EDITORIAL

Those of us who work with bereaved people soon become aware of their amazing capacity to survive and grow in the face of adversity. Loss can force us to become aware of strengths and potentialities that we would never otherwise have discovered.

The counsellor may witness and act as midwife to such transformations but the transition is not easy and not every bereaved person will grow through grieving. Some withdraw into any place of safety, others go on as if nothing had happened and refuse stubbornly to change at all.

We must recognise and respect their fear without sharing it. Rather than pity for their weakness, it is our faith in their strength that will get them through. Wise counsellors do not over-protect their clients, nor do they take over their lives and instruct them what to do. Our role is to provide a safe place and a secure relationship from which they can test out their thoughts and plans; not in order to begin again, but to build upon the foundations that have already been laid. It is often necessary to lose someone in order to become aware of the gifts that they have left behind.

Inevitably many of our articles focus on the difficulties that arise in bereavement, but we also welcome papers which reveal the opportunities for maturation that may result and the contribution counsellors can make to facilitate the journey through grief.

Colin Murray Parkes, UK

Sexual needs of those whose partner has died

Brenda Elliott

Brenda Elliott, *MA, Cert Ed, Dip Soc Studies, DipPST*
Psychosexual Therapist, Scarborough Hospital, Scarborough, UK

'We are never so defenceless against suffering as when we love, never so helplessly unhappy as when we have lost our loved object or its love'[1]. If bereavement is accompanied by changes in feelings, it is reasonable to assume that these changes should include sexual feelings and behaviour. This exploration looks at patterns of bereavement and sexual behaviour in women and in men, including sexual/intimacy differences, and tries to highlight some issues for the therapeutic relationship.

METHODOLOGY

Searching the literature, correlating bereavement and sexual arousal, showed that very little material existed except in connection with HIV/AIDS. Personal communications with Martin Cole and Colin Murray Parkes provided more information and support, for which I am grateful.

To supplement these sources, I decided to do some case study research. Finding respondents was very difficult, and approaches to organisations working with bereaved people were rejected by their ethics committees. The inference is that in dealing with the double taboo of death and sex, 'hard' research evidence is difficult to find. Eventually I did find eight people (see Table) who were interviewed, each for one hour, using a detailed questionnaire.

Qualitative research in any area of personal experience of painful events suffers from the ethical dilemma that respondents may find areas of past pain resurfacing, and so need time to talk through material other than that directly relevant to the researcher's brief. With this awareness, time was offered immediately after the questions had been discussed, and later by telephone contact, should the participant request it.

Bowlby[2] in his writing on attachment and loss suggests that we move through four main phases in bereavement: numbing; yearning and searching; disorganisation and despair; reorganisation. There is now wide acceptance of this process, with variation and particular application to individual situations. More recent research[3], shows that men and women have some differences in their grieving patterns. Certainly there appear to be gender differences in the sexual responses and in the behavioural outcomes in my sample. As a couple, sexual feelings can be safely contained in that union, but a widow or widower may be 'floating unanchored and undefined'; 'the passionate early days of being in love are very similar to the passionate painful days of grief', Wallbank[4].

EDITOR'S NOTE

While sex is often a problem after bereavement there have been few attempts to study the subject in a systematic manner. In this paper, Brenda Elliott reports her findings from a small but interesting survey which highlights some of the difficulties.

WIDOWS

Sexuality after bereavement

Writing specifically on a woman's experience of grief, Kitzinger[5] says that 'any strong emotional state affects

our feelings about sex – sometimes making us more sexually aroused, sometimes sexually frozen'. In the initial stages of grief, along with fatigue, sadness and stress, a woman's menstrual cycle may be disturbed, either with long, unexpected periods, or periods stopping altogether as if a woman's body were frozen in its grief. Grief can precipitate an early menopause, though my two respondents who were pre-menopausal noticed no difference in their menstrual cycle.

Widows may be confused by their sexual response patterns. A woman may start to feel aroused but 'her body says no, her vagina does not soften, moisten and unfold'[5]. Conversely she may be driven to sex, experiencing insecurity because the feeling seems to be incompatible with her loss. Respondent A in my sample desperately needed a casual sexual relationship within the first three weeks, to reaffirm herself as being alive.

Sexual arousal may also be strong because of long, enforced abstinence caused by the partner's illness. These feelings may be accompanied by guilt if the widow feels that she was withholding during the partner's illness. Some experience 'waves of acute physical yearning in the early days of loss. They need... to touch and be touched. For many people the act of intercourse provides comfort; nothing offers a greater sense of safety and security than the knowledge that they are joined to another living human being'[4].

Initial sexual feelings among my respondents ranged from guilt about not being sexual before the death and not feeling sexual afterwards, to 'is this the end of my sex life?' on the day of the partner's death, wanting a lesbian relationship, and feeling angry at the lack of opportunity to try out a new vaginal repair.

Gebhart[6], writing in 1970, said that 'sexual interest and desire were practically non-existent during the first six weeks of acute grief and with some [the absence] persisted for a year. The renascence of the sex drive was seen as the gradual recovery from grief'. More recent writers are less prescriptive, being aware of the conflict between intimacy and sexual needs and that, for some, feeling alive is affirmed by the sexual act. Kitzinger[5] writes of the paradox of a woman who may not be able to face the pain of an intimate, caring relationship and so seeks sexual partners without any possibility of closeness or commitment. Conversely conflict between intimacy and sexual needs may be experienced and often misinterpreted, the grieving widow wanting to be held close but not wanting a sexual relationship.

When erotic feelings do return they may come unexpectedly, like a thaw, often accompanied by guilt. Absent periods return, accompanied by searching behaviour to find the lost sexual partner in another relationship. Often sex seems the only way to achieve closeness. Needing to feel close but not committed, respondent E had an affair 18 months after her husband's death. During the intervening time she stopped flirting, something she had felt quite safe in doing when her husband was alive. She changed her dress style to one that was very formal and assertive, giving out messages that said 'stay away' to men.

Gebhart[6] found that, for widows: 'orgasm was enjoyed more frequently than while married due to selectivity, sexual maturity and having coitus when happy. The desire for physical closeness and for the affirmation of sexual identity grows as the grieving process moves towards considering new relationships.'

Meeting sexual needs without a partner

However, many women whilst feeling sexually aroused during their bereavement do not have the opportunity, or the desire, to find another partner. Kitzinger[5] does not mention masturbation, although this has been advocated by many from the 70's onwards[7, 8]. Hutton said that 'research shows that women who have practised self-stimulation for years have had a better health record than those who, under pressure of a sense of guilt, have given up the habit'[8]. She goes on to say that women who masturbate 'get it over with and forget about it, turning to their work with increasing energy and ease of mind'. Two out of the five respondents masturbated.

Malatesta *et al*[9] concluded that, as a means of achieving sexual satisfaction, the recourse to masturbation suggested by Masters and Johnson[7] 'is unlikely for the present cohort of older women, who will find masturbation and any form of sexual deviance too conflictual and thus will avoid these practices because of early cultural learning and/or strongly held religious beliefs about sex in general'.

For Malatesta's[9] 100 widows, the activity that rated the highest in satisfying sexual/affectional needs, was hugging, cuddling and holding grandchildren and children. The lowest rated activity was 'touching your body to make yourself feel good and giving yourself a massage'. Masturbation was not viewed as a viable source of sexual expression by the older widows, who preferred 'wearing lingerie in a highly significant manner' and 'having your hair done' (socially approved touching) but not, contrary to clinical folklore, caring for a pet. The younger widows (aged 40-49) expressed greater unhappiness with the lack of physical closeness with a man, showing concern about the change in their body image through ageing. For all the widows, expressing their spirituality was effective in meeting sexual and affectional needs. The researchers maintain that their findings are important to therapists, but add that the above means of expression could be compensatory activities.

All of my respondents were asked

Characteristics of the respondents to the case study questionnaire

	Sex	Age	Age of partner at death	Length of sex relationship (years)	Nature of death	Sex (satisfaction/frequency)
A	F	42	34	12	Sudden	Not very satisfactory, no passion, five orgasms in 12 years
B	F	61	56	31	Long illness	Not very satisfactory, climax infrequent
C	F	50	40	10	Long illness, sudden death	Not very satisfactory (his inhibitions)
D	F	58	56	34	Long illness sudden death	Spontaneous, enjoyable love-making
E	F	44	34	17	Sudden	Perfectly adequate at the time
F	M	74	52 + 71	33 + 19	Both long illnesses	Good + Satisfactory
G	M	68	66	6	Long illness	Very good in second marriage, poor in first (ended in divorce)
H	M	45	40	21	Sudden	Satisfactory

whom they could turn to for emotional support. One widow, E, had a close extended family to offer her love and attachment, and she only expressed sexual needs after 18 months bereavement. Another had an older female friend, but the rest had no one. Although the younger people in my sample had dependent children they did not see them as a means of satisfying these needs.

Inhibiting factors

In the reorganisation stage of bereavement, the widow's relationship with children and grandchildren, which may fulfil sexual/affectional needs, may also inhibit the forming of new sexual relationships. The very nature of the bond is seen by family members as establishing the widow, 'grandma', in a non-sexual role. Three main reasons make change difficult:

- the bereaved child may have enshrined the deceased parent and any replacement will be seen as sacrilege;
- the bereaved parent's sexual needs have to be acknowledged, 'There is enough latent sexual prejudice to make it easy to induce guilt and shame, so grandma is judged irresponsible if she marries and immoral if she doesn't[10]';
- the newly formed 'steady state' will be disrupted and that may be seen as a betrayal.

The other area of restraint on a new heterosexual relationship can come from the 'sisterhood'. Widows are often supported by a group of other single women, and a solely female-oriented, single-sex view of life can arise. Gibson[10] writes of widows who have felt that they needed to hide their heterosexual relationships from the sisterhood. One of the widows, D in my survey, belongs to a woman's voluntary group where she feels awkward when heterosexual behaviour is joked about, because she is aware of her own feelings which are of envy and longing, not disparagement.

Brecher's study[11] gives an indicator that in the next century single, elderly women may be prone to form lesbian relationships. Cole[12] wonders about the socially-constructed polarity of homo/hetero and thinks that in older age we may be able to move between the two. Respondent C had a homosexual relationship in the first year of her bereavement and, in looking back at the development of her sexual identity, believes that she was 'different' then. Gibson[13] says that those who do not fulfil their sexual potential lack an essential element of what makes for autonomy and personal worth.

WIDOWERS

Control and impotence

Looking at male patterns of grieving and the resultant sexual behaviour, Lendrum and Syme[14] report that 'men seem to need to regain control of their world more quickly, are more easily in touch with intense sexual feelings and are aware of the threat to their sexuality that loss of a partner can pose. They may describe themselves as feeling emasculated or even castrated'. Widowers tend to marry sooner than widows and often complete their grieving within the new relationship (respondents F and H moved into new relationships within a year – for H, at 73, his third). Fears of erectile insufficiency and performance anxiety are prevalent. Cole[12] says that the bereaved men, to whom he offers behavioural sexual therapy using a surrogate partner, experience grief, abstinence and the effects of ageing. These men had little sexual experience before marriage and suffer from performance anxiety, especially with women who have been sexually conditioned to be the passive partner and do not expect to stimulate the man's penis in foreplay.

The Relate guidelines on erectile dysfunction[15] after previous successful sexual experiences, name 'loss' as a precipatory factor. A study of six men who asked for therapy showed that recent, or older, unresolved grief, is a strong precipatory factor. It is as if their sexuality has gone to the grave with their deceased spouse, so that after years of abstinence their difficulty in resuming a loving sexual relationship is far in excess of what might be expected from the ageing process alone. Respondent G had a very unhappy first marriage with little sexual contact. When he re-met an old sweetheart his sexual life blossomed for the first time. Unfortunately his new wife developed a form of bone cancer so that in the last two years of their life together he was unable to touch her for fear of making her condition worse. H says that he is now impotent.

For a man, Stimson *et al*[16] conclude that 'an active sex life seems to be critical to his feelings of self worth'. Older widowers have to adjust to the double loss of their partner, with whom they may not have been sexual for many years, and their declining erectile function. Brecher[11] says that sexually inactive men have a much lower life-enjoyment level than sexually inactive women. Widowers fear that they will become impotent and no longer know how to please a woman. Staudacher[3] says that impotence occurs naturally and subsides as the grieving process continues. Many widowers need affection but feel that they cannot express such intimacy unless it includes sexual intercourse. She also states that a man 'may lose himself in the sexual act as a way to suppress his deepest feelings. Such an activity also serves to quell, temporarily, the need to have control over things, to exert power and to put the very act that produces life in the place of its opposite – death.' Often anger and aggression are grief substitutes for men. They need to take control of the death situation, engaging in solitary grief. They do not expect to be impotent sexually, or in other areas of their lives.

Unfulfilled desires

German researchers, Stoppe and Radau[17], had great difficulty in finding widowers for their study of male sexuality as an aspect of total well-being. They wanted to research unfulfilled desires and whether men wish to discuss sexuality (in my study, the men were much more tentative about the benefits of discussing sexuality than the women). They found that 50% of their sample, who had had no sexual activity in their last years of marriage, had their needs met by 'communication and psychological well-being' rather that by masturbation. The 33% who had had sexual relations prior to the death of their partner, soon entered a new relationship and noticed an increase in masturbation in the intervening period. This study showed there is a 'potential for sexual contentment linked to personality'[17].

Verwoerdt[18], in an earlier study, found that men showed more interest in sexuality than in sexual activity, and that the discrepancy between desire and ability increases with age. Men in Stoppe and Radau's[17] study wanted to talk to their doctors more than anyone else, but the authors believe that cultural prejudices about age and sex, and the men's own misunderstood shame, may prevent this.

The influence of sexuality on psychological well-being in old age needs a forum, especially as illness and medication often affect libido and sexual potency. My three male respondents masturbated as a form of tension relief and comfort, although G was unable to maintain an erection.

None of the respondents said they fantasised. Maybe this is a difficult area, especially if the remembering is at the level of the following account from Lendrum and Syme[14] by a man whose young wife had died suddenly.

'Several times I would hallucinate. In bed was worst. One side was so cold – so cold. As winter drew on I'd put two pillows where once she had lain. I'd wake up convinced that she was next to me, and then I would cry and sob with anger when it was a pillow. More than once I was making love to her passionately, not waking until after the orgasm, my thighs wet, just as they had been as a fantasising teenager.'

Hallucination is accepted as a usual part of the bereavement process; normalisation of this as part of the sexual response is needed. Wallbank[4] says that bereavement may be the first time we are fully aware that our body belongs to us. Education and permission-giving may be needed. The issue of safe sex needs to be addressed too. The biggest European group for heterosexually-transmitted HIV/AIDS is in the 50+ population. Gibson[13] writes of the possible number of homosexual males in the older population who may have been in heterosexual relationships. He estimates that we have 300,000 homosexual pensioners in the UK and that in working with widowers we need to be aware of this. Results show that older homosexual men form stable relationships.

GENERAL FINDINGS

Both sexes suffer from financial and sexual predators, being vulnerable in their grief and loneliness. In order to survive there is a need to feel psychologically strong as proof against an inner sense of abandonment[19]. If our long-term partnership has not fulfilled our early needs there is often an intense longing to reclaim this wholeness in another relationship. Widow B said that she had locked away her sexuality in death, just as she had done during her marriage, and wondered if she had missed something. D says that she no longer misses her husband, but she desperately misses the relationship and that she would not know how to be sexually attractive to anyone else. Widower F, who was entering his third sexual relationship, said he felt on the outside when he was without a partner. Despite the warmth and caring of his support group he could only feel on the inside of life when in a sexual relationship.

In writing about sexual behaviour it is difficult to differentiate between sexual, intimate, affectional, and attachment needs; all have different connotations. Parkes[20] says that there is a need to make a distinction between sexual and attachment drives 'which although they coexist are by no means the same phenomenon'. Leviton[21] offers a definition:

'Intimacy implies a very close relationship with another; a desire to be with and to enjoy that individual; perhaps a desire to hold and be held, a desire to share and to confide, or both. An intimate relationship may or may not include sex'.

Some of the sexual and affectional behaviour of the bereaved reflects these difficulties, both in wanting and wanted behaviour. We need to understand whether sexual needs are part of childhood or adult attachment, or indeed if they are constructed by society, and if that process is influenced by the experience of each individual cast adrift by the death of a partner.

CONCLUSION

There is limited research in this area. Early literature tends to be prescriptive; recent studies are more individually focused. There clearly are sexual issues for the bereaved which are affected by such variables as personality, gender, age and timing. Awareness of these variables can help the bereaved accept sexual feelings as part of their natural response to the death of their partner. There are gender differences in behaviour. Sensitive education to regain sexual skills and safe sexual behaviour should be part of therapy.

Widowers tend to enter new relationships before their grief is resolved, which may inhibit their sexual performance. The scarcity value that society puts on widowers was not comforting. All respondents in my study experienced being seen as sex objects by others. Heightened arousal and repression of sexual need is shown by both sexes, in different ways, but the expression of these needs is influenced by society's view of age and sexuality. Counsellors need to be aware of the modifying process of bereavement on sexual needs.

Brenda Elliott's husband, aged 54, died unexpectedly on 10 February 1996 as she was completing this paper. She has now returned to work and is continuing to expand her research.

References

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FORTHCOMING EVENTS

Dying and Bereavement: Providing Support. Bristol Cancer Help Centre workshop. 20 May 1997. Bristol, UK. Details from Susan Harvey, Grove House Education Centre, Cornwallis Grove, Bristol BS8 4PG. ☎ 0117 980 9520.

Responding to Bereavement and Loss. Age Concern training course.18 June 1997. London, UK. Details from the Training Manager, 54 Knatchbull Road, London SE5 9QY. ☎ 0171 737 3456

Jewish Baby Memorial Service: for those who have lost a pre-term or neo-natal baby or been unable to conceive. 18 May 1997. London, UK. Contact Rabbi J Tabick, West Lodon Synagogue, 33 Seymour Place, London W1H 6AT. ☎ 0171 723 4404.