

*ABC of sexual health***Sexual problems associated with infertility, pregnancy, and ageing**

Jane Read

Sexuality and infertility

Infertility may interact with a couple's or individual's sexuality and sexual expression in two main ways. Sexual problems may be caused or exacerbated by the diagnosis, investigation, and management of infertility (or subfertility), or they may be a contributory factor in childlessness. Any examination of a couple's difficulty in conceiving must include overt and clear questioning about their sexual activity.

Responses to infertility

In response to being unable to conceive, many people feel emotions such as anger, panic, despair, and grief, and these may have several effects on sexual activity. The stress of infertility and its treatment may be a cause of sexual difficulties for both the prospective father and mother.

Intercourse may be avoided, with patterns of behaviour established, so that one or other partner is not reminded of the fertility problem. Postcoital tests or having to provide semen samples may result in a man feeling under pressure to perform, adversely affecting his erectile or ejaculatory ability. For some men, one or two failures during intercourse begins a vicious circle of fear of failure, with anxiety leading to further failures. Partners may also develop arousal difficulties because of anxiety or distress. Some individuals feel that their partner seems to want them only when there is a chance of conception, and sexual activity can then become a battleground for issues of power and control.

These stresses all conspire to alienate the couple from the recreational aspects of sexual expression and focus them, sometimes obsessively, on the procreative aspect of sexual intercourse.

Sexual problems that result in infertility

Childlessness may be the result of an existing sexual dysfunction. One study of infertile couples found that 5% had a history of sexual problems.

To avoid wasting time and resources, it is important that patients are given the opportunity to discuss their previous pattern of sexual functioning, to see if it has changed in the light of their fertility problems. It seems inexcusable that people can undergo months or years of invasive and expensive treatment when simple, clear questions about their sexual lives may elicit information that could spare them the ordeal. Infertility examinations should therefore include an evaluation of couples' sexual behaviour, with special reference to frequency and timing of coitus.

Two further categories of sexual dysfunction need to be borne in mind. The first is retrograde ejaculation, in which, at orgasm, the ejaculate is expelled back into the bladder rather than externally. This can be checked fairly simply by examining a postejaculatory urine sample for the presence of sperm. Men with this condition experience "dry" orgasm, feeling the sensation of muscular action and orgasm but not producing an ejaculate. This is a fairly common presentation in fertility units and can be managed medically by centrifugation of the urine to collect the sperm.

The second point to consider is whether the sperm are being introduced into the vagina. This can mean talking in very



Fertility has always been vitally important in human society, and its absence can lead to anger, panic, despair, and grief, which may have several effects on sexual activity. (Photograph shows prayers being read before a lingam, the phallic symbol of Shiva, Hindu god of fertility)

Useful questions to elicit information*

- How have your fertility problems affected your relationship, including your sexual relationship?
- Has anything changed in your sexual relationship since you have been trying to conceive?
- How would you describe your sexual activity?
- How often do you have penetrative (that is, penis in vagina) sex?

*Taken from Read J. *Counselling for fertility problems*. London: Sage, 1995:104

Sexual problems commonly associated with infertility**Male problems**

- Loss of desire, with a consequent decrease in sexual activity
- Erectile problems
- Premature ejaculation—little or no control over ejaculatory response, and ejaculation may occur before vaginal entry achieved
- Retarded ejaculation—difficulty ejaculating intravaginally, or at all

Female problems

- Loss of desire
- Vaginismus
- Dyspareunia
- Anorgasmia

clear terms to the couple about the nature of their sexual activity. Some couples engage in anal intercourse, in umbilical sex, or in manual stimulation alone and somewhat naively consider that their sexual behaviour is normal and should be resulting in pregnancy.

Sexual difficulties in pregnancy

Pregnancy is a transition from one physical state to another. In the case of a first pregnancy it is a transition from one state of being to another—from being a couple to being a family, from being a person in relationship with another to motherhood or fatherhood. As with any transition, there is a sense of loss as well as excitement at entering another phase of life's experience.

It is important to remember that pregnancy is not always met with joy and that, even if a baby is planned and wanted, there may be some ambivalence: "Neither pregnancy nor its absence is inherently desirable. The occurrence of a pregnancy can be met with joy or despair, and its absence can be a cause of relief or anguish. Whether these states are wanted, the conscious or unconscious meanings attached to pregnancy and infertility, the responses of others, the perceived implications of these states, and expectations for the future all are critical factors in determining an individual's response."¹

Included in this response will be myths about pregnancy, taboos about sexual activity during pregnancy, fears about the baby and delivery, changes in the relationship with the partner, and beliefs about the roles of motherhood and fatherhood. The woman's changing body shape may cause distress and a sense of unattractiveness.

This ambivalence may become manifest in sexual difficulties that are essentially psychological in origin, as an emotional response to the changed or changing state, or they may be a direct physical response to the pregnancy. One, of course, does not exclude the other, and a mixed aetiology is common.² There may be a combination of sexual problems, and they may also occur in the period after delivery. A careful history should be taken to ascertain what is causing any difficulties.

Psychological factors

In cases when pregnancy is the result of infertility treatment or when there is a history of repeated miscarriages, fetal handicap, or neonatal death there may be high levels of anxiety, with repeated requests for reassurance or perhaps demands for scans or examinations. Apart from general anxiety, there may be specific concerns about body image, delivery, motherhood, changes to the couple's relationship, miscarriage, lack of self esteem, sexual guilt, and tiredness.

Myths about intercourse during pregnancy include the fear it may cause miscarriage, premature labour, or fetal damage. Savage and Reader confirmed that there is no significant increase in fetal problems in women who continue to be sexually active throughout pregnancy.³ They noted that 27% of these women had uterine contractions after orgasm that were sometimes painful. Those who experienced painful contractions were less likely to have sexual intercourse often or at all.

There are, however, obvious indications for abstaining from intercourse during pregnancy,⁴ which include

- Vaginal bleeding
- Placenta praevia
- Premature dilatation of the cervix
- Rupture of the membranes
- History of premature delivery
- Multiple pregnancy.

Physical factors associated with pregnancy that can reduce sexual activity*

- Tiredness
- Backache
- Dyspareunia
 - Pelvic vasocongestion
 - Vaginal congestion with reduced lubrication
 - Subluxation of pubic symphysis and sacroiliac joints
 - Retroverted uterus, particularly in first weeks of pregnancy
 - Weight of partner on uterus during intercourse in late pregnancy
 - Deep engagement of fetal head
 - Candida and trichomonas infections
- Haemorrhoids
- Urinary tract infections
- Stress incontinence
- Vulval varicose veins

*Data from Reamy KJ, White SE. Dyspareunia in pregnancy. *J Psychosom Obstet Gynaecol* 1985;4:263



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Points to consider when taking a history

- Assessment of relationship, sexually and otherwise, and the support network
- Whether the pregnancy was planned
- Previous pregnancies and outcomes (such as miscarriage, termination)
- Previous deliveries—type and presence of trauma
- Current children's health
- Contraception—past and current use and plans for the future

Sexual problems during or after pregnancy

Female problems

- Loss of libido associated with tiredness, negative body image, etc
- Anorgasmia associated with lack of arousal or pain
- Vaginismus associated with pain or trauma from delivery

Male problems

- Lack of desire
- Erectile dysfunction associated with fears raised by watching the delivery, causing pain on intercourse, fatherhood
- Premature ejaculation associated with fears raised by watching the delivery, causing pain on intercourse, fatherhood

Sexuality and ageing

Bancroft reported that there has been a widespread tendency to assume that elderly people are too old for sex activity and the sexuality of both men and women declines with advancing years.⁵ This decline depends on three main factors: the level of sexual activity throughout a person's lifetime, physical health, and psychological health.

Sexuality throughout life

People who have been sexually active on a frequent basis throughout their life will show a lower rate of decline in activity with advancing years than will those who have been less sexually active. Most elderly people who remain sexually active experience high enjoyment from sex,⁶ and, in a summary of studies on sex and ageing, Kaplan concluded that most physically healthy men and women remain sexually active on a regular basis into their ninth decade.⁷

What form this sexual activity takes could include solo and mutual masturbation, oral sex, and penetrative intercourse. It is essential to remember that elderly people may have just as wide a range of interests and preferences as younger people.

Physical health

Any condition or illness can have an impact on sexual function. For example, a woman with severe arthritis may have difficulties with using her hands to pleasure herself or her partner or finding a sexual position that minimises the pain. Careful positioning of pillows may help with the latter problem.

Patients may find it very difficult to raise subjects such as managing incontinence in sexual contact with another person and in solo masturbation, and it requires great sensitivity by the doctor to uncover such concerns. The use of appropriate creams to help with vaginal soreness—such as oestrogen cream (if the woman is not already taking hormone replacement therapy), KY Jelly or Senselle, or an aromatic oil such as sweet almond or peach kernel oil—may enable a woman (and her partner) to enjoy sexual activity much more fully. Giving patients “permission” to use vibrators to assist with access to genital areas and stimulation is often helpful.

Psychological health

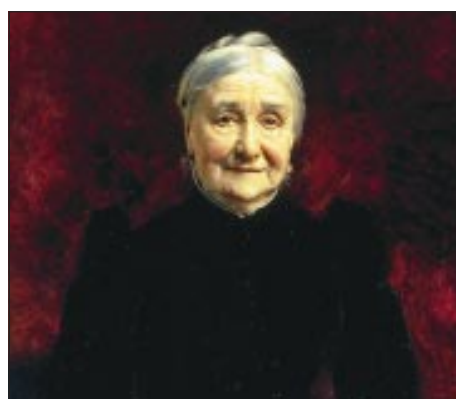
Myths and beliefs about sexual attractiveness and what it is may affect older women and contribute to low self esteem and possibly depression. A woman who has been widowed may find difficulty in finding a new partner because of the higher ratio of women to men in older age groups.

Elderly people may be embarrassed or ashamed of having sexual needs “at their age,” and they may feel fear and guilt about indulging in sexual behaviour after having been in a long term relationship, in effect a form of performance anxiety. For women especially, there may also be family expectations of celibacy that may be difficult to counter and other social expectations that elderly people are no longer sexual.

Percentage of older men and women who are sexually active and find it enjoyable*

	Age group (years)		
	50-59	60-69	70-79
Sexually active subjects			
All women (n = 1844):	93	81	65
Married (n = 1245)	95	89	81
Unmarried (n = 512)	98	63	50
All men (n = 2402):	98	91	79
Married (n = 1895)	98	93	81
Unmarried (n = 414)	95	85	75
Sex highly enjoyable (sexually active subjects)			
Women	71	65	61
Men	90	86	75

*Data from Brecher (1984)⁶



For women especially, there may be family expectations of celibacy and social expectations that elderly people are no longer sexual. (Detail of *Madame Bonnat, the artist's mother* (1893) by Leon Joseph Florentin Bonnat)

Health factors that inhibit sexual activity in elderly people

Physical factors

- Stress incontinence
- Diminishing mobility
- Decreasing muscle tone
- Uterine prolapse
- Skin tone and sensitivity
- Diseases such as diabetes and cardiovascular problems
- Chronic conditions such as arthritis

Psychological health

- Sense of unattractiveness
- Facing mortality; depression, bereavement and grief reactions
- Loss of partner or friends
- Lack of contact with others and loneliness

Further reading

- Read J. *Counselling for fertility problems*. London: Sage, 1995
- Reamy KJ, White SE. Dyspareunia in pregnancy. *J Psychosom Obstet Gynaecol* 1985;4:263

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