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.

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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.