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"I want to feel like I used to feel": A qualitative study of causes of low libido in postmenopausal women

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Abstract

Objective—Low libido is common among women over 60 and negatively impacts well-being and relationship satisfaction. Causes of low libido in this age group are not well understood. We used qualitative methods to explore older women's perceptions of causes of low libido.

Methods—We conducted 15 individual interviews and 3 focus groups (total N=36) among sexually active women 60 and older who screened positive for low libido using a validated instrument. Interviews were audio recorded, transcribed, and coded using a codebook developed by 2 investigators. Codes were examined, and themes related to causes of low libido emerged.

Results—Women noted a number of different factors that contributed to low libido. The common factors that women discussed included postmenopausal vaginal symptoms, erectile dysfunction in male partners, fatigue and bodily pain, life stressors, and body image concerns. Women often found ways to adapt to these factors. These adaptations required open communication between partners regarding sex, and some women noted these conversations were difficult or not successful.

Conclusions—A wide variety of factors contribute to low libido in women over 60, but many of these factors are addressable. Low libido in older women should not be automatically attributed to "normal" aging or to menopause; providers should take an approach to assessment and treatment that addresses biological, interpersonal and social, and psychological factors.

Keywords

low libido; female sexual function; menopause

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INTRODUCTION

The majority of United States women over 60 report low libido, and 10% meet criteria for sexual dysfunction (1). While there is increasing attention on low libido in perimenopausal women, low libido in women over 60 remains understudied. Low libido can have significant negative impacts on well-being and relationship satisfaction (2–5).

Multiple quantitative studies have examined factors that are associated with low libido in women. Stress, relationship dissatisfaction, mood symptoms, and a history of sexual trauma and violence are frequently cited (5–7). However, studies often exclude older women. In addition, qualitative studies, which allow women to speak at length regarding their experiences using their own words, may uncover themes that have gone previously unrecognized.

Understanding the factors that contribute to low libido among older women can facilitate the development of new and more effective behavioral and biomedical treatments. A better understanding can also help providers recognize the most important factors to address when assisting a woman over 60 with sexual complaints. The aim of this study was to explore factors that contribute to low libido among sexually active women 60 and older using a qualitative approach.

METHODS

We conducted 15 individual interviews and 3 focus groups (total N=36). Women were recruited from the general public of Pittsburgh using social media, flyers placed in senior centers and doctors' offices, the University of Pittsburgh Clinical and Translational Research Institute research registry, and the University of Pittsburgh Claude D. Pepper Older Americans Independence Center research registry. Women were screened over the telephone; eligible women were aged 60 and older, reported being sexually active at least once in the prior year with a partner (male or female), and screened positive for low libido using the Decreased Sexual Desire Screener (8, 9). Women were given the choice to participate in an individual interview or focus group. We used both approaches because some women may feel uncomfortable discussing sexuality in a group, while focus groups may foster connectivity and peer support that allows themes to emerge that would not in an individual interview.

Interviews and focus groups were conducted face-to-face in a private space. Sessions began by reading an informed consent script explaining the purpose of the study, risks to participating, and that participation was voluntary. Women were then invited to stay if they agreed. This informed consent process was recommended and approved by the University of Pittsburgh Institutional Review Board.

Interviews and focus groups used a semi-structured guide (supplementary materials). Women were asked about changes in their sex lives with aging, and factors that contributed to these changes, as well as the importance of sex in their lives. Consistent with the emergent nature of qualitative research, not all questions may have been asked in every session, and follow-up questions may have been asked that are not in the interview guide. Interviews and

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focus groups were led by one of two facilitators with extensive training and expertise in qualitative research, including sensitive topics. Interviews and focus groups lasted approximately 60–90 minutes and were audio recorded and transcribed verbatim. In interviews, brief notes were taken by the facilitator. In focus groups, notes were taken by a research assistant while the facilitator led the focus group. At the conclusion of the sessions, participants completed a brief pen-and-paper questionnaire including demographic information, partner status, and the Female Sexual Function Index 9-item questionnaire (10).

Sample size in qualitative research is guided by the concept of thematic saturation, which means no new information or themes are uncovered in the course of ongoing interviews and focus groups. Thematic saturation was achieved in this study.

The primary investigator and both facilitators met to discuss broad themes and develop an initial codebook. The primary investigator and one facilitator then iteratively refined the codebook using sets of 2 transcriptions at a time until a final codebook was agreed upon, with specific definitions and examples. These two then proceeded to code 5 interviews to ensure inter-coder reliability. The primary investigator then coded all data. Atlas.ti software (Scientific Software Development GmbH, Berlin, Germay) was used to assist with coding. Coding used a fine-grained, phenomenological approach. Codes were then examined using thematic analysis to draw out key themes.

RESULTS

Demographic data regarding the women is summarized in Table 1. Ninety-four percent of women were White, 83% were married or co-habitating, and 97% were heterosexual. Women noted a number of different factors that contributed to low libido; however, they often found ways to adapt to these factors. The common causative factors that women discussed included postmenopausal vaginal symptoms, erectile dysfunction in male partners, fatigue and bodily pain, life stressors, and body image concerns (Table 2). These factors were discussed by women in all three focus groups and in the vast majority of individual interviews. Other factors that were less frequently discussed included gynecologic surgery (although this was often discussed as a contributing factor in the past, such as 10–20 years ago), physical health problems, physical separation from a partner (e.g., a long distance relationship or a partner that travels frequently), and past physical or sexual trauma or abuse.

Postmenopausal vaginal symptoms

One of the most commonly discussed causes of low libido was postmenopausal vaginal symptoms. When asked what sexual problems she would seek treatment for, one woman said, “Well, I mean definitely the dryness. I wish there were something that could make my insides be 30 instead of 62.” They emphasized that dryness was bothersome, but so was a sensation of tightness and decreased elasticity. Said one woman, “I’ve noticed that I’ve gotten even more tight and more narrow since menopause. I was always small, but it’s even worse now.” These symptoms could result in sexual encounters that were unsatisfying or even painful, which in turn made them less interested in future sexual encounters. One woman explained she was actually unable to participate in penetrative sex due to dryness and pain: “It’s actually been years since I’ve been able to do full intercourse, but my

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husband is very understanding and patient, which is good for me. And we can do foreplay, but just not intercourse. So I would like to have that back."

Many women were able to adapt to vaginal symptoms in various ways, including use of vaginal hormones or lubricants or pelvic floor exercises. Some women who had used vaginal hormones or lubricants found them quite helpful, while others felt they were not very effective. One woman said, "I have a prescription for Premarin vaginal cream that makes it less bad, but not good." Even the women who had found vaginal hormones effective had lingering concerns. They reported that these treatments were messy, expensive, or they had concerns about potential side effects, including cancer. Explained one woman, "My Gyno didn't want to give it to me right away, because she was—let's try all the natural stuff first and everything. I wish there was something that was more natural and that didn't involve the hormone stuff. Because I worry about getting cancer from it at some point, or something like that." For this reason, some women preferred to use "natural" lubricants, such as coconut oil. Pelvic floor exercises were sometimes employed by women on their own, such as doing Kegels at home, or with a trained physical therapist. The women who had tried pelvic floor physical therapy generally had positive experiences with it.

Erectile dysfunction in male partners

Another commonly-discussed cause of low libido was erectile dysfunction (ED) in male partners. Women explained that ED in their partner affected their libido through two mechanisms. The male partner would have difficulty maintaining an erection long enough for the female partner to reach orgasm when participating in penetrative vaginal intercourse. This meant sex was less satisfying for the female partner, and subsequently she would be less interested in sex in the future. Women also discussed how male partners would become defensive or frustrated during sexual encounters due to ED, again making sex less satisfying and decreasing the female partner's interest in future sex.

Women tried to adapt to partner ED by employing changes in sexual behavior, sometimes with success. Some women encouraged their partner to use pharmaceutical treatments for ED. While these treatments were often effective, they could change the sexual dynamic. Women discussed how if their male partner took an ED treatment, she would feel obligated to participate in sexual activity, due to the cost of the pills, and women did not like feeling obligated to have sex. Additionally, many ED medications require couples to plan and prepare for sex, which some women felt made sexual encounters less romantic. Explained one woman,

> You get Viagra in there. And it puts a different slant on sex, in that now you have to have planned sex. You have to have time for that little pill to work. And it's expensive, so you don't want—it sounds stupid but you don't want to waste it [laughter], you know. And I know with my current husband, we would start off feeling good, and think tonight's the night, and he'd take the pill. And by the time you get to bedtime, it's like, I'm exhausted… We can come back from a situation and I feel really close to him and I think, 'Oh, sex would be nice.' And then it's like, 'Okay, let's go take the pill.' And he takes the pill. 'Well, let's lay down, let's

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> get in bed, let's take our clothes off.' Let's do this, let's do that. But then it's not very romantic.

In addition to pharmaceutical ED treatments, women also discussed using other types of sex, such as manual stimulation or oral sex, or incorporating vibrators into their sexual routine, to mitigate the effects of ED.

Some women had found these adaptations successful, but these adaptations require open lines of communication between partners regarding sex. Some women noted that trying to discuss ED with their male partners was difficult or not successful. Male partners sometimes became blaming, defensive, angry, or ashamed. A few women even discussed how they had "given up" on trying to discuss ED with partners, and in fact had de-prioritized their own sexual needs in response:

> My husband, he has erectile dysfunction. You know how men are, they just don't want to talk about anything like that, so I went through a period where it was very frustrating and very upsetting to now it's like, "Well if it happens, it happens. If it doesn't, it doesn't."… Not that I don't try to engage, but I kind of have to test the waters per se. It's more fulfilling for him than it is for me, because I kind of don't want to like, interfere when he's on a roll, per se. It's not fulfilling for me, but it's fulfilling for him when it does happen, if you get my drift… So I don't want him to feel less of a man because I'm like, why can't you stay hard? So it's like he's just shuts down, he doesn't want to talk. So it's not worth going there. He gets very defensive, he gets hurt. Angry—like sulky… I guess at some point you have to pick your battles.

Fatigue and bodily pain

Another causative factor women discussed was fatigue and bodily pain. Women noted that as they got older, they felt they had less stamina for sex, or they had more pain in their joints during sex, which made them want to participate in sex less frequently. Sometimes this pain was related to physical health problems, such as spinal cord issues or diabetic neuropathy. A few women had discussed adaptations for bodily pain, such as getting a specialized bed or using different sexual positions. Women in one focus group had this discussion:

> A: I have pains which makes it very hard to be mobile and move and do things that used to make it [sex] more intense… So just getting up and just moving can often be problematic. So I am very deliberate in how I move. When I walk, I'm very deliberate in how I walk, and when I'm having sex, I'm very deliberate how I move there, too. So it slows the process down, but still gets the job done.
>
> B: I think you're right, though. Some of those movements enabled a higher intensity of orgasm.
>
> A: Oh, absolutely.
>
> B: You know, being on top now is hard. And yet that was the best way to orgasm for me.

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C: We have an adjustable bed. That helps. My rationale was: Oh, you know, we're getting older, I've got to be thinking ahead. And then I thought: Well there's some good side benefits to this adjustable bed. [laughs]

Life stressors

Some women reported that life stressors contributed to decreases in their libido. These life stressors were often concerns about adult children or about grandchildren. Women noted that they had a lot of things on their mind and their to-do lists, and often sex simply became lower on the list of priorities. They expressed surprise – they expected that once they reached retirement age, they would have more time and flexibility in their lives for sex, but were disappointed to find life stressors continued, or worsened. One woman explained, "I think the difficult part is a lot of the emotional stuff. There have been some changes. My mother's 84, and I'm the last sibling. And so trying to manage spending more time down there, short term memory loss, her physical care, assisted living. My daughter went to rehab in February. She relapsed two months ago. There's a lot of emotional stuff going around, and so it's difficult to put that aside and then focus on having sex. I would like for it to be more frequent. But sometimes other things move up the rung as more important." Some women adapted to these competing priorities by scheduling sex with their partner on a regular basis. For some women, scheduling sex took the romance out of it, but for others, they liked the anticipation and the ability to prepare. Women also noted that low-stress environments, such as taking a vacation with their partner, could trigger desire. Women also discussed using mental focus to decrease distracting stressors during sex, such as focusing on bodily sensations.

Body image

Concerns about body image also contributed to women's low libido for some. Women noted that physical changes in their bodies with aging, such as weight gain or changes in the appearance of the breasts, made them feel less attractive or feminine. One woman said, "You know, obviously as you age and gain weight, you don't feel as attractive as you once did when you were thinner and younger and everything was tighter and firmer. So yeah, I think body image is important for a woman to feel sexy or feel attractive." However, some women felt they became *less* worried about their appearance as they got older. One woman explained, "I guess I used to be a lot more concerned and trying to do something to look more attractive and more sexy. And it's really not so important anymore."

DISCUSSION

In this qualitative study of older women with low libido, we found that a variety of contributing factors, namely postmenopausal vaginal symptoms, ED in male partners, fatigue and bodily pain, life stressors, and body image concerns. Women employed a variety of ways to adapt to these factors, sometimes with satisfactory results, but sometimes not.

We noted that women often felt sexual encounters were unsatisfying if one or both partners were not able to reach orgasm while participating in penile penetrative intercourse. Women had difficulty with penetrative intercourse due to dryness and tightness, and men had

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difficulty due to ED. Prior research suggests that many heterosexual couples consider penetrative intercourse to be the most important (but not necessarily the most satisfying) type of intercourse; other types of sex are sometimes not considered “real” sex (11–13). Couples in our study that shifted the emphasis away from penetrative intercourse to other sexual behaviors, such as manual stimulation, use of vibrators or dildos, or oral intercourse, often found this to be a satisfying solution to physical challenges. Providers caring for couples with sexual difficulties can encourage de-emphasizing the role of penetrative intercourse.

Vaginal symptoms were a common topic of discussion among women in our study. Our study highlights that while attempts at treatment were common, ranging from use of lubricants to use of vaginal estrogen to pelvic floor exercises, women were often disappointed with the results of such treatment. Common themes were: treatments are messy, treatments are too expensive, treatments do not work well, or concern about potential side effects, especially cancer. These themes highlight the need for continued work in developing treatments for postmenopausal vaginal symptoms that are patient-centered, effective, affordable, and easy to use. Concern about potential side effects of vaginal estrogen persist, despite a large body of evidence for safety (14). Some women in this study felt their providers were worried about the safety of vaginal estrogen; this highlights the need for continued education of both providers and patients regarding the safety of these treatments.

The importance of the ability for partners to communicate about sexual problems was highlighted by the discussions of ED in this study. Some women had attempted to discuss ED with their partners, but partners became defensive, to the point that one woman even gave up trying to discuss it and had resigned herself to unsatisfying sex. The emotions and sexual needs of the male partner are often prioritized over those of the female partner. There remains a continued need for healthcare providers and society as a whole to prioritize women’s sexual satisfaction as highly as men’s. This also highlights a need for behavioral interventions that can address communication regarding sexual issues. This may be through couples-based interventions or teaching women strategies for discussing issues with partners. Our findings also highlight that cultural norms that couple masculinity with sexual prowess may place an undue burden on male partners, i.e. that he must be able to maintain an erection for sex to be satisfying. This burden may be part of the reason why men are defensive or angry in discussions of ED.

Mood symptoms and trauma history are frequently cited as contributing to low libido in the literature, but they were not frequently discussed in this study (15, 16). It may be that the women who volunteered for this study had less mood symptoms or past trauma than women in population-based studies. It may also be that women felt more comfortable discussing “emotional baggage” and “stress” as opposed to mood symptoms such as depression and anxiety. Some women may have been hesitant to discuss trauma history, and we did not ask about it specifically.

This study has limitations. Women who volunteer for a study regarding sexuality may differ from those who do not. Despite attempts to recruit a diverse sample, our sample was

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majority White, and most of the women were heterosexual. There should be ongoing research among diverse groups to better understand if causes of low libido differ. Because we were interested in factors associated with low libido among women who have at least some current sexual activity, women who had not been sexually active in the prior year were excluded. There are women who are sexually inactive for 12 months or longer due to low libido, and this study does not examine causes of low libido in this population. We did not exclude older women, but no women over 71 years of old volunteered for the study. Causes of low libido may be different in these older women.

This study also has strengths. There are few qualitative studies of sexuality among women 60 and older; thus, we are addressing a relatively under-studied topic and population. We used a stakeholder-vetted interview guide and highly trained facilitators. We used a validated screening tool to ensure only women with low libido were included.

CONCLUSIONS

Overall our study emphasizes that there are a wide variety of factors that contribute to low libido in women over 60, but many of these factors are addressable. Providers should not automatically attribute low libido in older women to "normal" aging or menopause; rather, an assessment and treatment approach that addresses biological, interpersonal, and psychological etiologies can help address modifiable factors related to low libido.

Supplementary Material

Refer to Web version on PubMed Central for supplementary material.

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Table 1.

Participant demographics

	Interviews, N(%)	Focus group 1, N(%)	Focus group 2, N(%)	Focus group 3, N(%)
Total N	15	10	5	6
Mean age (range)	63 (60–68)	66 (62–71)	66 (61–71)	64 (61–67)
Race				
White	13 (87)	10 (100)	5 (100)	6 (100)
Black	2 (13)	0 (0)	0 (0)	0 (0)
Relationship status				
Married	10 (67)	8 (80)	4 (80)	5 (100)[a]
Co-habitating / civil partnership	2 (13)	1 (10)	0 (0)	0 (0)
Divorced	2 (13)	1 (10)	0 (0)	0 (0)
Never married	2 (13)	0 (0)	0 (0)	0 (0)
Widowed	0 (0)	0 (0)	1 (20)	0 (0)
Sexual orientation				
Heterosexual	15 (100)	10 (100)	4 (80)	6 (100)
Bisexual	0 (0)	0 (0)	1 (20)	0 (0)
Homosexual	0 (0)	0 (0)	0 (0)	0 (0)

[a]One woman in focus group 3 marked more than one response regarding relationship status

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Table 2.

Factors contributing to low libido and how frequently they were discussed

Factor	Number of interviews where this factor was discussed (out of 15 total interviews)	Number of focus groups where this factor was discussed (out of 3 focus groups)
Postmenopausal vaginal symptoms	12	3
Erectile dysfunction in partner	13	3
Fatigue and/or bodily pain	9	3
Life stressors	13	3
Body image concerns	14	3
Gynecologic surgery	2	2
Physical health problems (other than vaginal symptoms and bodily pain)	4	1
Physical separation from partner (e.g., long distance relationship)	5	2
History of physical or sexual trauma	3	1