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APUNTES BIBLIOGRÁFICOS SOBRE SALUD SEXUAL EN MUJERES DE EDAD MEDIANA

Bibliographic notes on sexual health in middle-aged women

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Resumen

En la mujer la línea de separación entre la adulta joven y la mujer de la tercera edad, es la mujer de mediana edad. El aumento de la esperanza de vida trae aparejado el incremento de mujeres que viven en este período del ciclo vital. La salud sexual requiere de un enfoque positivo y respetuoso de la sexualidad y las relaciones sexuales, Los estudios sobre el climaterio y la menopausia han reorientado la investigación en la última década, hacia aspectos cualitativos con la intención de profundizar la comprensión de las diferencias y a la vez demostrar con datos etnográficos que la experiencia de la mujer en esta etapa del ciclo vital, era captada de manera parcial por sus métodos de comprensión refieren los factores de riesgo que pudieran generar impacto negativo en la función sexual de la mujer en esta etapa de la vida. Todos los cambios biológicos y fisiológicos por los que transita la mujer en la edad mediana son parte de la evolución misma en la biología humana por lo que estos no justifican en sí mismo una perdida brusca y significativa de la actividad sexual.

Palabras clave: mujeres en la mediana edad, ciclo vital, menopausia, salud sexual.

Abstract

In women, the line of separation between the young adult and the elderly woman is the middle-aged woman. The increase in life expectancy brings the increase of women living in this period of the life cycle. Sexual health requires a positive and respectful

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approach to sexuality and sexual relations. Studies on climacteric and menopause have reoriented research in the last decade, towards qualitative aspects with the intention of deepening the understanding of differences and Once we have demonstrated with ethnographic data that the experience of women at this stage of the life cycle, was partially captured by their methods of understanding, they refer to the risk factors that could generate a negative impact on the sexual function of women at this stage of the lifetime. All the biological and physiological changes that women in middle age go through are part of the evolution itself in human biology, so they do not justify in themselves a sudden and significant loss of sexual activity.

Keywords: women in middle age, life cycle, menopause, sexual health.

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1. INTRODUCTION

The middle-aged woman represents the dividing line between young adulthood and old age. It is the stage of their life cycle, between 40 and 59 years of age, in which the climacteric occurs, a period in which the transition from the reproductive stage to the non-reproductive stage takes place (Sarduy Nápoles and Lugones Botell, 2006; FLASOG, 2016).

The concept of Sexual Health issued by the World Health Organisation (WHO) refers to the following:

> Sexual health is a state of physical, emotional, mental and social well-being related to sexuality and not merely the absence of disease, dysfunction or disability. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free from coercion, discrimination and violence (How sex changes by age, 2016; WHO, 2019).

An approach to the sexual health of middle-aged women refers to considering the multidimensional nature and the set of intervening factors, in terms of the biological, motive-affective-relational and cognitive components, without disregarding the set of conditions, structures, physiology, behaviours and socio-cultural contexts that allow the exercise of sexuality. It also includes the feelings, ways of expressing and relating, representations, subjectivities and behaviours of middle-aged women (McCabe et al. 2016).

The increase in life expectancy brings with it an increase in the number of women living in this period of the life cycle; the World Health Organisation estimates that by 2030 more than 1.2 billion women will be over 40 years of age, which means that their number will have tripled in just 40 years (Manzano Ovies, 2014; Navarro Despaigne & Fontaine Semanat, 2001).

2. ON SEXUAL HEALTH RESEARCH

In recent decades, the sexual health of middle-aged women and female sexuality have been addressed in both Cuban and international literature. Research in this area has focused on how women experience sexuality during the climacteric, postmenopausal and ageing periods; the results obtained express the existence of a prevalence of sexual dysfunction of between 25% and 43% in middle-aged women (Stalina Santisteban, 2011; Sarmiento Leiva, 2000).

Already in the second half of the 20th century, the explosion of knowledge about sexuality began; this has produced a change in the demand for information and this need has increased and the treatment of the subject has become more open.

The first research that related alterations in the sexual sphere to the menopausal phase was carried out by Dr. Hallstrom in 1977, and revealed the existence of a decrease in sexual desire, the ability to achieve orgasm and the frequency of coitus in women (González Cárdenas, Bayarre Vera & Hernández Melendez, 2019).

Studies on climacteric and menopause have reoriented research in the last decade towards qualitative aspects with the intention of deepening the understanding of the differences and at the same time demonstrating with ethnographic data that the experience of women in this stage of the life cycle was only partially captured by their methods of understanding (Couto Núñez & Nápoles Méndez, 2014).

One of the dimensions of the human being that has historically created differences in its interpretation and study is sexuality, as there are diverse opinions and approaches regarding its meaning, importance and relations with other aspects of human nature. Hence, each culture approaches this natural expression differently (Alfonso Rodríguez, 2010).

2.1. Middle age and physiological elements of sexual function

Women during middle age go through the climacteric period, a process about which until relatively recently there was little physiological knowledge about it. At this stage, an important event occurs: menopause, which is the permanent cessation of menstruation and represents the end of a woman's fertile life; its diagnosis is retrospective and will be made after a period of amenorrhoea of more than 12 months, according to the WHO (Sarduy Nápoles and Lugones Botell, 2006; FLASOG, 2016).

The female sexual response is controlled by the central nervous system, with the parasympathetic nervous system intervening in general activity and erectile tissues, while the sympathetic nervous system controls orgasm, being the product of anatomical, hormonal, vascular and neuronal changes that occur in the organism, with various neurotransmitters intervening.

The sexual response consists of 4 phases:

1. Desire (libido): desire for sexual activity, including sexual thoughts, images and desires.
2. Excitement: subjective sensation of sexual pleasure, accompanied by physiological

changes, including genital vasocongestion and increased heart rate, blood pressure and respiratory rate.

3. Orgasm: peak of sexual pleasure and release of sexual tension, rhythmic contractions of the perineal muscles and reproductive organs.
4. Resolution: muscle relaxation and general feeling of well-being after sexual activity.

A parenthesis will be made about sexual arousal, as this is a state related to some specific feelings, linked to the genitals; in women it has three main ways of expression:

- Central arousal: characterised by mental activation that produces erotic dreams, illusions or voluntary sexual fantasies that can activate physical, genital and non-genital peripheral arousal.
- Non-genital peripheral arousal: expressed by increased salivary secretion, sweating, cutaneous vasodilatation, nipple erection, etc.
- Genital arousal: expressed by engorgement of the vestibular vulva and clitoris, as well as vaginal lubrication (Levin, 1992; FLASOG, 2016).

Endocrine response plays a critical role in establishing the appropriate threshold for optimal response to sexual stimuli. Oestrogens maintain vaginal health, support lubrication and prevent dyspareunia, while androgens directly modulate the physiology of the vagina and clitoris by acting on the muscle tone of both erectile tissue and vaginal walls, facilitating arousal and thus vaginal lubrication; they also have a central influence as activators of desire (Nelson, 2008).

Sexual behaviour, although it should not be modified, undergoes some changes caused by the presence of vaginal dryness, the presence of prolapse, the appearance of chronic diseases dependent on atherosclerosis, osteoporosis, endocrine-metabolic imbalance and cancer, among others. At this stage it is common to observe a decrease in libido, dyspareunia and anorgasmia in women who until then had no difficulties in the sexual area (Bajo Arenas, Lailla Vicens & Xercavins Montosa, 2009; Navarro Despaigne, 2001).

In terms of sexual function, it is prudent to remember that oestrogens maintain vaginal health, contribute to lubrication and prevent dyspareunia, while androgens directly modulate the physiology of the vagina and clitoris by acting on the muscle tone of both erectile tissue and vaginal walls, facilitating arousal and therefore vaginal lubrication; They also influence at the central level, as activators of desire, as well as the decrease in androgens in the decrease of sexual desire, which means that the endocrine response plays a fundamental role in establishing the appropriate threshold for optimal response to sexual stimuli (Davis & Tran, 2001; Espitia De La Hoz & Orozco-Gallego, 2018).

After menopause, women undergo a process secondary to physiological variations in the hypothalamus-pituitary-ovary system, due to the inability of the ovary to perform follicular function, there is no follicular maturation, increasing the levels of follicle stimulating hormone (FSH) followed by luteinising hormone (LH); In the absence of follicular maturation, there is no synthesis and secretion of oestradiol and inhibin, nor is progesterone produced, the latter is the one that decreases the most, followed by oestrogens and androgens, which normally increase genital sensation and stimulate libido and orgasm, This brings about changes in the external genitalia as collagen fibres are reduced, the vaginal epithelium thins, there is an increase in fibrin and thinning of the connective tissue with the respective loss of folds, decreased vaginal

elasticity, vaginal dryness, decreased vascular response to sexual stimulation, and changes in the pelvic floor, particularly the levator ani or pelvic diaphragm and the bulbocavernosus and ischiocavernosus muscles, which, when contracted, contribute to penetration and the rhythmic contractions of orgasm, and therefore their changes are expressed in dyspareunia and decreased desire, as well as delayed and less intense orgasmic response (Navarro Despaigne, Méndez Gómez, & Duany Navarro, 2017). & Duany Navarro, 2017).

Given that sexual function and human sexual development spans a lifetime, each woman has sexual feelings, attitudes and beliefs processed through an individual perspective, shaping personal experiences, causing changes to vary from one woman to another.

The studies by Navarro Despaigne et al. (2017) in Cuba, as well as those by Espitia De La Hoz & Orozco-Gallego (2018) in Spain, refer to the risk factors that could have a negative impact on women's sexual function at this stage of life, a compilation of which is presented below:

Biological/organic factors: hormonal alterations, urological or gynaecological alterations, chronic diseases (diabetes mellitus, dyslipidaemia, metabolic syndrome, arterial hypertension, rheumatological and neurological diseases, etc.), use of legal drugs (drugs for the control of diseases prescribed by professionals, alcohol and tobacco) and illegal drugs (marijuana, cocaine, opiates, amphetamines, cannabis, lysergic *acid).*

Psychological factors: History of physical or sexual abuse, poor communication with partner, stress, anxiety, depression, unsatisfactory relationships, low self-esteem, body image conflicts.

Socio-cultural factors: Inadequate sex education, gender overload, conflicts with religious, personal or family values, social myths and taboos, lack of knowledge of one's own sexual anatomy and physiology, presence of sexual prejudice, traumatic or incestuous sexual experience, insecurity about sexual performance, fear of sexual intimacy, unrealistic expectations, previous personal sexual disorders, low self-esteem.

Partner/relationship-dependent factors: partner's sexual difficulties, lack of partner, lack of privacy, sexual partner's technique and skill, expectations of a negative experience, relationship quality and conflict, poor communication, third parties, boredom, disappointment, resentment.

3. ELEMENTS RELATED TO SELF-PERCEPTION AS CLOSING ELEMENTS OF THE RESEARCH PROPOSAL

> The adult brain is both plastic and resilient, and is always ready to learn. Experiences, thoughts, actions and emotions actually change the structure of the brain. Brain structure is not predetermined and fixed. We can alter the ongoing development of our brains and thus our capacities. Human beings are not prisoners of our genes or our environment. We have free will. It may be harder for those who have certain genes or environments; but being "harder" is far from being
> "harder' is far from predestination. The brain is constantly rethinking its connective patterns in response to everything its possessor perceives, thinks or does. Every experience, thought, and emotion creates new neural connections or reinforces existing

ones (Casañas Velástegui, 2009).

In anthropology of the life cycle, middle age is located in the stage of adulthood, so that women will reach it with a knowledge and representation in their thinking that will allow them to have a perception of themselves and their context.

Perception conceptually has had different aspects of study by the sciences of communication, philosophy and psychology, persisting as a process of formation of mental representations with the function of making abstractions through qualities, which define the essence of external reality, It is also said that perceptions are the processes by which one registers everything with which one is interacting and has meaning, including values, traditions, stereotypes, experiences and knowledge, which individuals have about certain aspects of life (Oviedo Gilberto, 2004).

Self-perception of health is the representation or idea that the individual has about his or her present state or condition of health, expressed in evaluative terms of pleasure or displeasure, satisfaction or dissatisfaction, and satisfaction or dissatisfaction with his or her health (Oviedo Gilberto, 2004).

Self-perception of health is the representation or idea that the individual has about his or her present state or condition of health, expressed in evaluative terms of pleasure or displeasure, satisfaction or dissatisfaction, which may or may not correspond to the actual level of functioning of his or her organism (Hernández Sánchez & Forero Bulla, 2011). or displeasure, satisfaction or dissatisfaction, and which may or may not correspond to the actual level of functioning of their organism (Hernández Sánchez & Forero Bulla, 2011).

Self-perception of health, both in terms of general health and sexual health, depends on life history, lifestyle, health and work conditions, both for those who work alone at home and for those who work double shifts, culture and its social construction, and is individualised in each woman, through her broad personality dimension.

The elements that move as a result of hormonal decline will be related to the experiences of each and every one of the stages of her life, and the socio-cultural elements, premorbid personality, life history and its social construction, which make up her personality, ways of thinking and living and therefore the potential and psychological resources that will allow them to face the climacteric in different ways in each woman, as well as the assimilation of ageing, make middle-aged women a highly vulnerable group in terms of health ((Hernández Sánchez & Forero Bulla, 2011; Orama Díaz, 2000; Artiles, 2007).

All the biological and physiological changes that women go through in middle age are part of the evolution of human biology itself, so they do not in themselves justify an abrupt and significant loss of sexual activity, but rather imply readjustment and new lifestyle projects that women will need, as no difficulty prevents full pleasure, given that sexual response is affected more by affective and cognitive factors: fantasies, valuation of the relationship, degree of

intimacy, sexual passion, among others (Argote, Mejía, Vásquez & Villaquirán de González, 2009).

In the Anthropology of the life cycle, it is referred that in middle age there is a self-evaluation where the woman evaluates to what extent she has come close to the fulfilment of her goals, this is how self-realisation will depend on the biography of life, on the route that the person has followed in her life towards the satisfaction of her needs, to the self-limiting adaptation, to the creative expansion and the maintenance of the internal environment.

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