

Intimacy, Desire, and the Changing Body

HUMAN SEXUALITY & AGING

A practical conversation about what changes, what doesn't, and what we can do about it.



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What do we mean by sexuality?

Desire

Touch

Pleasure

Identity

Connection

Sexual health is more than sexual performance.

It includes affection, closeness, companionship, sensuality, communication, and the ability to express intimacy in ways that matter to you.

A few myths worth retiring

MYTH

- Older adults are not interested in sex.
- Sex should work the same way at 70 as it did at 30.
- If desire changes, something must be wrong.

REALITY

- Interest varies widely at every age.
- Arousal and function often change—and adaptation is normal.
- Desire is influenced by body, brain, health, relationship, and context.

The framework for today



A change in one domain can affect all the others.

We Don't Age Outside of Our History

Sexual Attitudes are shaped by

- Generation
 - Culture
 - Religion
 - Family
 - Gender Expectations
 - Education
- Relationships
 - Life experiences
 - Trauma
 - Sexual orientation
 - Societal norms

What actually changes with aging?

Normal physiology is not the same thing as disease.



Aging changes the sexual response, not the capacity for intimacy

COMMON CHANGES

- Arousal may take longer.
- More direct stimulation may be needed.
- Recovery time may lengthen.
- Orgasm may feel different or take longer.

Don't Assume This is Just Aging

- Loss of all desire.
- Pain with sex that must simply be tolerated.
- Complete erectile dysfunction.
- Loss of affection, pleasure, or intimacy.

Menopause: estrogen affects more than hot flashes

- Lower estrogen can change vulvar and vaginal tissue.
- Dryness, burning, irritation, urinary symptoms, and pain with penetration may occur.
- The clinical term is genitourinary syndrome of menopause (GSM).
- These symptoms are common, and treatable.

Pain is not a normal price of aging.

Male sexual function also changes

- Erections may take longer and require more stimulation.
- Erections may be less rigid or less predictable.
- The refractory period generally lengthens.
- Testosterone may decline gradually—but sexual symptoms are not explained by testosterone alone.
- New erectile dysfunction can also be a clue to vascular or metabolic disease.

Sexual function is not a single switch

DESIRE → **AROUSAL** → **PLEASURE** → **ORGASM**

Real life is rarely this linear.

Desire can come before arousal, or emerge after touch, closeness, and stimulation begin.

Desire

"Why don't I want sex
the way I used to?"



Spontaneous desire vs. responsive desire

SPONTANEOUS DESIRE

- Desire appears first.
- “I feel like having sex.”
- Often emphasized in movies and cultural expectations.

RESPONSIVE DESIRE

- Connection or stimulation may come first.
- Arousal develops, then desire follows.
- Common in long-term relationships and across adulthood.

Low desire is usually multifactorial

Sleep

fatigue • apnea

Mood

depression • anxiety

Pain

arthritis • pelvic pain

Hormones

menopause • androgen
changes

Medication

SSRIs • opioids

Relationship

conflict • disconnection

Stress

work • caregiving

Body image

illness • surgery

A better question than “What is wrong with my libido?”

“What conditions allow desire to show up for me now?”

Sleep • privacy • time • safety • comfort • connection • stimulation

Desire discrepancy is common

- Partners rarely have identical levels of desire all the time.
- A mismatch does not automatically mean rejection, loss of attraction, or relationship failure.
- Pressure and repeated rejection can create a negative feedback loop.
- Curiosity and communication work better than blame.

When health enters the bedroom

Sexual symptoms may be a clue not just a complaint.



Cardiovascular & metabolic disease

- Vascular health matters for genital blood flow and arousal.
- Diabetes can affect circulation, sensation, lubrication, and erectile function.
- Hypertension and vascular disease can contribute directly, and some treatments can contribute indirectly.
- Sexual symptoms may provide an opportunity to evaluate overall cardiometabolic health.

Pain, arthritis & mobility

- Hip, back, knee, or shoulder pain can change positioning and endurance.
- Fear of pain can suppress arousal before intimacy even begins.
- Timing matters: pain control, energy level, and positioning can be planned.
- Pillows, side-lying positions, slower pacing, and broader definitions of sexual activity can help.

Neurologic disease & cognition

- Stroke, Parkinson disease, neuropathy, and spinal disease can affect movement, sensation, arousal, and orgasm.
- Dementia can change inhibition, initiation, communication, and relationship roles.
- Consent remains essential; cognitive impairment does not automatically eliminate sexuality.
- Caregiver/partner dynamics may profoundly change intimacy.

Cancer & treatment can reshape sexuality

- Breast, prostate, pelvic, and other cancers can affect hormones, body image, sensation, erectile function, vaginal comfort, and fatigue.
- Surgery and radiation may alter anatomy or function.
- The emotional impact can persist after treatment ends.
- Sexual rehabilitation should be part of survivorship care.

Urinary symptoms can quietly change intimacy

- Urgency, leakage, nocturia, prolapse, and prostate symptoms can create embarrassment or avoidance.
- Fear of leakage may be more limiting than the leakage itself.
- Pelvic-floor therapy, bladder treatment, and practical planning can make a meaningful difference.

Medications: sometimes the treatment affects the bedroom

COMMON CULPRITS

- SSRIs/SNRIs: desire, orgasm, arousal
- Opioids: sedation, hormones, desire
- Some antihypertensives: erectile function
- Sedatives: alertness and energy

ALSO CONSIDER

- Polypharmacy and cumulative burden
- Dose and timing
- Whether the symptom began after a medication change
- Do not stop prescription medication without a plan

When a sexual symptom deserves medical evaluation

- Sudden or major change in sexual function.
- New erectile dysfunction, especially with vascular risk factors.
- Pain, bleeding, genital lesions, or persistent urinary symptoms.
- Marked loss of desire with depression, fatigue, endocrine symptoms, or medication changes.
- Any symptom causing distress or relationship difficulty is worth discussing.

Sleep, snoring & separate bedrooms



Where we sleep and how we connect are not the same question.

“Is it bad for our relationship if we sleep separately?”

“Not necessarily.”

The important question is whether the arrangement improves sleep while preserving connection.

Why couples stop sharing a bed

- Snoring or obstructive sleep apnea.
- Insomnia or very different sleep schedules.
- Nocturia, restless legs, pain, or frequent movement
- Temperature preferences or pets.
- Caregiving needs.
- One partner simply sleeps better alone.

Snoring is not only a relationship problem

- Loud habitual snoring can be a marker of obstructive sleep apnea.
- Sleep apnea can contribute to fatigue, mood changes, cardiovascular risk, and sexual dysfunction.
- Treating sleep disorders can improve more than sleep.

Sometimes “low libido” starts with exhaustion.

If you sleep apart, protect the rituals of connection

- Do not let “separate beds” automatically become “separate lives.”
- Create intentional time for touch, conversation, affection, or sex.
- Consider beginning or ending the evening together, even if sleep happens separately.
- Measure the arrangement by sleep quality and relationship quality, not by convention.

Intimacy can evolve

Intercourse is one form of sexual expression—not the definition of it.



Expand the menu

Affection

Kissing

Touch

Massage

Cuddling

Mutual pleasure

Conversation

Companionship

Adaptation is not failure. It is how sexuality remains possible across a changing lifespan.

Communication is a clinical intervention

- Ask what feels good now—not what used to work.
- Talk about pain, fear, fatigue, desire, and expectations outside the sexual moment.
- Use specific language rather than hoping a partner will infer what you need.
- A therapist or certified sex therapist can help when patterns feel stuck.

What helps? Start with the cause

FOUNDATIONS

- Sleep
- Exercise & vascular health
- Pain management
- Mood treatment
- Medication review
- Relationship communication

TARGETED OPTIONS

- Lubricants & vaginal moisturizers
- Local vaginal hormone therapy when appropriate
- Pelvic-floor physical therapy
- ED evaluation / Medications when appropriate
- Sex therapy / counseling
- Specialty evaluation when needed

Lubricant ≠ moisturizer

LUBRICANT

- Used around sexual activity.
- Reduces friction and discomfort.
- Water- and silicone-based options are common.

VAGINAL MOISTURIZER

- Used regularly, not only during sex.
- Helps maintain tissue comfort between sexual encounters.
- Persistent GSM may require additional treatment.

Hormones: useful, but not a universal answer

- Local vaginal estrogen can be highly effective for GSM in appropriate patients.
- Systemic menopausal hormone therapy may help selected symptoms but is individualized.
- Testosterone is not a general anti-aging or relationship treatment.
- Hormone levels alone do not explain most sexual concerns.
- Treatment should target symptoms, risks, goals, and the underlying cause.

Erectile dysfunction: treat the person, not just the erection

- Review vascular risk, diabetes, medications, mood, sleep, and relationship factors.
- Certain medications are effective for many people but require appropriate cardiovascular/medication screening.
- Response depends on stimulation and correct use.
- Persistent symptoms may warrant urologic evaluation and additional treatment options.

Sexual health still includes safer sex

- Pregnancy risk may disappear, but STI risk does not.
- New relationships after divorce, widowhood, or separation may occur after decades without safer-sex conversations.
- Barrier protection and STI testing remain appropriate based on exposure and risk.
- Clinicians should ask without assumptions about age, orientation, relationship status, or activity.

What I want you to remember

- 1 Sexuality does not expire.
- 2 Aging changes function—but symptoms are often modifiable.
- 3 Desire is contextual and may be responsive, not spontaneous.
- 4 Health, medications, sleep, and relationships all matter.
- 5 **Intimacy can evolve without becoming less meaningful.**

A question worth asking

“What does intimacy mean to you now?”

The answer may be different than it was 10, 20, or 40 years ago, and that is okay.

Questions & Conversation

Sexual health is health. It is okay to talk about it.

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Selected clinical resources

- North American Menopause Society / The Menopause Society , GSM and menopausal hormone therapy
- American Urological Association , Erectile Dysfunction Guideline
- American College of Obstetricians and Gynecologists , Sexual health and menopause guidance
- American Academy of Sleep Medicine , Obstructive sleep apnea resources
- CDC , Sexually transmitted infections and older adults
- World Health Organization , Sexual health framework