

SUSAN KOLOD, Ph.D.

MENOPAUSE AND SEXUALITY

Abstract: Clinical research confirms that declining sex activity is one of the most common and vexing problems of menopausal women. Numerous physical conditions, many of which are treatable, contribute to this decline. Aging male partners also experience changes that can interfere with sex. Research, however, indicates that psychological and emotional factors are equally or more important causes of the decline in sexual activity. Accumulation of resentment toward one's partner and other dissociated sexual trauma are two important psychological factors that the author believes contribute to a decline in sexual interest and activity at menopause. This paper reports on a two-part treatment approach that helps menopausal patients bring dissociated sexual trauma to consciousness and allows them to reconnect with sexual desire. Clinical examples illustrate the use of this treatment.

Keywords: menopause, sexuality, midlife, female development, estrogen, hormones, psychotherapy, psychoanalysis

FIVE YEARS AGO 10 high school girlfriends and I got together for a reunion. We had been meeting at Patty's weekend house on the Chesapeake Bay every five years; first at age 40, then at 45, and now at 50. At this last reunion we talked about almost everything—children, careers, mates, our new menopausal symptoms, the past, the future. But one topic we avoided this time was sex. At prior reunions sex had been a big topic. Toward the end of the weekend when the subject finally came up, it seemed that all these extremely attractive women had more or less given up sex—even Sonia, a tall, slim, blonde woman, who had been the lead singer in a high school all-girl rock band and epitomized the 60s mantra of sex, drugs, and rock and roll; and Patty, the beautiful, dark-haired earth mother who tried to free all the parakeets at Woolworth's while tripping on acid and whose romantic adventures were well known. But between the ages of 45 and 50 these women had renounced sex. Moreover, sex had become an uncomfortable topic—a taboo all over again, embarrassing, something to dread.

When I returned home to New York, I observed that giving up sex at menopause was not exclusive to my old friends, the aging bohemians of Akron, Ohio. The same was true of many of my peers in Manhattan and the New York suburbs. My patients also talked about how their identities and self-concepts had changed during menopause. With embarrassment, they raised the subject of their sex lives in the *past tense*. Not every woman who had given up sex at menopause was at the vanguard of the sexual revolution. Yet it was the change in this group, for whom adventurous sex had been a defining characteristic, that seemed most striking.

In my clinical work I find that declining interest in sex is a common and highly disturbing problem for many menopausal women. Some patients have said they would choose to give up sex altogether if it were not for their partner's objections. Others want very much to continue or revive their sex life but are unable to do so. In this paper I describe a treatment technique that I have used successfully to assist women who are unhappy about having given up sex at menopause.

Many of the friends, colleagues, and patients I am talking about are women who came of age in the late 60s and early 70s and who describe themselves as having been sexually liberated and experimental in their late teens and 20s. A number of them are in relationships, some straight, some gay, and remain joined to people with whom they once had a vigorous and satisfying sexual relationship. Since entering perimenopause they have become less interested in and more avoidant of sex.

For some, this may be a welcome change. Like Bea, a middle-aged woman in the novel *Empire Falls*, by Richard Russo (2001), they think, "Saying good-bye to sex was like waking up from a delirium, a tropical fever, into a world of cool, Canadian breezes. Good riddance" (p. 127). But other women are extremely distressed by the decrease of sexual passion in their lives, particularly when partner-initiated sex has become something to dread.

There are a variety of reasons why a woman might give up sex at menopause. As the sex hormones decline, there is an accompanying decline in libido. In some cases the woman has never been particularly interested in sex, and, as she and her partner age, it becomes less important for both of them. Both men's and women's bodies are less attractive as they age. Sex also becomes physically more difficult for men and women alike and relationships change owing to a lessening of the sex drive of both partners. Some obvious conscious reasons for avoiding sex are painful intercourse due to vaginal dryness, cramping, and intense bleeding. Other

symptoms related to a decline in estrogen, such as insomnia and hot flashes, add to the woman's general sense of misery. As women go through menopause, their aging male partners also experience changes that can interfere with sex, such as erectile dysfunction and a general lowering of sex drive. Before the advent of Viagra, the combination of vaginal dryness, erectile dysfunction, and reduced sex drive led many couples to conclude that it was time to "close up shop."

But physical symptoms are not the whole story. There are remedies for many of these problems—hormone replacement therapy (HRT) reduces many of the most unpleasant symptoms of menopause; and the acute symptoms of menopause often disappear without treatment.¹ There are a variety of medications to treat both female and male problems. On the other side of the equation, changes in lifestyle would actually seem to facilitate freer sex. In many cases the children are now living out of the house, the stresses of early adulthood are lessening, and there is less or no need for birth control. But just as external conditions for sexual activity become more optimal, some women become fearful and anxious about sex. To work through that fear seems daunting, even impossible.

Despite the reasons why a woman might become less interested in sex or give it up altogether at menopause, a significant number of women are unhappy with the situation and would like to find a way to reignite their sex lives.

The Psychoanalytic Literature

In the psychoanalytic literature, little attention has been paid to identifying, and none to treating sexual problems in menopause. Helene Deutsch's (1945) famous statement is emblematic: "Woman's last traumatic experience as a sexual being is an incurable narcissistic wound" (p. 457) and "At the menopause everything that was granted the feminine being at puberty is taken back" (p. 61). The implication is that, psychologically, the problem is incurable.

A review of the contemporary psychoanalytic literature on menopause yields very sparse results. In addition to the classic papers on menopause written by Deutsch (1945) and Benedek (1950), more recent contributions

¹ Many women have stopped using HRT since the 2002 report from the National Institute of Health, which reported that women who use HRT over extended periods of time are more likely to develop breast cancer.

include those of Bemerdorfer (1996), Formanek (1992), Lax (1997), and Notman (1979, 2002). Pines (1994) and Chodorow (2003) have written on subjects tangentially related to menopause.

What accounts for this absence in the psychoanalytic literature? I identified three factors (Kolod, 2005):

1. It is difficult to distinguish the psychological effects of menopause from aging in general.
2. The most severe psychological symptoms of menopause are transitory. It can be hellish while you are going through it, but afterwards it is often remembered as a “nonevent.”
3. Whenever there is a focus on the psychological effects of changes in female hormones, there is a possibility of stigmatization. The classic psychoanalytic papers on menopause were extremely stigmatizing to women, and the ideas expressed in those papers influenced the psychoanalytic position on women’s midlife difficulties for more than 30 years.

Bemerdorfer (1996), in her review of the psychoanalytic literature on menopause, noted, as I did, how few articles there were in the analytic literature compared with the explosion of books on the subject in the popular press. She observes that a patient’s denial combines with the analyst’s blindness to keep the topic out of analysis. In addition, she notes that menopause is like jokes and parapraxes before Freud: a universal, unavoidable aspect of female experience that is so common its importance is simply overlooked. Like Poe’s “purloined letter,” it is hidden in plain sight.

My obliviousness to my own menopause is illustrative: I was in my late 40s and my period did not arrive as expected. I was convinced that I was pregnant. I was unhappy about the “pregnancy”—I definitely did not want a child at my age, but the prospect of an abortion was disturbing. I did eventually get my period, but the interesting part of the story is that this event repeated itself over the next six months—my period was either late or I missed it altogether, and each time I was sure I was pregnant. Finally, a midwife confronted me with the obvious: I was in perimenopause. The extent of my denial—that I would prefer to think I needed an abortion rather than admit to myself that I was entering menopause—is not unusual. I see it not only in myself, my friends, and my patients but even in the field of psychoanalysis.

Stigmatization

Of all the factors that contribute to the avoidance of the subject of menopause in contemporary psychoanalytic literature, the most significant may be the stigmatizing nature of the early writings on the subject and the backlash that ensued. Classical theory takes the position that the forward development that occurs physiologically and psychologically at puberty is reversed at menopause; and that during both puberty and menopause a regression occurs. Freud (1937) noted the similarity between puberty and menopause: "Twice in the course of individual development certain instincts are considerably reinforced: at puberty and, in women, at the menopause. We are not in the least surprised if a person who was not neurotic before becomes so at these times" (p. 226).

Deutsch (1945), elaborating on Freud's position, wrote that menopause reactivates the castration anxiety that has been kept at bay by the tasks of being a wife and mother, and that it is almost inevitable that women will become depressed at this stage. From Deutsch's formulation came the diagnosis of involuntional melancholia—depression caused by menopause. This diagnosis was very popular until it was removed from the 3rd revision of the DSM because it was deemed to be stigmatizing to women.

Benedek (1950) took a less extreme view but also saw puberty and menopause as closely linked in the sense that during both phases there is a regression to the infantile position: "The rebellion of puberty appears to be repeated when the internal frustration of the declining hormonal function activates aggressive, hostile and regressive behavior" (p.14). Benedek did not see depression as inevitable in menopause but notes the prevalence of "reactive depression" during this phase. She stated that the manner in which individual women respond to the stress of menopause depends on the vicissitudes of their identification with their mothers, which determines their acceptance of the feminine role.

The second-wave feminists took exception to these Freudian theories of female development and regression. Friedan (1963) and others regard concepts such as penis envy and the castration complex as ways of keeping women enslaved. Friedan (personal communication January 21, 2006) believes that if a woman has had a meaningful life, including a career and friends, she will not experience any unpleasant menopausal symptoms. With respect to the HRT debate, Friedan (1993) writes, "I am alarmed at this new epidemic of menopause mania. It seems to counter the effects of the women's movement of the last twenty-five years, erase our breakthrough

of that obsolete feminine mystique which used to define the cessation of reproductive sexuality as the ‘end of life as a woman’” (p. 484).

The second-wave of feminists has made an important contribution by questioning the axiom that “anatomy is destiny.” It is now politically unpopular in psychoanalytic circles, however, to acknowledge the effect of what I term “the hormonal body” on a woman’s psyche. Lax (1997) notes that, “feminists and certain groups of ‘hip’ women” attempt to deny the meaning of menopause and to behave as if what is occurring within them has no significance” (pp. 198–199). Chodorow (2003) now laments the avoidance of a woman’s hormonal body in psychoanalytic treatment, a trend she helped to foster. In the 1970s Chodorow (1978) urged women to wait until they had careers before becoming mothers, but she now questions the wisdom of ignoring the body and hormones. She notes that problems created by this avoidance of the hormonal body surface in many psychotherapies of women in their mid- and late 40s and 50s who waited too long to have children and are now unable to do so.

Empirical Studies on Menopause

My personal observations, based on a small sample of patients and friends, are confirmed by psychological research: declining sex drive is one of the most common and vexing problems of menopausal women. The empirical studies concur on the near-universality of problems with sex at menopause, but they differ from psychoanalytic writings in proposing medical as well as psychological treatments. Numerous studies have investigated the causes of this decline and provide indications for treatment.

Danaci and colleagues (2003), in a study of 324 women between the ages of 40 and 60, noted that “the frequency of sexual intercourse decreased significantly as the follicle stimulating hormone level of women increased” and that, “an increase in anxiety and depression that often accompany menopause affected sexual life in a negative manner” (p. 30). Mishrah and Kuh (2006) conducted a study with 1,525 women aged 47 to 54. They found that 95% of the postmenopausal women reported sexual difficulties; they recommend that health professionals (a) consider treatments directly for vaginal dryness, (b) identify somatic symptoms of difficulties with intercourse, (c) investigate psychological factors for a reported decline in sex life, and (d) consider the potential role of intimate partners.

Dennerstein, Alexander, and Kotz (2003) led the Melbourne Women’s Midlife Health Project, which is a prospective, observational study of

a community-based sample of Australian-born women aged 45–55 at baseline. There were eight annual assessments using self-report questionnaires and blood sampling for hormone levels. The authors write, “Sexual problems are among the most frequently presented health concerns of women attending the menopause clinics” (p. 64). As the women progressed from early to late menopause, the percentage of women with scores indicating sexual dysfunction rose from 42% to 88%. Dennerstein, Lehert, and Berger (2005) found that, “prior function and relationship factors are more important than hormonal determinants of sexual function of women in midlife” (p. 80).

In summary, the empirical psychological studies on menopause indicate that problems with sexual desire are among the most common, if not *the* most common, complaint in menopause clinics. More important, these authors conclude that, while the physical causes such as vaginal dryness and a decrease in sex hormones must be investigated and treated, the psychological components, such as the quality of the relationship, anxiety, and depression, are equally or more important to explore and address.

Clearly, this is a complex issue that involves physical changes in both female and male partners, current and past relationship problems, the sexual history of the woman, and other psychological issues that may be exacerbated by the onset of menopause.

Clinical Examples and a Treatment Approach

Of course, many women do not experience a decline in sexuality at menopause; among those who do, a considerable number do not find this decline to be a problem. For a significant number of women, however, the decline in sexuality is not only problematic but difficult to address because of the shame attached to it. Often, menopausal women come into treatment with issues unrelated to sex, most often depression. The emergence of the problem of declining sexuality is accompanied by a sense of embarrassment and futility.

The physical changes are often the first issues to come up: vaginal dryness, the male partner's erectile dysfunction, a drop in sexual responsiveness and ability to orgasm. As I said, there are medical solutions available for these problems. Hormone replacement therapy, taken orally or in the form of topical cream, can correct the problem of vaginal dryness. Viagra has significantly diminished the problem of erectile dysfunction. Testosterone is now being prescribed to menopausal women who are

experiencing low sex drive. In some cases, addressing the medical issues will clear up the problem. But people are often reluctant to pursue these medical aids, and analysts can confront the resistance to pursuing medical treatment.

I find that accumulation of resentment toward one's partner and dissociated sexual trauma are two psychological factors that contribute to a decline of sexual interest at menopause. Menopause is often a time when a woman takes stock of her life and considers what she wants to keep and what she wants to change. In taking stock of her marriage, the woman may become aware that satisfaction with the sexual aspect of her relationship has been deteriorating for some time. And as she reaches menopause and sexual need decreases, the entire notion of a sexual relationship with her husband may have become burdensome. Germaine Greer (1992) put it this way: "If she is one of the many women who have been fucked when they wanted to be cuddled, given sex when what they really wanted was tenderness and affection, the prospect of more of the same until death do her part from it is hardly something to cheer about" (p. 307).

Problems in a relationship may be dissociated for years because the woman is busy with children and building a career (Mitchell, 2002). Menopause frequently occurs at the same time the children leave home. Their absence creates a vacuum for the couple. The vacuum can reactivate problems in the relationship that bring things to a head. At that point the couple either separate or they work on the problems. Thus, menopause can coincide with a crossroads where relationships either end or improve.

I developed a two-part treatment approach that has worked well with menopausal women who are unhappy with the quality of their sex lives. This approach has been particularly effective with women who express a fear of sex at menopause. It is simple and straightforward and assumes that the sexual problem may, in part, have its roots in earlier, dissociated sexual trauma. Trauma can be defined in many ways and what is experienced as trauma by one person may not be traumatic for another (Bromberg, 2008). A woman can experience trauma not only from incest, rape and other sexual violence but also from infidelity of her partner or from an array of sexual adventures that occurred under the influence of drugs or peer pressure and were later experienced as humiliating. The type of sexual trauma that results from experiences that were thought of as adventures at the time is particularly prevalent in women who came of age during the sexual revolution of the late 1960s and early 1970s and are now in menopause.

In the first phase of the treatment I do a very careful detailed inquiry (Sullivan, 1954; Levenson, 1988) concentrating on the patient's sexual history. In particular, I focus on experiences that may have seemed like adventures at the time but are now felt to be painful, traumatic humiliating events.

There's an expression, "If you remember the 70s, you did not experience it." That is, those who were really living the 70s were too high on drugs to remember it. I believe it also speaks to the dissociation of this time of sexual experimentation, particularly for women. Common experiences for adventurous young women during that era included having sex while under the influence of such powerful drugs as Quaaludes, speed, or LSD, waking up in bed with someone the woman did not know, rape, date rape, abortions, sadomasochistic relationships, and being involved in cultlike groups where women had multiple sex partners. Such experiences were more common than we might think today. The *Harrad Experiment* (Rimmer, 1966) and *The Electric Kool-Aid Acid Test* (Wolfe, 1968) are rife with accurate descriptions of sex among the more daring young women of those days. Of course, women who were not adventurous also may have experienced sexual trauma that was dissociated.

Most interesting is that those "sexual adventures" may not have been experienced as painful, humiliating or traumatic *at the time they occurred*. It is only in retrospect, when one is going through the changes of menopause and experiencing sexual difficulties, that the events take on a traumatic feeling. Hegeman (2008) points out that through dissociation it is quite possible to be unaware that one has been traumatized, particularly if the traumatizing event is culturally normalized.

By focusing on these adventures, the patient may be overwhelmed with shame, remorse, and humiliation from the past. These painful feelings are exacerbated by current feelings of inadequacy, loss of attractiveness, poor body image, depression over aging, and loss of efficacy brought on by menopause. These are difficult feelings to acknowledge and the working-through constitutes a type of mourning.

The second phase of the treatment focuses on contacting and articulating thoughts and feelings that are erotically compelling to the patient—to facilitate reconnection to her sexual desires. One could call this a detailed inquiry of eroticism. Although most psychoanalysts are used to talking about sex with their patients, I have found that it requires some degree of courage in these situations, with women who have become anxious and phobic about sex and disconnected from sexual desire, to ask about their

sexual fantasies and masturbation practices and to inquire about the details of the sexual experiences that have been arousing to them. The analyst may be worried about intrusiveness or afraid she will humiliate the patient further. If the analyst patiently and slowly persists, however, she creates a climate in the room where such matters can be discussed openly.

Brenda and Ed

The following clinical vignette illustrates this two-phase treatment approach with a woman who began experiencing sexual problems at menopause owing to a combination of accumulated resentment toward her partner, unresolved trauma, and physical symptoms. Brenda, a 48 year-old lawyer, consulted me when her marriage of 21 years started to fall apart. She had missed her first period, and her younger child had just left for college.

Brenda and Ed were college sweethearts, and sex had always been a very important part of their relationship. Brenda recalled that the first year they were together they spent all their time in bed. Neither of them had had a lot of prior sexual experience, and Brenda reported that she had her first orgasm with Ed. Brenda was completely smitten with Ed, and Ed loved Brenda as well but wanted to experience sex with other people. He encouraged a *ménage-à-trois*, which they participated in while under the influence of cocaine, Quaaludes, or LSD. In addition, Ed engaged in recreational sex with both men and women outside the relationship. He hurt Brenda with some poorly hidden infidelities. Eventually his behavior became too much for Brenda, and she broke up with him. But they were both miserable apart and quickly got back together.

Brenda and Ed lived together for several years and finally got married. They got along with each other very well, and their sex life was very exciting but also traumatic for Brenda because of Ed's tendencies to stray occasionally. During Brenda's pregnancy with her first child, Ed had an affair. Brenda found out, was heartbroken, and decided to end the marriage. Ed begged her to stay, and they entered marriage counseling. Ed went into individual treatment. Their marriage improved enormously after that. Ed stopped straying and his career as an investment banker took off. Once the baby was old enough for nursery school, Brenda went to law school. They lived a happy, contented life together and then had another child.

For 17 years Brenda and Ed lived a busy, satisfying, constructive life. They both flourished in their careers and enjoyed being parents. They bought a house and furnished it beautifully. They loved entertaining family and friends in their comfortable home. Their life became quite routine.

Both Brenda and Ed were very busy with their careers and family—everything had to be planned, and some of the spontaneity had gone out of their sex life. As Mitchell (2002) pointed out, we let our love lives become routinized in order to create a climate of security and dependability.

Then the younger child left for college and Brenda entered perimenopause. She started to feel restless and edgy—she had lost her identity as a caretaker now that the children were gone. Although Brenda had never been a good sleeper, as her hormone levels dropped her insomnia became so bad she had to take medication to fall asleep. She felt irritable and moody much of the time. Life had lost its zest for her.

Ed was also going through a midlife crisis. He began to have problems maintaining an erection. Their lovemaking took on a tense quality because both Brenda and Ed never knew when or if he would lose his erection. They started to avoid having sex and became short tempered with each other. At Brenda's urging, Ed got a prescription for Viagra. This reduced the tension and relieved their anxiety during lovemaking, which improved dramatically.

But Brenda was still worried about Ed. He was working longer and longer hours. She noticed that he was drinking a lot and spent a great deal of time looking at pornography on the Internet. Ed began to suggest a *ménage-à-trois* again—something he hadn't brought up in more than 20 years. Brenda was very dismayed and disgusted by this prospect.

When Brenda asked Ed if something was wrong, he became evasive. If Brenda pressed him, he snapped at her. She felt that her life was coming apart. She was "going crazy" and had lost a sense of who she was. With the Viagra, Ed was pushing for more adventurous sex, and she was getting more and more disgusted with him. The Viagra had cured one problem but seemed to have created another one.

It was apparent to me that, whatever else was going on with Brenda, she was reexperiencing the trauma that she had gone through in the early stages of her relationship with Ed. Although they had weathered the infidelities, Brenda's pain and heartbreak never really went away—it just went underground.

In her sessions with me we went through those experiences in detail. It was as if the incidents had happened yesterday. Brenda still had traumatic dreams, recurrent dreams in which she found out that Ed had been unfaithful to her and she knew that she would have to leave him.

Our examination of the painful past prompted Brenda to confront Ed with the unbearable. She felt certain that he had been unfaithful to her again. At first Ed denied it but finally admitted that he had had sex with

another woman a few times to see if he could keep an erection without using Viagra. He discovered that even with this new person he needed the Viagra to keep his erection.

After this admission Brenda went into a tailspin. She felt angry at herself and ashamed for not having left Ed the first time this happened. Ed insisted that this affair was meaningless. He begged Brenda for her forgiveness. She insisted that they see a couples therapist.

After a year of couples therapy Brenda told Ed to move out. She could not get past his last betrayal. Ed found an apartment, but they continued in couples therapy and in their individual treatments. They saw each other on weekends.

During this time Brenda found it difficult to become sexually aroused with Ed. Every time they started to have sex, she imagined him with another woman and became very upset and sometimes cried. For a few months Brenda avoided sex altogether but that was not what she wanted. She wanted to be able to reconnect with her sexual feelings toward Ed.

At this point we began the second phase of the treatment. We explored the thoughts and fantasies that aroused her sexually, and she recounted the *ménage-à-trois* encounters from their early years together. On several occasions they had included another man. Although Brenda had no desire to include other people in their current sex lives, she did find the memories of these experiences to be very stimulating. With some trepidation I asked her to tell me about the experiences in detail, which she did.

The following weekend, when Brenda and Ed started to make love, she was distressed to find herself imagining Ed with another woman. But this time she changed the scenario to the *ménage-à-trois* with another man and was able to enjoy the sexual experience.

The separation resulted in both Ed's and Brenda's encountering each other with renewed passion. Ed's persistence in the marriage counseling and his pursuit of Brenda won her over. She acknowledged that Ed was not perfect but that she loved him very much, and he obviously wanted to be with her. Although Brenda reported that she sometimes had difficulty becoming sexually aroused when thoughts of the affair intruded, she was able to draw on other fantasies and scenarios with increasing ease. After six months, Ed moved back into the house with Brenda. There was a noticeable difference in the quality of their relationship. They acknowledged each other in a way they never had before. Best of all, their sexual relationship was invigorated, and they regained the passion of their early years together.

The case of Brenda and Ed has all the elements I mentioned that can contribute to a decline of sexuality in menopause: physical symptoms,

accumulation of resentment toward one's partner, and early trauma in the relationship that went underground. Although difficulty with sexual arousal was not her presenting problem, it became apparent that Brenda was very distressed and did not know what to do about it. I used the two-part approach: First, I took a detailed sexual history and then focused with Brenda on fantasies and scenarios that she found to be sexually compelling.

Harriet

I also used the two-part approach with Harriet, a 52-year-old real estate broker with a traumatic sexual history who developed a phobia of sex at menopause. Harriet came to my office seeking treatment for depression. She reported that she was happily married but had been feeling very down since her one child, a son, had left for college. The death of her mother the previous year was also contributing to her sadness. Harriet's irregular or missed periods caused her to feel premenstrual tension most of the time. She lost her temper easily and burst into tears. The future looked bleak and empty to her. After a month or two, Harriet mentioned that she was avoiding sex with her husband and dreaded the thought that he expected sex from her. This fear of sex had started two years earlier and had gradually become worse. Prior to that time, their sexual relationship had been quite good.

Initially, Harriet was reluctant to talk about her sexual phobia. She had come to believe that this was a personality trait that could not change, and she had given up hope. She was unhappy about it, as was her husband, and she worried that it could snowball and lead to more serious problems in the marriage. She reluctantly agreed to address the phobia, and we started by going over her sexual history in depth. As we explored her sexual "adventures," we were both astounded at the amount and extent of her sexual trauma.

When Harriet was 15 her father divorced her mother and married a much younger woman. He became unavailable and more or less abandoned Harriet. Harriet was an attractive teenager and noticed that she could gain power over boys and men by using her sexuality. Her mother, who was quite depressed, paid little attention to Harriet's nighttime activities. She described a series of encounters that started out to be fun and exciting. They began as flirtations that gave her a feeling of power. Drugs were often involved. Before she knew it, Harriet was having sex with someone she barely knew. Harriet related these incidents with a great

deal of shame. She repeatedly wondered to me how she could have had such a low opinion of herself?

In her early 20s she had longer term relationships with two different men that became explicitly sadomasochistic. One man was a great deal older than she and had a Svengali-like influence over her. She was both enthralled and afraid of him. As they became more involved, he was increasingly abusive, both physically and psychologically. Finally, she was able to flee from this relationship.

Eventually she married Bob, her current husband, whom she refers to as her “soul mate.” Harriet found Bob to be very attractive, and he was (as he still is) very attracted to her, but she had limited their sexual contact increasingly over the last two years. She was tired and moody now, and the prospect of sex filled her with dread. Harriet stated that she would give up sex altogether were it not for Bob’s objections. She reported that she had started to feel acutely anxious when they had not had sex for a while and she knew that Bob was about to initiate it.

We spent several months going over the details of her traumatic sexual history. Harriet was surprised by how much it still upset her to think about these experiences. Although she had gone through a lengthy psychoanalysis in her 20s, she did not recall examining her sexual history; her prior analysis had focused more on family dynamics, possibly because her analyst was a man but more likely because she was not experiencing sexual difficulties at that time.

Once we completed the examination of her sexual history, we went on to the second phase. Our sessions began to focus on her desires, sexual and otherwise, and her ambivalence at seeing herself as a sexual being at this time of her life. I repeatedly asked her to think about and tell me what turned her on. I asked her if she masturbated (she did) and whether she used a vibrator (she didn’t). I asked if she enjoyed pornography and what kinds of scenarios she found arousing. These questions were difficult for me to ask because they aroused shame in Harriet and were embarrassing for her to answer.

One day she brought in a “Victoria’s Secret” catalog. As we went through the pages together she explained what was sexy and what was not. She had always thought black underwear was sexy. Maybe she should buy a few pairs. She bought and wore them and reported that they did indeed make her feel different. She felt sexy but it was hidden—no one but she knew.

The first big change occurred when Harriet decided not to stop herself from becoming sexually aroused. She wondered, What would happen if I do not try to stop it? She started to enjoy sexual encounters with her husband as long as he did not notice that she was enjoying it. But she balked when her husband commented on her increased passion. She felt reasonably relaxed about being a passive object of desire. She could not yet, however, own her desire.

As we continued to explore her sexual thoughts and fantasies, she started to experiment with initiating sex with her husband, tentatively and with a great deal of anxiety. She talked with him about her fears. He was sympathetic and patient, and their intimacy increased as she shared negative experiences with him. After a while sex became easier and less scary. Eventually, their sexual relationship improved to a point beyond what it had been when they were first together, making them feel closer than they had felt in years.

Harriet's presenting problem was not her difficulty with sex. She came for treatment because she was depressed about life changes. Her sexual difficulties were something she regarded as "unfixable" and hopeless. She was extremely reluctant to address her sexual inhibition. An examination of her sexual history revealed a great deal of trauma. Interestingly, her sexual escapades had been experienced as adventures at the time. The traumatic element was dissociated and the fears surfaced only at perimenopause and then grew more intense once her periods had stopped altogether. This exploration of her sexual fears resulted in an improved relationship with her husband and a more open acceptance of her own desires and passions. Harriet now is more truly open to sexual experimentation than ever before.

Anne

I tried the two-step approach with Anne, a 54-year-old writer. The results taught me how complicated the issue of sexuality at menopause can be. Anne had battled with periods of psychosis since her adolescence and had been hospitalized several times. Now, with medication and psychotherapy, she was functioning quite well. She and her husband had had an adequate but unexciting sexual relationship, but at menopause the marriage had become completely asexual. She did not mind giving up sex, but it made her feel "weird" and her husband objected.

As we explored her sexual history, she related several incidents when she had experienced psychotic episodes in her early 20s while having

sex. She had become completely disoriented and lost a sense of who or where she was. She felt that her body was coming apart and ended up wandering around in a trancelike state. A few weeks after we started exploring her sexual history, she suddenly reported that she and her husband had begun having sex again. Soon after that, Ann experienced psychotic-like episodes in which she found herself wandering around in a trancelike state again. These episodes terrified her. We discontinued the approach, and she stopped having sex with her husband.

Sarah

All the women I have described thus far were in relationships. Wondering if this approach would work with an unmarried menopausal woman, I tried it with Sarah, a woman in her late 50s. Sarah had never been married but had always enjoyed sex and had had many different partners. She mentioned that she had been avoiding sex for the last few years and was afraid she was not physically able to do it anymore.

As we began to go through her sexual history, she and I were both astounded at the extent of the trauma she had suffered. She had never thought of these experiences as anything but exciting adventures—just what was going on at the time; she thought everyone had had similar experiences. Her very first love affair resulted in a late-term illegal abortion. The experience was both sordid and painful. Then, on a hitchhiking trip through Europe, she was beaten and raped. Those are just a few of an endless array of painful sexual experiences she encountered in her quest for “liberation.” Surprisingly, those experiences did not inhibit her sexual responsiveness until she started to undergo the changes of menopause. At that point, the idea of having sex started to feel very frightening to her.

We had just started the second phase when she met a man and began a sexual affair. She had no problem responding to him, and her concerns that her vagina had atrophied were unfounded. This affair lasted only a few months, and Sarah is alone again. She wishes she were in a relationship but she is no longer worried that she is unable to have sex.

I have concluded that if a woman enjoyed sex in the past, particularly with her current partner, and both of them want to improve or reignite their sexual relationship, this treatment approach is very useful. Where it was not successful, too much resentment had built up over the years and either one or both partners were unable to surrender to the pleasures of lovemaking. In those cases I strongly recommended that the couple see a therapist together.

Conclusion

Menopause is a different experience for every woman. However, most women report that they “take stock” during this transitional stage—they think about what to save, what to throw out, and what to try that they have not tried before. Taking stock of one’s sexuality is often part of this transition. Some women gradually lose interest in sex as they approach menopause and eventually give it up altogether. For others, this is a time when dissatisfactions with their sexual relationship come into focus.

If giving up sex is a relief, then it is not a problem to be explored in treatment. But there are women who find that their sex lives have become unsatisfying at menopause and are very unhappy about this. I have found that the two-part approach is often successful in helping women to reconnect with their sexuality.

Last year my high school friends and I met for our reunion, and it was fascinating to see how some of us had resolved problems with sex and desire that we had been so reluctant to discuss five years ago. Patty had divorced her husband of 25 years. She has a new boyfriend and is enjoying a renewed interest in sex and romance. Sonia and her boyfriend also split up. She has advanced significantly in her career and is eager to pursue a new love interest but is currently living alone. Some of the other women continued to be reluctant to explore this topic.

Menopause is not an easy transition for many women. It can be a time of mourning; a time of taking stock and facing old age and death. But it also is a time in a woman’s life when she can try something new—do things differently and, to use Jessica Benjamin’s (1991) phrase, become the “subject of her own desire.”

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Susan Kolod, Ph.D. is Training and Supervising Analyst, William Alanson White Institute.

330 West 58th Street #204
 New York, New York 10019
 skolod@psychoanalysis.net