UNIVERSIDADE LUSÓFONA

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BEREAVEMENT AND SEXUAL INTIMACY: EXPLORING THE INTERACTION BETWEEN SEXUAL INTIMACY AND THE PROCESS OF GRIEVING IN BEREAVED CLIENTS

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Resumo

O presente estudo explorou a correlação entre intimidade sexual e o sentimento de luto nas vidas de indivíduos que se deparam com este sentimento, através de interacções com dez psicólogos clínicos e psicoterapeutas sobre o trabalho que realizam com clientes que atravessam um período de luto. Os estudos prévios nesta área são escassos, e o potencial papel da intimidade sexual nas vidas das pessoas que atravessam um período de luto permanece relativamente inexplorado. Para indivíduos que se deparam com o sentimento de luto, o acompanhamento psicológico ou a psicoterapia poderão constituir espaços valiosos nos quais poderão falar com segurança sobre a sua experiência, uma vez que este poderá ser um tema de abordagem difícil, social e culturalmente inabordável. Apesar do papel importante que as relações íntimas desempenham no dia-a-dia, o tema da intimidade sexual é ainda considerado tabu, e de forma ainda mais pronunciada num contexto de luto. A realização de entrevistas com profissionais de saúde permitiu a recolha de dados e material relevantes, com base nos anos de experiência clínica destes especialistas. O presente estudo qualitativo foi analisado através da 'Constructivist Grounded Theory', e, por conseguinte, os resultados derivam directamente do discurso dos participantes, nas suas próprias palavras. Os resultados mais significativos evidenciam que o tema da intimidade sexual durante o período do luto é regularmente evitado, mesmo num contexto de relação terapêutica, e que existe uma correlação entre os dois tópicos (intimidade sexual + luto) que, em alguns casos, contribui para um desconforto ou sofrimento acrescidos. Os terapeutas entrevistados sentiram de igual modo que, para alguns clientes, a intimidade sexual poderá vir a desempenhar um papel potencialmente benéfico no âmbito do processo de cura. Os participantes partilharam os seus pontos de vista e reflexões acerca da necessidade de exploração do tópico da intimidade sexual durante o período de luto, bem como a possível necessidade de uma abordagem mais integrada, incluindo um reconhecimento acrescido face à importância da sexualidade, e também [a necessidade] de uma gama de abordagens psicoterapêuticas tais como a incorporação de um maior reconhecimento somático. Foram muitas vezes abordados os tópicos da falta de desenvolvimento profissional no campo da sexualidade, e também da necessidade de maior amplitude ao nível da formação para terapeutas.

Palavras chave: sexual; relações; intimidade.

Abstract

This study explored the interaction between sexual intimacy and grief in the lives of bereaved individuals by talking to ten clinical psychologists and psychotherapists about their work with bereaved clients. There is very little previous research in this area and the potential role of sexual intimacy in the lives of bereaved people remains relatively unexplored. For grieving people counselling or psychotherapy may be a valuable space where they can discuss their experience with a sense of safety, as it can be a difficult subject to broach elsewhere which may be considered socially and culturally unmentionable. Despite the prominent role intimate relationships play in day to day life, the subject of sexual intimacy is still often considered taboo and within the context of bereavement even more so. By interviewing mental health professionals this study was able to gain evidence from their years of clinical experience. This was a qualitative study analysed using Constructivist Grounded Theory in order that the results should be drawn directly from the participants' own words. The main results found that the topic of Sexual intimacy during grieving was often avoided even within the therapeutic relationship, and that there is a bi-directional effect between the two topics which can in some cases contribute to significant added suffering. The therapists interviewed also felt that there was a potentially helpful role for sexual intimacy within the healing process for some clients. The participants shared their insights and reflections on the need to explore the topic of sexual intimacy during grieving and the potential necessity for a more integrative approach, including greater awareness of the relevance of sexuality as well as a range of psychotherapeutic approaches such as incorporating the inclusion of more somatic awareness. Lack of training in the area of sexuality came up often and highlighted the need for broader therapist training .

Keywords: sexual; relationships; intimacy.

List of abbreviations

DPM – the Dual Process Model of Coping with Bereavement (Stroebe & Schut, 1999)

SE – Somatic Experiencing (Levine, as cited in Kuhfuß et al., 2021)

SI – Sexual Intimacy

TMT – Terror Management Theory (Rank & Becker, 1991. As cited in Mikulincer et al., 2003)

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Introduction

The process of grieving is increasingly acknowledged to be a non-linear and distinctly individual in character, the idea that a person must traverse a series of phases or achieve resolution to their grief within an established timeframe holds less credibility in modern bereavement research (Dyregrov & Dyregrov, 2008) Complicated or traumatic grief often impacts those who experience sudden, traumatic or close bereavements, causing disruption to the process of grieving and causing significant impact on emotional capacity (Erskine, 2014). Often the bereaved person may become unable to express or even experience their own emotions, inevitably their close relationships are affected (Erskine, 2014). The behaviour of a bereaved person with regard to their intimate relationships may depend on their individual strategies of coping, the additional stress of relational distance or disharmony may become a significant stressor which in turn aggravates the grieving process further (Stroebe & Schut, 2016). This study intends to explore how sexual intimacy (SI) and grief interact in the evolution of the grief process for individuals who may be at greater risk of developing prolonged or complicated grief because of their proximity to the deceased.

When we think of bereavement, sexual intimacy may not be a topic which obviously comes to mind although it is acknowledged to be an important part of individual wellbeing as well as couple satisfaction (Yoo et al., 2014; Skalaka & Gerymski, 2019). While exploring the topic it became apparent that there is considerable online content regarding sex during bereavement although it is significantly less present in academic research. While SI has the potential for meaningful connection between partners for some it may become absent or irrelevant in the early period of grieving while for others it is a means of escape. The interaction between death, grieving, sexual activity and sexual desire is complex and may be regarded as a topic which is off limits or societally and culturally unacceptable but given the amount of material encountered while researching these themes it clearly affects lives and warrants a deeper discussion.

For the purpose of this study sexual intimacy is defined as any eroticised physical contact or sexual touching and close bereavement is defined as the loss of a child, parent, sibling or partner but not discounting the loss of a close friend or other significant non biological relationship (Dyregrov & Dyregrov, 2008).

Models of grief and bereavement and the role of intimate relationships while grieving.

The idea that working through the process of grief can involve other significant relationships is often seen as an important factor in the trajectory of an individual's grieving. Freud's theory of Grief work (1957) suggested that the activities and relationships in which the bereaved person felt able to invest their emotional energy were important in the resolution of their relationship with the deceased (Stillion & Attig, 2015). Bowlby (1982) went on to highlight the role that close relationships may have in the management of anxiety during stressful moments in a person's life. Proximity to a significant other for example an intimate partner, may be a source of safety, reassurance and comfort and a way to moderate the effects of distress or anxiety and a way to counter the flight or fight threat response therefore serving as a potential protective factor (Mikulincer et al., 2003). Bowlby went on to discuss that during the necessary process of working through grief the breaking and re-establishing of attachment bonds is an important part of the adjustment to the loss of a beloved person (Stroebe, & Schut, 1999). In their 2018 study Gewirtz-Meydan et al. considered the role of attachment style within couples to be of importance both to their individual attitudes towards sexual activity and in their dyadic approach to intimacy. One of their conclusions was that avoidance of sexual activity can be used to navigate anxieties within the couple. For example, when one withdraws the other may not seek sexual contact to increase intimacy thereby creating a cycle of avoidance within the dyad, (Gewirtz-Meydan et al., 2018) a stressful situation such as a bereavement could create such anxiety.

More recently the Dual Process Model of Coping with Bereavement (DPM) suggests that a bereaved person experiences a very individual process of oscillation between activities, thoughts and emotions relating directly to the experience of loss and a further series of activities, thoughts and emotions relating to the restoration of their own life post loss (Stroebe & Schut,1999). The role of intimate relationships with significant others or indeed the formation of new relationships has a role in this oscillation which takes place within the everyday life of the bereaved person. In a later revision of their work Stroebe and Schut (2016) go on to explain that the concept of overload, or the bereaved person's perception of having more going on in their life or more emotional stimulus than they can cope with may interfere with the resolution of the grieving process. This may relate to interpersonal difficulties, such as the emotional demands of engagement in sexual activity

with their partner. These difficulties within significant relationships in the person's life can impact their loss or restoration orientated coping while grieving (Stroebe & Schut, 2016).

The potential impact of severe grieving on social relationships was previously examined by Bonanno and Kaltman (2001) in a review of grief studies. It was observed that negative displays of thought and emotion by a bereaved person could lead others to withdraw from them; a number of bereaved persons also turned to self-isolation in the initial months following a bereavement. This process may result in physical distancing from their intimate partner for example, and an avoidance of sexual contact. Greater loneliness and especially emotional loneliness have been associated with lower restoration orientated coping (Bonanno & Kaltman, 2001).

The need for positive affect within restoration orientated coping may be partially fulfilled by the close relationships experienced by the grieving person. However there appears to be a difficulty many people experience in that deliberately seeking a pleasurable activity or a way to feel better while grieving may bring about feelings of guilt (Fasse & Zech, 2016). This guilt may cause them to feel that it is inappropriate to engage in sexual intimacy for a period of time. When distance is created it is possible that a secondary loss, either of the sexual dimension of an intimate relationship or in some cases the ending of the relationship itself may be felt. Yet another source of connection is removed from the grieving person's life, augmenting their sense of isolation.

The idea of continuing bonds of attachment which developed from attachment theory is also present in the DPM. While a person may seek a continuing bond with the deceased, for example in the retention of personal belongings or rumination about their past relationship this may result in a disproportionate level of loss orientated activity. A subsequent study by Niemayer and Gillies (2006) found that when combined with meaning making, continuing bonds could interact in a way that enabled the bereaved person to resolve their relationship with the deceased and reduce the possibility of experiencing complicated grief symptomology. Disproportionate loss orientated activity may not only have an impact on the possibility of developing complex grief (Stroebe & Schut, 2016), but may also have repercussions for intimate relationships and their potential for contributing to restorative activity.

Frequently associated with bereavement is the idea of resolution or acceptance in the form of a person's own narrative construction about their loss. With focus on the DPM, the idea that meaning making as both an individual and interpersonal process was relevant to

couples' relationships in response to the loss of a child was concluded in a study by Albuquerque et al. (2017). While this study did not focus on sexual intimacy it found that the positive impact of a supportive and validating couple relationship was important to the process of making meaning from loss. From a Social Constructivist perspective bereavement can be viewed as a relearning process rooted in the struggle to find meaning as a result of loss (Hagemeister et al., 1997). As well as a process of renegotiating the individual's relationship with the deceased, meaning making takes place in interactions with others (Hagemeister et al., 1997). While studies such as that conducted by Albuquerque et al. (2017) provide valuable insight about the importance of meaningful relationships, the role of sexual intimacy and its contribution to the healing process needs to be explored in further research.

Meaning making is relevant to the study of sexual intimacy, while not excluding the physiological element of sexual intimacy it can also be argued that meaning is attached to sexual behaviour as defined by aspects of culture such as politics or religion. Perspectives about sexuality vary according to social and cultural norms and their relevance to the individual (Baber & Murray, 2004). In their 1997 study into the sexual relationships of couples following the death of a child Hagemeister et al. found that the meanings attributed to sexual intimacy, to the child's death and to their individual grieving were key in understanding the absence, decline or resumption of sexual contact. For example, for some the idea of sex was "too painful because it was how the child had been made" (Hagemeister et al., 1997, p231), whereas for others it was life affirming. Often, they found that differences existed between men and women in their meaning making with regard to sexual intimacy while grieving, some felt it was comforting while others were repelled by the idea or mystified by the desire or lack of desire experienced by their partner (Hagemeister et al., 1997). The meaningful potential of SI may be being shaped within individual, dyadic and wider social perspectives and it is important to gain insight into how these differing perspectives can alter this perception. If importance is not placed on this topic or it is dismissed as shameful, any potential role it may play in helping clients with their grief process also remains unaddressed.

Post traumatic growth suggests the potential evolution of positive change or growth in the life of an individual which develops as a response to trauma and adversity (Stein et al., 2018). This growth may be impacted by and/or related to other relationships in the life of the bereaved person, as well as in their individual process of adaptation to new life

circumstances and personal development (Michael & Cooper, 2013). It has been suggested that as a result of the meaning making which takes place during the process of grieving, relationships with others may take on a new importance as the individual re-examines their ongoing priorities (Stein et al., 2018). Intimate relationships may be one of many factors which help to mediate loss and assist with coping (Waugh et al., 2018). This may apply to existing intimate relationships or potentially the desire to seek out sex in order to experience a physically intimate connection with others, however this is not clarified in existing research.

Inspired by the work of Otto Rank and Ernest Becker Terror Management Theory (TMT) places emphasis on the human need for self-preservation and the cultural importance of death (Solomon et al., as cited in Mikulincer et al., 2003). TMT (1991) suggests also that a reminder of, or proximity to death motivates the formation or maintenance of intimate relationships. The powerful reminder of our own mortality experienced in bereavement may provoke an existential terror response in humans because of their ability to understand that they are alive but will eventually die and their subsequent motivation to live life and ward off the threat of death (Mikulincer et al., 2003). The desire to shield ourselves when we are exposed to death may be a powerful factor in seeking closeness to others which in turn may also provide validation and enhance self-esteem (Mikulincer et al., 2003). However in others it may cause them to retreat from other people to insulate themselves from the pain of further loss.

When connection with a significant figure is lost, it may be possible that the loss of intimacy in another significant relationship or an absence of intimacy in the life of the individual could be a potential contributory factor to prolonged or aggravated grieving. Examining the role of sexual intimacy within the grieving process may give insight to the meaning attributed by individuals to their sexual life as sexual satisfaction is acknowledged to be an important source of connection and to be influential in determining the success of couple relationships as well as individual wellbeing (Gewirtz-Meydan et al., 2018). In reviewing the literature it is clear that sexual intimacy during grieving is an under-studied phenomenon. Current theories point to ways in which bereavement may be detrimental to intimacy, but also towards the potential for SI to be a helpful factor in positive adaptation to loss. By looking at two subjects which can be considered both delicate and even taboo this study hopes to promote an open dialogue in which these themes may be explored.

The current study

The purpose of this study is to examine the interaction between sexual intimacy and the grieving process in individuals who have experienced a close bereavement through the lenses of clinical psychologists and psychotherapists who are experienced with grieving processes.

The role of sexual intimacy post bereavement receives relatively little attention in research, with the majority of studies focusing either on the loss of children or spousal bereavement. Yet the idea that sexual intimacy and death are connected in an existential or theoretical context such as in Terror Management Theory is present within psychological research and thinking. More attention is often given also to pathological aspects of sexual behaviour such as sexual compulsivity or risky sexual conduct in response to bereavement.

While there is an existing body of work concerning the death of children such as the studies conducted by Albuquerque et al. (2017) and Hagemeister et al. (1997) the current study will include other close bereavements such as those of parents, siblings or close friends in order to better understand and support individuals and their partners in their grieving. By recruiting professionals and not bereaved individuals directly this study wishes to explore its themes from the perspective of those who regularly explore themes of coping and grief impact. In addition, studies such as that conducted by Fasse and Zech (2016) found that very often individuals found it difficult to distinguish their motives for engaging in certain activities and found it hard to tell whether an activity was loss orientated or restoration orientated. These aspects may be easier to define by someone who has observed such cases with professional knowledge and objectivity.

Methods

Participants

The participants for this study were 10 mental health professionals who were asked to reflect on their clinical experience with bereaved clients. The recruitment of participants was conducted using purposive and snowball sampling. Professionals were contacted either via current professional contacts known to the researcher or project supervisors, or suggested by previous participants following their interview. The mean age of participants was 43 years and their clinical experience varied from 10 to 28 years. Participants were all licensed clinicians

who currently work with the bereaved or have within the last five years worked with bereaved individuals, such as those working in private practice, hospice care or hospitals.

Procedures

This study received ethical approval from CEDIC, the ethical and deontological committee for scientific investigation at Lusófona University. Informed consent was obtained for all participants and a letter outlining the purpose of the study was sent to everyone who was invited to participate.

This project was conducted in the form of semi-structured interviews which took place online via Zoom and recorded in audio format only. The average interview lasted 60 minutes. Participant names were not included in the recorded interviews and each was assigned a code which was then used for the transcription and analysis. Participants were also reminded that any information they provided about their clients should be sufficiently anonymised that they could not be individually identified. During the interview participants were asked about the frequency with which sexual intimacy was introduced as a topic with their bereaved clients and in what context this might take place, as well as what role they felt sexual intimacy had for these clients. Questions were also asked about how they thought difficulties may be overcome and how SI might contribute to client coping. Finally the clinicians were asked about the most important take-home messages for those experiencing difficulties in this area.

Analysis

The audio recordings were transcribed and then coded using Constructivist Grounded Theory. Grounded theory applies an exploratory approach to qualitative data; therefore, no hypotheses are constructed before the data is gathered and theoretical conclusions are drawn based on or "grounded" in the data through the process of coding, categorising, comparative analysis and interpretation (Charmaz, 2006). Grounded theory allows for the collection of rich data based on the participants experience from which theory may be constructed via an iterative process, an approach which is particularly suited to a research area where there is currently limited understanding of the phenomenon in question (Chun Tie et al., 2019). The interview process was considered sufficient once no new codes had begun to arise from the transcriptions. The coding process was completed by hand and did not use additional software. The initial phase of line by line coding examined the transcriptions and identified the descriptions and

views given by participants and initial memos were noted, these were then examined and grouped into categories in order to integrate and reduce the volume of data. The final phase of axial coding looked at the relationships between the categories and how they could be incorporated into subcategories and broader themes. The integrity of codes and themes at each level was discussed in meetings with a supervisor at each stage. By constantly comparing the codes and categories and referring back to the transcripts helped ensure the validity of the data. Having the interviewer conduct the transcription and coding it also helped to maintain the integrity of the data. During this phase researcher bias was minimised by constantly referring back to the transcripts and in discussion with a supervisor.

Results

Table 1. shows the main results of the coding process.

Table 1.

Main Themes and Categories

Themes	Categories	Subcategories
Therapist attitudes to SI in bereaved people	Therapist's general lack of initiative/reluctance concerning sexual intimacy and grief Complicating factors (that hinder communication on the topic) – why is it not talked about: Facilitating factors / What helps to address the topic / Actions to surpass this difficulty: Positive impact in clients of communication on the topic Conclusions on the importance of the topic.	- General factors (that include both the therapist and the client) - Factors attributed to therapists - Factors attributed to clients - Therapists' views - Therapeutic relationship
Bidirectional Impact.	Factors on the impact in relationships/sex intimacy – disengagement	- General impact of grief on relationships - Secondary loss - Complication factors because of grief
	Impact of relationships/SI on grief	- Relationship difficulties and disengagement in sexual intimacy ▪ Consequences of disengagement: ▪ Role of sexual intimacy in the healing/recovery process.
Restoring sexual intimacy	Communication within intimate partner relationships	- How working on communication can help. Role of therapy in helping with communication.
Other advice from therapists		

Participant quotations are coded below according to gender and years of clinical experience e.g. (f, 10).

Therapist Attitudes about sexual intimacy in bereaved people

While not one of the initial aims of this study it was clear during the process of analysis that this was an extremely relevant topic. For many of the therapists (eight) in this sample sexual intimacy was not a topic that arose frequently in their sessions with bereaved clients. A reluctance to approach the topic unless it was specifically brought up by the client was felt by a number of the participants (seven) although some stated that with the appropriate context it was a subject they considered important and were willing to introduce. For the majority of therapists (seven) the initiative for discussing SI came from their clients if it was introduced at all. *"when this topic was introduced it left me thinking, how many times have I actually broached this topic? By my initiative…not many"* (f, 21).

- **General factors**

General factors which hindered communication on the topic for both client and therapist were frequently cited as cultural discomfort, the taboo nature of both SI and death, lack of client education on the topic, lack of training on the part of the therapist, client age – older clients were described as more reluctant and younger clients more open, the type of loss experienced, gender and clients with particularly sensitive history around the topic – such as those in abusive relationships.

Ease with introducing the topic of sexual intimacy was most often linked to explorations of the client's relationships and sources of support, the importance of establishing this context with clients was considered very important before broaching the topic. Familiarity with the topic of SI in grieving clients varied among the therapists with some (four) placing great importance on intimate relationships as part of clients' holistic wellbeing.

- **Normalising**

The importance of normalising discussion around both sexual intimacy and death in order to help clients discuss their difficulties was highlighted during the interviews.

- **Therapeutic Relationship**

The importance of the therapeutic relationship was often a subject that arose during interview, therapists felt that once a rapport was built with the client there were more potential opportunities for discussing how different aspects of their lives were being affected by their

grieving. *"it's about you know reading a little bit what the other person is bringing to you"* (f, 11).

When therapists did bring up the topic with clients this helped with recognition of the impact of relationships as well as the generation of insight that had previously gone unacknowledged and for which clients were often grateful. When clients themselves felt able to introduce the topic it was often a source of relief to voice their inner conflict, many struggled with guilt and discussing this alleviated some of the suffering they experienced. *" I can tell you that I never had a situation on which I asked and the person told me 'oh I don't feel like talking about that'"* (f, 11).

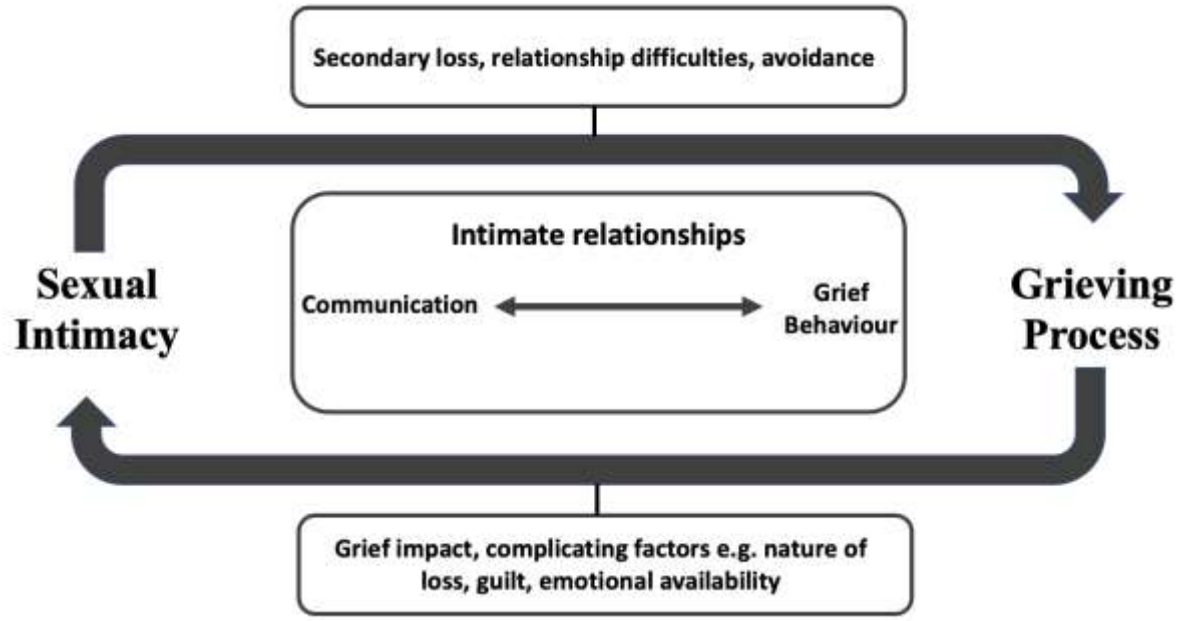
For a few clients their relationship issues took central focus because they were such a supportive aspect of their lives and positive experiences of sexual intimacy with their partner helped them to feel loved and cared for in their grieving.

Bi-directional impact

Bi-directionality came up in during the interviews as an important aspect of looking at SI during bereavement and it was suggested that for those clients whose relationships and relational issues were of high importance during grieving that in turn these are the most at risk from relationship difficulties such as SI being affected by grieving. When looking at the transcripts overall it seemed clear that factors such as existing relationship problems could impact the process of grieving as well as the process of grieving impacting other aspects of a person's life. Bi-directionality within intimate relationships in terms of communication and grief behaviour is also taking place within this larger process.

Figure 1.

Bi-Directional Impact.



Factors influencing the impact of Grief on relationships and sexual intimacy

Grief can have an impact on a person's ability to love and be loved in return and nine of the therapists felt they could say that sexual intimacy is often affected by bereavement. *"Sexual Intimacy is about connection and grief is about the loss of connection"* (f, 12). Those who experience the most difficulties after a bereavement likely experience problematic effects in other areas of their life as loss can inhibit the person's ability to return to many aspects of their lives. The experience of transitional changes, especially in the early period after a loss are often resolved but for some their ability to engage in sexual activity is impaired or their partners may become distant.

- **Secondary Loss**

For bereaved individuals secondary loss is often the reason that the topic of sexual intimacy arises in therapy sessions. The loss of a relationship or of relationship intimacy becomes a second source of grief for those who are already suffering. Sometimes when a relationship has a particular meaning for the client when this ceases or stops feeling good it becomes yet another loss and for those who live in unhappy relationships sometimes this feels like loss that will never end. *"when a relationship is bad or people are just not happy in the relationship, if it ends or if not it feels like a loss"* (f, 11). For people who experience secondary loss they can feel intense loneliness and isolation. It can impact the amount of care and attention

given to their intimate relationships and increase feelings of hopelessness. When a significant connection to another person has already been lost, communication and companionship can gain importance elsewhere in the life of the bereaved person.

- **Emotional availability**

For some people sexual intimacy continues to be a positive part of their life while grieving and emotional availability for this intimacy is likely to be greater in relationships where intimacy is strong and feels secure. For others grieving can rob them of the ability to engage at the emotional level that they are accustomed to. *"it happens, they cannot leave the grieving experience for 10 minutes"* (m, 25). Emotional availability can be complex and have reverberating effects between the partners which affects their intimate lives. For many emotional availability for sexual intimacy is reduced early in grieving but may be gradually regained.

- **Traumatic and Sudden loss**

Traumatic or sudden losses may be more likely to cause difficulties with sexual intimacy. There can be a level of adaptation in advance when a death is expected such as in cases of terminal illness. Traumatic stress may be evoked by grief experiences which can impact intimate relationships. The presence of pathologies such as Post Traumatic Stress Disorder and depression can lead to loss of libido, as can associated medication. There may also be a sensorial element associated with intrusive thoughts and memories which make sexual intimacy particularly challenging.

"Especially when the loss involves some sort of traumatic experience you know with strong sensorial stimuli, I would say that in that situation I would see that this is kind of intrusive" (m, 10)

How a death occurs can be relevant to the impact on a person's sense of safety which can be problematic for sexual intimacy. In newer relationships safe and unsafe communication and connection may not yet be established and can add to the sense of a lack of physical safety felt after a traumatic loss. Equally conflict within intimate relationships may leave a person feeling that their intimate partnership is volatile or unsafe. Once a sense of safety within a couple's relationship has been damaged it can be difficult to recover. Therapists also mentioned that there was a need for further research into grief and trauma.

- **Nature of loss**

For those who lose their partner, their intimate life as they know it is also taken from them and the thought of being with someone else can bring excessive feelings of guilt, one therapist described that *"it can feel like treason or dishonour"* (m, 10). For many widowed

people especially those who are older and from religious or culturally conservative backgrounds losing their partner condemns them to a life without pleasure. Discussing the loss of a spouse or partner with a therapist often increases awareness of all the types and layers of intimacy involved in a long-term relationship of which sexual intimacy is one dimension.

The death of a child is considered the most devastating and intense type of loss seen in clinical practice. As the two individual parents face their own process of grieving this can be a complicating factor for their intimate relationship. Often one or both partners struggle to communicate their feelings and needs with the other partner. There can be a reluctance to re-engage with sex because of the link to the conception of the deceased child or because of the fear and uncertainty of becoming pregnant again. For parents the responsibility of having another child can be overwhelming. If there is anger, blame or resentment towards the other partner this is destructive for their relationship and may result in divorce and in some cases infidelity. In other clients however, therapists saw compulsive sexual activity in couples who had lost children. This compulsivity played out both in the desire to have more children quickly but also in avoidance of suffering and comfort seeking *"they want to feel strong emotions"* (f, 28). Therapists felt that sexual intimacy often came up in clients who had lost children because relationship issues were so significant.

Parental loss was a subject that arose for some clients in relation to caring responsibilities which often disproportionately affect women. *"I remember some daughters who said they stopped having (sexual) relations because of the pressures of caring"* (f, 21). Caring for a dying parent and the aftermath of their loss may cause distress and physical fatigue. Very often the role reversal of caring for a dying parent left a mark on the lives of their bereaved offspring. There may also be difficulties around privacy when caring for a dying parent, or after losing one parent the other parent may become the sole focus of their attention as they try to help them overcome their loss. In a few cases there was a sense that deceased parents could be idealised and the partner of the bereaved felt negatively evaluated in comparison which was a source of friction in their relationship. *"it can be a kind of jealousy, like you loved your father more than me"* (m, 19). This type of loss was also frequently linked to couples distancing from each other as partners were impatient or insensitive to the bereaved person's reluctance to engage in sexual intimacy which sometimes lasted many months and in some cases even longer.

Notably some participants (four) highlighted that the closeness of the bereaved person's relationship to the deceased may be a more significant factor than the formal relationship between them.

- **Intensity of Grief**

Some individuals may be so consumed by the pain of grief that they have no space for anything else in their life. *"the person can end up completely isolated and just focused on the person they lost"* (f, 21) During grieving clients often struggled to recognise their own needs and to move forward from their sadness. Again this can cause friction and difficulties in their relationships and prevent them from feeling able to be intimate with their partners.

- **The needs of the bereaved individual**

The therapists (seven) noted that sometimes bereaved people place little value in their own needs and may become disassociated from their sense of self and from their physical body. Or they may feel driven to live more as an individual which distances them from their partner, they may have a strong sense of wanting or not wanting attachment and for some people the thought of sexual touching brought discomfort especially in the early stages of grieving. Therapists (three) also mentioned cases where in the wake of loss individuals were prompted to re-evaluate their lives and relationships and this could also cause them either to seek intimacy or distance themselves from their existing partner.

The age of both the deceased and of the bereaved were sometimes considered contributory factors. Some therapists (Four) also mentioned gender as a factor as they felt that the role and meaning placed upon SI was different for men and women. Individual responses to grieving were also highlighted as well as the acknowledgement that while clients may experience multiple losses in their life they may respond to them differently for many reasons. Individuals and couples may also respond differently in times of high anxiety or stress. Partner infidelity and divorce were also mentioned as consequences of the impact of grieving on sexual intimacy as extended periods of distance and disengagement increased conflict and disharmony.

The Impact of Relationships/sexual intimacy on the process of grief

- **Relationship difficulties and disengagement in sexual intimacy**

Existing problems in communication within partner relationships was highlighted in all of the interviews as a problem as well as the threat of judgement from a partner. Physical distance from their partner, neglect, guilt, blame and ambivalence are difficulties experienced in intimate relationships which contributed to greater suffering for bereaved persons. A lack of pleasure in their relationships, perceived disrespect and poor partner understanding amongst other relational difficulties were mentioned as potential links between problematic sexual or

intimate relationships and compounded feelings of loss and emotional distress for those who were already grieving.

Forced or coerced participation in sex was also a frequent topic among female clients in particular. *" a wife can feel that a husband is not respecting her not being emotionally available and forcing sex when she is not in the mood"* (m, 19). Often male partners grew impatient and made demands for SI that their grieving partners did not want to fulfil. Resentment and blame on both sides increased the suffering of these clients and became an additional burden. One participant described a particular partner in the life of a client as a *"menacing figure"* (m, 10).

The role of sexual intimacy in the healing/recovery process

A healthy bereavement takes place in connection with others in connection and the expression of emotion in order to integrate and process the experience.

"it is something that that's shared and the, the way to cope with it and to wait and to deal with it for me at least, I think that it passes through others" (m, 10).

The idea that sexual intimacy could be a helpful and even curative part of this was expressed by most of the participants (nine). Some (three) acknowledged a small but meaningful increase in the positive outcomes of those clients who had maintained SI during periods of grieving although for other clinicians they did not have enough examples to make a judgement. Most felt that resuming SI could also be a sign of recovery, however the meaning attributed to SI for individuals and couples is a relevant aspect to consider before placing too much importance on this factor. Participants felt that most clients did usually regain their desire after a period of time.

SI as a potential protective factor was suggested as well as being a manifestation of care and a way to validate emotions in this way it may be a helpful coping mechanism.

"if your sexuality is lived in a relationship where the person has a sense of space, feels empowered and protected and accepted, this is fundamental for the evolution of grief and its integration" (f, 21).

The importance of trust building and safety in the wake of bereavement was also found to be important. SI may be helpful in building self-esteem and confidence when engaged in consciously and positive experiences may be helpful in the re-building of a person's identity post grieving and how they project themselves in the future. While for some people touch may be challenging in the early stages it could be helpful later in the process both to reduce

rumination and to feel less alone. Some clients become dissociated from their physical body and SI may also be helpful in this regard.

It was also acknowledged that SI as a means of the avoidance of difficult emotions and compulsive sexual activity may become problematic or even dangerous for some individuals.

Restoring sexual intimacy

- **Communication within intimate partner relationships**

The most fundamental aspect of overcoming difficulties with SI while grieving was communication this came up in all the interviews, the importance of mutual empathy and knowledge of the other person are vital for navigating the experience together. Couples should communicate both about their grieving and about their relationship in order to try and understand the other person's perspective.

"I think that communication is one of the most vital ingredients really, yeah and it can be very difficult for people, the more that they manage to communicate the better, then the situation will advance" (f, 20).

Therapy can help with this process and help couples look at alternative ways to approach communication. Misunderstandings can be worked on with the help of a third party and a therapist can facilitate the exchange of perspectives between partners. Three of the therapists stated that they liked to actively involve partners in homework activities for their clients and encouraged partner communication as a part of the meaning making process. It is also important to address sexual problems within the context of grief and bereavement rather than avoiding the topic.

- **Advice from therapists for other therapists**
    - Using systemic approaches might be helpful to encourage better communication for clients and their partners.
    - Genograms can be a useful way to understand both sources of support and difficulty but also previous bereavements.
    - Try to work with clients about how they see the world, when intimate relationships are central to their life it is important to discuss SI and for bereaved clients it can help increase their sense of safety.
    - Normalising conversations around SI and death and grieving may be a great relief for clients who are suffering with issues they don't feel able to talk about.

- **Advice from therapists for those experiencing difficulties with sexual intimacy while grieving**
    - It is not wrong that sexual intimacy is important for you even though you are grieving it can be "natural, healthy and helpful" (f, 11)
    - Respect your own body and what it needs, there is "enormous wisdom" (f, 21) in your own body.
    - Take the time you need and understand that it is important to respect this.
    - If you are concerned then talk to someone, there are professionals who can help and the more we talk about these difficulties and break taboos the better.
    - If you have experienced traumatic losses there can be layers of trauma which are affected by aspects of SI and grieving.

Therapist comments about this study

In all of the interviews the participants at some stage reflected on the opportunity to think about how SI and the grieving process may impact each other. For seven of the therapists some discomfort or reluctance to approach the topic was expressed initially, while three came to the interview with the opinion that this was an important topic for discussion and they welcomed the opportunity to talk about it. The idea that both sexual intimacy and death represent social and/or cultural taboos also came up in each interview, later in the interview they also considered the wider importance of breaking these taboos in order to normalise discussion and ease guilt, shame and suffering. Despite their initial reluctance all of those who expressed reservations reflected at the end of the interview that discussing the topic really made them think about its importance and two participants even questioned whether previous interventions would have benefitted from the inclusion of the topic. Participants were keen to discuss this with colleagues and expressed interest in any possible recommendations for clinical practice that may arise as a result of this study.

Discussion

Therapist attitudes to the discussion of SI and grief formed a prominent part of the results of this study. All of the therapists interviewed expressed curiosity about the topic, some expressed the need for more recognition of the importance of researching this area and were glad to participate in furthering this. However, for others the link between the topics was less

clear. Despite those who were unconvinced, all welcomed the opportunity to consider the topic and reflect on whether it had been a factor in their client processes. Participants questioned why they felt reluctant to introduce the subject of SI and whether they might be missing something that was more important than they initially thought. While both clients and therapists may have avoided introducing the topic it may be important for therapists to reflect on whether they create the necessary conditions for clients to speak openly about sensitive subjects. Lack of ease with the topic as well as lack of training were given as reasons for not approaching the subject on the part of the therapists. Therapist reluctance to talk about sensitive topics may be conveyed implicitly to clients convincing them these topics are unimportant or off limits, which may obstruct discussions about death (van Deurzen & Arnold-Baker. Eds. 2005) or discussions about sex which despite the evidence of their importance to clients are often not disclosed in therapy (Love & Farber, 2017). The combination of sexual intimacy and bereavement may therefore present a particularly complex combination for both therapist and client. This result is in line with the existing literature which highlights that many health professionals are lacking in education about topics related to sexuality (Cesnik & Zerbini, 2017; Alarcão et al., 2012).

It is important that therapists are able to provide the space for open dialogue as well as reflection and insight which the client is unlikely to have within their other relationships (Dyregrov & Dyregrov, 2008). The normalising of conversations about difficult subjects like SI and grief can be created within the safety of the therapeutic relationship ensuring that areas which are troubling the client can be addressed and processed without added shame (Mearns & Cooper, 2018). The need to normalise topics within therapy came up frequently in the interviews as well as the need to progress more generally from social and cultural taboos. The need to train health professionals in order to both acquire knowledge and identify existing gaps in their existing knowledge of sexuality related topics is necessary and research has already highlighted the benefits of brief programs focussing on this type of training (Hordern et al., 2009). This study expands on existing knowledge by clearly advocating the need for clinical psychologists and psychotherapists to also receive further training in sexuality related issues, this need was highlighted by participants in the current study and by research demonstrating rigid sexual beliefs held by medical students (Pascoal et al., 2017) which may be changed through education (Komlenac et al., 2019).

Difficulties in discussing SI during bereavement is not surprising, Dyregrov and Dyregrov (2008) note that in their studies very few participants had discussed their difficulties in counselling or therapy and even fewer with friends or family. The perceived expectations of

others in terms of how grieving should look or how long it should last, as well as the double taboo of discussing sexual intimacy and death mean that potentially many people experiencing difficulties are less open to asking for help. For those who experience traumatic or sudden deaths and those bereaved by suicide this difficulty may be even greater as these types of death may have greater social stigma (Chapple et al., 2015) this is particularly relevant to spousal loss and child loss. The therapist's willingness to openly discuss topics that the client may feel are social and cultural taboos in an environment of safety may help to ease client shame and guilt (Love & Farber, 2017). Our results show that professionals themselves may not feel prepared to address the topic of SI which may in turn compromise a client's ability to disclose difficulties they experience in this area.

Bi-directional impact was often framed by participants in the context of the significant pain of grieving that may make it difficult for clients to feel they can experience pleasure or disengage from grieving. Or in the significant role that relationship factors like SI could have in either providing support and relief from grieving, or contributing to added suffering and secondary losses. The results of this study suggest that from a therapist's perspective sexual intimacy can be a positive factor for some people in terms of providing comfort and connection with a partner, this reinforces existing research about the role of sexual intimacy in the promotion of relationship wellbeing (Yoo et al., 2014). This finding also supports the theory presented in the Dual Process Model (DPM) of Coping with Bereavement (Stroebe & Schut., 2016) in that activities which provide some time away from coping with either loss orientated or restoration orientated activities are beneficial for the bereaved person. Participants in this study felt that their bereaved clients needed to recognise that experiencing pleasure while grieving was not wrong and that they should not feel ashamed of their needs, including sexual needs and SI with their partner could provide a helpful distraction from their grief. SI could also be part of restoration orientated activity as it may help with improving and investing in their relationship. For a few clients it was notable that SI became a compulsive way to escape their grieving but therapists were divided as to whether this was necessarily a bad thing. SI as a way to relieve tension during grieving is included in the work of Dyregrov and Dyregrov (2008), however they also found that difficulties in SI were relatively common after a death and that there is often a mismatch between partners in terms of desire and emotional availability for SI. The stress of problematic SI was common for the clients who did discuss their difficulties with the therapists interviewed in this study. For many clients a period of reduced sexual desire was common and when partners were not supportive or understanding this led to greater

relationship tension and suffering for the bereaved person, this concurs with research highlighting couple distress caused by differences in sexual desire (Marieke et al., 2020). Some clients mentioned that differences in desire for SI put intense pressure on their relationship and led to either forced or coerced sex, disengagement from their partner and in some cases ultimately it was a factor in the ending of their relationship. The added stress factor was often the reason that the topic of SI arose in therapy. Sometimes additional external stressors were present which increased conflicts within relationships. Stroebe and Schut. (2016) discuss how such stressors and secondary losses can contribute to overload for the grieving person and that this, in a similar way to other types of overwhelm or burnout (e.g. workplace stress or familial tension), can lead to reduced coping and physical fatigue amongst other symptoms which could plausibly make a person more likely to experience prolonged or complicated grief.

For those who experience relationship difficulties as a result of changes in SI during grieving, communication was highlighted by all participants as the most important factor in overcoming this. Existing relationship satisfaction especially in the areas of communication and sexual intimacy is likely to influence how a couple's relationship progresses when one or both experience bereavement. Therapist interventions around communication and sexual intimacy may be beneficial for a couple's overall relationship satisfaction (Yoo et al., 2014). The relevance of sexual communication and the expression of feelings to sexual satisfaction and sexual function has already been established by other literature (Sukhanova et al., 2022; Pascoal et al., 2019; Mallory 2021). But as some participants stated these types of interventions are often not offered as part of grief and bereavement counselling or therapy. Three of the therapists interviewed actively sought the perspectives of partners or involved them in their client interventions. This involvement and shared communication can be valuable for meaning making (Hagemeister et al., 1997). Which can, in turn be helpful for the integration of grief (Stroebe & Schut., 1999). Participants felt that sharing this part of their process may also be a constructive way to increase dialogue around the individual needs of partners. The discussion of individual needs can help a couple understand how they can best support each other (Dyregrov & Dyregrov, 2008) if both are invested in the improvement of their relationship.

In addition the interaction between trauma and touch is important to recognise. Certain types of trauma especially interpersonal trauma may increase a person's aversion to all forms of touch (Strauss et al., 2019). A number of participants referred to clients having difficulty with touch and also in connection with their own body as a result of traumatic loss. One participant specifically referred to training in Somatic Experiencing (SE). Getting back in touch

with the physical self helps build a person's feeling of agency and a useful focus away from specific memories (Van der Kolk, 2014). Body based trauma therapies such as Somatic Experiencing are beginning to receive positive recognition as effective methods for treating both physical and affective symptoms of trauma (Kuhfuß et al., 2021). SE and other therapies such as Trauma Releasing Exercise (Bercelli, 2008. as cited in Haines, 2016) may with more research be useful tools for therapists when working with clients who are experiencing trauma.

Positive client experiences were limited but cases of parents who lost children but went on to deeper levels of mutual understanding and improved sexual intimacy were reported along with cases of bereaved clients who went on to develop new resilience and improved quality of life and in some cases new relationships. This was also relevant in cases of spousal loss and is coherent with previous literature on post traumatic growth and similar to the experience illustrated by Sarner (2021). Post traumatic growth is still evolving as an area of study but factors such as stability, social context and narrative construction may all be indicators in the formation of positive psychological change (Jayawickreme et al., 2020). For clients with stable and supportive home environments these changes may be understandable, many participants felt that supportive partners and positive sexual intimacy were helpful. For other clients this may be harder and they may need greater therapeutic and social support in order to work with their experiences and go on to effect transformative changes. (Doherty & Scannell-Desch, 2021)

Limitations

The small sample size of this study may be considered a limitation and it may be of benefit for a future study to interview bereaved persons in addition to therapists in order to compare how their experiences may differ. Working with the bereaved directly is ethically complex and this study has dealt with challenging and difficult material, in any future project it would be necessary to ensure as far as possible that participant safety is protected. In order to have a better understanding of the impact on future relationships of bereaved people a future study may consider interviewing participants at different intervals following bereavement in the form of a longitudinal study.

For this study the criteria for participation was having worked recently with bereaved clients, therefore grief therapists and those working in palliative care made up the majority of participants. However, it would also be interesting to explore the same topic with therapists

whose primary area is clinical sexology and this could be a possible direction for further research.

Nine of the Participants were Portuguese and all were currently working in Portugal. At least five participants had worked in other countries at some point in their career or currently worked for helplines or online services providing international support for clients from various backgrounds and ethnicities. It was interesting to note that while many of the therapists attributed client reluctance to specific Portuguese cultural factors all the therapists referred to similar themes, most notably guilt and shame. Possible future studies may consider broadening the international scope of this theme with a more diverse participant sample.

Asking participants to be interviewed in their non-native language may also be considered a limitation, however this was made clear to all participants when they were approached. Many of the Portuguese participants were quite accustomed to speaking English but where necessary questions were re-framed or words translated in order to make sure there was sufficient understanding.

Strengths of this study

The literature on sexual intimacy during bereavement is very limited, and therefore this study is quite novel in addressing the topic. One of the strengths of qualitative research is the depth to which a topic can be explored and for an unusual topic it is important to work in a bottom up approach such as Grounded Theory where results are based directly in the words of the participants themselves (Charmaz, 2006). By discussing the topic with therapists who have had many years of client experiences it was possible to benefit from their accumulated experience and insight.

This study highlights that while SI during grieving may not be a problem for all clients, those it does impact may be at risk of significant added suffering and they may feel great guilt or shame such that they cannot introduce the subject. When a therapist displays willingness to address the topic it is often a great relief for those affected. The importance of therapist openness, underpinned by appropriate training and therefore the provision of a safe environment for the client to disclose are key factors addressed by this study. During the interview process it was demonstrated that the more holistic and integrative the approach of the therapist, the greater the openness for discussing SI with bereaved people. For this reason the

potential integration of training in sexual intimacy and relationships could be beneficial for grief therapists in order to broaden the scope of their interventions and for supervision. One of the therapists interviewed had trained both in clinical sexology and grief counselling and it was clear during the interview that this offered a different perspective on the topic. A more integrative approach to therapies or greater collaboration between therapists with different areas of expertise could therefore be of benefit. Therapist openness to discuss the topic of sexual intimacy with their grieving clients and the ability to include or refer couples for interventions that may help them in terms of communication are the primary recommendation of this study.

By bringing together two topics which are fundamental in human experience, sexuality and death, this study has not been afraid to address complex and difficult subjects in a way that is often treated with squeamishness and avoided. The importance of normalising discussion about these topics is an opportunity which is often overlooked in other research and this conversation needs to begin within the academic and scientific community so it can be addressed in an objective way and hopefully a wider acceptance created. Without further exploration we will also be unable to fully understand the prevalence of difficulties in this area or the scope of this topic.

Conclusion

For many grieving people sexual intimacy may either remain as it was before or resume after a period of time without great consequence for their process of grieving. For a few it may become a much needed refuge and place of comfort and support, but for others significant relationship difficulties, guilt, fear of public shame or ongoing trauma may play out within the interaction of sexual intimacy and the process of grieving which can place a heavy load on a person who is already struggling to cope and recover. The therapeutic environment may be a vital place for this to be explored and for a person to receive support they badly need. It is important therefore that therapists remain open to discussing the topic and that they feel appropriately prepared to offer interventions in this area. The discussion of sexual intimacy during bereavement should not be left to the dark corners of the internet, the academic and scientific communities can more adequately understand and support the needs of grieving people by building on existing knowledge. Further research in this area can help provide recommendations for how best individuals can be supported as well as greater understanding of the implications of the complex interplay between these two topics.

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