaginal size is reduced. Vaginal lubrication decreases, which can result in uncomfortable intercourse. The sensitivity of the nipples, clitoris, and vaginal tissue is reduced, and the strength and amount of vaginal contractions during orgasm decrease. In addition, the majority of women undergoing menopause experience other symptoms such as mood lability, fatigue, body aches, and hot flashes.7

In addition to changes in estrogen, the menopausal woman also undergoes a decrease in testosterone production. Androgen deficiency in women is associated with a global loss of sexual desire or libido, decreased production of body oils, thinning of pubic hair, reduced vital energy, and decreased sensitivity of the nipples and clitoris.10

BIOLGICAL FACTORS AND SEXUALITY IN AGING

In addition to the hormonal changes that occur via menopause, the older woman faces other biologic factors which impact sexual functioning. Many medical and psychiatric illnesses are more prevalent in older adults and are known to impact the quality of sexual activity. These illnesses are often the primary cause of sexual dysfunction in this population.7 Illnesses such as urogenital cancers, cardiovascular disease, arthritis, and chronic obstructive pulmonary disease, as well as many neurologic diseases (stroke, Parkinson’s disease, multiple sclerosis, and others), are associated with sexual dysfunction.

The medical condition itself may directly affect sexual functioning. Diabetes, in particular type II, has been associated with sexual complaints among women, including lack of libido, reduced orgasmic capacity, decreased vaginal lubrication, and reduced sexual satisfaction.11,12 Similarly, studies on the sexual functioning of stroke patients have shown that sexual dysfunction and dissatisfaction are common among women.13 Some illnesses such as arthritis may cause pain or limit flexion and range of motion, leading to uncomfortable intercourse.14 Psychiatric conditions including depression, dementia, and substance abuse can also lead to reduced sexual interest and impaired functioning. Medical illnesses may have an indirect effect on sexual functioning as well. Fear of pain or of exacerbating a medical condition such as angina may lead to an inability to relax and enjoy sexual activity.15 Some illnesses, such as breast cancer or gynecologic malignancies, may result in altered self-image and reduced feelings of sexual attractiveness.14

Various symptoms of sexual dysfunction may arise iatrogenically, as a result of prescription medications. A recent review on medications and sexual function reported that >100 drugs or drug classes have been associated with sexual dysfunction, and that the impact of medications on sexuality increases with age.16 Sexual side effects in women secondary to medications may include loss of libido, reduced capacity for arousal, and difficulty achieving orgasm. Psychiatric medications, including selective serotonin reuptake inhibitors (SSRIs), tricyclic antidepressants, mood stabilizers, and antipsychotics are known to carry a risk of sexual side effects. Antihypertensive medications, such as β-blockers, diuretics, and clonidine, among others, have also been associated with sexual side effects. Other medications associated with sexual dysfunction include digoxin, corticosteroids, antiestrogens, histamine subtype 2 receptor blockers, opioids, and cancer chemotherapeutic agents.7,16

PSYCHOSOCIAL FACTORS AND SEXUALITY IN AGING

Psychosocial factors also significantly impact sexual activity among older women. The life expectancy of women is greater
Sexual Dysfunction in Older Women

Hypoactive Sexual Desire Disorder

Sexual desire comprises a critical portion of the human sexual response cycle, and includes sexual fantasies and thoughts as well as motivation and receptivity to sexual activity. This phase has been postulated to include biologic, motivational-affective, and cognitive components. Basson suggested that a woman's sexual response arises not from a biologic neediness or urge, but rather from intimacy. Motivation to participate in sexual activity is theorized to derive not only from sexual pleasure, but also from closeness and tenderness. Therefore, a woman may choose to experience sexual activity in order to have intimate relationship needs met.

Female hypoactive sexual desire disorder (HSDD) may occur in up to 33% of adult women in the United States. The complaint of low sexual desire alone does not meet criteria for the diagnosis of HSDD. However, such a complaint is not uncommon among older women. The prevalence of lack of interest in sex for women in the US 50–59 years of age has been reported as 27%, slightly lower than rates in younger women. A more recent study, however, reported prevalence rates of 38% to 49% for women 57–85 years of age. It is important to note that not all women are distressed by a decrease in sexual desire. In 2007, Hayes and colleagues reported that while the proportion of women with low sexual desire increases with age, the proportion of women distressed about their low desire actually decreases with age.

The diagnosis of HSDD is made when the patient has persistently or recurrently deficient (or absent) sexual fantasies and desire for sexual activity, which cause marked distress or interpersonal difficulty and are not better accounted for by another Axis I disorder, general medical condition, or substance. Frequently, in women, HSDD and the physiologic effects of a general medical condition are both present. Thus, HSDD due to combined factors is diagnosed. HSDD may be lifelong (eg, patients with history of sexual trauma or abuse) or acquired (as in the case of a general medical condition). It may be generalized or situational and is frequently associated with dysfunction in sexual arousal and orgasm. An extreme version of HSDD, sexual aversion disorder, consists of persistent or recurrent extreme aversion to, and avoidance of, all genital sexual contact, which causes marked distress or interpersonal difficulty.

Female sexual desire in later life may be impacted by numerous factors. As reviewed above, these factors may include medical or psychiatric illnesses, medications, and psychosocial factors such as availability of a partner or marital harmony. Hormonal fluctuations associated with surgical or natural menopause and endocrine disorders such as diabetes mellitus may affect desire. Psychiatric conditions such as major depressive disorder or panic disorder may also contribute to lack of desire or even aversion to and avoidance of sexual activity. Medications, including psychotropics, antihypertensives, tamoxifen, and antiepileptics, may result in decreased libido.

Female Sexual Arousal Disorder

Female sexual arousal disorder (FSAD), as defined by the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition–Text Revision, includes a persistent or recurrent inability to attain, or maintain until completion of sexual activity, an adequate lubrication-swelling response of sexual excitement. As in HSDD, the symptoms cause marked distress or difficulty with interpersonal functioning and may not be better accounted for by another Axis I diagnosis, general medical condition, or substance. Approximately 36% to 43% of women 57–85 years of age report difficulty with vaginal lubrication during sexual activity. The clinician should make the distinction between difficult lubrication due to physiologic changes during menopause versus a symptom of FSAD. In the older woman, this distinction may be challenging as estradiol deficiency prevents an adequate lubrication response. Gathering an adequate medical and sexual history, including the timing of onset of the arousal difficulties, may help the clinician make this distinction.
Female Orgasmic Disorder

Among women, there is significant variability in the type and intensity of sexual stimulation that results in orgasm. In addition, orgasm may vary within an individual over her life cycle. Female orgasmic disorder (FOD) is defined by the *DSM-IV-TR* as a persistent or recurrent delay in, or absence of, orgasm following a normal sexual excitement phase. Given the variability of sexual response among women, the *DSM-IV-TR* dictates that the diagnosis of FOD should be based on the clinician's judgment that the patient's orgasmic capacity is less than would be expected for her age, sexual experience, and adequacy of sexual stimulation. As in the other sexual disorders, inability to achieve orgasm may be a problem she has had all of her life or one that has developed due to any wide variety of biopsychosocial issues including relationship issues, the normal process of aging, general medical conditions, or any of a variety of possible medications.

Up to 38% of women >57 years of age report an inability to climax. Some women have never experienced orgasm, possibly the result of inexperience, religious inhibitions, or emotional or sexual trauma. Others acquire FOD after previously enjoying a satisfying sex life. As with the other female sexual disorders, if a woman "had it, lost it, and wants it back" for herself, treatment will generally have a more favorable outcome. FOD is more common among unmarried women and those without a college degree. Psychosocial factors including relationship quality, self-esteem, and attitudes toward sex may also contribute to FOD. Medical etiologies of anorgasmia include medications, substance abuse, hormonal deficiency, surgery, or trauma.

Sexual Pain Disorders

Eleven percent to 18% of women 57–85 years of age report pain during intercourse. Sexual pain disorders include dyspareunia and vaginismus. The two disorders are characterized by difficulty with vaginal penetration. The *DSM-IV-TR* defines dyspareunia as recurrent or persistent genital pain associated with sexual intercourse. Vaginismus is defined by the *DSM-IV-TR* as recurrent or persistent involuntary spasm of the musculature of the outer third of the vagina that interferes with sexual intercourse, though some authors have proposed reconceptualizing this disorder as either an aversion/phobia of genital penetration or a genital pain disorder. In order to make either diagnosis, the symptoms must cause marked distress and interpersonal difficulty and are not better accounted for by another Axis I disorder (eg, somatization disorder) or a general medical condition or substance.

Dyspareunia may be due to psychological factors or a combination of psychological factors plus a general medical condition. DeUgarte and colleagues suggested dividing dyspareunia into three categories for ease of diagnosis: pain with intromission (often secondary to vestibulitis, vaginismus, or superficial vaginal lesions), mid-vaginal pain (often secondary to vaginal dryness, surgical scars, etc), and deep-thrust dyspareunia (secondary to endometriosis, pelvic adhesions, neoplasm, or interstitial cystitis).

Vaginismus may be so severe that penetration of the vagina by any means (tampon, speculum, or penis) may be impossible. Vaginismus may be primary, wherein no penetration has ever been achieved, or secondary, wherein penetration has been achieved in the past. There is often a negative feedback cycle, wherein the discomfort and humiliation of attempted penetration leads to a phobic avoidance of any sexual contact at all. Proposed psychological factors contributing to vaginismus may include psychosexual conflicts, strict religious upbringing which associates sex with sin, a history of sexual abuse or rape, or emotional disconnect between sexual partners.

ASSESSMENT AND TREATMENT OF SEXUAL DISORDERS IN THE OLDER WOMAN

Assessment

The evaluation of the older women who present with a sexual complaint requires careful consideration of the patient and the multitude of factors that impact on the various
components of the sexual response cycle (Table 1). A comprehensive medical and psychiatric history must be obtained, with special attention paid to any psychiatric or medical condition which may impact sexual functioning (eg, depression, anxiety, substance abuse, menopause, diabetes). A complete sexual history is imperative and includes attitudes toward sexuality, level of sexual knowledge of the patient and partner, relationship with the current partner, past sexual behaviors, and current and past sexual levels of functioning (ie, desire, arousal, and orgasm).

Equally as important as assessing the patient’s current level of sexual functioning is assessing her level of distress due to her symptoms. Shifren and colleagues recently reported that while sexual problems are greatest in elderly women, sexual problems causing distress are least prevalent in this age group. They noted that the reasons for this are unclear, but may include changes in partner status or partner’s health, significance of other medical conditions, or other factors important to relationships of long duration. Clinicians should be able to identify relevant age-appropriate issues with older couples; it may be helpful to interview partners alone and together. Accurate assessment of sexual dysfunction in late life is contingent upon a trusting, secure doctor-patient relationship in which both parties feel comfortable discussing these sensitive topics.

The use of a simple intra-individual assessment tool such as the Sexual Energy Scale (SES) may be helpful in providing an objective means of measuring the patient’s report of their subjective experience of vitality/sexual energy. The patient is educated that sexual energy is not comprised merely of the frequency of intercourse or masturbation, but also includes sexual dreams, fantasies, genital sensations, and sexual appetite. The patient rates her current sexual energy on a scale of 1–10, with 1 being the lowest sexual energy she has experienced in her adult life, and 10 being the highest (Figure). The SES may be repeated at subsequent visits. The busy primary care physician can use this simple, one-item scale to track symptomatic improvement over time as the patient is being treated. The scale may help both patient and physician evaluate response to treatment.

A thorough medication inventory, including over-the-counter medications, is essential. As discussed above, many medications carry risk of sexual side effects and may impact all components of the sexual response cycle. Physical examination, including gynecologic examination, may help identify medical factors impacting sexual functioning (eg, vaginal atrophy, cystocele, leakage). Laboratory testing may include complete blood count, electrolyte levels, lipid panel, and thyroid function tests as well as levels of prolactin, follicle-stimulating hormone, estrogen, and free and total testosterone.

### TABLE 1
EVALUATION OF FEMALE SEXUAL DYSFUNCTION IN LATE LIFE

<table>
<thead>
<tr>
<th>Procedure</th>
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<tbody>
<tr>
<td>• History: include any sexual abuse history, the quality of relationship with her partner, level of sexual knowledge of patient and partner, and current environmental stressors</td>
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<tr>
<td>• Assess prior (before sexual dysfunction) and current levels of desire, arousal, and orgasmic function (consider use of an assessment tool such as the SES)</td>
</tr>
<tr>
<td>• Inquire about use of recreational substances (eg, alcohol, cocaine, tobacco)</td>
</tr>
<tr>
<td>• Consider the impact of general medical conditions (eg, hormone deficiency, diabetes mellitus); medications (eg, tamoxifen, anticonvulsants, antidepressants, antihypertensive agents); and/or surgery (eg, hysterectomy)</td>
</tr>
<tr>
<td>• Screen for undiagnosed or comorbid psychiatric disorders, such as major depressive disorder or panic disorder</td>
</tr>
<tr>
<td>• Physical examination including gynecologic examination, if indicated</td>
</tr>
<tr>
<td>• Laboratory as appropriate: complete blood count, thyroid function tests, and levels of prolactin, follicle-stimulating hormone, estrogen, and free and total testosterone</td>
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SES=Sexual Energy Scale.


### Treatment

Treatment for the older woman with sexual dysfunction depends in part on whether the problem is considered a sexual disorder that she has had all of her life or one that has developed more recently (Table 2). If the problem has developed more recently, assuming that there is no significant change in her health, then the clinical prognosis is likely to be more optimistic. In either case, the patient should be encouraged to cultivate a positive attitude toward sexuality in late life and avoid unrealistic expectations, such as that sex must be the same as when she was younger. Education may be required as to what constitutes normal and dysfunctional sexuality as well as how to modify sexual activity in the face of fatigue and pain. Maintaining open and honest communication between partners is essential. Lifestyle adjustments are likely to be benefi-

#### FIGURE

**SEXUAL ENERGY SCALE**

On a scale of 1–10, with 1 being the lowest sexual energy level you have experienced in your adult life and 10 being the highest sexual energy level you have experienced in your adult life, rate your current energy level. Please circle the number that indicates your current energy level.

<table>
<thead>
<tr>
<th>Lowest Sexual Energy</th>
<th>Highest Sexual Energy</th>
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<tr>
<td>Level in Adult Life</td>
<td>Level in Adult Life</td>
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<tr>
<td>1 2 3 4 5 6 7 8 9 10</td>
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</tbody>
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cial. Patients should be instructed to cease smoking and avoid alcohol or illicit drugs. Regular exercise, as tolerated, including pelvic floor exercises, proper nutrition, and sleep hygiene techniques should be encouraged, in addition to stress management techniques and social and partnership skills training.\(^\text{23}\)

If the disorder is due to a substance such as a prescription or over-the-counter medication, one could wait to see if tolerance will develop and the sexual side effect will attenuate, though this does not commonly occur.\(^\text{35}\) Attempts to reduce or eliminate that medication may be undertaken, if feasible. If the patient is felt to require the medication, consideration may be given to switching to another class which may have lower likelihood of sexual side effects (eg, switching from fluoxetine to bupropion for treatment of depression). An alternative strategy is to utilize antidotes to reverse sexual side effects (eg, bupropion or sildenafil for SSRI-induced sexual dysfunction). Of note, no medication is Food and Drug Administration-approved for the treatment of sexual disorders in women.

<p>| TABLE 2 |</p>
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<th>TREATMENT OPTIONS FOR FEMALE SEXUAL DISORDER IN LATE LIFE(^\text{23})</th>
</tr>
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**I. Lifestyle Assessment**

Instruct to cease smoking and avoid alcohol abuse and/or any illicit drug abuse

Strongly encourage exercise on a daily basis and proper nutrition

Educate on sleep hygiene techniques, good health practices, and stress management techniques

**II. Biologic Considerations**

Assess signs and symptoms of estrogen deficiency and begin with replacement of estrogen

Assess signs and symptoms of androgen deficiency and consider replacement with androgen

Treat any medical problem that could impact desire (eg, hypothyroid, diabetes mellitus)

Assess signs and symptoms due to particular medications (eg, antihypertensives, antidepressants, tamoxifen, cimetidine) and consider switching to another medication with fewer sexual adverse effects or adding an antidote (eg, bupropion or sildenafil [exclude if on nitrates])

**III. Psychosocial Considerations**

Refer for marital counseling, interpersonal psychotherapy, or sexual education, as appropriate

Social and partnership skills training/suggestions (eg, encourage regular and consistent displays of kindness and affectionate behaviors, discuss levels of sexual interest for each partner, evaluate sexual skill level of each partner based on the patient’s perspective, and evaluate the patient’s and partner’s abilities to communicate intimate desires with one another).


If the sexual dysfunction is due to a medical or psychiatric condition, treatment for that condition (eg, hypothyroidism, depression, vulvitis) should be optimized first. Postmenopausal women should be assessed for signs and symptoms of estrogen deficiency (ie, hot flashes, vaginal dryness) and androgen deficiency (ie, global loss of sexual desire, decreased genital sensitivity). Hormone replacement therapy (estrogen and/or testosterone) may be considered and is available in a variety of routes of administration (oral, transdermal, injection or topical). The use of estrogen replacement has been controversial in the US because of its reported association with breast cancer, stroke, and ovarian cancer. In selecting patients for estrogen replacement, the clinician should carefully consider the individual’s medical history, including history of smoking, migraine headaches, breast cancer, or stroke.

The testosterone patch is currently available for women with HSDD in Australia, Canada, and Europe. While it is known that testosterone can improve sexual desire in postmenopausal women on estrogen therapy, the question has been raised as to whether or not the testosterone patch is effective for HSDD in postmenopausal women who are not on estrogen. To answer this question, Davis and colleagues\(^\text{34}\) conducted a randomized, double-blind, placebo-controlled multisite trial. They found that for postmenopausal women with HSDD not on estrogen, 300 mcg/day of testosterone had a significantly greater improvement in the 4-week frequency of satisfying sexual episodes than those using placebo. In the US, physicians may prescribe physiologic replacement levels of testosterone for women using low doses of products that are approved for men or by referring patients to compounding pharmacies. Prior to beginning testosterone replacement, clinicians should engage patients in a thorough discussion of the risks and benefits. Potential long-term risks may include hyperlipidemia, hirsutism, clitoromegaly, voice changes, liver tumors, and transaminase dysfunction, although these side effects are generally considered dose dependent. Physiologic replacement levels of testosterone in women do not appear to have significant adverse events. A clinician may want to order a baseline fasting lipid profile before initiating testosterone, with a repeat panel in several months. Women in this age group are at increased risk of hyperlipidemia, and if these studies have not been done within the last year, then it is prudent to obtain these studies.

While many medications have been tried in the treatment of female sexual disorders, randomized controlled trials are limited, particularly in older women. Agents such as sildenafil, bupropion, prostaglandin E1, phentolamine, and others have been reported as possible treatments for female sexual disorders, in addition to medical devices such as vacuum therapy and electronic stimulation.\(^\text{23}\) Currently, there are non-hormonal medications for the treatment of low sexual desire in ongoing phase III clinical trials in the US (ie, flibanserin).

For the older woman whose sexual disorder is felt to be relat-
ed to psychological issues, sex and/or marital therapy should be considered. Cognitive-behavioral techniques are replacing previously used psychodynamic models of therapy. Therapy often begins with psychoeducation and support, to help cultivate more positive attitudes toward sexuality in late life. The therapist may help correct “all or nothing” cognitive distortions, wherein the patient feels that if orgasm is not achieved, sex is worthless. Patients may be educated on techniques such as self-stimulation, sensate focus, and foreplay, so that the focus of sexual activity is not exclusively intercourse. For the older woman with vaginismus, psychoeducation and cognitive-behavioral therapy may be accompanied by the use of vaginal dilators of graduated sizes, allowing the woman to be in control while extinguishing the involuntary muscle contraction.

**CONCLUSION**

As women are living longer, healthier lives, they seek to maintain sexual health and satisfaction throughout the latter decades. Many biologic and psychosocial factors uniquely affect the older woman and place her at risk for sexual dysfunctions. She must overcome hormonal fluctuations, medical conditions, necessary medications, changes in intimate relationships, and a culture which equates sexiness and vitality with youth. Physicians who treat older women should be familiar with the effects of aging on the normal female sexual response cycle, as well as the biologic and psychosocial factors which impact female sexual functioning in late life. Physicians should routinely inquire about patients’ sexual functioning and satisfaction and provide an open, supportive environment in which to discuss such concerns.

Older women may experience disorders of sexual desire, arousal, orgasm, and pain. Identifying the biologic and psychosocial contributors is essential in the treatment of these disorders. Treatment in all cases should include psychoeducation and lifestyle adjustments, such as exercise, proper nutrition, sleep hygiene, elimination of alcohol and drugs, and improving communication skills among partners. Treatment should also include optimizing treatment of underlying medical and psychiatric conditions, reduction or elimination of problematic medications, and referral for sex therapy, as clinically indicated. Medications for the treatment of various sexual disorders in women are currently under investigation. Given the strong association between sexual dysfunction and quality of life, further research is needed in this area. Sexual dysfunction is a common, but neglected area in medicine, in particular for the older woman.

**REFERENCES**