SEXUALITY AND AGING: NAVIGATING THE SEXUAL CHALLENGES OF AGING BODIES

Daniel N. Watter

Can you imagine old age? Of course you can't. I didn't. I couldn't. I had no idea what it was like. Not even a false image—no image. And nobody wants anything else. Nobody wants to face any of this before he has to. How is it all going to turn out? Obtuseness is de rigueur.
Philip Roth, The Dying Animal

Introduction:

Most people will say that they are not looking forward to aging. Much like the above quote from a Philip Roth character (2001), our images of an aging person are often filled with negativity, loss, and fears of irrelevance. Much of Western society is clearly oriented toward a culture of youth, and aging is often treated as a "disease" to be avoided at all costs.

Berliner and Solomon (2018) aver that adults often resist describing themselves as aging because they are aware that being old is a devalued, stigmatized personal identity. However, it is projected that by the year 2035, one in five people in the United States will be sixty-five or older (Joint Center for Housing Studies of Harvard University, 2016). Bioethicists have recently expressed concern that as American society has aged, many of our policies regarding the elderly have also become outdated (Berliner & Solomon). Specifically, they have come to see that a view of aging that focuses almost exclusively on illness is no longer sufficient to meet the ethical and lifestyle challenges of an aging society. This is certainly the case when it comes to understanding the relationship between sexuality and aging. There was a time when the idea of linking sex with aging would have been considered an oxymoron. Historically, Western cultures did not see a society's elders as having sexual needs, wants, desires, and/or interactions. The prevailing narrative of the impact of aging on sexual functioning has been an inevitable process of decline that can only impede one's enjoyment of sex (Agronin, 2014; Bouman & Kleinplatz, 2016). Presently, we understand that this is far from the reality of many aging adults, yet many misunderstandings, misperceptions, and biases persist.

The aim of this chapter will be to refute this view by presenting research and clinical information that brings us to a more complete understanding of the role sex plays in the lives of an aging population.

Research on Sexuality and Aging

Despite the aging of the population, little is known about the sexuality of older people (Lindau et al, 2007). We have few studies, and this results in modest amounts of data. In addition, flaws in our research design taint much of the meager data we do have. Bouman and Kleinplatz (2016) have suggested that the conflating of aging and disease has had serious detrimental implications for our research strategies. They further argue that much of our research on sexuality and aging has considered the aging population as a single cohort, ignoring the cultural, health-related, religious, and age variance among this heterogeneous group. In addition, the majority of our professional literature on sexuality and aging has concentrated on topics such as sex in residential and nursing home settings, sex and illness/disability, sexuality and dementia, disinhibited sexual behavior, and other topics related to the link between aging and sexual deterioration. Other concerns emphasized by Bouman and Kleinplatz include the inadequate characterization of the sample populations, and the drawing of conclusions from small, non-representative and non-random samples and limiting interest to the presence or absence of coital activity.

What we do know is that aging bodies bring changing bodies, and that sexual functioning changes over time for both men and women. Several researchers and clinicians have documented the physical and sexual changes of aging over the years, (Agronin, 2014; Laumann & Waite, 2008; Leiblum and Sachs, 2002; Lindau, et al, 2007; McCarthy & Metz, 2008). Changes such as decreased frequency of morning erections, decreases in penile sensitivity, the need for more direct penile simulation, slower occurring erections, less rigid erections, reduced ejaculatory urgency/intensity/consistency/volume, longer refractory periods, and more rapid post

ejaculatory urgency/intensity/consistency/volume, longer refractory periods, and more rapid post ejaculation/orgasm detumescence are all common occurrences in men as they age. Similarly, for women vaginas may shorten and narrow, vaginal walls may thin and stiffen, vaginal lubrication will decrease and take longer to occur, and orgasm will become more inconsistent. Both genders will likely experience a decrease in frequency, desire, and intensity, and intercourse will become more difficult as well. Despite these changes, however, Lindau et al (2007) and Stulhofer et al (2018) report that the majority of older adults in their samples consider sexuality to be an important part of their lives. This was particularly true for those who were involved in spousal or other intimate relationships. These findings were echoed by Bouman & Kleinplatz (2016), DeLamater & Koepsel, (2016), Reece et al (2010), Schick et al (2010), Herbenick et al (2010), and Elders (2010). Solway, et al (2018) found that among those 65-80 years of age, 76% agreed that sex is an important part of a romantic relationship at any age, and 54% of those in a romantic relationship reported they are currently sexually active. Of note is that in this poll, 73% of those responding indicated they were satisfied with their sex lives (37% extremely or very satisfied, 36% somewhat satisfied). Women were more likely to be extremely or very satisfied than men (43% vs. 31%), as were those with a romantic partner as compared with those without one (40% vs. 30%), and those in better health as compared with those in worse health (40% vs. 28%). It is noteworthy that despite the overwhelming data indicating that sexual function changes with age, and that what are typically considered sexual "dysfunctions" are correlated with aging, most adults in these polls report being quite satisfied with their sexual lives.

Of course, we know that much of what limits satisfying sexual activity is related to health, medications, partner availability, and several other mitigating factors. It has been well documented that the causes of sexual difficulties in later life are typically multi-determined (Agronin, 2014; Lindau, 2007). However, as Kontula & Haavio-Mannila (2009) reported, although a significant number of older adults report experiencing chronic health conditions, they are rarely cited as barriers to sexual functioning and enjoyment. Given these criticisms, and the data suggesting that almost three quarters of those surveyed are satisfied with the quality of their sexual lives, it seems advisable that we consider the likelihood that our assumption that changing bodies equate with sexual dissatisfaction may be erroneous.

Personal Distress and the Fear of Aging:

One possible way of reconciling diminished function with increased satisfaction is suggested by the existential therapy literature. Yalom (2008) suggests that many of us cling to the irrational belief that life is a never-ending upward spiral. We often assume that life is supposed to continue to be a productive and constantly improving quest for immortality. As a result, he posits that it feels incumbent upon us that we do all within our power to thwart (deny) the inevitability of an eventual physical decline. In essence, Yalom proffers the notion that much of our anti-aging fear and bias is rooted in an existential anxiety regarding death. For many, it is not so much the actual process of dying that is feared, but rather the irreversibility of the passage of time, the understanding that physical decline and eventual death is in front of us, and the growing awareness that our lives may not have had the meaning or significance we had hoped to realize.

Yalom (2008) and Watter (2012, 2018) have asserted that sex is often experienced as a life force that creates (and maintains) the sense of being alive and vital. Indeed, both Yalom and Watter have separately described multiple cases of patients turning to sex to mollify their terror of death. If we view sexuality as a potent source of vitality and existence, it is no wonder that many men and women suffer great existential angst when their ability to reproduce is compromised. When penises and vaginas no longer function as we have come to expect in our youth, the result is often a crisis in our understanding of what it means to exist, live meaningful lives, and have strong, connected relationships. For many adults, the penis or vagina is the path to living a life of such substance. A fully functional penis/vagina is central to the sense of wholeness, desirability, belonging, and connection. Many of the men I treat with erectile difficulties will lament, "I feel like less of a man," or "I feel so broken," or "I feel so weak." To these men, their problematic erectile functioning wounds them at their core, and their feelings of vulnerability are palpable. This is no less the case for many of the women who are unable to have pain- free intercourse due to the vaginal changes that accompany the aging process.

Consider the following scenario:

Richard was a 68 year old, married man, who had undergone radical prostatectomy 3 years before our meeting. Much to his dismay, he never regained erectile functioning following

surgery. He tried oral medications without much success, and found penile injections to be uncomfortable, intrusive, and unsatisfying. As a result of not being able to function sexually as he would like, Richard retreated from all sex and affection with his wife. When queried about this, his response was, "Why start something I can't finish?" Clearly, Richard suffered extreme embarrassment and frustration due to his erectile loss, and this created considerable distress for his wife and his marriage. Richard was angry that he wasn't one of the fortunate men to undergo prostate cancer treatment and emerge from surgery with his erectile ability unimpaired. He also admitted feeling dreadfully broken and didn't see how he would ever again be able to view himself as a fully functional man. He further described that even if he were able to regain erections by means of some assistive device, he would be unhappy because he would know that he was unable to sexually function autonomously. Richard's wife was extremely sympathetic and understanding. She understood the anguish Richard was experiencing, and she tried to offer an alternative view of being sexual. She described her great enjoyment of oral and manual sexual stimulation and tried to frame it as a "journey back in time." She fondly and lovingly recalled the times when they were dating and before they had intercourse. "I don't want to go back to having sex like an adolescent," said Richard. "Yes, but we had such fun back then," she reminded Richard. Richard looked away with contempt, and replied, "Yes, but back then there was the anticipation that we were 'going somewhere.' Now we are going 'nowhere.' For Richard, his loss of erectile functioning meant substantially more than just not being able to have erections. His changed penis represented to him an existential crisis of being insignificant, a loss of vitality, and the "death" of his youth. A therapy that focused solely on Richard's presenting symptom (erectile dysfunction) would miss the underlying existential anguish that he was suffering. Therapy for Richard, and later with Richard and his wife, consisted of a deep exploration of his fears of death, isolation, and loss of ability to connect with his wife. Once these concerns were adequately addressed, Richard was able to find meaning and connection within the constraints of his physical limitations.

Political Economist Paul Sagar (2018) notes that fear is not our lone emotion regarding death. He adds that we also may *resent* death because it is experienced as an assault on our personal agency. He submits that much of our personal distress with regard to aging and death is that it may claim us before we are ready. This loss of agency and decision-making may be perceived as a personal affront, a taking away of one's time and vitality before one is ready to let it go. He insinuates that the desire for immortality is not simply about the desire to live forever, but rather the desire to choose and control when life/sexual functioning will end. Certainly for Richard, the loss of personal agency was palpable.

Can Sex Actually Get Better As We Age?

Despite the bodily changes that will inevitably occur with aging, there are several authors who suggest that sex (and life) may actually improve with age. McCarthy and Metz (2008) describe a certain "sexual wisdom" that comes with maturity and the greater knowledge, awareness, and comfort with one's body. Sachs and Leiblum (2002) describe a woman who had become much freer and more open regarding her sexuality at age 75. She reported to them that she is no longer as concerned about what people think of her, and is much more at ease in strongly expressing herself and her opinions. One older female clinician described sex in older age as being different than the sex of youth, but no less satisfying. She relates:

Sex when you're younger is like downhill skiing—you get towed up to the top of this mountain and then, whoosh, you come straight down. But sex when you're older is like cross-county skiing. You get to take your time, see the scenery. It takes time to enjoy yourself, but in highlife, you've got a lot of time. You may be retired, or at least not tied to any schedule, and you can make love whenever you choose (Leiblum and Sachs, 2002, p.129).

Implications for Treatment:

In their book on sexuality and the context of culture, Hall and Graham (2013) note that due to the dearth of research on sexual problems in non-Western cultures, we have little knowledge or understanding of what issues may be most important for those of differing cultural backgrounds. While not a different culture, per se, our interventions for the aging are plagued by a similar lack of representative research and appreciation for the culture of aging. It seems reasonable then to advance the notion that our emphasis on the restoration of the sexuality of youth implies an inadequate understanding of the "culture" of aging. Much of what we determine to be sexual dysfunction in the aging body is in actuality quite representative of what would be expected as

dysfunction in the aging body is in actuality quite representative of what would be expected as age-appropriate developmental changes in the later stages of the life cycle. As a result, our "treatment" of the sexual problems of the elderly has largely concentrated on the alleviation of the presenting sexual symptom, and the attempt to restore prior sexual functioning. Medical approaches such as sildenafil citrate (and similar medications), penile injections, vacuum devices, urethral suppositories, penile prostheses, and assorted hormonal regimens have dominated the recent sex therapy and sexual medicine literature. In addition, Agronin (2014) describes cases in which some of the standard sex therapy techniques have been employed. Sensate focus, sex education related to normal bodily changes associated with aging, suggestions for making accommodations for chronic illness and/or pain conditions, and couples therapy have all been prescribed with varying degrees of success. While these options have undoubtedly been welcomed and appreciated by many, there are others who have found such interventions to be lacking and ultimately unsatisfying.

Among the most sex/aging-positive views of treatment is that of Barry McCarthy and Michael Metz. McCarthy and Metz (2008) and Metz and McCarthy (2007) are strong advocates of the notion that we can be happily sexual well into our 80's and beyond. They have suggested that the most important positive, realistic expectation is that we be accepting of our bodies and their changing functionality rather than fight against the natural aging process. They propose an approach to treatment referred to as "The Good-Enough Sex Model (GESM)." In the *GESM,* the focus is on enjoying pleasurable sex, as opposed to some self-defeating performance criterion. Good sex is about acceptance, pleasure, and positive (yet realistic) sexual expectations. In their model, intimacy and satisfaction are the ultimate purpose of sexual behavior, and individuals and couples are encouraged to develop their own sexual styles that reflect the realities of their changing bodies. They believe that their model encourages creativity, flexibility, and growth as aging individuals and couples explore and re-define a model of sexual activity that de-emphasizes the importance of rigid penises and well-lubricated vaginas, and instead values pleasure, intimacy, satisfaction, and acceptance.

McCarthy and Metz are not the only authors who suggest that sex in later life can be extremely pleasurable and satisfying. As mentioned earlier, Menard et al (2016) have found that contrary to popular belief, many older adults are quite capable of experiencing highly enjoyable sex. Their study found that many of the respondents credit personal maturity, receptive openness to experiences, and relationship growth as significant contributors to their sexual enjoyment. Kleinplatz (2010b) has found that aging adults who are present in the moment, experience connection, intimacy, authenticity, risk-taking/exploration, have good communication, and are willing to allow themselves to take risks and be vulnerable can find a sexual connection that is extraordinarily satisfying. Kleinplatz, (2010a), Kleinplatz et al (2009), DeLamater (2012), and Shaw (2001), call upon sex therapists to support patients as they struggle with the challenges of change, growth, and vulnerability rather than merely helping them attempt in vain to restore the sexual function of youth.

While many sex therapists would likely endorse the philosophies of sex and aging presented above, most will also voice the frustrating reality that it is often difficult to get our patients to happily accept these suggestions. If we turn back to the case of Richard above, we see a man who was unwilling to accept the notion that satisfying sex can be found in the absence of a firm penis and sexual intercourse. True, there are many who willingly accept, adopt, and appreciate the sexual changes that aging brings. However, these are rarely the individuals and couples seen in sex therapy/sexual medicine offices. We are most likely to be sought out by those who are unable to successfully navigate the inevitable changes and resulting challenges that aging bodies represent.

How, then, does the sex therapist help those who resist accepting their changing bodies find contentment and sexual satisfaction? It is noteworthy that the discussion of how best to manage this resistance seems to be absent from the sex therapy/sexual medicine literature.

The ability to accept or resist the reality of the changing sexual function of aging may lie more within the existential realm than the traditional sex therapy frame. Most sex therapists will likely first gravitate toward those therapeutic strategies that have already been noted earlier in this chapter. However, in those instances in which therapeutic outcomes are unsatisfactory, it may be the result of two important overlooked factors: the anger, frustration, and inability to grieve the loss of function, as well as the more existential dilemmas that one must confront as one ages.

As mentioned earlier, Sagar (2018) is of the opinion that humans not only fear loss, but we actually may "resent" it. That is, we may experience loss, especially loss that is beyond our control, as a personal "affront," or as an assault on our personal agency. For many of our patients, they are palpably angry about aging (or illness, surgery, etc.) robbing them of the sexual functioning they have come to enjoy and expect to maintain. They condemn and rail against the forces that frustrate them, but to no avail. If this rage, frustration, and sadness regarding the loss of functioning and youth is left unaddressed, acceptance of a new sexual script will remain elusive.

Much of this distress may also be rooted in the existential angst many find within the aging process. Early existentially oriented psychologists, such as Erik Erikson (1963) have noted that if one has not lived well, one will not accept aging well. If when reflecting on a life one believes that he/she has not led a meaningful and satisfying life, despair over a life lived regretfully will result. This principle has been echoed over the years by other existential psychotherapists, as well (Yalom, 1980; May, 1953).

Until recently, existential approaches to sex therapy have been largely ignored (Barker 2011; Kleinplatz, 2017; Watter, 2018). Yalom (1980, 2008) and Watter (2018) have suggested that much of our sexual distress is rooted in the realm of existential crises. Specifically, aging (and the awareness of an aging body) may precipitate a confrontation with the reality of one's mortality and eventual death. For many, sex represents a life force, the antithesis of death that can neutralize the terror of the end of one's existence. Yalom (2008) has described sex as "death-defeating" and often sex will be sought following a collision with mortality. In describing the relationship between sex and death, Yalom (2008) offers the following:

Sex, the vital life force, often counters thoughts of death. I've encountered many instances of this mechanism: the patient with a severe coronary who was so sexually driven that in an ambulance carrying him to the emergency room, he attempted to grope an ambulance attendant; or the widow who felt overcome with sexual feelings while driving to her husband's funeral; or the elderly widower, terrified by death, who became uncharacteristically sexually driven and had so many sexual affairs with women in his retirement community and created such divisiveness that the management demanded he seek psychiatric consultation (pp. 212-213).

Many who become increasingly aware of, and distressed about, their body's changing sexual functioning may unconsciously perceive these changes as an awareness of their aging and the creep toward death. As a result of this fearful awakening, they experience great difficulty navigating the challenges of aging and sexual function. Therefore, sex therapy for the aging may be most helpful if it focuses on the emotions associated with the distress and regrets of having not lived life well.

Existential psychotherapy in general, and existential sex therapy in particular posits that those who successfully attain the Eriksonian aspiration of integrity will have an easier time navigating and accepting the vagaries and challenges of developing new sexual scripts that will allow them to find happiness, satisfaction, and pleasure in their sexuality. It is only through the successful resolution of the existential crises of living that one is likely to be welcoming of the prospects of creating a different, but nourishing and sustaining sexual life. Given the above-mentioned principles of existential thought, the assessment process of existential therapy differs somewhat from what is considered traditional in sex therapy. Psychometric testing, DSM (or ICD) diagnoses, and extensive sex histories are seen as less important than a developmental history that attempts to identify the existential crises the patient may be struggling to navigate through. It is through the successful resolution of the existential crises of living that one becomes open to allowing oneself to be vulnerable, and willing to take the risks of allowing the past to be behind us while discovering the new and different sexual styles ahead of us.

Case Discussion:

Harold was an 82-year-old widowed man who presented for treatment after being referred by his urologist. Harold's primary complaint was that he was noticing decreased penile sensitivity that resulted in a less pleasurable orgasm. In addition, Harold complained that it would sometimes take up to an hour of masturbation to reach climax. At the time of referral, Harold had no partnered sexual activity. His wife of almost 50 years, Jocelyn, had passed away the year before, but they had not had any partnered sexual activity for the last 40 years of their marriage. According to Harold, neither seemed to enjoy partnered sex, and he derived a great deal of pleasure from solitary masturbation. His enjoyment and interest in solitary masturbation

pleasure from solitary masturbation. His enjoyment and interest in solitary masturbation continued until this past year.

At first glance, I found Harold's presentation surprising. It seemed obvious that an 82-year-old man should, indeed, be experiencing reduced penile sensation and a longer time to reach orgasm. I had expected he probably had some difficulty with erections as well, but Harold said that erections were not problematic. I assumed that much of our work would consist of some basic sex education about the normal sexual changes that an aging body will experience, and/or some unresolved grief about the death of Jocelyn, but something told me to hold my tongue and ask him more about his life. It is noteworthy that the assessment process in existential therapy differs somewhat from what is considered traditional in sex therapy. Psychometric testing, DSM (or ICD) diagnoses, and extensive sex histories are seen as less important than a developmental history that attempts to identify the existential crises the patient may be struggling to navigate through.

Harold recalled always being an "odd" person. He was never very socially comfortable, and believed he always struggled to pick up social cues. His childhood was traumatic, and he feared both his mother and father. His parents divorced when he was 11 years old, and he recalls he was a "neglected" and lonely child. He did have an older brother, but his brother was quite cruel and abusive. Harold felt like much of his life had been a disappointment. He was Ivy League educated, including a doctoral degree in English Literature. Harold hungered for a university faculty appointment, but positions in English Literature were few and far between. With a poor job market and his inadequate social skills, Harold was unable to obtain the employment he desperately wanted. He settled for a job in a library that allowed him to surround himself with books he loved, but considered the position far below what he had envisioned for himself. Harold met Jocelyn in graduate school and they married after two years of dating. He reported enjoying married life very much. Although the relationship was minimally sexual, he enjoyed pleasing his wife in non-sexual areas, and she seemed to appreciate him as well. The couple enjoyed reading, visiting museums, and attending chamber music concerts. These are activities Harold had enjoyed doing solo before meeting Jocelyn, and continued to delight in them even after her death. During Jocelyn's extended illness, Harold took great pleasure in being her caretaker, and felt as if he had little to occupy his time since Jocelyn's death. Indeed, Harold reported becoming increasingly distressed about the prospect of his own mortality following the death of Jocelyn. The couple had two children, both now grown, and both live several states away from Harold. He reported having a positive relationship with each of the children, but neither required much of Harold. They would not see each other often, but would speak by telephone on a weekly basis.

At our second session, Harold revealed his infatuation with a 15-year-old girl, who was the daughter of a family friend. Harold spoke of her in very romanticized, loving, yet non-sexual terms. He loved sending her poems, music, and books he imagined she would be interested in. She would voice appreciation for these gifts, but Harold was frustrated by her seeming lack of enthusiasm for his guidance in life matters. This was not the first time Harold had experienced such frustration. He often found himself enamored by older adolescent/young adult females, and would excitedly try to interest them in his cultural pursuits. Unfortunately, for Harold, while most of the girls were polite and gracious, none ever reciprocated his attentiveness.

Harold spent an entire session showing me pictures of his family of origin. His narratives were filled with stories of loneliness, neglect, parental fighting, and a general sense that the world was experienced as an unsafe place. He recalled a life of restraint, fear, tentativeness, loss, and isolation. Harold found his relationship with his mother particularly confusing, as her behavior toward him was very inconsistent. One moment she would be telling him that he was her best friend, and the next she would be humiliating him with insults about his looks and mannerisms. As a result, he both feared his mother, and longed for her love, attention, and approval. As he progressed through life, every rebuff reawakened his fears of not being good enough and made him acutely aware of the loneliness and isolation he endured.

Though Harold's stories were painful for him to tell, and for me to listen to, he began to report an improvement in his sexual functioning and enjoyment. Orgasm was becoming easier to achieve, and he was experiencing sex as increasingly more pleasurable. This trend appeared to continue as our sessions progressed. Harold began to reach out to friends and family he had not communicated with for several years. He still enjoyed his solitary time, but reported

experiencing a newfound enjoyment in social interactions. He joined a hiking group and decided to try on-line dating. One afternoon, while picking up his dry cleaning, he began a conversation with a 31-year-old woman, Sami, who was working behind the counter at the drycleaners. Harold found Sami to be extremely attractive and friendly, and he began making frequent trips to the drycleaners. One day, Harold decided to ask Sami out for lunch. To his great surprise, she accepted. Harold was very, very excited and began looking forward to seeing Sami socially. Sami was a recently divorced, mother of a young girl, who had recently moved to New Jersey from Oregon. She knew few people in the area, and was also a bit of a loner. She and Harold began seeing each other frequently, but the relationship remained platonic. Apparently, Sami saw Harold as a mentor and supportive friend. For his part, Harold had more romantic feelings toward Sami, but much as in his marriage, he did not crave partnered sex. Rather, he discovered a feeling of "aliveness" in his relationship with Sami and he relished her appreciation of his cultural sophistication, and her enthusiasm for accompanying him to museums, films, and concerts. Harold reported a significantly enriched sexual enjoyment through masturbation, as well as a generally enhanced overall life satisfaction. Harold's relationship with Sami flourished for approximately 8 months, after which Sami relocated back to the West Coast to be closer to her sister and her sister's family. While disappointed at not being to see Sami regularly, Harold recognized that his relationship with Sami "brought him back to life," and provided him with a renewed sense of "meaning." Harold reported feeling like a "wet blanket" was lifted from covering him, and he found much greater enjoyment in his days. He felt much less lonely, and his fear of his own death substantially diminished. Harold and Sami maintained regular contact via Face Time, and Harold continued pursue limited social opportunities with verve. Sexually, Harold was also quite content.

This case illustrates that for many aging patients, their loss of sexual functioning can have meaning that goes well beyond the sex per se. For Harold, sex represented life and vitality, and the loss of his sexual functioning was representative of his isolation, loneliness, and mortality.

Summary and Conclusions:

Sexuality remains an important part of life throughout the lifecycle. The perception that aging represents a "disease" or a "defect" that needs to be resisted must be challenged and contested. Studies have shown that almost 75% of the elderly population in North American and much of Europe report that sex is important to them, and that they experience a high degree of sexual satisfaction. This chapter has further explored the existential dilemmas and crises the aging process will create for some individuals and couples. The implications for sex therapy and sexual medicine practitioners include the need to look beyond our existing sexual scripts that glorify the sexuality of youth while demonizing the sexuality of aging.

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