Couple Sexuality After 60

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This conceptual/clinical article explores the psychobiosocial model of understanding and reinforcing couple sexuality in the 60s, 70s, and 80s. The importance of positive, realistic psychological, biological, and relational expectations in facilitating desire, pleasure, eroticism, and satisfaction is key. As couples age, levels of sexual satisfaction can remain high as long as the focus is on being an intimate, erotic team and abandoning the need for perfect intercourse performance. The major advantage of aging sexuality is that the partners’ need each other and sexuality is more human and genuine.

KEYWORDS aging and sexuality, couple satisfaction, couple therapy, sexual health

INTRODUCTION

The field of sex and aging has not been adequately examined either empirically or clinically. Most literature focuses on sex dysfunction, ceasing sexual activity, and medical factors interfering with individual sex function. There has been very little empirical or clinical attention to healthy couple sexuality after 60.

Lindau et al. (2007) completed the most comprehensive study of sexual desire, function, and satisfaction among couples and singles from ages 58 to 85. The positive finding is that both men and women can be sexual into at least their mid-80s. The distressing finding is that by age 75 most couples have stopped being sexual. In most cases the decision is made unilaterally by the man and conveyed nonverbally. He experiences anticipatory anxiety, tense and failed intercourse performance, and increased frustration...
and embarrassment, eventually leading to sex avoidance (Metz & McCarthy, 2007). He says to himself, “I don’t want to start something I can’t finish.” When it’s “intercourse or nothing,” nothing will eventually win whether at 45, 65, or 85.

The classic Massachusetts Aging Study (McKinley & Feldman, 1994) is an excellent empirical examination of the challenges of sex and aging. Other studies (Bretschneider & McCoy, 1988; Kingsberg, 2000) confirm the complexity of sexual function and dysfunction with aging. Burgess (2004) conducted an excellent review of both data and clinical concepts involved in maintaining sexual desire and function with aging.

Healthy couples adopt the new sexual mantra of desire, pleasure, eroticism, and satisfaction (Foley, Kope, & Sugrue, 2011). They emphasize variable, flexible sexual expression and adopt the Good Enough Sex (GES) model focused on sharing pleasure and eroticism and discard the pass–fail intercourse performance model (Metz & McCarthy, 2010). They take pride in “beating the odds” and savor the advantages of aging sexuality; they need each other and sexuality is more human and genuine. Desire is facilitated by sexual anticipation; older couples value sensual, playful, and erotic experiences as much as intercourse and orgasm. Pleasure and eroticism is valued whether mutual or asynchronous; sexual satisfaction is more highly valued than sex function. The key to sexual satisfaction is positive, realistic psychological, biological, and relational expectations. The couple accepts that the roles and meanings of sexual encounters will vary between partners and different experiences.

**MEANING AND VALUE OF COUPLE SEXUALITY WITH AGING**

When discussing couple sexuality and aging, the clinician is faced with two sensitive (traditionally taboo) topics: aging and sexuality. Rather than being value neutral, which is neither possible nor genuine, Annon (1974) challenged the clinician to assume a pro-sexuality, permission-giving stance and to provide scientifically valid, helpful information to clients about psychological, biological, and relational/social factors. The psychobiosocial model of sexuality (McCarthy & McCarthy, 2009) encourages the careful assessment of psychological, biological, and relational factors, which promote healthy sexual function with aging, and confronts psychological, biological, and relational factors that subvert sexual function with aging. The therapeutic plan is to reinforce positive strategies and techniques: value the GES model of variable, flexible couple sexuality; emphasize the positive sexual challenge of “beating the odds”; openness to sensual and erotic pleasure, as well as asynchronous sexual experiences; emphasize a healthy body and positive habits of sleep, exercise, and eating; use of pro-sex medications and aides to facilitate function; view each other as intimate, erotic friends; use a mix of
partner interaction, self-entrancement, and role enactment arousal scenarios; and maintain a regular rhythm of sensual, playful, erotic, and intercourse touch. Conversely, it is crucial to monitor and change negative factors that include dwelling on loss with aging; anticipatory and performance anxiety; depression and feelings of being “over the hill”; poor health habits, especially having more than one alcohol drink before sex, and feeling controlled by illness and medication side effects; trying to prove something to your partner or perform for your partner; overemphasizing intimacy or overemphasizing eroticism; and longing for the return of the “magical sex of youth.”

**PSYCHOBIOSOCIAL MODEL OF SEXUALITY AND AGING**

Typically, physicians and other health professionals emphasize biological and medical factors and interventions. The field of sexual medicine focuses primarily on new physiological findings and is driven by drug company funding, with an overemphasis on medication protocols (Rowland, 2007).

In contrast, we advocate the psychobiosocial model of assessment, intervention, and relapse prevention (McCarthy & McDonald, 2009). This is more than a semantic difference. The core issue is sexuality as a couple process of sharing desire, pleasure, eroticism, and satisfaction rather than the traditional emphasis of the Diagnostic and Statistical Manual of Mental Disorders (DSM) and sexual medicine on individual sex performance and dysfunction. With aging couples, the psychobiosocial model is more clinically relevant and helpful (Foley, 2005).

A psychological key to healthy sexuality with aging is to accept the physiological realities (lessened vascular and neurological efficacy, illness, and especially side effects of medications) and to view maintaining sexual desire and function as a challenge. Individuals and couples who emphasize, or even obsess, about feelings of loss with aging subvert both psychological well-being and sexual desire. The essence of sex and aging is giving and receiving pleasure-oriented touching rather than individual sex performance.

Another focus is acceptance of asynchronous sexual experiences rather than exclusively valuing mutual sexual encounters. Although sexual experiences where both partners are desirous, aroused, and orgasmic are preferable, it is crucial that this not be a demand/mandate. As individuals and couples age, learning to value asynchronous sexual experiences is a valuable addition to their couple repertoire. Examples include encounters where the woman is more easily desirous and orgasmic than the man; encounters where she pleasures him to orgasm and enjoys the experience at a low level of arousal; encounters where the man enjoys intercourse but is not orgasmic and they transition to a scenario where he stimulates himself to orgasm as she cuddles and strokes him; encounters where she is aroused/orgasmic and then they transition to a warm, cuddly scenario; or encounters where he
is orgasmic during intercourse and she prefers a sensual afterplay scenario. Quality couple sexuality does not require orgasm or a mutual, synchronous sexual experience.

In terms of physical/biological/medical factors, it is important to maintain good behavioral health habits, especially sleep and physical conditioning; to reinforce an accepting, positive body image; and to be a knowledgeable, active patient in dealing with illness and strategies to compensate for side effects of medications. Perhaps the most helpful suggestion is to encourage the couple to have a joint consultation with the internist or specialist with the focus on being a good patient and minimizing sexual effects of the illness and medications. The challenge is to maintain a vital, resilient couple sexuality while dealing with illness.

Relational/social factors, especially psychosexual skill factors, have a crucial role in quality couple sexuality with aging. The couple views each other as intimate and erotic friends. This means embracing the fact that in aging the man and woman need each other for satisfying sexual experiences. Strengths of aging sexuality are it is more human and genuine, with a focus on variable, flexible GES rather than perfect sex performance. Socially, the couple and the culture can affirm the value of intimacy, touching, and sexuality. Remaining open to sensual and sexual touching enhances quality of life with aging.

Psychosexual skill factors become crucial with aging. Three prime psychosexual skills are as follows:

1. Transitioning to intercourse at high levels of erotic flow with the woman guiding intromission
2. The man learns to “piggy-back” his arousal on hers and to use multiple stimulation during intercourse
3. Openness to asynchronous sexual scenarios and techniques involving manual, oral, rubbing, vibrator, and intercourse stimulation

Sexual intercourse is a natural continuation of the pleasuring/eroticism process, not a pass–fail performance test. Rather than the man trying to force intercourse as soon as he’s erect because he fears losing his erection, they can enjoy pleasuring and erotic stimulation and transition to intercourse at high levels of erotic flow. She can guide intromission so that he can focus on giving and receiving multiple stimulation both before and during intercourse.

Pleasuring and eroticism are mutual processes rather than traditional “foreplay” where the man prepares the woman for intercourse. Instead, both people, but especially the man, are open to the partner’s responsivity and realize that an involved, aroused partner is the best aphrodisiac.

Almost all sex self-help advice, as well as cultural beliefs, emphasize the value of synchronous sexual experiences where each partner
experiences desire, arousal, orgasm, and satisfaction. Research with happily married, sexually functional couples demonstrates that although most sexual experiences are positive for both partners, less that 50% are synchronous (Frank, Anderson, & Rubenstein, 1978). Often, a sexual experience is better for one partner than the other. It is crucial to note that it is normal for 5% to 15% of sexual encounters to be dissatisfying or dysfunctional. With aging, sexual satisfaction can remain high even though sexual function becomes more variable, flexible, and asynchronous.

In adopting the psychobiosocial model of human sexuality, the prime psychological factor is to view sex and aging as a challenge rather than a loss. Biologically, a healthy body promotes sexual response. Vascular, neurological, and hormonal problems and poor health habits can subvert sexual response. Vascularly and neurologically the person’s physical systems are less efficient and resilient. The major cause of biological problems is not aging itself but illness and side effects of medications. A helpful strategy is to consult the internist or specialist as a couple. Discuss how to be an active, knowledgeable patient, including how to reduce medication side effects or compensate for them. In addition, confronting poor health habits, especially sleep, exercising, and eating patterns, is crucial. Moreover, smoking cessation and either no drinking or just one drink before being sexual is important.

Relational and psychosexual factors become crucial with aging. Unlike in the 20s and 30s, to be sexual in the 60s and beyond requires being both intimate and erotic partners (McCarthy & McCarthy, 2009). In essence, quality couple sexuality becomes a team sport, not an individual sex performance. In addition, the couple needs to be aware of and implement psychosexual skills. These skills include (but are not limited to) using physiological and psychological relaxation techniques, increased awareness of each partner’s cognitive and physiological arousal continuum, enhanced bridges to sexual desire, learning to “piggy-back” one’s arousal on the partner’s arousal, use of self-entrancement and/or role-enactment arousal scenarios, and transitioning to intercourse at high levels of erotic flow, when sex does not flow to intercourse being able (without panicking or apologizing) to transition to an erotic, nonintercourse or a sensual, cuddly scenario. It is important to develop afterplay scenarios, which add to sexual satisfaction and meaning.

CASE ILLUSTRATION: MAX AND DOROTHY

Dorothy, 78 years, practically had to drag Max, her 76-year-old husband of 24 years, into the therapist’s office. This was Dorothy’s second and Max’s third marriage. Dorothy had been a widow for 22 years (her husband had been killed in combat and she raised two children as a single mother). Max had been divorced twice and was very enthusiastic about marrying Dorothy. He told his two adult children that she needed his financial stability.
and companionship. Max said nothing to them about intimacy or sexuality. In contrast, Dorothy told her two adult children that she was in love with Max and looked forward to sharing marital intimacy.

Max and Dorothy were very fortunate in that the four adult children were friendly and accepted the new stepparent. Max and Dorothy enjoyed being grandparents to nine children who ranged in age from 17 to 2. They valued their marriage, but now sexual avoidance was a “poison” that subverted their relationship. Their nonsexual marriage had a very negative impact on Dorothy and Max, although a very different one for each person.

Throughout this marriage it was Dorothy who was more enthusiastic about intimacy, touching, and sexuality. At first, Max had been sexually responsive and enthusiastic, but this began fading during his mid-50s. Dorothy was the sexual “cheerleader,” especially using oral sex to arouse Max before intercourse. It was Dorothy who encouraged Max to ask for a Viagra prescription from his internist. The internist explained to Max that because he was taking blood pressure and cholesterol medications it was normal to “need” a pro-erection medication to compensate for the effects of the other medications.

Unfortunately, the doctor did not give Max any specific suggestions of how to integrate the medication into their couple style of intimacy, pleasure, and eroticism nor did he suggest a couple consultation. Max hoped and expected he would get erections with the ease and predictability of his youth. Erectile confidence increased both as a placebo effect as well as the medication making vascular function more resilient. However, after seven successful intercourse experiences, Max lost his erection at the time of intromission. He felt shocked and devastated, and the encounter came to a screeching halt. Dorothy tried to pleasure him to orgasm and later talk with him, but Max was totally shut down.

When each sexual encounter is viewed as a pass–fail intercourse performance test, sexual failure is almost guaranteed whether after 2 weeks or 2 years. The traditional male model of autonomous erections, total predictability and control, and perfect intercourse performance is unrealistic and self-defeating with aging. Traditional men who cling to the perfect intercourse performance model are likely to stop being sexual in their 50s or 60s.

The clinician urged Max to be a “wise” man and adopt the pleasure-oriented, variable, flexible GES model of male and couple sexuality. These men and couples continue to be sexual in their 60s, 70s, and 80s. Dorothy was easy to convince because GES is congruent with female sexual socialization and experience. Dorothy, like most women, learned sexual response as an interactive process, not as autonomous; experienced variable, flexible response rather than sex being totally predictable; and viewed sexual satisfaction as more than intercourse and orgasm. Also, Dorothy realized that
subjective arousal and objective arousal often were not congruent, especially with aging. For example, Dorothy regularly used a vaginal lubricant because even when she felt highly subjectively aroused, her lubrication (objective arousal) was lessened.

A danger in couple sex therapy is the man feels “ganged up on” by his partner and the clinician. Rather than feeling empowered by the GES model, he feels blamed and intimidated. Fortunately, Max believed his experiences and perceptions were accepted, and he felt empowered to meet the challenges of embracing variable, flexible GES sexuality in his 70s and 80s.

The most challenging issue for Max, as it is for most men, is this approach to couple sexuality. Max had learned that “first class sex” always involved an erection, intercourse, and orgasm. This continued to be his preferred way of being sexual, which is healthy. However, Max (and Dorothy) needed to view this as a valued preference, not a mandate or demand. He had to rid himself of the “tyranny of intercourse performance” and replace it with a pleasure orientation and the GES approach.

Specifically, this meant that Max and Dorothy resumed a regular rhythm of sensual, pleasurable, and erotic touching. Their hope was that touching would lead to erotic feelings and that 75% to 85% of encounters would proceed to intercourse. The new strategy was to transition to intercourse at high levels of erotic flow. Max was open to Dorothy guiding intromission. When the encounter did not flow to intercourse, they were able to transition (without panicking or apologizing) to an erotic, nonintercourse scenario or a sensual, cuddly scenario. Max preferred a mutual erotic encounter, although often Dorothy preferred pleasuring Max to orgasm (with intercourse pressure off, Max enjoyed orgasm with erotic sex). Dorothy was more open to alternative erotic and asynchronous scenarios than Max.

To facilitate the change process, Max and Dorothy adopted the clinician’s approach of read, talk, and practice. Dorothy was more the reader and talker, whereas Max emphasized the doing. Max was particularly motivated by the concept of “beating the odds” and staying sexually active. He did not embrace GES with the enthusiasm that Dorothy did but did learn to “piggy-back” his arousal on hers. Dorothy was more willing than Max to use a variety of pleasuring and erotic techniques, including self and vibrator stimulation, asynchronous sexual encounters, and taking a “rain check” and cuddling. Dorothy emphasized the crucial role of maintaining connection, whereas Max emphasized “successful” sexual encounters. They united as intimate and erotic allies in confronting the common enemy, sexual avoidance.

The mantra of desire, pleasure, eroticism, and satisfaction was more strongly valued by Dorothy, whereas Max enjoyed the focus on orgasmic sex and beating the odds. Max was grateful that Dorothy promoted marital sexuality—it allowed him to be a healthier person and they were a satisfied couple.
Max and Dorothy agreed to a semistructured relapse prevention program that featured 6-month check-in sessions over a 2-year period. There were three key strategies:

1. Be sure that a “lapse,” a negative sexual experience, did not turn into a “relapse”—the pattern of anticipatory anxiety, tense sex approached as a pass–fail performance test, sexual frustration, embarrassment, and avoidance. Dorothy would initiate a playful or erotic date within 3 days and often Max would take Cialis, knowing it had both a vascular and placebo effect.

2. Introduce a new addition to their sexual repertoire every 6 months. Usually, this was a small but significant technique such as buying a new lotion to enhance pleasuring, trying a variation of side rear entry intercourse, or a new afterplay scenario featuring reading love poems. Dorothy was the bigger risk-taker, and her initiation featured trying a role enactment scenario—being at a resort hotel and pretending they were meeting for the first time.

3. Every 2 to 3 months they initiated a sexual play date with a prohibition on intercourse. This could be a particularly fun and exciting time but had a very different meaning for Dorothy than Max. He was reassured that Dorothy found erotic, nonintercourse sex satisfying so he was confident that if sex did not flow to intercourse, they could still have a good time and be orgasmic. For Dorothy, these were often the most inviting and satisfying sexual encounters because the focus was on erotic playfulness; sex was lighter, not always serious.

The follow-up sessions helped maintain Max and Dorothy’s motivation and sense of accountability to each other and to therapeutic goals. Sexuality cannot be treated with benign neglect, especially not in aging couples. The key element in quality couple sexuality is desire, which depends on positive anticipation and valuing the dimensions of touch, affection, sensuality, playfulness, eroticism, and intercourse.

**DISCUSSION**

This clinical case illustrates the complexity of couple sexuality after 60 and the utilization of the psychobiosocial model for assessment and treatment. Perhaps the biggest challenge for the couple, especially the man, is to embrace the variable, flexible GES model as first-class male and couple sexuality after 60 rather than clinging to the traditional model of predictable erections and intercourse as the pass–fail performance test.

Continuing to value intimacy, touching, and sexuality in the 60s, 70s, and 80s improves quality of life for the man, woman, and couple. The focus
on sharing pleasure as a couple rather than individual sex performance is a key concept. The emphasis is on desire and satisfaction rather than intercourse and orgasm. The couple is motivated to stay connected and engage in sexual play rather than fall into the performance, frustration, embarrassment, avoidance trap. The broad-based GES model includes sensual, playful, and erotic touch that promotes desire and satisfaction.

There are several limitations and concerns regarding this conceptual clinical model of sexuality and aging. The first is the need for empirical validation. A second is to carefully examine its applicability to different couple sexual styles in terms of the right fit for a specific couple. Sexually, “one size never fits all.” Another important factor deserving careful exploration is the role of illness, side effects of medications, behavioral health habits, and gender issues in maintaining healthy couple sexuality with aging. How can individuals with diabetes, cancer, cardiac conditions, or chronic pain use the psychobiosocial model to confront the effects of illness and medications that interfere with vascular, neurological, and hormonal function? How can psychological, relational, and psychosexual skill factors compensate for these medical/physiological vulnerabilities? What are realistic expectations regarding pro-sexual medications and aides? What are the challenges for the couple to successfully integrate medications into their style of intimacy, pleasing, and eroticism? There is no doubt that sexuality and aging is a very important, complex area deserving of much more conceptual, empirical, and clinical attention.

SUMMARY

Embracing the GES model of couple sexuality is a challenge to the man, woman, and couple but is the path to vital, resilient sexuality in the 60s, 70s, and 80s. The challenge for aging couples is to embrace variable, flexible sex functioning based on pleasure rather than performance and to accept the aging process with positive expectations, including less efficient, resilient physiological function. The keys are to view sex and aging as a challenge, not a loss; to be active, knowledgeable patients and enhance behavioral health habits, while integrating medical interventions into the couple sexual style; to view each other as both intimate and erotic friends; and to commit to beating the odds and flexibly using psychosexual skills to maintain a sexual relationship focused on desire, pleasure, eroticism, and satisfaction.

REFERENCES


