Sexual problems that can arise in long-term and committed relationships

The cycle of limerence is not the only factor contributing to waning desire in long-term relationships. Individual clients can exhibit either intense or decrescent intimacy. It is common that clients lack the skills and attitudes required for discussing sensitive issues such as the specifics of their sexual relationship with their partners (Bienvenu 1980). Furthermore, research has shown a positive relationship between the frequency and quality of a couple’s talk about sex (both men and women) and their level of sexual satisfaction (Timm & Kelley 2011, Baus, 1987, Merets & Capuch 1989, Sprecher & McKennedy 1993). This highlights the need for counsellors to address and facilitate communication in the therapeutic session.

The link between relationship issues and sexual difficulties

It is important to remember that with sexual issues also involved in working with relationships. Sexual and relationship issues can exist independently of one another, but relationship problems can cause sexual problems and sexual problems can cause relationship problems. Links between relationship and sexual problems are not always easy to identify, hence the importance of taking detailed histories of both individuals and couples.

Illness and sexual rehabilitation in long-term and committed relationships

A number of factors can affect a client’s physical, mental and emotional health. It is important to understand that a diagnosis of illness can disrupt both emotional intimacy and physical sexual function. Many couples experience relationship stress from a diagnosis of illness and, generally, couples who were experiencing relationship problems before a diagnosis are more likely to continue to have problems afterwards. Relationship support should ideally begin at the onset of diagnosis, and should occur alongside conventional medical support. Disappointment, isolation and poor quality of life can result if sexual issues are not identified, understood and counselled.

Men can present with conditions—including cardiovascular disease, diabetes, depression, prostate cancer and post-prostatectomy conditions—that can directly affect the physiological functioning of the male genitalia, namely erectile dysfunction (ED), and may cause distress to both the individual and the relationship. The availability of therapies can be in use in order to improve erectile function, depending on the severity of the client’s condition. Common therapies used include the use of PDE5 inhibitors—more commonly known as Viagra, Levitra and Cialis. Long-term complications of cardiovascular disease can also include the use of ICI (intracavernosal injection) therapy and, in extreme cases, penile implants. When used properly, these physical therapies can often alleviate feelings of disappointment and improve self-esteem while also restoring confidence in the couple’s ability to resume sexual activity.

Women often present for counselling when recovering from mastectomies, or during the course of other chronic conditions like chronic fatigue syndrome, depression, and cancers of the female reproductive system breast, ovarian, uterine or cervical. Permanent injury or disability and chronic conditions significantly impact a client’s ability to function sexually. The therapist will need to work with the couple in exploring alternative ways to achieve sexual intimacy, which may require the couple to broaden their sexual repertoire. In good case management, the therapist liaises in a collaborative effort with the clients’ other health practitioners, increasing the possibility of achieving a lasting resolution to both the individual’s sexual difficulties (McCabe, et al. 2010) and laying the foundation for the couple to resume their pre-illness sexual relationship.

References

Bienvenu, M.J. (1980), “Limerence: love at First Sight,” in Intimacy and Sex, Sill (2005) discuss two main frameworks in the literature. The first and most common framework suggests that sexual desire is an innate biological drive that motivates individuals to seek out sexual stimuli or activity. The second framework sees sexual desire as an external force that manifests in the potential partner rather than from one’s own desire. (Verbalis & Heiman, 1979). Clinical experience has shown that clients can exhibit both innate and external desire, which may occur interchangeably within their relationships.

Sexual desire defined

Clients often cite a reduction in sexual desire for their partners after the relationship has passed from the initial phase (as early as three months) into the committed and long-term phase. This can be explained by the natural cycle of limerence, which is the initial phase of the relationship. It is common that clients lack the skills and attitudes required for discussing sensitive issues such as the specifics of their sexual relationship with their partners (Bienvenu 1980).

Sexual desire in long-term relationships

People often present for counselling when recovering from mastectomies, or during the course of other chronic conditions like chronic fatigue syndrome, depression, and cancers of the female reproductive system breast, ovarian, uterine or cervical. Permanent injury or disability and chronic conditions significantly impact a client’s ability to function sexually. The therapist will need to work with the couple in exploring alternative ways to achieve sexual intimacy, which may require the couple to broaden their sexual repertoire. In good case management, the therapist liaises in a collaborative effort with the clients’ other health practitioners, increasing the possibility of achieving a lasting resolution to both the individual’s sexual difficulties (McCabe, et al. 2010) and laying the foundation for the couple to resume their pre-illness sexual relationship.

The Role of Communication in Long-term and Committed Relationships

Clients often present in the moment of crisis when communication on all levels has broken down. Sexual as well as non-sexual communication can be regarded as crucial to many relationships. When communication fails, the relationship is at risk. The ability to communicate about issues in long-term relationships is a key skill that all clients can benefit from learning.

Communication can also improve the psychological standpoint of the relationship. Couples can also communicate through body language and touch. In long-term relationships, non-verbal intimate communication can involve both sexual touch (stroking genitals, penetrative sex, oral sex) and non-sexual touch (cuddling, holding hands, spooning). Communication can be either increase or decrease of intimacy. Hence it is important that the therapist understand the role communication plays in the dynamic of the relationship in order to best facilitate the clients’ work.

Both sexual touch (stroking genitals, penetrative sex, oral sex) and non-sexual touch (cuddling, holding hands, spooning). Communication can be either increase or decrease of intimacy. Hence it is important that the therapist understand the role communication plays in the dynamic of the relationship in order to best facilitate the clients’ work.

The therapist will need to work with the couple in exploring alternative ways to achieve sexual intimacy, which may require the couple to broaden their sexual repertoire. In good case management, the therapist liaises in a collaborative effort with the clients’ other health practitioners, increasing the possibility of achieving a lasting resolution to both the individual’s sexual difficulties (McCabe, et al. 2010) and laying the foundation for the couple to resume their pre-illness sexual relationship.

Sexual problems that can arise in long-term and committed relationships

The cycle of limerence is not the only factor contributing to waning desire in long-term relationships. Individual clients can exhibit either intense or decrescent intimacy. It is common that clients lack the skills and attitudes required for discussing sensitive issues such as the specifics of their sexual relationship with their partners (Bienvenu 1980). Furthermore, research has shown a positive relationship between the frequency and quality of a couple’s talk about sex (both men and women) and their level of sexual satisfaction (Timm & Kelley 2011, Baus, 1987, Merets & Capuch 1989, Sprecher & McKennedy 1993). This highlights the need for counsellors to address and facilitate communication in the therapeutic session.

The link between relationship issues and sexual difficulties

It is important to remember that with sexual issues also involved in working with relationships. Sexual and relationship issues can exist independently of one another, but relationship problems can cause sexual problems and sexual problems can cause relationship problems. Links between relationship and sexual problems are not always easy to identify, hence the importance of taking detailed histories of both individuals and couples.

Illness and sexual rehabilitation in long-term and committed relationships

A number of factors can affect a client’s physical, mental and emotional health. It is important to understand that a diagnosis of illness can disrupt both emotional intimacy and physical sexual function. Many couples experience relationship stress from a diagnosis of illness and, generally, couples who were experiencing relationship problems before a diagnosis are more likely to continue to have problems afterwards. Relationship support should ideally begin at the onset of diagnosis, and should occur alongside conventional medical support. Disappointment, isolation and poor quality of life can result if sexual issues are not identified, understood and counselled.

Men can present with conditions—including cardiovascular disease, diabetes, depression, prostate cancer and post-prostatectomy conditions—that can directly affect the physiological functioning of the male genitalia, namely erectile dysfunction (ED), and may cause distress to both the individual and the relationship. The availability of therapies can be in use in order to improve erectile function, depending on the severity of the client’s condition. Common therapies used include the use of PDE5 inhibitors—more commonly known as Viagra, Levitra and Cialis. Long-term complications of cardiovascular disease can also include the use of ICI (intracavernosal injection) therapy and, in extreme cases, penile implants. When used properly, these physical therapies can often alleviate feelings of disappointment and improve self-esteem while also restoring confidence in the couple’s ability to resume sexual activity.

Women often present for counselling when recovering from mastectomies, or during the course of other chronic conditions like chronic fatigue syndrome, depression, and cancers of the female reproductive system breast, ovarian, uterine or cervical. Permanent injury or disability and chronic conditions significantly impact a client’s ability to function sexually. The therapist will need to work with the couple in exploring alternative ways to achieve sexual intimacy, which may require the couple to broaden their sexual repertoire. In good case management, the therapist liaises in a collaborative effort with the clients’ other health practitioners, increasing the possibility of achieving a lasting resolution to both the individual’s sexual difficulties (McCabe, et al. 2010) and laying the foundation for the couple to resume their pre-illness sexual relationship.