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ORIGINAL ARTICLE

Sexual intimacy and aging: An integrative framework to promote intimacy resilience in couple therapy

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Abstract

In our work at the *Intimacies Project* at The Ackerman Institute for the Family we became aware of a gap in attention about sexuality and aging in the couple and family therapy field. In this article, we provide an integrative framework to guide therapists on how to address problems of sexuality and aging in the therapy room. Starting from considerations about the *social context of aging* and *the self of the therapist*, we contend that when normative sexual challenges become entangled with stigma, misconceptions about sexuality, limiting gender narratives, vulnerabilities, and defensive postures, they often result in emotional and sexual shutdowns. Through a combination of *the vulnerability cycle* with an expansive *definition of sexuality*, we demonstrate how we deconstruct impasses, disentangle normative quandaries from reactive dynamics, and help couples transform their sexual narratives. We outline how we conduct individual sessions to obtain relational sexual histories, utilize Sensate Focus as a mindful touch exercise, and help partners expand their sexual menus beyond *penetration and orgasm*s. We also describe relational skills that may need to be strengthened to help aging couples deal with the ebb and flow of intimacy, sustaining resilience over time.

KEYWORDS

aging, couples therapy, integrative clinical framework, sexual intimacy

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[Correction added on 20 April 2022, after first online publication: Acknowledgements has been moved as footnote on page 1 and footnote has been corrected in this version]

INTRODUCTION

> Life is a process of becoming, a combination of states we have to go through. Where people fail is that they wish to elect a state and remain in it. This is a kind of death.
>
> Anais Nin (1964)

In the last few decades, the *zeitgeist* about sexuality and aging has changed significantly. Thanks to burgeoning advances in public health and medical fields, many of us are being granted "extra life" (Johnson, 2021). Through prevention, mitigation of serious illnesses, and repair of old age disabilities (joint replacement, heart valves, cancer treatments, surgeries, medications, and more), we are living longer than any previous generation. Seniors today run marathons and remain involved in political, academic, and creative endeavors through their 70s, 80s, and even into their 90s. Moreover, within this extended life span an increasing number of older adults are dating, marrying, and remarrying, striving to maintain sexuality and intimacy until the end of life.

An evolving narrative about life after 60 has emerged in the popular culture. Movies like *Something's Gotta Give* (2003) and *The Best Exotic Marigold Hotel* (2011) as well as television series such as *Grace and Frankie* (2015–present) and The *Kominsky Method* (2018–present) show the trials and tribulations of older adults and their love lives. The proliferation of dating sites like Sixty and Me, Our Time, and Silver Singles also testifies to the quest for intimacy in later years. A groundbreaking photographic study by Arianne Clément (2020), *Sexy at 100*, breaks traditional molds when it portrays octogenarians, nonagenarians, and even centenarians expressing sensuality and sexuality irrespective of their age.

Studies in adult development suggest that aging well is not simply a matter of genetics. Instead, it relies on cultivation of habits such as eating well, physical and intellectual activities, creativity, and participation in social networks (Vaillant, 2002). In addition, current research points to a strong correlation between healthy aging and the quality of intimate relationships (Jia & Lubetkin, 2020; Lindau & Gavrilova, 2010). In spite of this evidence, the field of couples therapy still lags behind in supporting older adults of all sexual orientations in dealing with dilemmas of sexual intimacy in their lives.

In this article, we highlight the need for attention to this growing population. In Part One we outline myths and challenges that constrain older adults' sexual experiences and propose how therapists can position themselves to create a conducive therapeutic setting. In Part Two, we describe an integrative conceptual/clinical framework to guide the therapist on how to help couples move from impasses to more vitality and intimacy in their bonds.

PART ONE

Ageism and the erotic marginalization[1] of the old

The prevailing creed in Western societies has been that older adults are not interested, cannot, or should not have sexual feelings and sexual relationships. On a daily basis we encounter stereotypes such as the "dirty old man," or the "desperate old crone," where the subtext is a notion that older adults who persist in having sexual feelings are sordid and despicable. We are also impacted by cliches proclaiming that "sex is for the young," "post-menopausal women

[1]We borrow this term from Constantinides et al (2019) who use it to refer to LGBTQ people at risk of marginalization both inside and outside of the therapy room.

are no longer sexual beings," and "real men are always ready for sex." Lesbian couples are often typecast as inevitably succumbing to "bed death." These subliminal preconceptions keep older adults from talking about their sexual feelings and dilemmas, both inside and outside the therapy room.

Therapists' biases and omissions

Research shows that a great majority of older adults, especially those who are healthy and have partners, practice sex until late in life (Harvard Health Publishing, 2017; Kinsey et al., 1948, 1953; Masters & Johnson, 1966; Starr & Weiner, 1981). Many sexologists emphasize that sexuality is actually among the last of our faculties to decline with maturity (Bouman & Kleinplatz, 2015; Kaplan, 1990; Schwartz, 2016). As therapists working with older adults, self-awareness of implicit biases is one of the most critical elements in the creation of a therapeutic setting where sexual experiences can be discussed freely.

Many therapists not trained in sex therapy are unsettled by feelings of anxiety, envy, arousal, inhibition, and disgust when working with matters of sexuality in couples therapy. This quandary tends to be even worse when the couple is older and the therapist ignores their sexual life altogether. One of our team members described the intense reactions she encountered while showing a videotape of a couple in their mid-70s to master level students in their 20s and early 30s. They were dumbfounded that "these two very old people still wanted to have sex." One student was affronted by the notion that the couple needed to schedule sex so the husband could take Viagra: "This is crazy, sex should be spontaneous!" Another student was put off by the couple's explicit negotiations about their changing sexual needs: "It's like they're talking about tax returns!" Still another student went as far as to say: "If talking to old folks about sex is part of the job, I don't want to be a couples' therapist!" These reactions of disgust, if not deconstructed and tempered, are clearly the most serious barriers to helping couples address sexual dilemmas.

In addition, there is an assumption in the couple and family therapy field that if we address the couple's emotional and communication difficulties, their sexual problems automatically disappear without needing to be directly addressed. We know today this is not the case and that, in order to help couples resolve sexual issues, the therapist must be able to track their sexual interactions and talk about their specific sexual preferences, fantasies, practices, and desires. She must also understand their dilemmas within the context of their relational and power dynamics.

Creating a conducive therapeutic setting

> … let us recognize ourselves in this old man or in that old woman. It must be done if we are to take upon ourselves the entirety of our human state.
>
> Simone de Beauvoir, 1968

In order to help older couples deal with their sexual dilemmas, the therapist must be able to step out of the toxic environment that surrounds older adults and become curious and open about details of the couple's sexual life. This preparation involves a process of self-reflection that includes personal questions such as: What is *my* first memory of sexuality? What did I learn about sex when I was growing up? How was sexuality connoted in my family, community, culture, or religion? What are my inhibitions, discomforts, and fears? Have I experienced sex as disgusting, painful, or traumatic? Questions such as these help the therapist locate personal

narratives and experiences that will inevitably be carried into the therapy room. In addition, in order to provide a conducive environment for the partners to consider a *wider sexual menu*, the therapist must be able to convey respect for diverse types of sexualities and preferences that may be quite different than his or her own.

Through a mix of colloquial, scientific, and playful language, the therapist must be able to guide the couple to talk about their specific sexual preferences and initiate new conversations about potential use of sexual toys, pumps, rings, injections, Viagra, lubricants, dilators, vibrators, and other countless options. The sexual menu needs to include *relational items* such as foreplay, role play, fantasy, sensual experiences, and desires for seduction inside and outside the bedroom. It may involve *emotional considerations* that are unique to each partner such as yearnings for romance, tenderness, transgressions, and even aggression. The menu must also take into account a partner's need to manage vulnerabilities related to past sexual traumas, with reconsideration of who will be in control and who will relinquish control (Bader, 2002; Iasenza, 2020).

Life cycle challenges that come with age

In addition to self-awareness, the therapist must be knowledgeable about the challenges that come with age. Life after 60 typically includes losses and vulnerabilities. Couples face empty nests, retirement, relocations, illnesses, disabilities, widowhood, and the death of parents and close friends. There are also many physical changes—gray hair, sagging skin, weight fluctuations, minor and major medical conditions, diminishing hormonal levels, lower libido, and less energy. On the social level many older adults deal with a progressive sense of isolation, invisibility, and being superfluous. These changes are often experienced as a sense of decline and can be quite disorienting. Moreover, on the existential level, with the clock ticking louder than ever, the partners come face to face with the limited amount of time that lies ahead. In order to help couples maximize vitality in this stage, the therapist must authentically recognize their inevitable quandaries, yet support the partners to seize the day, see possibilities, and remain true to what is most important to them in their lives.

Physiological changes, illnesses, and disabilities

As we age, we experience changes in our sexual responses. Due to waning hormones, sexual arousal often requires more stimulation, reaching orgasm may become more laborious and intercourse may become difficult for one or both partners. Many men experience some degree of erectile difficulty, while many women experience thinning of the vaginal walls and dryness that promote pain during intercourse. These physical changes can make penetration difficult for both men and women and particularly stressful to those couples whose sexual scripts have been dependent on penetrative sex (Kurner, 2021). When these predicaments are not identified and acknowledged, they tend to promote mystification, sexual avoidance, and blame.

Older adults are also impacted by medical interventions that compromise sexual enjoyment. Pharmacological interventions, such as psychotropic and heart medications, as well as the effects of cancer treatments and surgeries—prostatectomies, hysterectomies, mastectomies, and heart stents—can adversely impact sexual functioning and experience. Disabilities such as back and joint pains can easily interfere with the couple's usual sexual practices. Moreover, chronic illnesses such as Parkinson's, Alzheimer's and dementia generate complicated ethical dilemmas in which the partners may need to deal with matters of sexual consent and/or decisions about remaining monogamous when the partner is chronically ill, disabled, or going through a prolonged process of dying. When one partner is suffering from a chronic or

terminal illness, and the other is in the role of caretaker, it is crucial for the therapist to offer individual sessions given their different needs and dilemmas (Rolland, 2018).

In working with an older population, there is a psychoeducational dimension to the therapeutic work that is critical for clarification of misleading assumptions and mythologies (McCarthy & McCarthy, 2022). Rolland (2018) emphasizes how important it is for the partners to get clear medical information from their doctors about their specific illnesses, disabilities, and medications that might be affecting them sexually. For instance, chemotherapy and radiation can result in diminished sexual desire and cause serious fatigue. Prostate cancer surgeries, MS, and diabetes typically impact erectile and ejaculation functions. Mastectomies often promote body image insecurities that can promote sexual inhibition and shame. Medications for depression and hypertension tend to compromise libido, ejaculation, and the ability to reach orgasms. Therapists also need to seek information about pharmacological and medical issues in order to appreciate the couple's dilemmas and to know when to encourage the partners to consult with their medical providers for assessment and possible interventions (i.e., Viagra, hormone replacement therapies, reconstructive surgeries, etc.).

As we work with couples dealing with physical limitations, it helps to convey the narrative that "... as long as we have a body, we have the potential to experience sensual and emotional pleasure, no matter how well our parts function" (Iasenza, 2020). Therapists can also remind the partners to stay focused on their available sensual experiences in the here and now rather than postpone pleasure based on the illusion that they will someday recover the zest of their youth.

The case of Joana and Pedro illustrates these points. Both partners were 78 years old when they sought couples therapy, two years after Joana had back surgery. They tried having intercourse after the surgery, however, Pedro's weight caused Joana great pain. After a few attempts they concluded their sex life was over. Cognizant about the importance that sex had for this Brazilian couple, the therapist asked each one to make a list of sensual pleasures they had enjoyed in the past. Although initially reluctant, Joana shared: "I love lots of kissing, petting and sensual massages like we used to do when we dated!" Pedro added that he enjoyed taking showers together and loved manual stimulation, which they had put aside for many years. Through this simple exercise, the therapist helped them expand their sexual menus, go from intercourse to "outercourse" (Klein & Robbins, 1999) and renew their ways of being sexually connected. On their way out the door, Joana commented playfully: "It's fun to mess around and pretend we're teenagers again."

Body image

In almost every culture, a subjective sense of our bodies as appealing is critical for our confidence and willingness to be sexual with others. For many women, and also many gay men, this sense of confidence is often trumped by the predominant socially constructed narrative in which wrinkles, gray hair, and/or weight changes in later life are conceived as serious departures from what is considered ideal. Even though our notions of beauty are slowly changing to include a diversity of body types, sizes, and races, we still live in a global culture that portrays beauty as young, light-skinned, and thin.

Heterosexual women of all ages, more so than heterosexual men, tend to suffer a great deal from insecurity and shame about their bodies (Roy et al., 2016). Starting in adolescence, irrespective of ethnic and cultural backgrounds, women become preoccupied with their perceived imperfections and loss of youth. One attractive 25-year-old came to therapy distressed about a few lines showing under her eyes. Another client, a former professional dancer, talked about her increasing alienation from her body as she gained ten pounds after menopause. Still another client, a 60-year-old woman, youthful and fit, announced that she was "closing shop;"

she was too old to have sex ever again. For these women, feeling unworthy and self-deprecating were major blocks in engaging sexually with their partners.

Conversely, several of our male clients have talked about feeling shame about their erectile difficulties and diminished desire. Comparing themselves to younger men, or to younger versions of themselves, their preoccupation was with their performance, virility and identity as "a real man." In order to help couples cultivate intimacy, the therapist must challenge these narrow standards about appearance and performance, and support narratives based on pleasure and connection. The therapist must help women shift from seeing themselves primarily as sexual objects and embrace instead a vision of sexuality in which they are the protagonists attending to their own subjective sense of pleasure and connection. When interviewed about women over 60, Jane Fonda explained, "Our joints may ache and our eyesight may dim, but our hearts and minds may be primed for deeper intimacy than we've ever experienced before…. After 60, we know who we are, we can let go of gender roles, we know better what we want, we tell it as it is, we have more time to play, we don't hold back, and we are primed to focus on the moment" (Goudreau, 2011). Therapists may also need to help male clients to develop a new sense of sexuality in which connection and intimacy are priorities, rather than performance and competition.

Letting go of earlier gender roles, precepts, and expectations

Older couples are often hard pressed to re-evaluate gender roles scripted in the past that no longer work for them. Marcia and Paul, a biracial couple in their mid-60s, requested couple therapy due to their dwindling sexual activity. Throughout the marriage they had a very active sexual life in which Marcia sought to please Paul with her attractiveness and availability while Paul was the pursuer and the one in charge. Although Marcia was orgasmic with masturbation, she never taught Paul how to arouse her. Although Paul cared about being emotionally attuned, when it came to sex his focus was on frequency and performance. As they aged, and Paul developed erectile difficulties, he became increasingly reluctant to initiate sex. This left Marcia feeling sad and rejected. The therapist prescribed a homework task in which they would reverse roles. Marcia would initiate sex and guide Paul on what to do to please her; Paul would follow her instructions. This task stirred up anxiety in both. Marcia was concerned that by assuming a position of control, Paul would feel "unmanly"; Paul was concerned that Marcia would not be able to direct the show. Indeed, in the first couple of weeks doing this exercise Paul reported feeling criticized by her commands. Over time, as the therapist highlighted a narrative of self-discovery and new pleasures, both began to relax. After a few weeks doing the exercise, a positive cycle began to evolve. The more Paul was able to let go of control and follow Marcia's lead, the more pleasure Marcia experienced, which reciprocally turned Paul on. Both were surprised and aroused by these changes.

PART TWO

The couple therapy/sex therapy divide

In a groundbreaking article Kaplan (1990), a psychoanalytic sex therapist pioneer, broke the silence about older adults' sexuality when she highlighted the fact that loss of sexuality is not an inevitable aspect of aging. In fact, a great majority of older adults, especially those who are healthy and have partners, remain sexually active into their 70s, 80s, and even into their 90s. Kaplan was clear about the inevitability of physiological changes that come with age. However, she was able to see that there is a layer of psychosocial stressors—misinformation,

stigma, inhibitions, and self-esteem—that need to be considered. This psychosocial layer is amenable to psychotherapeutic change and must be addressed in the process of therapy.

In the following thirty years, many sex therapists followed Kaplan's footsteps. They went on to change the landscape of sex therapy (Fleishman, 2020; Loulan, 1984; Pope et al., 2007) and many addressed sex and aging from an educational perspective (Brick, 2009; Butler & Lewis, 2002; Fleishman, 2020; Price, 2006). Using an intersectional lens, Fleishman (2020) and Harvey et al. (2022) identified unique psychosexual dilemmas of older LGBTQ couples, pointing out that when internalized stigma about aging conflates with homophobic prejudice, sexual and relational problems tend to escalate.

In spite of these developments in the sex therapy field, a clinical divide between couple and sex therapies remains, shortchanging all those couples who come to couple therapy with sexual/ relational issues intrinsically entangled. While sex therapists are good at dealing with sexual behavior, they usually have little training in interactional and relational dynamics from a systemic perspective. Conversely, a great majority of couple therapists have no training in sex therapy and remain silent or uncomfortable talking about sex in the therapy sessions (Iasenza, 2010). This divide is also reflected in the couple therapy literature which, with a few exceptions, lacks an integrated conceptual and clinical framework to orient the therapist on how to navigate the delicate terrain of sexual intimacy.

Among these exceptions in the couple and family therapy field is the groundbreaking work of David Schnarch (1991) who utilized a Bowenian approach to understanding sexual concerns. Similarly to Kaplan, McCarthy and Pierpaoli (2015) underscored the biophysiological, cognitive, emotional, and social changes that often thwart sexual pleasure in later life. They emphasized that when couples acquire *psychosexual skills* such as embracing physical changes, communicating well, and seeing the partner as a "sexual friend," they can prevent dysfunctional dynamics and cultivate pleasure at any age. In a recent book, McCarthy and McCarthy (2022) offer their knowledge and wisdom to a general readership. In a psychoeducational style, they confront myths and misconceptions about sexuality and aging and propose a view of *good enough sexuality* that is based on pleasure-oriented touching rather than focused on intercourse and orgasms. Also recently, Johnson et al. (2018) have been making an effort to bring sexuality into the EFT model. In a forthcoming *Clinical Handbook of Couple Therapy* (edited by Lebow & Snyder, Fall 2022) several authors address topics related to sexuality and aging that are relevant to working with couples in later life.

Our integrative framework

In the *Intimacies Project*, in addition to incorporating a psychoeducational dimension to our work based on all these relevant contributions, we combine ideas from the couple and sex therapy fields into one overall conceptual framework and clinical approach. We integrate the Vulnerability Cycle (Scheinkman & Fishbane, 2004) with an expansive conceptualization of sexuality (Iasenza, 2010, 2020), to help couples deconstruct impasses, expand their sexual narratives, and strengthen relational skills that will help them sustain pleasure and intimacy resilience over time.

In a nutshell, the Vulnerability Cycle is a systemic/intrapsychic framework (Scheinkman & Fishbane, 2004) that describes critical relational processes that keep couples locked in impasses. We use the VC here as a map to guide the therapist on how to track reactive interactions, identify vulnerabilities and defensive behaviors that are being triggered, and bring forward resonances that may be contributing to the couple's reactivity and escalations. We integrate the VC with an expansive definition of sexuality that allows for diversity of preferences and practices beyond penetration, intercourse and sex always culminating in orgasms. This broader definition, long recognized in the LGBTQ community, is based on notions of *willingness* and *sexual menus* (Iasenza,

2010, 2020). It defies traditional models of sex therapy that presume that healthy sex must follow a single sequence of desire, arousal, penetration, and orgasm. Our expansive definition underscores the perspective in which, in addition to anticipatory desire, partners may initiate sex for many other reasons including a wish to feel close, celebrate a special occasion, repair their bond after a fight or participate in a sexual routine that gives them pleasure. Furthermore, sex that is based on willingness, rather than spontaneous desire, tends to foster greater frequency, and a wider scope of sensual experiences (Iasenza, 2010, 2020). This ample definition is helpful to adults in any life stage. However, its *plasticity* is particularly well suited for aging adults whose physiological and emotional vicissitudes require flexibility and revision of their practices.

As a final point, our integrative approach is grounded in a broad multicultural framework that considers both the therapist's and the partners' notions about intimacy to be informed by sociocultural and gender narratives (Scheinkman, 2019). With this awareness in mind, we are careful not to proselytize. Instead, we aim at helping partners define what is pleasurable and desirable *for them*. On this basis we facilitate negotiations toward a joint vision of sexual intimacy.

From impasses to intimacy: A road map for the therapist

In order to deconstruct couples' impasses, neutralize persistent reactivity, and stimulate intimacy, we consider several steppingstones in the therapeutic process:

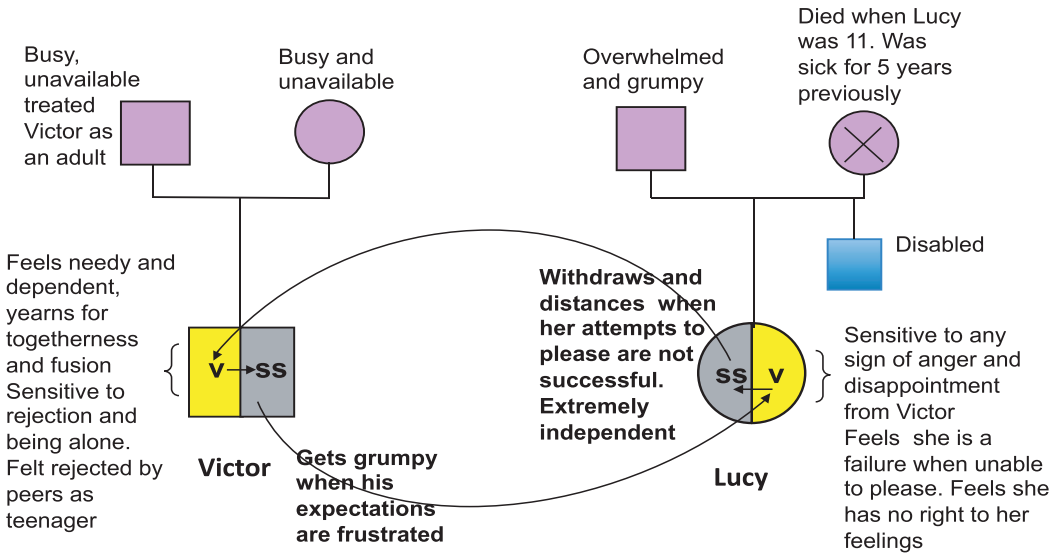
A Mapping the couple's vulnerability cycle
B Identifying overlaps of meaning between present and past
C Underscoring strengths in the couple's relationship
D Transforming sexual narratives
E Strengthening relational processes that support intimacy resilience over time.

Mapping the vulnerability cycle

From the beginning of therapy, we try to understand if and how the couple's presenting problem is embedded in an interactional/relational dynamic that is contributing to their derailment. We consider two axes of clinical exploration. On a *horizontal level*, we focus on the couple's interactions in the here and now and the impact of various ongoing contexts. After asking the partners for specific examples of the problem, we track their sequences of actions and reactions and demonstrate to them the inefficacy of their circular pattern. For instance, we may show them how the more James blames Brian for their sexual problems, the more Brian evades, and the more Brian evades, the angrier James becomes. In order to help this couple sidestep these pernicious dynamics, we mentalize (Fonagy et al., 2002) the vulnerabilities that are being stimulated in each partner, pointing out to them how their survival strategies are keeping them stagnant. Still on the *horizontal level*, we try to understand how their interactional dance might be reinforced by narratives and stresses emanating from their sociocultural, gender, racial, and bio-medical contexts.

As we ascertain the couple's current relational pattern, we shift our attention to a *vertical axis*. On this level, we focus on each partner's sexual relational history in terms of relevant narratives, injunctions, or traumas in the past that may be resonating with their present dynamics. We also explore the potential impact of multigenerational legacies and patterns. As shown in the diagram below we utilize the vulnerability cycle diagram to map all these critical processes informing the couple's dynamics.

Victor and Lucy's Vulnerability cycle



While some couples come to therapy caught in a conflictual pattern, others find themselves in a predominantly pursuer/distancer dynamic, while others are mostly trapped in mutual withdrawal and evasions. Irrespective of their ostensive interactional pattern, whenever a couple finds themselves locked in mutually reinforced reactivity, we consider they are trapped in a vulnerability cycle that interferes with their ability to reflect and make thoughtful choices about their relationship (Scheinkman, 2019). Consequently, our primary goal on the clinical level is to disarm the couples' reactive interactions and encourage the partners to relate to one another from positions based on vulnerabilities, desire, and yearnings. We see these therapeutic steps as critical for the promotion of dialogue and co-construction of a better intimate fit between the partners (see Scheinkman, 2008; Scheinkman & Fishbane, 2004).

Victor and Lucy are a white, educated couple, originally from working-class backgrounds. They came to see us at the clinic due to the "enormous stress" they were experiencing around their sexual relationship. In their mid-70s and married for fifteen years, they led a bohemian life in retirement in which they spent much of their time exploring the arts and participating in grassroots activities in their community. They complained their sex life had been challenging from the beginning, but recently it had pushed them into a serious crisis. Victor lamented, "It is not a matter of no sex, we've stopped touching altogether!" Lucy explained, "Intercourse with Victor has always been painful because I have vaginismus, but lately sex is just pressure and frustration." Over the years, Lucy had tried to "fix the problem" by using lubricants, vaginal dilators, and trying to spice up their sex life with playfulness and fantasy. However, over time, as she realized that her attempts to please Victor were futile, she stopped trying. Victor experienced her sexual withdrawal as a major rejection; Lucy saw his constant moodiness as the main reason why they "would not make it."

In the first session, the therapist was able to see that this couple was caught up in an escalating cycle. The more Victor acted dissatisfied and grumpy, the more Lucy withdrew, the more Lucy withdrew, the more grumpy and outwardly angry Victor became. In order to interrupt this pattern, the therapist identified their respective defensive positions and demonstrated to them how their strategies were not only unproductive, they were actually making things worse. Trying to mentalize Victor's vulnerabilities, the therapist asked, "Could it be that beneath all this grumpiness, you feel lonely? neglected? perhaps rejected?" Nodding his head vigorously he said: "YES! YES! And YES!" Turning to Lucy, she inquired, "Could it be that underneath

your withdrawal you are feeling helpless? That you will never be able to make Victor happy?" Taking a deep breath, Lucy exclaimed, "I've tried everything I can to make him happy, but this past year, when I turned 75, I realized I can't go on living like this, with so much anger." In a wounded voice, she turned to Victor and cried out, "Maybe I am not the woman you want!".

When the therapist inquired about their attempted solutions, Lucy bemoaned, "Initially we tried to talk about our sex life but talking only made things worse; all we did was fight and blame each other." She admitted that at some point, to prevent these painful interactions, she began to "hedge around." Victor was relieved to hear that she was aware that she had been evading. "I understand you want to avoid our fights" he said, "but when you hedge around, I feel even more unwanted than when we started." Punctuating their interactions, the therapist demonstrated to them how their actions and reactions were interlocking, promoting increasing misunderstandings and derailment.

Identifying overlaps of meaning between present and past

As we highlight to the couple how their survival strategies are ineffective, and help them articulate vulnerabilities that are being triggered, we focus on how their entrenched positions in their dynamics might be reinforced by resonances coming from their sociocultural context, and/or difficult experiences in their past. At this point, we invite the partners to individual sessions in order to obtain their sexual/relational histories.

We typically use two or three individual sessions with each partner (Iasenza, 2020) to explore their *sexual relational histories*. It is our experience that, in the privacy of these sessions, each partner is able to reveal delicate emotional and sexual material without preoccupation with or interference by the other.

The sexual relational history typically begins with questions: "What is your earliest memory of sexuality?" "What were important experiences that impacted you personally and sexually as you were growing up?" "What were the stories created to explain them?" Typically, powerful narratives emerge about divorces, illnesses, deaths, boundary violations, rejections, shame, and other traumas.

An important focus of the therapist is to identify overlaps of meaning in which the couple's present dynamics evoke similar emotions and perceptions the partners experienced in their past. The therapist elicits these connections through questions such as: "You often talk about 'feeling criticized and humiliated' by John' jokes; is this a familiar feeling you experienced in other relationships? How early in your life do you remember having these feelings of humiliation? What was going on in your life when you originally had these feelings? How young were you when you first felt this way? How do you think these early experiences might be affecting your sexual interactions now?"

As the partners gain insight about their vulnerabilities, and the contexts in which they emerged, they usually become better able to discern what is going on *now* from what happened *then*. This process of differentiation often allows embedded narratives to lose their grip.

In addition to disentangling present feelings from past experiences, the therapist explores how the person learned about sexuality, how they have felt about their bodies, and what is pleasurable and unpleasurable to them. She is curious about fantasies, secrets, hopes, and desires that inform their positions with one another and also their mindsets. Although our policy is to maintain confidentiality about what is disclosed in individual sessions, we encourage the partners to share insights about those specific overlaps of meaning that might be fueling positions in their cycles.

After identifying Victor and Lucy's vulnerabilities and survival strategies, the therapist went on to explore if and how their entrenched positions were reinforced by aspects in their social context and/or resonances from their past. In an individual session, as the therapist

was trying to understand Lucy's tendency to withdraw and to distance, a powerful story emerged. At age seven, Lucy's mother became terminally ill and thereafter was unable to care for the family. In response to her mother's decline, Lucy's father became depressed and often "very grumpy." In order to protect both parents, Lucy learned to "walk on eggshells." put her needs aside and keep distance from both parents, in order to protect them but also to protect her own self. This strategy was later reinforced by her stepmother who conveyed to her that, "To hold a man, you must please and defer." These early experiences made it natural for her to over-accommodate to Victor. Yet she held enormous resentment and a wish to run away. As the therapist highlighted the overlap between her present situation and her history, Lucy could see how her frustration toward Victor was infused by emotions from her past.

In individual sessions with Victor, the therapist questioned the feelings of rejection he often experienced with Lucy. He volunteered that he knew these were very old feelings and told the following story: when he was eleven years old, his family moved from a politically charged working-class neighborhood in Chicago to an apolitical middle-class suburb in New Jersey, where he felt ostracized for his radical ideas. He recounted several incidents in which he felt misunderstood by his teachers and bullied by his peers, leading him to become shy and reclusive. In adolescence he longed to have a girlfriend but passively waited for girls to approach him. When this did not happen, he felt rejected and "grumpy." In the session, he had an "aha" moment, recognizing how these old experiences were amplifying the rejection he felt with Lucy.

As Lucy and Victor began to see their present situation unencumbered by these phantoms from the past, they felt freer and more able to see their sexual difficulties as being primarily based on vicissitudes of aging. At this juncture in the therapy, they were able to talk about new sexual scenarios with a sense of adventure.

Underscoring strengths in the relationship

In addition to exploring the couple's impasse in detail, the therapist must also focus on the strengths and resources in the relationship that can empower them to solve their problems.

In the first session, Lucy and Victor described themselves as being in "free fall." They alternated between bickering and distancing and doubted the viability of the relationship. They claimed they had been unhappy for several years, however, on her 75th birthday, Lucy announced she was moving out. Recognizing the couple's problem-saturated presentation, the therapist sought to draw out their resources and strengths by asking, "What attracted you to each other when you first met?" and then, later on, "Can you help us understand what has kept you in this relationship all these years?" The couple's answers radically altered the atmosphere in the therapy room. Lucy stated, "Victor and I are two peas in a pod." She went on to say that they were uniquely compatible in terms of political and ethical ideals, enjoyment of the same friends, and they had a similar penchant for adventure and travel. They valued time with family, and the fact that Victor was a grandfather made Lucy a happy grandmother by association. Lucy described Victor as "the smartest partner I ever had." Victor was clearly pleased by her comments and added, "Lucy not only gives meaning to my life, she organizes my very existence!" Both agreed they should be capable of happiness together but the tension around their sexual relationship had become so toxic and so pervasive that it was contaminating every aspect of their lives.

To highlight strengths in the relationship, the therapist reframed their situation: "Your sexual difficulties have become such a monster! And the worst part is that this monster is eclipsing all these amazing rays of light that still emanate from your bond. You are telling me that you admire each other, you share so many interests, the same worldview, and you thrive in your

complementarity! What we need to figure out here is what is going on in your sexual relationship and how come it exerts such ominous power."

Transforming sexual narratives

The process of transforming sexual narratives requires a movement away from judgments of right and wrong, or "this is the way it should be," toward notions of sensual pleasure and intentional co-creation of intimacy. Many older couples find themselves trapped in limiting narratives such as "real sex equals intercourse," or "sex should be passionate to be worthy, as it was in our youth," or "sexy women must have orgasms with penetration," or "real men are always ready for sex and erect." When older couples are able to forgo these preconceptions and initiate sex on the basis of willingness and a desire to be connected, they tend to diminish their tendency to blame the other and increase their frequency of lovemaking (Iasenza, 2020).

Sensate focus is a technique developed by Masters and Johnson (1966) meant to encourage couples to move away from pass/fail standards and stay focused on their feelings and sensations in the here and now. They proposed for couples to engage in weekly exercises in which the partners would take turns touching each other's bodies, starting from nonerogenous zones and moving progressively, week by week, to the ultimate goal of having intercourse (Masters & Johnson, 1966). Iasenza (2020) reconceptualizes sensate focus as a "mindful touch" exercise in which the weekly tasks given by the therapist do not have to progress necessarily from nonerogenous zones toward genitals, penetration, and orgasm. Instead, she emphasizes a mindfulness dimension in which she instructs the partners, while touching one another, to become conscious of the "noise going on in their heads." Through homework tasks and private journaling afterwards, she asks each partner to track the thoughts, emotions, sensations, vulnerabilities, and fears that may be distracting them from staying present. The major point of the exercise is to help partners become aware of narratives that interfere with pleasure and connection. She asks them not to discuss their reflections at home, and instead directs them to bring their notes to the therapy sessions so they can be processed individually or conjointly depending on the situation.

In our project, we have utilized sensate focus flexibly, with different goals in mind. For instance, many couples come to therapy after several months or even years of not having had sex with each other. In these situations, sensate focus is a useful device to disrupt their existing alienation and offer them an entry into the realm of body-to-body connection. For some couples, the structured dimension of the exercise is what ends up being most helpful. For example, the instruction of a five-minute time limit for each partner to provide touch, and then five minutes to receive touch, combined with clarity about who will go first and second, can offer the partners a safe container that diminishes worries about starting and ending the encounter.

Victor and Lucy's narratives about their sex life were a big part of their problem. Victor had rigid preconceptions that sex should be spontaneous, pleasure should be simultaneous, and sexual encounters should always culminate with intercourse to be considered "real sex." Since sex between Victor and Lucy did not follow these scripts, over the years he was convinced that there was something seriously wrong between them. Lucy, however, assumed that for them to have pleasure they needed to be more playful and indulge in joint fantasies. She had tried to involve Victor in imaginary sex plots, to no avail. Victor found her plots to be "artificial and silly" and they actually made him feel unseen. Moreover, Lucy's opinion that "simultaneous orgasms are a fiction," left him feeling criticized and profoundly disappointed. Over time, they had settled for a narrow sexual script of manual stimulation and frustrating attempts at intercourse. In neither of these were they particularly pleased. In addition, Lucy was unhappy about the tension that emerged between them every time she tried to conclude their sexual encounter in order to go to sleep. Victor felt rejected by her "interruptions" and by what he

considered to be her "mechanical behavior" during sex. He wanted her to remain fully present until he reached orgasm. After their sexual encounters Victor was usually in a bad mood, for several days, which would trigger Lucy's frustration that she would never be able to please him. As their postures of "grumpiness" and "avoidance" became calibrated and mutually reinforced, they remained skeptical about the viability of their relationship.

In order to challenge their narratives and postures, the therapist prescribed sensate focus, with an emphasis on mindful touch. Her instruction was for them to take turns touching each other in nonerogenous zones for three minutes each. She asked them to keep a journal about their feelings and thoughts, paying special attention to the "noise in their heads" interfering with them remaining present. The therapist's intention was for them to re-engage physically, diminish the pressure they had built around intercourse, and stay close to their sensations rather than to their "shoulds" and grievances. Victor became clear that his preoccupation with intercourse and orgasm was indeed detracting him from the simple pleasure of being physically connected to Lucy. In a parallel way, Lucy became aware of a harsh critical part of herself that became activated whenever she was trying to please Victor and he acted frustrated or disappointed. In addition, the structured nature of the exercise, in which they would do the homework twice a week for total of 6 minutes each time, had an interesting paradoxical effect. To our surprise, Victor and Lucy defied the therapist's instructions and together they chose to devote 20 to 30 minutes to their homework, five times a week. Over time, their little act of independence eroded the problematic narrative of "sex must equal intercourse," and initiated them on a new path focused on sensual connection.

Strengthening relational skills that support intimacy resilience

In the project of a life together, intimacy ebbs and flows. While some couples have the wisdom to know how to move back and forth from disconnection to connection, from being hurt to repair, others become paralyzed when disconnections occur. Often times fractures in the relationship settle in when the partners are unable to reconcile differences about the importance given to sexuality, sexual frequency, and/or the type of sexual practice they would like to have. Many couples that come to therapy have been in physically distant, sexless relationships for months, years, and even decades.

It is important for the therapist to keep in mind that while for some individuals sex is a panacea, for others it is not paramount. For instance, while engaging in "vanilla sex" once every few months is enough for Martha to feel validated and attractive, her partner Anne desires weekly sessions of kinky aggressive sex to feel a sense of vitality. While Robert considers intercourse to be essential for him to feel loved, his wife Sara yearns for more pillow talk, cuddling, and kissing and considers penetration unnecessary for her to feel intimate.

Faced with partners' differences, the therapist is usually invited to be a referee and take sides about what is right and wrong, what is "normal" and what is "perverted." From a clinical point of view, these invitations are mine fields that can easily explode. In our work, we often ask ourselves, "What is possible for this couple?" What are realistic goals and limitations for what we can accomplish as therapists? Mindful that intimacy is subjective and that it can have different meanings and shapes (Scheinkman, 2019), we are careful not to impose monolithic notions of sexual intimacy. Instead, we aspire to maintain a position of curiosity about each partner's wishes, how they differ, and if and how we can help them manage their differences and still bridge their gap.

With the goal of helping the couple move toward an overarching common narrative, and more pleasure between them, we start by legitimizing each partner's unique preferences and differences. Only then do we address their willingness to stretch in order to join the other. In

order to promote an atmosphere of generosity and giving, we turn our focus to the underlying relational processes we consider to be the major pillars of intimacy resilience (Scheinkman, 2019).

Differentiation of self and the ability to define boundaries

We consider differentiation of self to be an umbrella concept that subsumes many different abilities necessary for the sustenance of intimacy over time (Morin, 1995; Schnarch, 2009). Contrary to the idea that differentiation of self is an individualistic pursuit, we consider it to be a relational necessity. In order to be authentically connected the partners must be able to sustain clear boundaries yet be able to bring their separate self in all shapes and forms to the interior of their relationships (Lerner, 1989). When boundaries are overly rigid, the partners end up feeling disconnected. If boundaries are blurred, the partners become prone to enmeshment and resentment. Often times, couples alternate between these two poles (Bowen, 1978).

In order to facilitate differentiation of self, the therapist needs to support each partner to feel entitled to his or her sexual feelings and priorities, even when they differ or conflict with the feelings and priorities of the other person (Lerner, 1989). While some cultures place a premium on differentiation in terms of verbal expression of feelings, others prioritize more indirect methods (Falicov, 2014; Papp, 1983; Scheinkman, 2019). This was illustrated by Naoko, a Japanese woman who came to therapy after discovering her husband's long-distance affair. She was not only profoundly hurt by her findings but also clear that she did not want to talk to him about her feelings and admit that she had read his emails. Such conversation would provoke even more humiliation than she was already feeling and lead to more distance between them. She asked the therapist to help her devise a more indirect strategy that would help her preserve her dignity. She decided she would tell her husband a parable about her friend who was betrayed. Through this story she would convey her position about the necessity of fidelity for maintaining tenderness and respect. She also planned to let her husband know that she had advised her friend, "There should be no second chances for cheating."

In our work with Victor and Lucy, their sense of enmeshment was manifested in many areas of their life, including their sexual relationship. Their inability to express sexual needs, and feel validated in their differences, was a major roadblock to feeling intimate. Witnessing their confusion with boundaries, the therapist created a space in which each one could express their feelings and wishes. Lucy talked about her desire for playfulness, and for them to be able to take turns in giving and receiving pleasure. Victor expressed his yearning to be touched throughout the day, and for them to spend more time together. He also underscored the importance he placed on penetrative sex. Even though their priorities remained different, feeling heard opened the door to calmer negotiations. Lucy volunteered that she was willing to try intercourse again with the caveat that it would be time limited. As Victor experienced Lucy's willingness, he reciprocated saying he was willing to play with her and be part of her plots in spite of his shyness.

Ability to communicate through appreciation and yearnings

Very often, the partners make bids for intimacy via complaints and accusations that focus on the other person's wrongdoings. These misleading strategies not only do not work, they actually promote defensiveness and power struggles. In order to challenge these toxic

interactions, the therapist must coach the partners to express feelings from an "I position" in which they keep the focus on their own selves and preface their expectations with appreciation for what is already working. In other words, it is crucial for the partners to reformulate complaints into wishes and yearnings. These softer start-ups (Gottman, 1995) may be verbal or nonverbal. They may be conveyed through words or actions that promote positive feelings such as doing a favor, touching the other lovingly, or any intentional effort to help and please the other.

Over the years, whenever Victor or Lucy tried to initiate sex, their invitations backfired. Victor habitually asked Lucy to have sex with back-handed sarcasm, "I know you're not interested in me, but I will take the crumbs. Can we have sex tonight anyway?" His victimized tone inevitably triggered Lucy's irritation, "Could you try being a little bit more manly and romantic?" On the rare occasions they did engage sexually, Victor was quick to accuse Lucy of being "absent" and "mechanical." Feeling criticized and unseen in her efforts to please him, Lucy would up the ante declaring that none of her previous lovers had ever complained; in fact, they thought she was very hot and sexy. It was only him, Victor, who complained because he was sexually inexperienced. Since Victor in fact had very few sexual partners in his youth, he experienced her comments as demoralizing insults.

While focusing on their communication, the therapist encouraged them to express their expectations in terms of wishes and yearnings rather than focus on a narrative about what the other person was or was not doing. Victor was able to say that being touched was the way he felt most loved and wanted. Lucy expressed how much she liked skin to skin contact with Victor. Both were surprised by these tender revelations that had been obscured beneath the insults they had been hurling at one another.

Ability to maintain equity in the couple's quid pro quo

Balance of power is a fundamental dimension in couples' relationships (Goldner, 1988; Walsh, 1989; Walsh & Scheinkman, 1989) and a basic underlying condition for the partners to feel sexually open and desirous. When partners experience inequities in their relationships, be it due to gender patterns, divisions of labor, financial disparities, or a pervasive skew due to a chronic illness, resentment often corrodes sexual interest and willingness.

In order to address inequities, the therapist invites the partners to examine their arrangement and helps them to work toward more equitable exchanges. It is important to keep in mind that equity and a fair distribution of labor do not mean the couple must organize their relationship in terms of equal roles and responsibilities. Many couples assume dissimilar roles yet find a way to create complementarity that feels fair in an overall way (Walsh, 1989).

In the early years of their relationship, Lucy and Victor evolved a satisfying *quid pro quo* based on traditional gender roles. Lucy was responsible for arranging their social and domestic life, while Victor was in charge of overseeing their finances, undertaking home repairs, and negotiating major purchases. With the passing of time, as aging began to take a toll on Victor's acuity, he became increasingly insecure in his role and dependent on Lucy who, in turn, felt overburdened. This came to a head when Victor procrastinated buying a car for their summer travels. Feeling he was not doing his share, Lucy exploded. In a frank conversation in the therapy room, Victor explained that his reluctance was not due to laziness but instead it was based on recent cognitive difficulties impacting his ability to make decisions. As his changing behavior was situated within his developmental changes, the therapist encouraged renegotiation of their responsibilities, which both ended up feeling were better suited to their current state.

Ability to trust

For most couples, sexuality is a hypersensitive dimension of their intimate life in which they expose desires, fantasies, expectations, and their naked bodies. In order to keep revealing themselves, the partners must have confidence that the other will accept that which is being exposed without the threat of criticism and rejection. When a person feels judged, dismissed or treated with indifference they automatically assume a defensive position that triggers vulnerability and may lead them to shut down sexually and halt their willingness to play. Vulnerabilities that are commonly triggered in sexual situations include fear of being rejected, revelation of unconventional desires that may be criticized, and painful associations with past traumas. Many women experience insecurity about their bodies and physical appearance and yearn to be reassured. Many men experience insecurity and shame if their ability to perform is perceived as compromised. The therapist must keep in mind that trust is more than an individual capacity; it is also a relational experience that requires the active participation of both partners. When one of the partners reveals a sensitive facet of their being, he or she must trust that other person will receive such disclosure with acceptance and respect (Wynne & Wynne, 1986).

It took Victor and Lucy almost seven months in therapy to trust they could expose vulnerabilities they each had been experiencing related to aging. Having felt criticized by Victor about her sexual behavior, Lucy had stopped talking about the physical discomfort she experienced during intercourse. Victor was petrified to share his difficulties with delayed ejaculation and ashamed to talk about the aches and pains that lately were interfering with daily activities. As the therapist consistently normalized these experiences in developmental terms, Lucy began to trust she could approach the topic of intercourse once again. She explained to Victor that sexual thrusting had become painful and asked him to participate in a different way. Following her lead, with much trepidation, Victor admitted he had been afraid to talk about his problems with ejaculation and have Lucy think he was "damaged goods." This conversation prompted Victor to make an appointment with his doctors to see if there was a medical treatment for his problem. Moreover, these revelations led them to agree to continue the sensate focus sessions that were making them feel sensually connected.

Ability to give and receive pleasure

In our practices, we encounter many couples who, having come of age before or outside of the feminist movement, have assumed stereotypical gender roles in their sexual relationships. Many women who grew up in the 1950s and 60s were socialized to relate as nurturers and caretakers. They accepted a marital bargain in which sexual pleasure was a man's privilege and a woman's duty to provide. In these pacts, women typically saw themselves as sexual objects pruned to enchant and please the other rather than sexual subjects entitled to seek their own pleasure. In a parallel way, as far as sexuality was concerned, their male counterparts were socialized to be in charge, to perform and to get what they wanted.

Many of these women, as they age, resign this sense of duty and avoid sex altogether. Sometimes their sexual withdrawal is due to internalized stigma about sex and aging. Sometimes they are concerned with what they perceive as loss of beauty and sex appeal. Often times they are also impacted by the physical discomforts that arise in the menopausal years. Perplexed by their partner's changes, and also dealing with their own sexual challenges related to aging such as erectile difficulties, declining spontaneous desire or sometimes difficulties ejaculating, many men respond to the partner's withdrawal with frustration and blame. Mystified by these changes, and unaccustomed to attuning to their partners, they end up feeling helpless and abandoned and often times believe that finding a younger partner is the solution.

In working with couples whose sexuality was inscribed in traditional gender roles, the therapist may need to work individually with each partner. She may need to support the female partner to feel entitled to sexual pleasure, to focus on her own sexual experience and sensations, and to communicate her preferences constructively. The therapist may also need to work individually with the male partner to challenge his sense of sexual entitlement and help him to focus on critical relational skills, such as listening, empathizing (Real, 2002) and accepting directions, in order to attune and give pleasure to the partner.

In addition to these gender-based dynamics that need to be transformed there are lingering mythologies, also founded in male privilege, that deter couples from reciprocity. For instance, the assumption that "real sex equals intercourse" can be a major roadblock to a couple's explorations of alternative sexual activities. The idea that partners should be able to experience orgasms simultaneously is another misguided expectation that prevents women from taking control and exploring what is important for them to get aroused. These commonly held beliefs blur differences between giver and receiver and obscure the fact that, for a large number of couples, taking turns in giving and receiving pleasure is necessary for mutual satisfaction. Bader (2002) emphasizes that arousal requires the person to feel entitled to focus on their own sensations and pleasure without being preoccupied with the needs or pleasure of the other. Moreover, generosity begets generosity and often generates a positive reciprocal cycle of giving and receiving that promotes willingness to give again (Scheinkman, 2019).

Lucy and Victor had very different ideas about what they deemed sexually pleasurable in their relationship. Lucy had told Victor that she was aroused by transgressive fantasies and, with great timidity, had invited him to role play scenes in which they were having sex in public places. Regrettably, her invitations backfired. Victor was offended by her propositions, which he interpreted as rejections in which he was not the primary source of her pleasure. Over time, as the therapist kept emphasizing the natural place of fantasy in sexuality, Victor began to shift. He revised his narrative about Lucy's desires being signs of rejection and began to participate in her sexual reveries. He also brought up his need to have Lucy reassure him that he was loved and desired. As Lucy felt heard and accepted, she became more reassuring of her love for him. As Victor felt cherished, he became more relaxed and more playful.

Ability to repair

Repairing wrongs experienced within the couple's relationship itself is probably the most crucial challenge couples must deal with in order to sustain resilience in their relationships. The ability to repair requires *self-reflection* about how one's actions and behavior have impacted the other person, *accountability* for the offenses they may have caused, and reassuring *gestures* to demonstrate to the other that they are now on solid ground. Repair also requires the reciprocal willingness of the hurt person to *receive* these reparative gestures, to forgive, and to move on.

The trials and tribulations of repairing hurts in intimate relationships have been well documented in the couples therapy field (Gottman, 1995; Lerner, 1989; Real, 2002; Siegel, 1992). While some couples repair everyday hurts by analyzing the injurious event and talking through their feelings, others prefer more indirect means such as efforts to contain their escalations and intentionally moving the relationship in a positive direction. Sometimes, a simple statement such as, "Let's stop this craziness," or "Can we rewind and start again?" is all a couple needs to get back on track. There is also a range of attitudes and behaviors that can work as repair mechanisms such as apologizing, sending flowers, being extra generous and attentive with daily chores, humor, playfulness, affection, and sex. In addressing serious injuries such as a long-term affair, a financial secret or an addiction, we take into account the intricacies of forgiving and not forgiving (Abrahms Spring, 1996, 2004).

In addition to considering the nature and severity of the injurious behavior, we always try to understand if the couple is caught up in a vulnerability cycle that is exacerbating their mutual wariness and distance. When the partners remain calibrated in defensive interactions, they tend to reify their negative perceptions and theories about the other. Demonization such as "he is incapable of love," "she is lazy," "he is a narcissist," often crystalize negative feelings that engender more and more rigidity and erosion of intimacy. In any case, we consider the failure to initiate repair, and/or the failure of the hurt person to respond to the partner's attempts to repair, to be the most negative forecast for sustenance of intimacy in the long run.

When Lucy and Victor arrived in our office they were profoundly skeptical about their future and considered their marriage was probably over. They had tried couples therapy a few times before and this was their final attempt to fix their problems or else to separate constructively. Contrary to their predictions, in the very first session, a process of repair began to take place and it proceeded step by step over the next several months. During the initial phase of the therapy, through mediation of the therapist, they focused on the history of their relationship and reflected about how they had unwittingly hurt one another. As they felt understood by the therapist and the team, and heard by the other, they put down their shields, recognizing how their words and actions had been misguided, and they both apologized. Then, following a sculpting session in which they each performed their vision for the future (Papp et al., 2013), they stopped talking about separation. Victor sculpted them as birds flying together; Lucy sculpted herself as a trunk supporting the relationship. Yet, for a while, they remained on the fence, unsure whether it was prudent for them to re-engage emotionally. As the reflecting team emphasized "no risk no gain," slowly but surely, they resumed joint activities and began to create new pleasurable routines and experiences. They started going to bed at the same time and continued doing their own version of sensate focus several times a week. They started planning trips and we noticed that when they returned, they were much more involved in self-care and dressing up for the other. They also found many occasions to enjoy themselves with family and friends. As they began to negotiate explicitly times for togetherness and separateness, we observed that Lucy became much more eager to "hang out" with Victor rather than doing things alone. In the meantime, in the therapy sessions, they focused on the physical side of their sexual difficulties and Victor finally made an appointment with a urologist to see what he could do medically about his difficulties with ejaculation. Through comments and questions about what was working well for them now, the therapist helped them amplify a positive narrative about their relationship and shrink their preoccupation with their sexual difficulties and dilemmas. As they became busy with their travels, and it was the beginning of summer, we decided to stop the therapy. In our last session, Lucy talked about how proud she was to be Victor's partner while Victor talked about Lucy's attractiveness, intelligence, and how compatible they were. They acknowledged their sexual issues were not totally resolved, yet both felt a great sense of relief to know they were now good friends, rather than enemies.

CONCLUSION

In working with older adults in couples' therapy, we have come to understand that when normative life cycle challenges intertwine with toxic sociocultural narratives about aging, misconstructions about sexuality, outdated gender patterns, and defensive interactions, they generate core impasses that block emotional and sensual intimacy. In this article, we suggest a clinical framework to guide the therapist on how to help couples disentangle these knots in order to actualize their potential for pleasure and for connection. Based on an integration of the vulnerability cycle with an expansive conceptualization of sexuality, we describe how we deconstruct impasses, expand couple's sexual menus, and reinforce relational processes that give

older couples more ability to deal with the ambiguities and challenges of aging while sustaining sexuality, intimacy, and resilience.

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