Incontinence and sexuality in later life

Dawne Garrett and Karen Tomlin discuss the physiological changes that can affect sexual function as people age and how nurses are best placed to provide sensitive assessment of the need for treatment.

Abstract

This article explores the interrelated aspects of incontinence and sexuality in older age. It describes the physiological changes that may have an effect on sexual function and the genitourinary system as people age. The enduring importance of sexual intimacy is discussed. Treatments for incontinence and to improve sexual function are explored.

The authors conclude that nurses, particularly those involved in continence management, have a role in ensuring sensitive assessment and access to treatment, which can support many older people to maintain fulfilling sexual activity.

Keywords

Ageing, continence, intimacy, sexual behaviour, sexual dysfunction, urogenital system

Physiological and psychological changes occur with ageing, affecting emotions, appearance, movement, senses and activity. These changes occur at different rates and have varied implications for individuals. During the life course the normal reduction of testosterone, a hormone found in men and women, has profound effects. Testosterone supports the libido and is produced by the testes and ovaries. The ovaries also produce oestrogen and androstenedione (Mueller 1997). In a review of the physiological evidence on sexual ageing, Meston (1997) stated that libido reduces in men, which is supported by age-based findings from cross-sectional studies demonstrating a decline in desire and sexual activity (Skultety 2007). Decline in oestrogen production and its implications for urogenital ageing is the physical change most often noted in women (Pariser and Niedermier 1998).

Urogenital ageing is particularly associated with vaginal dryness and atrophy; the consequences for women range from none to severe disturbance. In an American review of the literature relating to sexual function in older women, the prevalence of difficulties associated with sexual activity in post-menopausal women was between 68-86% (Ambler et al 2012).

Urinary incontinence

Urinary incontinence occurs when the normal process of storing and passing urine is disrupted. It is usually divided into three categories: stress, urge and overflow. Stress incontinence occurs when the pelvic floor muscles are weak or damaged or the urethral sphincter is damaged in women. Frequent causes are nerve damage during childbirth, obesity, oestrogen depletion and some medication. Episodes of stress and urge incontinence may occur during sexual intercourse or orgasm and have a significant effect on an individual’s and couple’s sexual quality of life. Urge incontinence is the urgent and frequent need to pass urine and can be caused by bladder muscle (detrusor) overactivity, neurological conditions such as Parkinson’s disease or multiple sclerosis, urinary tract infections (UTIs), alcohol and caffeine, constipation and medication. Overflow incontinence, also called chronic urinary retention, is often caused by bladder obstruction. In men this may be due to enlarged prostate and in both sexes by constipation or bladder stones. Chronic urinary retention may also be due to a neurological condition causing detrusor underactivity where an ineffective nerve supply prevents the bladder from emptying fully (Getliffe and Dolman 2007).

The ageing process reduces the capacity of the bladder and decreases the sensitivity of nerve
receptors that make individuals aware of the desire to void. As a result, older people may be aware of the need to void much later than younger people (Nazarko 2013).

In women oestrogen depletion affects sexual activity and urinary continence. Oestrogen maintains the plumpness of the urethral tissues, enabling the sphincter to remain closed against pressure from the bladder. With the loss of oestrogen, the urethra is less able to remain closed against pressure leading to stress incontinence. Pariser and Niedermier (1998) identified urinary incontinence as another sequel of oestrogen reduction that may result in irritability, urethritis and recurrent UTIs. Mueller (1997) suggested that regular pelvic floor exercises increased tone and reduced urinary incontinence and that hormone replacement therapy (HRT) may still be appropriate for some women. Topical oestrogens applied locally may also help reduce symptoms.

In men, the prostate may enlarge and overgrow as a result of malignant or benign processes. This can be referred to as prostatism. Prevalence increases with age and more than 30% of men over the age of 65 can be affected by urinary symptoms (National Institute for Health and Care Excellence (NICE) 2014a). In older men the prevalence of nocturia or urinating at night, which is often associated with prostatism, is about 78% and can have a significant effect on quality of life. Around one third of men will develop urinary tract (outflow) symptoms, of which the principal cause is benign prostatic hyperplasia (BPH) or overgrowth of the prostate.

Men experiencing recurrent UTIs, that is two or more in a three-month period, should be referred to a urologist for further assessment (NICE 2014a). Once symptoms of enlarged prostate arise, progress is variable and unpredictable with about one third of patients improving, one third remaining stable and one third deteriorating. Symptoms and surgical intervention can have a profound effect on a couple’s sexual intimacy. Moderate to severe BPH can be treated with medication. Alpha blockers, such as tamsulosin, reduce muscle tone in the bladder neck making it easier to pass urine. Sexual dysfunction and abnormal ejaculation are potential adverse effects of this group of medications, however. Despite this, research suggests that men find them more manageable than the original symptoms in terms of effect on intimacy and sexual function (Kaplan 2009).

In more severe cases of BPH, 5-alpha-reductase inhibitors such as finasteride are used. These also carry a risk of adverse events such as decreased libido and erectile dysfunction that can affect sexual performance and that may continue once medication has stopped. As a result of these side effects, it is important that sexual history is discussed before prescribing and the patient is aware of potential risks. Surgery may be recommended for those with severe symptoms or those who do not respond to medication. Surgery to debulk the prostate and improve the flow of urine also carries the risk of erectile dysfunction and abnormal ejaculation (NICE 2014b). An alternative procedure using an implant to lift the prostate and increase the inner lumen of the urethra has been identified as effective and potentially carries less risk to sexual function (NICE 2014b).

Treatments for incontinence

Traditionally many older people see incontinence as inevitable and untreatable with containment, such as the use of pads, the only option. Many misconceptions about incontinence exist as it is rarely discussed in public and individuals are often reluctant to seek further information. Simple lifestyle changes, pelvic floor exercises, medication and surgery can all provide a reduction in or cessation of symptoms. Suitable treatments vary depending on the type of incontinence and therefore a comprehensive assessment is vital (Getliffe and Thomas 2007).

Some people may experience urine loss during sexual intercourse and advice can be given to help minimise this, for example, emptying the bladder before intercourse or trying positions that place less pressure on the bladder. Medication can be used to reduce the symptoms of overactive bladder. Antimuscarinics such as tolterodine and solifenacin work by reducing nerve impulses to the bladder and therefore relaxing it. This reduces bladder spasm and the symptoms of frequency and urgency. It is commonly reported (British National Formulary (BNF) 2015) that this group of medications causes dry mouth and many patients do not continue to take them long term. It is important that where bothersome side effects occur, medication is reviewed and the type and dosage altered to try to find a suitable treatment that helps symptoms and can be tolerated. Antimuscarinics should be used with caution in older people as they may cause confusion (BNF 2015).

Sexual activity and incontinence

Health benefits associated with sexual activity in older age have been identified. Davey-Smith et al (1997) found the mortality risk was 50% lower in men who had orgasms at least twice a week than in men who had sex less than once a month.
The gradient was most marked in coronary heart disease, although participants were in the younger age range of older people. However, Gott (2003) argued that the idea of sex as beneficial physical activity was countered by an absence of evidence that lack of sexual activity made people sick. Physical and mental wellbeing are important to sexual expression (DeLamater 2012) and sexual intimacy in relationships can be a great joy and contribute to a sense of comfort and wellbeing (Pariser and Niedermier 1998).

It is believed that people who have sexually intimate relationships live longer, are happier with the quality of their lives, have higher self-esteem and fewer depressive symptoms (Zeiss and Kasl-Godley 2001). Kiecolt-Glaser and Newton (2001) suggested that regular consensual sexual expression contributed to physical and psychological wellbeing and may reduce physical and mental health problems. In addition, Gott and Hinchliff (2003) found that physical intimacy through cuddling and touching appeared central to wellbeing when penetrative sex was no longer possible.

Research exploring the effect of incontinence on sexuality is scarce. Cassells and Watt (2003) examined the carer’s perspective and found that while incontinence did not affect physical intimacy, it did in some instances affect sexual intercourse. Faecal incontinence had a greater effect than urinary and some couples reported sleeping in separate bedrooms, although they did not directly attribute this to incontinence.

The physiological sexual changes that occur in older men and women may affect their previous sexual function, however, such changes do not necessarily result in an inability to maintain sexual activity or coitus. Meston (1997), having reviewed the many physiological sex-related changes that accompany normal ageing, suggested that men and women should not fall into the psychosocial trap of expecting or trying to force the same sexual response as in their youth. Neither should they believe myths that suggest decreased physical intimacy is an inevitable consequence of older age. In a review of sexual expression in later life DeLamater (2012) explained that while normal ageing does cause physical changes, they do not necessarily result in a decline in sexual function. Good physical health and access to a healthy partner enable older people to remain sexually active.

**Medication to enhance sexual function**

The availability of pharmacological enhancements to sexual activity can improve quality of life, for example, drugs such as sildenafil (Viagra). While it does not cause erections, sildenafil affects the response to sexual stimulation by increasing blood flow to the corpora cavernosa and corpus spongiosum in the penis and so enhancing erections. The widespread use of this drug and others in the group demonstrates a need for such medication and there has been some interesting cascade prescribing in couples, where one drug is started to manage the actions of another. As sildenafil is commenced the need for post-menopausal androgens increases for female partners (Pariser and Niedermier 1998). Water-soluble and oestrogen-enhanced lubricants are readily available and often prescribed. They may be used in addition to, but not necessarily in conjunction with, HRT. A more sophisticated use of analgesia such as timing medication before intimacy may also promote sexual activity by allaying pain.

**Implications for practice**

Incontinence remains a taboo subject in society and not all individuals affected seek treatment for their symptoms (Strickland 2014). There are a number of reasons for this, with the most common being that people accept incontinence as an inevitable part of ageing with few treatment options.

Incontinence is a symptom of a urological condition that requires further investigation and which could potentially be treated or cured. Individuals may associate incontinent episodes with sexuality or intimacy (Bradway and Strumpf 2008), which may also affect their decision to seek care. Embarrassment and shame may also discourage them from seeking treatment. This places a responsibility on healthcare professionals to ensure they discuss continence and sexual intimacy with patients as part of holistic assessment. However, sexuality and sexual health needs are under assessed in practice. Watters and Boyd (2009) argued that healthcare professionals rarely address sexuality, and Gott (2003) found that a number of participants in her study said they had never had the opportunity to speak about sex before. Healthcare professionals may be reluctant to approach the subject with patients because of their own embarrassment or lack of knowledge (Roe and May 1999).

Nurses who care for patients with continence difficulties may be ideally placed to discuss the implications of interventions on sexual activity, thereby opening a dialogue about wider sexual issues. It is important to discuss whether incontinence affects sexuality rather than simply asking if patients are sexually active. It is possible that they are no longer sexually active as a result of their incontinence and a simplistic approach to
questioning will not provide a true insight into the individual’s situation (Katz 2009). Mueller (1997) explained that nurses’ discomfort with the subject of sexual needs may cause them to unconsciously limit interaction that would promote a discussion. Skultety (2007) suggested that healthcare professionals must acknowledge their difficulties in discussing sex and realise we are all influenced by societal and cultural messages about sexuality. While good history taking is important, Skultety (2007) believed sexual discussion was less about details and more about beliefs and ideas relating to sexual activity. She stated it is crucial to allow and encourage a broad definition of sex, to consider a range of sexual behaviours and not concentrate on intercourse. Skultety (2007) suggested sexual dysfunction is not part of ageing but a complex set of diagnoses determined by culture, expectations, definition of problems and recognition by healthcare providers.

Conclusion
This article has explored the effect incontinence often has on sexuality and intimacy for older people. As both are considered difficult subjects in society, those experiencing both have to cope with twice the trepidation when deciding whether to seek treatment from healthcare professionals. All nurses, but particularly those involved in the assessment of continence, are ideally placed to discuss sexuality with patients. Sexual needs should be part of an holistic assessment. Nurses should ensure they have the knowledge, skills and attitudes to undertake an assessment and suggest interventions or make referrals to support older people to overcome or manage difficulties.

References


