Addressing Sexual Concerns in Older Couples

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As the senior population grows in America, there is a greater need for clinicians to become competent in treating older adults, which includes marital problems. Older adults and elderly individuals' adjustment often becomes more dependent on their marital and sexual relationships than in earlier life. These life changes impact the nature of couple's therapy. The Hope Focused Approach may be modified to accommodate such changes while still providing effective therapy for couples who are facing retirement, menopause, health problems, sexual dysfunction, etc. This paper addresses changes couples experience while going through the aging process, common sexual changes, and adaptation of the Hope Focused Approach to accommodate such changes.

Literature Review

Aging involves numerous transitions in family life, health, work, and relationships. Even things that may seem positive, such as retiring, can be stressful for many couples. According to Trudel, Boyer, Villeneuve, Anderson, Pilon, and Bounader (2008a), the transition to retirement does not necessarily lead to a "second honeymoon" period, and is often marked by health problems, financial difficulties, and sensory loss. Often various conflicts left laden for years due to lack of time to address them begin to surface and can cause severe communication difficulties in the couple. The transition to retirement can also be a significant source of stress; in fact, couples who are recently retired report greater marital distress and less marital satisfaction than couples who have been retired for some time. One's occupation has a strong influence on one's sense of identity, self-esteem, and self-worth, so clinicians should attend to the impact on retirement on the couple's satisfaction (Kingsberg, 2000). Despite these life changes, Trudel et al. (2008a) says that marital satisfaction in couples who have recently retired tends to reflect their marital satisfaction before retirement. The marital relationship continues to be one of the most important sources of social and emotional support for couples in later life (Mohr, 2003).

Sexuality is an important part of the marriage relationship that can be significantly affected by aging. Kingsberg (2000) suggests that the quality of the marital relationship is "enhanced by emotional intimacy, autonomy without too much distance, an ability to manage stress and distractions by external factors, and achieving a satisfying sexual equilibrium" (p.33). Effective counseling with older couples should address the three components of sexual desire:

- drive, beliefs and values, and motivation
- the sexual equilibrium within the relationship
- and the physiological changes in male and female sexual functioning (Kingsberg, 2000).

Trudel, Villeneuve, Anderson, and Pilon (2008b) concluded that sexual functioning and interest declines with age and is often precipitated by the onset of a sexual dysfunction that affects one or more phases of sexual activity. These changes may be wrongly perceived by the couple as a sign that it is time to stop having sex; however a cessation of sexual activity may represent a major loss of pleasure, affection, and intimacy. Trudel et al. (2008b) reported that sex was one of the five most important topics of marital difficulties identified by older couples and one of the leading sources of marital dissatisfaction.

The effective therapist should have knowledge about sexuality and aging and be comfortable addressing such issues with the couple. The therapist should be aware of his/her stereotypes and biases about sexuality and aging and be careful not to let those influence the therapeutic work with the couple. It is important for the therapist to attend to the reactions of him/herself as well as those of the couple

and be aware of transference/countertransference issues (Evans, 2004). While it is easy to become intimidated or uncomfortable discussing sexuality with an older couple, the therapist demonstrates competency and sensitivity by not being afraid to broach the topic with the couple as the need arises and providing the couple with the appropriate information and interventions.

Assessment of sexual issues in older couples

Common complaints in older adults include:

- erectile dysfunction,
- low sexual interest in women,
- health problems that affect sexuality,
- medications that affect sexuality,
- and sexual discomfort after menopause.

Assessment is used to guide treatment and also determine the couple's appropriateness for the Hope Focused Approach. Sexual problems are more common in older adults, but they should not be assumed as normal. Couples, their doctors, and therapists can easily collude to poorly address sexual issues with older adults out of faulty assumptions or prejudices regarding sexuality in older adults.

Common faulty assumptions about sexuality in older adults include:

- older adults don't desire sexual contact after a certain age
- after menopause women should not desire sex since they can no longer have children
- the decision to use Viagra or other medications to improve sexual functioning is just reaching for a lost youth
- If medications cause sexual side effects, they should just be accepted
- Older adults should have extensive knowledge about sex due to their experience

The therapeutic and medical community can often lack sensitivity to sexual issues with older adults. Couples counselors may need to act in the role of advocate for couples who need to address sexual issues with their medical doctors. Sometimes couples may hold the same faulty assumptions that causes them to stay in a "pre-contemplation" stage of change about their sexuality. While some acceptance of sexual decline may be necessary with some aging and medical conditions, therapists should be open-minded in regards to whether all steps have been taken to address medically caused sexual issues.

In the case of complaints of low sexual interest in women, it will be important to assess the woman's health, emotional intimacy in the relationship, and current sexual context (Basson, 2007). A broad assessment allows the clinician to consider several areas that contribute to low libido in women. Health assessment will include asking about the woman's energy levels, physical health (including indication of whether she is pre or post-menopausal), medication use, self-esteem, body image, feelings of attractiveness to her partner, and stress levels. Emotional intimacy should be assessed to determine whether the partners feel emotionally connected. Use of a 1-10 scale may be helpful for some questions with 1 being as low as it has ever been and 10 being as high as it has ever been. The current sexual context involves a number of considerations, including communications about sexual issues, sexual techniques, feelings of privacy/safety, the couple's sexual script, and reasons for being sexual. The sexual script is essentially the couple's typical pattern that leads to sexual intimacy. This encompasses whether the husband or wife typically initiates, what time of day they usually engage in intercourse, whether they offer feedback on how they feel during intercourse.

For women. Women who are menopausal are more likely to experience sexual discomfort (Goldstein, 2007). This problem should be normalized; however, the clinician should gain more information so that the necessity of a medical evaluation can be assessed. Common problems that occur with female sexual discomfort include decreased interest in sex, diminished arousal, vaginal dryness or poor lubrication, difficulty achieving orgasm, and increased pain during sexual intercourse. The use of over the counter lubrications should be highlighted as it is recommended in all women over age 40 (McCarthy & Thestrup, 2008). The frequency of gynecological examinations should be assessed. For a woman in the older age range, exams should occur at least annually. In addition, if the client has experienced changes since her last annual examination, she should be referred to her gynecologist for an evaluation (Goldstein). The gynecologist will likely assess for alterations in color such as redness, epithelial integrity, tender areas, and hypertonicity of the pelvic floor. If the therapist is uncertain, he/she should recommend an examination by a physician to address any physical or medical causes.

For men. Regarding complaints of male erectile dysfunction, assessment should be used to determine the diagnosis and specifiers. The DSM-IV-TR criterion for male erectile disorder is the persistent or recurrent inability to attain, or to maintain until completion of the sexual activity, an adequate erection that causes marked distress or interpersonal difficulty (APA, 2000). It must be determined that the disorder is not better accounted for by another Axis I disorder that is not sexual or due to direct physiological effects of a substance, medication or medical condition.

There are three specifiers for erectile dysfunction:

1. The first step is to determine whether the disorder is the lifelong or acquired type.
2. Second, the clinician must specify whether erectile disorder is of the generalized or situational type. The generalized type occurs in all situations with all partners whereas the situational type occurs only under certain conditions.
3. Third, one must assess whether the disorder is due to psychological factors or combined factors. This should be determined through evaluation of medical problems. Medical causes of the disorder may be general (alcoholism, diabetes, cirrhosis), iatrogenic (psychotropic drugs), endocrine (hypogonadism; hypo and hyperthyroidism), vascular (aortic bifurcation obstruction), or neurological (temporal tumor, spinal cord injury).

Clinicians should keep in mind however that only 5-10% of referred cases of erectile dysfunction are organic in origin (Buvat, Buvat-Herbaut, Lemaire, Marcolin, & Quittelier, 1990). After appropriate assessment, it is important to determine whether referral, treatment through the Hope Focused approach, or both are most appropriate. Unless erectile dysfunction is primarily due to a medical condition, the couple is likely appropriate for the Hope Approach with special attention on closeness and sexual intimacy if this is their primarily goal for treatment.

Psychoeducation

The myth that sexuality is the first function to suffer from age has permeated the general public and professionals (Trudel, Turgeon, Piché, 2000). This is particularly detrimental to older adults' sexual assumptions and subsequent sexual behavior. A more accurate description is that sexuality changes in intensity, frequency, and quality with age (Rosenau, Childerston, & Childerston, 2004; Trudel, Turgeon, Piché, 2000). Kaplan (1990) reported that sexual potential and erotic pleasure exist until the end of life. Physiological changes are important for couple members to understand regarding the topic of sexuality. While intimacy and sexuality are important topics for any couples pursuing therapy, they are particularly important to consider among older couples due to inaccurate stereotypes and the enhanced emphasis on the marital relationship post retirement.

Psychoeducation is the first step in approaching sexuality in therapy. Before beginning any specific interventions for sexual problems, psychoeducation should be conducted. The sexual response

cycle is a helpful way to describe typical sexual functioning (Masters & Johnson, 1970). It also provides a way to contrast changes in early sexual functioning and changing sexual functioning in older adults.

1. The first stage is excitement. This change is characterized by a response of the body to feelings of sexual desire. In men and women, this is the point when blood fills the genitals (clitoral shaft increases in women and men obtain a full erection), heart rate increases, and blood pressure increases. It may last between one minute and several hours. In older age, full erections may not be as firm or stand as erect as in the past (Rosenau, Childerston, & Childerston, 2004). Whereas previously, an erection may have stood in the 1:00 position, in older age it may stand that the 3:00 or even 5:00 position. This is a normal response to age as blood valves are more susceptible to leaks.
2. The second stage is plateau. This stage is the highest peak of sexual excitement. This point generally lasts between 30 seconds and several minutes. In females, the outer 1/3rd of the vagina engorges and the clitoris retracts under the hood. In men, the testes engorge and are elevated. At this point, the loss of an erection is unlikely. As individuals age, the plateau may not reach the same subjective height however it is still able to be reached.
3. The third stage is orgasm. This is the point at which sexual tension is released. It usually lasts for less than one minute. It is also characterized by muscle contractions.
4. The fourth stage is resolution. This is the period in which the body returns to its original stage. This is often referred to as the refractory period. The amount of time that elapses between orgasms increases with age ranging from minutes in 17 year old males to days and up to a month in 80 year old males (Rosenau, Childerston, & Childerston, 2004).

The clinician will need to adapt their psychoeducation to the couple's needs. A general understanding may be achieved through description of the Sexual Response Cycle; however particular couple problems should be normalized or highlighted depending on the nature of the concerns. Differences in the sexual response cycle between men and women should be discussed since the model has been criticized for its insensitivity to women's sexuality. Many couples' sexual difficulties are due to anxiety, therefore psychoeducation can be a very reassuring aspect with which to begin therapy.

Interventions

The Hope Focused Approach contains many interventions on communication and intimacy which leave room to include discussions of sexuality. Additional interventions on sexual intimacy and functioning can be included if the need arises. Trudel et al. (2008a) found that simple exercises such as sensate focus can improve sexual functioning, sexual satisfaction, and sexual desire of older couples. Heiman (1997) found that treatments that include sensate focus resulted in significant decreases in erectile problems and increases in female experiences of orgasm. Masters and Johnson (1970) developed sensate focus which consists of bodily caresses, moving from nonsexual to increasingly sexual touching, that the couple does at home (Heiman, 1997). Sensate focus uses relaxation to counter anxious, self-focused feelings as more sexually arousing interactions are gradually introduced (Wiederman, 2001). This method has been used along with directed masturbation, systematic desensitization, sensory awareness training, and other cognitive-behavioral home assignments to treat female orgasmic disorder, male erectile dysfunction, and other sexual disorders (Leiblum, 2007). In addition, decreased desire will be an important sexual issue to address among this population for which communication exercises, sensate focus, and fantasy are useful therapeutic tools (McCabe, 1992). Counseling on sexual attitudes, interpersonal and sexual communication, and bibliotherapy can also be included (Leiblum, 2007). For more information on the application of these interventions, see the annotated bibliography.

Case Illustration

Larry and Valerie have been married for 32 years. Larry is 58 and Valerie is 56. They became interested in couples therapy after Valerie's retirement. Larry complains of erectile dysfunction, but says he has experienced problems for the past 10 years and has little distress concerning his problems. When asked if he has considered medication, Larry reported that he would use medication if this would please Valerie but would not be interested personally. When asked about medical problems, Larry reported high blood pressure. He reported being on medication to address this problem. Valerie reported increasing dissatisfaction in the relationship since her retirement. She shared that their only child moved out of the home four years ago and lives six hours away. Valerie reported loneliness and loss of satisfaction in things that used to give her pleasure, such as her marriage. However, she did not indicate clinically significant depression. Valerie's depression symptoms were assessed to be difficulties associated with her changing phase of life. She also indicated decreased interest in sexual activity since menopause and reported that she has moderate distress regarding this problem.

The therapist considered the couple's decreased marital satisfaction and sexual difficulties when forming their treatment plan. The husband was encouraged to ask his doctor about the impact of high blood pressure and his medication on his experience of erectile dysfunction. The impact of retirement and sexual difficulties was normalized as a struggle most couples face when going through such life transitions. Larry was able to gain greater insight into Valerie's distress after retirement as he realized she was not being unreasonable, but going through a process most retired individuals go through as they lose outside connections. The therapist addressed sexual concerns by teaching the couple about expected changes in sexual functioning with age. This psycho-educational component provided an avenue for the couple to openly discuss sexual frustrations and concerns within the context of their overall closeness and intimacy as a couple. The couple agreed that they would like to invest more time into their sexual relationship. Sensate Focus was incorporated into the treatment plan to help the couple engage in low-pressure, intimate time together. The intervention decreased Larry's anxiety about ED, and it provided a context to increase stimulation which led Valerie to greater sexual desire.

Resources and Annotated Bibliography

APA Aging and Human Sexuality Resource Guide http://www.apa.org/pi/aging/sexuality.html
The APA's Office of Aging has several resources and information, including numerous abstracts of journal articles and books.

Rosenau, D. E., Childerston, J. K., & Childerston, C. (2004). *A Celebration of Sex After 50*. Nashville, TN: Thomas Nelson Publishers.
This work may be particularly helpful as a reference to provide for Christian couples. The book provides information, techniques, and skills to increase sexual intimacy in older couples. It offers a review of common medical problems and solutions, effects of menopause/drugs/disease on sexual functioning, techniques for increasing sexual desire, etc. It may be a helpful recommendation during the psychoeducation session.

McCarthy, B. & Thestrup, M. (2008). Integrating sex therapy interventions with couple therapy. *Journal of Contemporary Psychotherapy, 38,* 139-149.
This paper discusses several helpful ways in which to address sexuality in couples' therapy, research on the impact of the sexual relationship on the couple's relationship, common sexual problems, guidelines for increasing sexual desire, etc. It is an excellent one-stop source for general sexual concerns.

Leiblum, S. R. (Ed.) (2007). Principles and practice of sex therapy (4th ed.). New York: Guilford.
The book outlines interventions for sexual dysfunction including the use of sensate focus, cognitive behavioral interventions, directed masturbation, systematic desensitization, and sensory awareness training.

Joanning, H. & Keoughan, P. (2005). Enhancing marital sexuality. *The Family Journal, 13,* 351-355.
The article outlines an enrichment program based on Master and Johnson's Sensate Focus exercises for couples seeking greater sexual desire in their relationship. It provides a guideline for assessment of the couple to determine if intensive sexual therapy is more appropriate than marital therapy.

McCabe, M. P. (1992). Program for the treatment of inhibited sexual desire in males. *Psychotherapy, 29,* 288-296.
The article outlines the treatment process for males with low sexual desire which can be modified to incorporate the couple. It includes emphasis on communication, sensate focus, and fantasy.

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