

Therapy with Sexual Minorities

Queering Practice

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The universe is not only queerer than we suppose, it is queerer than we *can* suppose.

—EVOLUTIONARY BIOLOGIST J. B. S. HALDANE
(quoted in Bagemihl, 1999, p. 9)

For many therapists, the description of the dazzling variety of sexual options and behaviors practiced and enjoyed by nontypical clients may be both provocative and challenging. In this chapter on therapy with sexual minorities, Nichols and Shernoff reject both the pathology model and the medical model of sexual nonconformity. They maintain that sexual impulses can be "hostile, dangerous . . . and anxiety evoking" as well as "joyful and intimate, and sweet"; there is no preferred or "natural" way of expressing one's sexuality. Rather, sexual diversity is to be appreciated and affirmed and clinicians can treat sexual minorities effectively only if they abandon their preconceptions about what is "normal" and what is "pathological."

Nichols and Shernoff provide a thoughtful review of the recent history of the "Gay Pride" movement and its implications for the sexual behavior and practices of both gays and straights. It is not unusual for clients to present with questions and issues concerning a variety of sexual lifestyles about which the traditional sex therapist may be unfamiliar—everything from how to deal with jealousy in polyamorous relationships to how to persuade one's partner to explore BDSM.

Nichols challenges the notion of lesbian bed death, presenting data suggesting

that lesbians may enjoy more varied sexual relations and may experience orgasms from a greater variety of sexual acts than heterosexual women. Shernoff reminds the reader that while homosexual men present with many of the same issues as heterosexual or bisexual men, there are some differences. For example, gay men may seek assistance in dealing with pain during receptive anal intercourse or raise concerns about HIV and safe sexual practices.

An intriguing variety of clinical case vignettes is presented, suggesting the range and diversity of issues experienced by sexually atypical clients. As the authors remind us, working within the "queer" community challenges clinicians to expand their sexual knowledge and learn things not commonly taught in graduate school. Suspending preconceived notions about gender, relationships, and sexual lifestyles may enable the "traditional" therapist to grow in unexpected and satisfying ways.

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Since the 1960s, one of the most interesting changes in the sexual culture of the United States and Western European countries has been the emergence of "sexual minorities"—groups of people who affiliate, self-label, and seek human rights and acceptance for sexual lifestyles that are often considered psychologically and/or morally deficient by mainstream citizens. As Bettinger (2002) states, "We live in a sexually multi-cultural society. Different ways of expressing sexuality have resulted in the creation of distinct subcultures within the dominant American culture" (p. 94). Members of these different subcultures have gradually affiliated so that in the 21st century, the "queer community"—the subculture of sexual and gender minorities that began as the gay and lesbian community—includes within its boundaries bisexuals, transgendered individuals, people who practice the many varieties of dominant-submissive sex ("kink," BDSM [bondage, discipline, sadomasochism], "leathersex," "S&M"), and those who are pioneering alternative forms of nonmonogamous relationships.

The goal of this chapter is to help prepare therapists of all sexual persuasions and orientations to be better prepared to work with sexually nontypical clients. While we focus primarily on gays and lesbians, we include all the other sexual minorities listed above. We hope to challenge the "pathology" paradigms most of us have been taught, and to provoke readers into examining some of their own biases and positions about what constitutes normal, healthy, and adaptive sexual expression. Although this chapter primarily describes sexual minorities near or in a large urban/suburban setting, it is still relevant to more rural or mid-American areas. When refer-

ring to this group we use the term "LGBTQ"—lesbian, gay, bisexual, transgendered, queer—where "queer" refers to other sexual minorities, most prominently "kinky" and "polyamorous" people, and to people who embrace multiple identities (e.g., a butch bisexual dominant woman).

This chapter is written from what Morin (1995) calls the "paradoxical perspective" of sex. This paradigm considers the pathology model of sex to be simplistic moralism, and the "new sex therapy" approach mechanistic and medical. In the paradoxical model, sexuality is powerful, complex, multidetermined, and multifunctional; it is part hard-wiring and part early environmental imprinting, with perhaps a few modifications along the way. "Environmental influences" may be chance—an exposure to something or someone at a moment of arousal—or they may be an expression of universal experiences that have to do with the terror and powerlessness inherent in childhood, for example. Thus sex is by design hostile, dangerous, shame and anxiety evoking, objectifying, and frightening as well as joyful and intimate and sweet. The paradoxical view takes little for granted, including the two-gender system, the assumption of heteronormativity, and romantic views like the belief that monogamy and high sex drive are compatible.

From the paradoxical point of view the queer community is particularly interesting because of its sheer diversity and inventiveness. Extremes of sex and gender behavior can be observed in intelligent and psychologically healthy individuals. The community, particularly in urban centers, validates and seems to encourage pushing the envelope of tradition. Thus the paradoxical paradigm of sexuality allows clinicians to work with sexual minorities in a way that is free of preconceptions about what is "normal," and allows genuine appreciation of diverse sexual expression rather than a pathologizing of the unusual.

The reader should be aware that there are problems inherent even in arriving at common definitions of sexual minorities, because the phenomena we are attempting to define are so variable and complex. Let us take sexual preference as an example. Sexual orientation is often conceived as (1) dichotomous (you're either gay or straight) or at most tripartite (gay, "bi," "het"); (2) a single phenomenon in which identity, behavior, and attractions are all consistent; (3) unrelated to gender identity; and (3) stable throughout one's lifetime. In fact, it seems none of these things are true. As Kinsey et al. (1948) pointed out over 50 years ago, same-sex attractions exist along a continuum, and we superimpose discrete categories upon this continuum. Desire, behavior, and self-identification are not consistent within an individual; for example, many people experience at least occasional same-sex desire, while fewer indulge in behavior with same-sex individuals, and fewer still consider themselves to be gay (Laumann, Gagnon, Michael, & Michaels, 1994).

The categories themselves are arbitrary and artificial, and vary with

factors such as historical time period or who is applying the label. For example, many individuals with primary same-sex attraction and secondary heterosexual desire self-label as "gay" if they are over 35 and "bisexual" if they are under 25, simply because the "older generation" of gay people tends not to believe in a tripartite or continuous view of sexual orientation. Moreover, sexual identity and gender identity seem to be related to one another, at least for some. For example, we have records of women who "passed" as men back into the early part of the 20th century. And Joan Nestle explains the persistence of "butch/femme" labels where "butch" denotes, "I'm both male and female, more man than woman" (Nestle, 1992).

And while sexual identity is indeed stable and fixed for many, some individuals seem to have more fluid and changing orientation (Diamond, 2003b; McWhirter, Sanders, & Reinisch, 1990). The switch from lesbian to bisexual is so common that some women call themselves "wasbians" or "hasbians."

In fact one of the most fascinating attributes of the queer community is the "mixing and matching" of stereotypes and beliefs about sex and gender (sometimes colloquially called "gender fuck" or "gender bending"). The male tendency to split lust and love and pursue the former relentlessly is evidenced at its extreme, but gay men also write and speak openly about sex, including group sex and anonymous sex, as a spiritual experience. There are male-to-female transgendered lesbians and support groups for gay male semen donors used by some lesbians desiring children. While many lesbians value relationships above all, there are gay women CEOs and others who produce lesbian-oriented pornography or run lesbian topless bars.

Finally, it must be remembered that social class, education, and geography have a great influence on the lifestyles of queer people. The suburban gay male couple may have more in common with their hetero neighbors than they share with urban, "gay ghettoized" gay men.

PSYCHOTHERAPY MEETS SOCIOLOGY: THE IMPORTANCE OF HISTORY

In order to understand the issues that LGBTQ clients bring to therapy, one must understand the subculture of sexual minorities that has developed just since the 1960s. As recently as 1950, few people self-labeled as gay, those who did so were ashamed of themselves, and only a few, mostly urban, homosexuals got to affiliate with others. Throughout most of history, same-sex behavior was just that—acts, not "essential" nature. By contrast, in most Western industrialized nations today, homosexuality connotes not just a preferred sexual partner; it also represents an identity, a lifestyle, and a subculture (Boswell, 1980). The very newness of the community suggests

its fluid, evolving nature; so far, it has expanded from gay men and women to embrace pretty much all adult consensual sexuality.

In some ways, sexual minorities resemble racial or ethnic minorities, but while the discrimination may be similar, there is at least one major distinction. Gays can hide as racial minorities rarely can; this has been both a curse (when people don't "see" you they can demonize you more) and a blessing (generally speaking, if you pass you can make more money). Because gayness can be hidden, individual gay people have the option of "passing" for straight with all the psychological issues attendant to that choice, but also with the economic advantages of passing. In this regard, many gays could be compared to, for example, Jews who change their names and try to assimilate or light-skinned blacks who "pass" for whites.

But one thing that makes LGBTQs distinctive is that members of racial or ethnic subcultures can generally count on family support to help with the stresses of life. Because sexual preferences are frequently not passed from one generation to the next, LGBTQ people cannot count on family-of-origin networks to help buttress them against prejudice or hostility from the mainstream culture. To compensate for this loss, the LGBTQ community has done an outstanding job of creating traditions for forming extended families.

Identity, Shame, and Pride

Arguably, the most common problems LGBTQs bring to treatment involve the development of a personal identity that includes sexuality, and the resolution of shame and fear around having a socially stigmatized self. The latter problem—transforming self-hatred—was first tackled by gay men and lesbians with the help of gay activists. Before the late 1960s, gays were still regarded as sick, pathetic, depraved creatures who were at best to be pitied and at worst a danger to society. Then, in the wake of the civil rights, peace, and women's rights movements, along came the Gay Liberation movement, largely considered to have begun with the Stonewall Riots of 1969 (Carter, 2004). From the beginning, mental health practitioners, especially psychiatrists, played a role in influencing public opinion. In 1973, the American Psychiatric Association ceased to consider homosexual adjustment as psychopathological (Bayer, 1981). It is hard to overestimate the impact of that decision. First, declaring homosexuals "normal," or at least as normal as heterosexuals, undermined laws, civil commitment procedures, and the practice of therapy itself. Before the American Psychiatric Association decision, involuntary hospitalization, aversive conditioning techniques, and extended attempts at cure by "talk therapy" were routine in the "treatment" of homosexuality, and legal rights were denied to gays on the grounds of moral turpitude and mental illness. Today the situation is vastly different and most mental health professionals accept at least les-

bian and gay orientations as inherently "equal" to heterosexual orientation, though most have problems with other sexual minorities.

More importantly, the decision reinforced the basic ethos of the Gay Pride movement. Like the civil rights and women's movements before them, the Gay Liberation movement helped people get ride of the shame they all carried and replace it with pride. The DSM decision helped pump up gay pride—"we're just as good as heterosexuals." This, in turn helped encourage gay people to do perhaps the single most politically valuable thing possible—come out to others. As more people discovered gays in their families, among their friends, and as their neighbors, the demonizing of them decreased. Indeed, lesbians and gay men have succeeded in many of their activist efforts, and therefore achieved a remarkable gain in "social acceptability"—acceptance by the heterosexual majority—in about three decades.

When the authors of this chapter began private practice early in the 1980s, a good number of our clients tried to deny their gayness, were riddled with shame and self-loathing, and experienced rejection and punishment from family, friends, and employers. But social acceptance does a lot to help self-esteem. Today when we see young people in our urban and suburban practices, they more rarely reject their sexual orientation and experience substantially less shame, and if they have identity issues, they are more likely to be struggling with whether they are poly or just into BDSM with "playmates" on the side than they are to be wondering whether they are gay or heterosexual. The number of gays entering treatment with identity or shame issues has dramatically decreased. Nevertheless, outside of urban areas these may be still be the most common issues one sees in treatment.

Gay Male Communities

There is no better testimony to the fact that male homosexuality does *not* result from the absence of testosterone than the development of the gay male community from the 1970s on. Not surprisingly, when gay men began to build community in the 1970s a good deal of it revolved around sex and sexual availability. Bathhouses, bars, and discos with "back rooms" or "sex floors" proliferated wildly. Unburdened of shame for the first time, many men celebrated by being as sexual as possible. In urban areas men enumerated their sexual partners in the hundreds, at least, and the "norm" for many gay male relationships was nonmonogamy (Kippax, Crawford, Davis, Rodden, & Dowset, 1993; Bryant & Demian, 1994). Moreover, gay men experimented in large numbers with sexual practices previously considered the domain of fetishists (Jay & Young, 1979).

The golden age of gay male sexual adventuresomeness was short lived—a decade long—because AIDS struck in the early 1980s. As the era

of unrestrained sexual expression was replaced by the time of funerals and memorial services, sex became anxious and frightening. AIDS elicited homophobia in the general public and "erotophobia" among gay men, thus having a profoundly negative impact on how they viewed their sexuality. Many gay men came to view penises and ejaculate as "toxic" or dangerous. Inhibited sexual desire (ISD) and sexual aversion, problems once rarely encountered among gay men, became more widespread. A few men found themselves unable to stop unsafe sex practices, and the concept of "sex addiction" was discussed for the first time in the gay male community. Religious fundamentalists placed the blame for AIDS upon gay men ("You deserve this disease because you caused it by your sinful promiscuous behavior") and, not surprisingly, some gay men blamed themselves as well.

Faced with a disease that had few treatments and no cure, the health care and AIDS activist communities developed campaigns to try to prevent HIV and other sexually transmitted diseases (STDs). Programs were developed to help gay men eroticize safer sex (Palacios-Jimenez & Shernoff, 1986; Shernoff & Palacios-Jimenez, 1988; Shernoff & Bloom, 1991) and to use condoms more reliably during anal intercourse. Widespread AIDS prevention programs and effective antiretroviral drugs for those who could afford them resulted in the "normalization of HIV." At least in the United States among gay men with health insurance, HIV became primarily a long-term chronic illness, rather than a death sentence.

Without a heightened sense of HIV as "deadly," and without visual reminders of obviously ill men, large numbers of gay men have grown more complacent about the disease. Experts agree that the riskiest form of sex for transmitting HIV is unprotected anal intercourse (Vittinghoff, Douglas, & Judson, 1999). This form of sexual behavior has increased in recent years, as have new infections among men who have sex with men (Centers for Disease Control, 2002). This type of sex has a name in the gay male community: barebacking. Barebacking may be increasing in frequency both in its unprotected/unsafe form and its unprotected/safe form. Unsafe sex refers to condomless anal sex between an HIV-negative man and either a partner of unknown HIV status or one known to be HIV positive, thus opening the possibility of HIV transmission and new infection. Unprotected safe sex is anal intercourse without a condom between two HIV negative men. Men in monogamous male-male relationships where both partners know that they are HIV negative are not at risk for transmission of HIV even if they do not use condoms, provided that they have sex only with each other or only have safer sex with any outside sexual partners.

In recent years one particular drug has played a large role in the upsurge of unsafe sex among gay men. That drug is crystal methamphetamine, referred to as crystal, Tina, meth, crank, or ice. Use of this drug is associated with enhanced hypersexuality, feelings of euphoria, eased self-esteem, and

confidence (Murray, 1998; Guss, 2000; Halkitis, Parsons, & Stirratt, 2001). It often leads to unprotected and unsafe sex.

Lesbian Community, Lesbian Sex

At the same time that gay men were building a community emphasizing sexual experimentation, novelty, and diversity, lesbians were building communities based on feminist principles. For many gay women, feminism became the foundation of their orientation, and they were more likely to join feminist or lesbian-only organizations than gay rights organizations. Not only was sex not the focus of lesbianism, it was actually quite a problematic issue. The women's movement of the 1970s focused its interest in sexuality upon the sexual exploitation of women: rape, incest, and pornography occupied center stage; women's sexual pleasure was less discussed or explored.

Within the lesbian community this perspective resulted in the promulgation of sometimes absurd standards of "politically correct" sex. Anything associated with stereotypical heterosexual sex was viewed automatically as "patriarchal," even when practiced by two women. This attitude toward sex proved stifling for many gay women, and eventually this minority made their voices heard.

Lesbians in the 1980s, in contrast to gay men, became *more* interested in sex. The community fostered a sex radical movement that continues to grow and that has no parallel among heterosexual women. The sex radicals included both lesbian and "bi" women, and they went far beyond enthusiastically promoting the joy of sex for its own sake. The radicals also engaged in sexual activities that were outside the boundaries of "normal" female sexuality, especially BDSM sex, sex with multiple partners, and role-polarized sex (Nichols, 1987). By the mid-1980s, women were producing pornographic magazines and videos for lesbians, creating support groups for women who liked kinky sex, holding "play parties" where women could be sexually active more or less anonymously, and running sexual paraphernalia stores.

Within the lesbian community, the current ethos of diversity and respect for individual difference stands in sharp contrast to earlier years. Thus the explosion of lesbians choosing motherhood has been matched by an explosion of lesbians interested in reexamining sex. Lesbian mental health professionals have questioned heterosexual norms of sexual expression (Rothblum & Brehony, 1993), just as their heterosexual female counterparts question phallocentric sexual definitions (Basson, 2000; Kaschak & Tiefer, 2001). In the lesbian community, manifestations of lusty sexuality continue to abound for lesbians, especially "kinky" ones. At the same time, the romantic side of sexuality is being expanded: lesbians are quite prominent in the polyamory movement.

Bisexuality as Identity and Community

Although a "bisexual pride" movement was just becoming visible in the 1980s and 1990s, even within the gay community, bisexuality was viewed with suspicion, and bisexuals were seen as "gays in transition" or gays who were too afraid to come out to themselves. There continues to be some truth to that, at least among men (Carey, 2005). But beginning in the 1990s, the scientific discourse about bisexuality had increased (Klein & Wolf, 1985; Weinberg, Williams, & Pryor, 1994), as had the publication of personal testimonials (Hutchins & Kaahumanu, 1991). The number of self-identified bisexuals appears to be increasing, and some of this increase comes from the ranks of those who previously identified as gay. In fact, during this decade a new phenomenon emerged in the gay and lesbian subculture: a bisexual movement led by women, often by women who had formerly identified as lesbian (Clauson, 1990; Nichols, 1994; Weise, 1992). Many bisexuals prefer to affiliate with the gay community.

The 21st Century: Emergence of the "Queer Nation"

Among the newest sex or gender groups to join or be considered part of the community of sexual minorities are transsexuals and anyone on the transgender continuum. Among many, the old categories of "transsexual" versus "transvestite" were abandoned in favor of an array of gender/orientation variations ranging from postoperative transsexuals who self-define as homosexual to "he/she"s—men who retain their penises but dress as females and take hormones to increase breast size and change secondary sex characteristics to "bois," (lesbians who identify as male and dress and comport themselves as males without taking hormones or contemplating gender reassignment surgery). A general relaxation of the strictures of the two-gender system has resulted from the acceptance of transgendered folk.

Additionally, alliances were formed in the "kink" community between lesbian, bisexual, gay, and heterosexually oriented kink organizations, so much so that sometimes these groups now overlap or call themselves "pansexual." The polyamory movement, people espousing a lifestyle of multiple loving/sexual relationships are now also considered to be part of the sexual minority community. As we discuss later in this chapter, gay men have always experimented with "open relationships" as did heterosexuals in the "open marriage" movement of the 1970s, but now, polyamory is becoming more common in the lesbian community (Anapol, 1997; Munson & Stelbourn, 1999). In fact, there is considerable overlap among all these communities, and it is not uncommon to find people who consider themselves members of multiple groups—a kinky lesbian living a polyamorous lifestyle, especially within urban areas and especially among younger people.

If there is a current political division in the LGBTQ community it is between the majority who espouse assimilationist politics—witness the huge gay marriage movement—and those who tend toward separatism and are proud of and want to foster differences (Warner, 1999). It is an issue that has probably been part of the growth of every minority group in America and the queer version of this scenario has been triggered in part by the gay marriage movement.

ISSUES AND CASES IN SEX THERAPY

Overall Similarities and Differences

For the most part gay men, lesbians, and members of other sexual minorities utilize psychotherapy for the exact same reasons as do their more mainstream counterparts. In these situations, the sexual orientation of the client may be largely irrelevant. However, it is important that the therapist be perceived as “queer friendly,” by doing things like using gender-neutral language, not making the “heterosexual assumption,” especially when asking about sexuality, and making statements that indicate an accepting attitude toward diversity. An alarming number of queer people don’t come out to their doctors, even their psychotherapists, because they don’t feel certain that the professional would be accepting of their sexual orientation. Most psychotherapists would agree that this kind of withholding mistrust on the part of a client would necessarily interfere with therapy. Yet many clients naively imagine they can “deal with their depression” without mentioning their sexual orientation.

Some issues may have a different spin for members of sexual minorities. For example, while many people experience trauma in childhood, people on the sexual fringe have additional stresses. Gay men who were “sissy” boys often have been deeply damaged by the reactions of others in childhood; gay, lesbian, bisexual, transgendered, and kinky clients who were aware of their predilections in puberty have almost never had “normal” adolescent experiences, as their experience was complicated by an unusual degree of secrecy, shame, and self-hatred.

And there are problems that just don’t seem to exist, or to exist in the same way, for queer clients. For example, vaginismus and dyspareunia are rare complaints for lesbians; women who experience these difficulties tend to avoid penetrative sex. Delayed ejaculation often does not particularly trouble gay men: many gay men accept masturbation as a way of culminating a sexual encounter. In addition, there is an absence of gender-specific roles among gay and lesbian couples. Even in couples where partners seem role stereotyped in physical appearance, these apparent roles rarely hold up in actual behavior. The partner who looks masculine may be the one who likes keeping house, whereas the woman in the lipstick and high heels

may repair the plumbing. It is rare to find one member of a gay or lesbian couple totally financially dependent on the other, and it is less common for a gay or lesbian household to contain children. Thus, gay couples obviously are less likely to stay together because one person is financially dependent on the other or "for the sake of the kids." These differences make the power dynamics in gay couples somewhat different and, interestingly, make the quality of their sexual/intimate relationship assume a higher priority than in many more traditional heterosexual marriages.

The absence of rigid gender roles influences sex therapy with couples in other ways. Same-sex partners do not have opposing sexual role expectations (e.g., male must initiate, female must be submissive), so therapists do not have to work to eradicate these sex role stereotypes. Gay men and lesbians tend to have a more varied sexual repertoire than heterosexuals; penetration is not the main focus of sexual activity for either men or women. Moreover, some sexual beliefs held by heterosexuals are less frequently held by gay people. Many gay men and lesbians feel that their orgasm is truly their responsibility; there is more tolerance for each person masturbating themselves to orgasm at the end of a sexual encounter, less false romanticism attached to the idea that your partner has to bring you to orgasm. Lesbians, and especially gay men, often are very knowledgeable about sexual technique, and because there is nothing in gay sex comparable to the heterosexual emphasis on vaginal intercourse, they may be more willing to be sexually experimental.

Special Issues of LGBTQ Clients

Table 13.1 charts the problems most commonly encountered with queer clients by sex therapists, along with indications of which subgroups of the LGBTQ community are most likely to experience them. We will touch on all of these problems in the discussion and case examples below.

Identity Problems

Because our culture still demonizes members of sexual minorities, it is difficult for anyone who has a statistically nonnormative sexual orientation to come to terms with his or her identity. The natural internal resistance to accepting that one is a member of a despised minority, coupled with lack of information and role models, makes identity formation a complex problem.

Gay men and lesbians probably have the easiest time with this process, because of the increased acceptance of homosexuality over the last several decades. In the past, an individual with same-sex attractions could be expected to experience a sometimes prolonged period of internal struggle and conflict before embracing a gay or lesbian identity (Nichols, 1990, 1995).

TABLE 13.1. Most Common Sexual Issues in LGBTQ Community

Issue	Found among these groups ^a
Identity/coming-out/shame issues	
1. Determining orientation	All; bi, trans, kink
2. Changing orientation	Bi (women) *
3. Overcoming shame	Gay/lesbian/bi/trans/kink
Sexual dysfunction issues	
1. Aversion to oral or anal sex	Gay
2. Low/discrepant desire	All; lesbian
4. Discrepant scripts— dominant/submissive discrepancy	Gay, kink
Other	
1. Open versus closed relationships	Gay/lesbian/bi
2. HIV positive/negative issues	Gay/bi men
3. Risk reduction/harm reduction	Gay/bi men
4. Counseling multiple partners	Gay/lesbian/bi/kink/poly

^a Boldface type = most common.

Now, many self-identified lesbians, gays, and bisexuals come out to themselves and others with a minimum of fear, shame, or self-hatred. The degree to which gays and bisexuals experience internalized homophobia has also diminished pathology dramatically. Nevertheless, these cases do still exist, particularly among individuals with strong ties to an ethnic or religious community very disapproving of sexual diversity. When internal shame is extreme, some people may deny their orientation. An example of this is men on the "down low," a phenomenon observed first among African American males (Trebay, 2000; Denizet-Lewis, 2003; King, 2004) but prevalent among men of all racial and ethnic groups. The expression "down low," or "DL," refers to sexual relationships between men that are never discussed or openly acknowledged. The refusal of men on the "down low" to acknowledge their gayness may have disastrous consequences: "These men's unwillingness to address the fact that they may be gay or bisexual leads many to engage in unprotected sex when on the DL. To use a condom would be to acknowledge in some way what one is actually doing" (Williams, 2004, p. 6).

Alternatively, some clients who come to therapy now with identity concerns are grappling with more complex issues of personal orientation. They may be bisexual and still feel pressured to "choose up sides," and may be unsure about both sexual and gender orientation. An example is women who are not sure if they are butch lesbians or female-to-male trans-

sexuals. Some individuals may be going through an unexpected (and possibly unwanted) change in what they thought their sexual orientation was, such as bisexuals who self-identify as heterosexual and later experience same-sex attractions—or those who self-identify as gay or lesbian and later experience opposite-sex attractions! Finally, many transgendered or kinky clients present with the same degree of shame and self-hatred as did gays in the 1960s and 1970s. A nonjudgmental, accepting therapist can literally transform the lives of these clients.

Case Example: Internalized Homophobia and More. Daniel, 26, entered therapy complaining about the conflict between his self-acknowledged identity as a gay man and his hatred of gay people, especially gay men. His revulsion for gay men was so complete that he could only masturbate to heterosexual pornography or heterosexual fantasies.

Daniel grew up in a suburban town with cold, unsupportive, disapproving parents, and he was routinely ridiculed and scapegoated for his effeminacy by peers. As a freshman in college, he became active in the student gay and lesbian group, apparently transforming rapidly from someone who exhibited immense shame about his homosexuality to a proud, angry young activist. However, he managed to alienate nearly everyone in the student group with his judgmental attitudes and hypersensitivity. Shortly after leaving the campus gay community, Daniel suffered a severe manic episode and was hospitalized. His return to school was marked by poor performance, isolation, and suspicion and hostility toward almost everyone with whom he had contact, especially his gay and lesbian peers. He barely managed to graduate.

When Daniel came to therapy he was underemployed by the university from which he had graduated, living in a rooming house, drinking too much, and isolated from all but one or two heterosexual female friends.

Daniel's therapist (Nichols) was able in a few months to use cognitive methods to help Daniel transition back from homophobic to accepting feelings about his sexuality. Because Daniel prided himself on his intellect, she assigned him to read complex, highly researched academic books that demonstrated the widespread existence of homosexuality as a normative variation in animals and humans throughout history. She specifically challenged some of Daniel's negative beliefs about gay relationships and behavior, again documenting her assertions with research. In all probability, Daniel's respect for Dr. Nichols's intellect facilitated the cognitive work; in addition, he was genuinely impressed by the books he read, most of which had been written by gay men. Unconsciously, Daniel, who himself harbors ideas of being a writer, started to identify with the authors of the books. As a result, Daniel was forced to acknowledge that his feelings about gay men were in fact an expression of his feelings about himself, and his sexual function changed: he became comfortable masturbating with pleasure to

gay male images and fantasies. He came out to coworkers with success and assumed the queer label with a defiant pride characteristic of his personality.

But after two years of treatment, Daniel is still isolated, still drinks too much, and has avoided contact with other gay men. Daniel warrants several diagnoses: bipolar disorder, posttraumatic stress disorder (PTSD), and alcohol abuse on Axis I (PTSD from childhood peer victimization as well as from 9/11) as well as avoidant personality disorder and some features of paranoid personality disorder on Axis II. Current treatment, which includes EMDR and hypnosis, is aimed at the PTSD. At Daniel's request, EMDR sessions targeted his experience on 9/11, but, not surprisingly, the memories that surfaced during EMDR were all memories of his early stigmatization and abuse for being a "sissy boy." This process has helped Daniel understand how much of his self-hatred stems from childhood incidents of being victimized by peers and being unprotected and unsupported by his parents. Daniel's self-esteem is growing and he is beginning to recognize the victimized outsider role he consistently plays out in his daily life. Daniel's alcohol abuse undoubtedly helps keep him isolated—alcohol substitutes for human relationships—but he is resistant to giving up drinking and manages to control it enough so that it has not seriously interfered with his life in other ways. Nichols works from Prochaska, DiClemente, and Norcross's stage model of addiction (1992), which conceptualizes recovery in phases that begin with precontemplation (being in denial of the problem) and proceed to contemplation (knowing one has a problem but not ready to take action), and then to planning, action, and maintenance. She is trying to gently move Daniel from precontemplation to contemplation by offering him information (e.g., that his mood shifts may have to do with alcohol consumption, that his inability to save money to move from a rooming house to an apartment may have to do with the amount he spends at bars).

Currently, another trauma has emerged. During the manic episode that preceded his hospitalization, Daniel stalked a man with whom he was infatuated. He is now deeply ashamed of himself for this behavior and has acknowledged he is afraid to have contact with other gay men for fear of repeating the stalking. This trauma is being targeted for EMDR and hypnotherapy work, and Daniel feels if he can overcome this fear he might be ready to venture out socially. Clearly, for Daniel, internalized homophobia and concomitant sexual problems were intricately tied in with other disorders, and turned out to be the least troublesome of his problems.

Lesbian Issues

THE NATURE OF LESBIAN SEX

In 1983, Blumstein and Schwartz compared heterosexual married, heterosexual cohabitating, gay male, and lesbian relationships and found lesbian

couples to have the least frequent sexual contact. Shortly after this, other work written from a clinical perspective also noted the existence of lesbian couples who had little or no genital contact (Hall, 1984; Loulan, 1984; Nichols, 1987). By the end of the 1980s the term "lesbian bed death" was in common usage in the gay community and eventually became part of a stereotype: the lesbian as a sensual-but-not-sexual woman. Lesbian relationships were viewed by professionals and lesbians alike as unions in which both partners had relatively low sex drive, low sexual assertiveness, and a high degree of intimacy (Nichols, 1988, 1990).

In recent years, some sexologists have criticized mainstream sexual theory as being phallocentric and heterosexist (Kaschak & Tiefer, 2001; Kleinplatz, 2001; Rothblum & Brehony, 1993). Lesbian psychotherapists have been vocal in questioning the traditional definition of sex as genital contact directed toward orgasm, and have questioned using sexual frequency as an indicator of sexual health. For example, some studies have shown that lesbians spend more time on the average sexual encounter than do heterosexuals; using the measure of time spent on sex rather than sexual frequency, lesbians might be healthier than their straight counterparts (Iasenza, 2002). Still others (Cole, 1993) contend that sex is not necessary for healthy relationship function. In particular, lesbian relationships, which some view as more egalitarian and intimate than the average heterosexual marriage (Schwartz, 1994), may not need genital sex for connection—sex may be in effect, redundant. Some lesbian psychotherapists argue that lesbian bed death is a myth based on insufficient data. Matthews, Tartaro, and Hughes (2003) found no differences in sexual frequency rates of heterosexual versus lesbian women. And Iasenza (1991) found lesbians to be more sexually arousable and more sexually assertive than heterosexual women.

Nichols and her colleagues at IPG Counseling/Institute for Personal Growth collected hundreds of Internet surveys from women of all sexual identities and backgrounds and analyzed the data with regard to how self-identified lesbians and women currently in relationships with other women compared with bisexual and heterosexual women and women in relationships with men (Nichols, 2005, 2004).

Some of the findings to date from the IPG Internet study indicate that:

- Including both single and coupled women, lesbians had less sex in the year preceding the survey ($p < .02$) but did not differ from heterosexual women in their frequency of masturbation or how often they thought about sex.
- Overall, women with men had slightly more frequent sex than women with other women ($p < .02$) and this difference was independent of length of time in relationship. There was no difference between the groups in the percentage of women who never had sex, however, thus casting suspicion on the concept that lesbians are more likely to have totally nonsexual relationships.

- As for other aspects of sexuality, the women involved with other women spent more time on sex ($p < .000$), had more non-penis oriented sexual acts as part of their typical repertoire ($p < .001$), and were less likely to have sex because their partner wanted it ($p < .001$). Most significantly, they were more likely to have orgasms during sex with their partner than were women involved with men regardless of marital status or length of relationship ($p < .001$). And the tendency to orgasm during partner sex was not at all related to the length of time the partners had been together, but was strongly related to the amount of time spent on sex for both women with women and women with men ($p < .000$).

- The typical sex acts associated with orgasm for women (regardless of gender of partner) were kissing ($p < .000$), nongenital touching ($p < .006$), receiving oral sex ($p < .000$), digital-vaginal stimulation ($p < .001$), and the use of sex toys ($p < .004$). And of these acts, kissing ($p < .000$), nongenital touching ($p < .01$), digital-vaginal stimulation ($p < .000$), and use of toys ($p < .000$) were more likely to be practiced by women with other women than by women with men.

If we incorporate new information about the lesbian community with the results of more recent research and theory about female sexuality, the picture of lesbian sex is more complex than the old stereotype portrays. While it may be true that women in lesbian relationships have somewhat less sex than their heterosexual counterparts, it is by no means true that the typical lesbian relationship becomes asexual. Women in relationships with other women are less likely to have sex simply because their partner wants it, which may account for part of the difference in sexual frequency.

Furthermore, there is evidence to suggest that lesbian sexuality is "better" for women: it lasts longer, is more varied, includes more sex acts likely to lead to orgasm for women, and is in fact more correlated with orgasm. Indeed, if one measures sex not by frequency but, say, by Kinsey's original standard—sexual contact to the point of orgasm—women with other women have more sex than women with men, and are more likely to have that sex of their own volition. In addition, lesbian sex is healthier: several studies including the IPG Internet study showed lesbians to have lower rates of sexually transmitted infections than bisexual or heterosexual women (Nichols, 2004; Roberts, Sorenson, Patsdaughter, & Grindel, 2000).

SEXUAL DYSFUNCTION IN LESBIANS

What about lesbian sexual dysfunction? Clinical data suggest that sexual desire discrepancy between partners and/or low sexual desire is the most common problem lesbians face, as it is with heterosexual women (Loulan, 1987; Nichols, 1995). There is little nonclinical information on the nature

of lesbian sexual dysfunction as compared to that of heterosexual women. Therefore, the IPG Internet study compared the self-reported sexual problems of lesbians with other women. In the IPG research, lesbians reported significantly fewer sexual problems than heterosexual women ($p < .002$). Not surprisingly, lack of interest in sex and/or having less desire than one's partner were the most frequently reported problems for all women, followed by problems with orgasm, problems experiencing more desire than one's partner, trouble lubricating, and anxiety about sex. Lesbians checked significantly fewer problems than heterosexual women in 6 of 11 categories. The greatest difference² ($p < .000$) was in the number of lesbians versus hetero women who reported trouble lubricating during sex, followed by the number who reported orgasm as a problem ($p < .02$) and those who said they experienced pain upon penetration ($p < .02$). The orgasm data is consistent with data sharing that women sexually involved with women orgasm more reliably than those with men. There is no way of knowing whether lesbians indeed lubricate more and have less painful penetration than heterosexual women, or whether lesbians simply avoid these problems by downplaying the role of vaginally penetrative sex.

The cases that follow illustrate therapy with lesbian couples who have low or discrepant desire. It must be mentioned, however, that when lesbian couples present with complaints of low sexual frequency, it is important to determine the nature of the complaint. There are many lesbian couples who rarely have genital sex together but are otherwise happy, affectionate, and well-functioning couples. Some of these women have been influenced by the cultural belief that frequent sex is necessary for the success of a relationship, and so seek sex therapy because they believe they should be having more sex, not because they actually miss it.

Case Example: Genuine "Lesbian Bed Death." Liz and Scottie requested sex therapy for lesbian bed death, describing a sexual frequency of only once or twice a year. The pair had been together for 12 years and sex had dwindled down to this minimal level 2 or 3 years before they came to therapy. The therapist (Nichols) first questioned whether the couple genuinely wanted to be more sexual or whether they felt they were supposed to have more sex because sex was an indication of a healthy relationship.

In this case, Scottie had lost desire first and after many rejections Liz first gave up trying to initiate sex behaviorally and then "gave up" experientially: she, too, lost desire. But a recent experience in which Liz found herself attracted to another woman frightened her and motivated her to insist that Scottie and she seek sex therapy.

The couple reported good intimacy in nonsexual aspects of their relationship. However, their age undoubtedly contributed to their sexual problems—both women were in their mid- to late 40s, prime time for perimenopausal drops in both hormones and sexual desire in women.

Moreover, both women had gained some weight and become less attentive to their appearance. Cognitive-behavioral approaches were used in the treatment of this couple.

First, Scottie and Liz were taught about the "Basson model." Basson (2000) has proposed an alternative model of the female sexual response cycle in which many women in long-term relationships are presumed to have changed from experiencing an active, lusty desire to what Basson calls "receptive desire." In this model, the decision to have sex is driven by the desire for intimacy, not lust. Receptiveness to sex leads to sexual activity, which in turn leads to arousal and *then* desire. Lesbian relationships sometimes suffer from what might be termed the "Basson squared" effect. That is, if both women lose active desire, then, without consciousness of what is happening, no one initiates sex at all. In the case of this couple, Scottie had experienced what Basson describes while Liz had not. Nevertheless, both women benefited from being educated about this model, Scottie because it validated her experience and Liz because it helped depersonalize Scottie's rejection of her sexual advances. Scottie became aware that she had rejected Liz in the past because of her belief that if she felt no active desire, sex would not be enjoyable.

Once Scottie was aligned with the concept of "sexual willingness" rather than "lust," the couple was disabused of their belief that sex should be spontaneous, and convinced to make "dates." They were also encouraged to behave as though they were on a date—choose clothing carefully, look their best, act seductive and flirtatious.

Both women were trained to foster "simmering" (Barbach, 2001). They were taught that once they had made a date, during the time leading up to that date, they could make themselves ready for sex by consciously thinking and fantasizing about sex, facilitating arousal over time. "Simmering" is particularly helpful to women who have a relatively long arousal period.

Liz and Scottie were encouraged to be pragmatically honest about their sexual differences. They were helped to see that certain overromanticized myths about sex impeded their working out a good compromise. For example, they believed all sexual encounters had to end in orgasm on the part of both partners, orgasms that were "given" by one partner to the other. But equality doesn't always work in bed. The truth was Liz had a higher sex drive than Scottie, and was easier to arouse and bring to orgasm. Scottie's lower sex drive meant that there were lots of times she would have liked to engage in sexual contact with Liz, and would have been happy to facilitate an orgasm for Liz, but the pressure of her having to have an orgasm, too, made her refrain from such contact. Scottie and Liz were helped to redefine a sexual encounter: it loosened up to include "sensual/genital contact between them that may or may not result in orgasm for one or both partners, and if orgasm ensues, it may or may not be

facilitated by one's partner." This freed the couple to have sexual encounters where Liz orgasmed and Scottie didn't; the overall frequency of their sex life increased in a way that gave pleasure to them both.

This couple had a rather narrow sexual repertoire, limited to oral and manual genital sex, lots of touching, a little digital penetration. When prodded, they acknowledged having role-played once or twice, and it seemed they were open to the idea of expanding their repertoire. Scottie and Liz spent a session with the IPG Toy Box—a therapeutic aid that includes a large collection of sex toys ranging from vibrators, dildos, and butt plugs to feathers and bondage straps and lube samples. Nichols demonstrated the use of these toys in an enthusiastic and matter-of-fact way to reduce negative fears and attitudes about the use of "toys." The women were given the homework assignment to go to a local women's sex store and make a purchase together. Finally, they were given copies of sexual negotiation questionnaires that have been developed by BDSM groups—documents that promote open, specific communication about sexual likes and dislikes. Within a dozen sessions, this couple increased their frequency to about once every 6 weeks, using the women's new, freer definition of "having sex." They were both satisfied with this result.

Case Example: Complex Low Desire. Carole and Stacy have been involved sexually for only 8 months, although they had been casual friends for years. Carole sought EMDR treatment to uncover what she thought might be repressed memories of incest; her fear was not based on memory but on the fact that she had sexually withdrawn from several otherwise good relationships, and had begun to shut down sexually to Stacy. Carole did have some symptoms suggestive of abuse: aversion to sex with intimate partners; experiencing sexual touch as painful; positive sex followed by terror and the need to withdraw; having to be in control in sex; hypervigilance, and sleep disturbance.

EMDR treatment did not uncover repressed memories, but it did bring back incidents Carole had not thought about in years. These incidents were a series of sexual experiences with somewhat older boys that were exploitative and repulsive to Carole—she was purely lesbian, with no heterosexual attractions, from an early age. These memories were not repressed, but Carole had tried for many years to block them from her mind in order to avoid reexperiencing them. From an early age Carole had been a timid child, perhaps constitutionally fearful. When stressed, she became paralyzed and could neither fight nor flee; Carole always froze. Carole had frozen during the sexual incidents in her childhood, not even being clear about how much she said no, and that made her feel guilty. She feared remembering these events, and suffering through the attendant feelings of fear, revulsion, and shame. As Carole processed these memories through EMDR she "thawed out" a bit to Stacy.

Carole's fearfulness and compliance under stress made her the object of mild to moderate exploitation in many of her day-to-day relationships. This extended to her love relationship. Carole was unable to say no to some of Stacy's unwanted touching, which complicated the issue of her sexual desire. This was corrected in therapy with a couple session and homework; a follow-up visit revealed that Stacy had not kept her bargain to cease pressuring for the unwanted touching. Once Stacy became convinced that her behavior would impede the progress of the sex therapy, she moderated her behavior while at the same time, Carole developed the courage to say no.

Carole's temperament and background made it difficult for her to resist Stacy's entreaties to live together after only 8 months. Carole was feeling suffocated with the current frequency of togetherness, three nights a week. In the next couple session, both women were asked the following question: "On a scale of 1 to 10, where 1 represents you'd like your partner in your back pocket and 10 represents you'd like to live in New York and have her in San Francisco, where are you?" Carole laughed and gave herself a 7; Stacy gave a rating of 3. The scale, however, normalized for Carole that it was okay to want lots of separateness in the relationship, and rattled Stacy a bit in that it undercut her assumption that living together was the goal of dating.

Several more sessions of couple counseling helped the women work out the differences in their needs for closeness versus independence. Meanwhile, in individual counseling Carole worked on believing in herself and standing up for herself, with an emphasis on standing up for her desires around sexuality. Carole's sexual symptoms were dramatically reduced and she was able to give up some control in the relationship. The couple also worked out an arrangement that acknowledged the differences in their sex drive; sometimes Carole makes love to Stacy with no reciprocation, and no pressure to get aroused and orgasm. Both women enjoy this, and it has brought sexual frequency up enough for Stacy to feel better about their sex life without pressuring Carole.

Issues of Gay Men

Many gay men present with the same issues as heterosexual or bisexual men: problems of erectile dysfunction, inhibited sexual desire, or desire discrepancy between partners. However, some issues are different. Gay men, unlike purely heterosexual men, sometimes seek help because they are experiencing pain during receptive anal intercourse, or because they want to learn how to stifle the gag reflex that can interfere with the enjoyment of performing fellatio. Sex therapy with gay male couples often focuses on helping them negotiate relationship openness agreements, or working out HIV positive/negative issues. Additionally, counseling may in-

volve harm reduction work with men who bareback, or have condomless sex.

Case Study: Receptive Anal Sex. Dan and Peter, an HIV-negative couple, have been together for 2½ years. Since the onset of their relationship, both enjoyed performing as well as receiving oral sex. But anal sex was different: Peter was willing to penetrate Dan, but not to be anally receptive with Dan. The couple sought therapy because both partners wanted to change this situation. Anal penetration was problematic and painful for Peter. Peter had been anally date raped in college and that had been his only experience of receptive anal intercourse. The experience had been traumatic both emotionally as well as physically, and resulted in the need to be sutured in order to stem the rectal bleeding. Prior to starting couple therapy Peter never shared this experience with Dan. When Dan heard this story, he reassured Peter that as much as he wanted to expand their sexual repertoire, he had no interest in doing anything that would be physically or emotionally painful for Peter.

Several sessions were spent discussing the date rape and its impact on Peter's sexuality. Peter's reluctance to engage in a behavior that had the potential to retraumatize him was affirmed by both men, but Peter was eventually able to say that his love and desire for Dan were so powerful that he was willing to explore being the receptive partner in anal intercourse with Dan. He was frightened of the pain it might incur and had to overcome his basic aversion to the thought of anal intercourse.

In response to his concern about cleanliness, the therapist (Shernoff) educated him about various options that might reduce his negative feelings, such as how to anally douche himself. Once he had grown comfortable with these cleansing options he was asked if he was ready to explore the possibility of his anus becoming a erogenous zone. He was cautiously receptive. He was given the suggestion to first douche and then explore his own anus while sitting in a warm bath and simultaneously masturbating. If he was comfortable, he was invited to try inserting a finger.

The next week, Peter and Dan entered the session beaming. Peter started by reporting on how sexy it was to explore his butt while masturbating. At this point Dan cut in and described how Peter had called him into the bathroom, invited him into the tub, and asked him to touch his butt. Dan had penetrated Peter with one finger and they had sex in the bathtub that included digital penetration of Peter. I told them to continue experimenting with this and try inserting more than one finger as well. Once Peter was comfortable the next step was for them to go to a sex boutique to shop for what I called "marital helpers," a.k.a. dildos. I told them to buy several, in various sizes, beginning with the very smallest. At first the therapist suggested Peter experiment with using the smallest one on himself. Upon hearing this, Peter said: "No way. I want Dan to be the one

putting those inside of me." They were reminded to use plenty of lubrication, and to experiment with various positions, in order to determine the ones most comfortable and pleasurable. If pain was experienced, they were told to stop. Peter was also coached on how to do deep breathing to ease the discomfort of being penetrated. After about 3 months they decided they were ready to try the "real thing." On their first attempt, Dan was so nervous that he was unable to maintain his erection. But within a few days this was no longer an issue. Soon they were incorporating anal sex with both men being versatile.

Case Example: Learning How to Fellate without Gagging. Often when working with sexual minority individuals, sex therapy issues emerge as one component of a long-term psychotherapy. Such was the case for Rafael, a 35-year-old Latino man who had moved to New York from California to get some distance between himself and his family since they were not accepting of his homosexuality and refused to ever discuss his being gay after he disclosed it to them. He sought therapy for depression, which focused on helping Rafael become comfortable with accepting himself as a gay man despite his family's lack of acceptance and support. This was a slow process as initially he described feeling more sadness and pain about the shame that his being gay caused his family than any anger or sadness about their nonacceptance of it. As Diaz (1998) suggests, this is not an uncommon reaction on the part of Latino gay men to nonacceptance or silence about their sexuality by Latino families, and must be transformed in order for them to develop healthy identities as gay Latino men. One way therapy addressed this issue was to encourage Rafael to meet other Latinos who would accept him as a gay man so that he could develop an alternative family.

Since the desire to feel loved was a core aspect of developing a positive gay identity for Rafael, weaning himself from the anonymous sexual encounters that always followed a bout of heavy drinking, both of which he used as efforts to anesthetize his pain and loneliness, and learning to date was another focus of treatment. Spirituality was something Rafael explained that he missed, so his therapist (Shernoff) encouraged him to shop around for a church where he could meet other Latinos who would accept him for who he was. Additionally, he was encouraged to volunteer at gay organizations so he could learn how to meet other men in "homosocial" venues that were not highly sexualized. One issue that arose during his long-term psychotherapy was his inability to perform fellatio on another man without gagging and choking. The precipitating factor for Rafael raising this issue was that a man he was dating and romantically interested in found his initial unwillingness and then his unsatisfactory technique performing fellatio a problem if their relationship was going to grow. For many gay men the ability to "go down" on another man comes naturally, but for others, like Rafael, it is a skill that needs to be learned.

After Rafael reported that his boyfriend was complaining about how poor he was at "giving head," therapy explored whether performing fellatio was even something that he was interested in doing. He initially reported that he desired to do this in order to increase the sexual satisfaction of the man he was dating. But continued exploration allowed him to disclose that he loved men's penises and wanted to be able to make love to them for his own pleasure as well as that of his partner. Once it became clear that Rafael's desire to learn how to fellate another man was not an example of "sexual codependence," helping him overcome this difficulty was not complicated, and only took two or three sessions. He was an expert swimmer. When the therapist instructed him to use the same method he employed while swimming to keep from breathing in water, he first seemed perplexed. It was then that he was told he needed to learn to exhale while he was moving down on a penis and to inhale on the upstroke. This technique is similar to when a swimmer exhales while turning his face down, into the water, and inhaling while he turns his head sideways. After a few times of practicing this instruction, he was able to relax and enjoy performing fellatio. Once the therapist learned that Rafael loved to swim, he also suggested that he look into joining a gay swim team in order to both practice the sport and meet other gay men with this shared interest. Eventually his association with both the swim team and church allowed him to develop a family of friends that became a central part of his non-professional life. Largely due to the acceptance he experienced in the relationships he formed with men at the swim team and at church he found the strength to confront his family's silence about his being gay.

One of the major issues that comes up during sex therapy with gay men is helping couples negotiate discrepant desires regarding sexual exclusivity and nonexclusivity, and dealing with the lack of sexual interest on the part of one or both partners. Since the onset of AIDS the issue of whether or not to use condoms by men in relationships has emerged as a frequent presenting problem as well.

Case Example: Using Harm Reduction with a Sexual Risk Taker. Toby is a 30-year-old professional who had retested HIV negative 3 months prior to our initial consultation. He sought therapy because of concerns about barebacking with partners he met on the Internet. A friend of his had recently become HIV positive, was on combination antiretroviral therapy, and reported not having any adverse side effects. Using a motivational interviewing approach (Miller & Rollnick, 2002) we explored his ambivalence about his behavior. Toby perceived that the major advantage of barebacking was that by not insisting on condoms, he increased his sexual currency. Thus he was able to have sex with men he deemed more attractive than himself who he feared might not be interested in him were he to

insist on safer sex. Obviously these concerns raised issues regarding body image, self-worth, and self-esteem. But to explore them fully in therapy would take a long time, during which Toby would most likely still be engaging in high-risk sex.

Motivational interviewing is an ideal tool for use with men who are barebacking. Motivational interviewing is a therapeutic approach based on the stages of change model, developed by Prochaska, DiClemente, and Norcross (1992). The stages of change approach to treatment posits that people go through the following stages in the process of changing: precontemplation, contemplation, determination/preparation, action, and maintenance, and that motivational interviewing helps a person explore his or her ambivalence about changing any particular behavior and then helps the client move through the stages of change at whatever pace he or she is ready to embrace. The great gift of using motivational interviewing as a way to approach harm reduction is that it enables a therapist to assess where the individual is in his or her process of approaching change, which translates into therapy that is on target for where the client is, instead of where the therapist wishes the client would be.

Toby reported not being ready or willing to regularly use condoms or confident of his ability to do so. The therapist suggested he try the harm reduction approach known as "serosorting" (Suarez & Miller, 2001), where men have unprotected sex with other men of the same HIV status in an effort to remain uninfected by HIV, which was Toby's expressed preference. Early in treatment we worked on his asking potential partners about their HIV status prior to arranging a sexual liaison, and have sex only with men who identified as being HIV negative. Prior to starting therapy this was not something he did.

Toby felt unable to raise the topic of HIV status with any man he was chatting with online that he was attracted to, from fear of being sexually rejected. In response to hearing this the therapist suggested that in order to develop the psychic muscle necessary to learn this skill, he begin by asking men he was not attracted to whether or not they knew their HIV status. After being successful at this, he was then coached to try inquiring about the HIV status of men he had only a moderate attraction to. Eventually after about 3 months he was able to ask all the men he flirted with online their HIV status, and had sex only with men who identified as being HIV negative. Clearly, this is not a foolproof method for remaining HIV negative, but it does take a step toward reducing the possibility of seroconverting.

Bisexuality and Fluidity of Orientation

In a culture that stigmatizes same-sex behavior, one would expect the incidence of same-sex attractions to be higher than the incidence of same-sex

behavior, and both should be higher than the number of people who self-label as gay. Indeed, every study from Kinsey to the present day has found this. Virtually all studies from the 1950s (Conrad, 2001) to the present (Bell & Weinberg, 1978; Jay & Young, 1979; Laumann et al., 1994; Roberts et al., 2000) have found that the vast majority of self-identified lesbians and gay men have had heterosexual sexual experience.

However, the reality is complicated. Recent evidence suggests that women may be more physiologically "wired" for bisexuality than men (Chivers, Rieger, Latty, & Baily, 2002). When presented with lesbian and heterosexual visual erotica, women of all orientations show physiological arousal to both, whereas men's arousal is targeted. Heterosexual men respond to heterosexual erotica and gay men respond to gay male erotica. This confirms what a number of theorists already believe: that women may have a more fluid sexual orientation than men (Peplau, 2003, 2001, 2000; Diamond, 2003a; Weise, 1992). Diamond (2003b) found that a significant number of lesbian-identified college women change their self-labeling to bisexual or heterosexual over a 5-year period. Moreover, these women do not disavow their former lesbian identity and are open to the possibility of sexual change in their futures. While the leadership of the bisexual movement has often come from "former lesbians," gay men redefining themselves as bisexual are more and more common, and both men and women who defined themselves as heterosexual before relabeling as bisexual usually feel comfortable within the LGBTQ community. A greater degree of fluidity of sexual orientation appears to exist. In practical terms, it is clear that self-identification is at best an incomplete description of self-orientation, which makes it imperative that a sexual health practitioner not make any assumptions about the sexual behavior of a client without a careful history that includes questions about contact with both men and women regardless of the patient's expressed identity.

It is also apparent that there is substantial overlap between the bisexual, BDSM, and polyamory communities. Moreover, it may be true that bisexuals are more sexually active than their gay or hetero counterparts (Weinberg et al., 1994). The IPG Internet study found that bisexual women were more sexually active, had more sexual thoughts and more sexual partners, and masturbated more than other women.

Case Example: Sex between a "Gay Man" and a "Lesbian." Anthony and Rachel were gay male and lesbian identified when they met at an AIDS activist group. There was an immediate attraction on a number of levels that soon blossomed into an affair. They consulted with one of the authors (Shernoff) as a couple after having fallen in love and deciding they wanted to begin living together. Each wanted to be able to have "hit and run" sex with same-sex partners, but they also wanted an emotionally monogamous relationship with each other. They were struggling to figure out how to de-

fine themselves. Were they still gay and lesbian if they were involved in an opposite-sex love affair? Some of their friends were nonsupportive of the relationship and accused them of straddling the fence or going back into the closet. These accusations made them sad and angry. They finally just decided that they were "queer," in a very "queer" relationship.

Another issue common to some bisexuals is how to be in an intimate committed relationship and still "exercise the bisexual option."

Case Example: Incorporating Bisexuality into a Marriage. Terry and his wife, Nydia, both self-identified as bisexual from adolescence. For the first 10 years of their marriage they were monogamous, not from moral principles but because they felt their relationship needed stability before they could "open" the relationship without damage. Terry is probably a "Kinsey 4" or a 5: more gay than straight. However, he is deeply in love with Nydia and feels no conflict about giving up the possibility of a primary relationship with a man. Nydia is most likely a Kinsey 2—mostly straight, but with significant attractions to women, always in the context of a relationship.

Soon past the 10-year mark in their marriage, Nydia and Terry came to therapy for help negotiating the change in the relationship. With a counselor's help, they decided that it would be less threatening for them to "open" the relationship by incorporating extra people into their couple sex, rather than by having separate sexual liaisons. They located their first outside sexual contact, a bisexual man, at a support group for bisexuals. Terry, Nydia, and Luis met for sex and friendly companionship several times and the couple successfully negotiated feelings of jealousy, exclusion, and insecurity. They found that these feelings were triggered when the sexual pleasure seemed unbalanced, that is, if one member of the couple seemed to be getting more during a sexual encounter—for instance if Luis seemed uninterested in one of them; or if one of them felt something sexual was happening in his or her absence. By talking openly about their insecurity the couple was able to negotiate agreements that made the sexual triad viable.

However, Nydia was unhappy because she wanted same-sex contact herself. Through the Internet they located other couples who desired this kind of sexual contact. Here, however, they discovered that most "bisexual couples" were in fact heterosexual men with bisexual women, and Terry became frustrated. During this entire period of time, their therapist helped them deal with the feelings of frustration, resentment, and jealousy that arose occasionally as well as helping them brainstorm what kinds of situations would work best for them. After a year of experimentation, they finally began to locate couples where both partners were bisexual and, to their delight, found two such couples who were not only good sexual partners but became good friends as well.

Transgender Issues

An in-depth discussion of transgender issues, including assessment and gender identification, can be found in Chapter 16, by Richard Carroll.

KINK AND BDSM

"Kinky sex," "leathersex," S&M, or the more current "BDSM" sex has been one subculture of the gay male community for at least 30 years. Kinky sexual activities are commonly practiced among gay men who also enjoy so-called vanilla sex, and even men with no interest in leathersex are rarely extremely judgmental about it. Similarly, kinky sex has been normalized within much of the lesbian community. A lesbian learning of her partner's BDSM desires might decline to participate, and the issue might even break up the relationship—but she rarely will consider her girlfriend pathologically disturbed because of her kinky proclivities. Moreover, the various BDSM communities have begun to overlap more and more. In New York, for example, TES, the oldest straight BDSM organization in town, now labels itself as a pansexual group, and it is not unusual to find self-defined lesbians, bisexuals, and gay men at meetings. The major gay male and major lesbian BDSM groups in New York sponsor some joint events.

Among knowledgeable mental health professionals there is now a movement to remove the category of paraphilias from the DSM (Moser, 2001). As the manual currently stands, many consensual BDSM acts are de facto evidence of psychopathology and thus provide the basis for discrimination against kinky people. The National Coalition for Sexual Freedom describes hundreds of people who have been arrested on domestic violence charges, lost their homes, or lost custody or visitation of their children because of discriminatory laws. Empathic professionals working with this population need to recognize the very real danger kinky people may be in regarding the law.

The most common problems the sex therapist encounters from members of the BDSM community are identity confusion, and shame and self-loathing, particularly among heterosexual kinky people. In addition, many people, especially heterosexuals, are married and have children by the time they come out to themselves, making the actualization of their sexual orientation that much more complex. When counseling kinky couples, script discrepancy can be a problem. The examples we give represent these issues. There are, however, many other sexual issues unique to this population. It is beyond the scope of this paper to explore these. Readers are referred to Kleinplatz (2001); Moser & Kleinplatz (2006), and Wiseman, (1996).

Case Example: Discrepant Desire with a BDSM Sexual Script. Aurora and Shelley, both attractive women in their 20s and together for 3

years, sought treatment because of discrepant sexual desire. These women began sex therapy because Shelley seemed to have lost nearly all her interest in sex with Aurora. They were encouraged to make dates and do sensate focus exercises. But they reported never doing any of their homework because Shelley sabotaged their attempts. After several months of treatment, Shelley finally admitted that she had consuming fantasies of S/M sex and felt compelled to try it, although she had not yet acted upon her fantasy. Shelley's fantasies had been present since childhood, but because they seemed freakish and "sick" to her, she had always tried to push them to the back of her mind. But over a period of years the S/M fantasies became stronger and eventually pushed away any desire Shelley had for vanilla sex. Shelley's lack of sexual attraction to Aurora was partly a genuine aversion to non-BDSM sex, and partly the result of generalized repression of all sexual feelings triggered by the highly ego-dystonic nature of Shelley's fantasies. Once it became clear that Shelley was in the midst of embracing her kinky desires, therapy focused on normalizing her sexuality for both members of the couple, and trying to get both women to be accepting of BDSM as a sexual variation that is in many ways a sexual orientation in itself. Nichols, the therapist, made her views very clear. She held strongly to the position that nothing in BDSM is inherently pathological, and that "kink" is a natural, if statistically nonnormative, sexual variation.

But Aurora was an incest survivor who was horrified at the thought of sex that involved dominance and submission. Aurora was not able to validate or accept Shelley's sexual orientation, and was unwilling to vary their sexual repertoire to include even the mildest kind of role-playing or dominant/submissive games. In a heterosexual couple, the person in Shelley's position is usually the male, and might feel deep shame about his impulses. His wife might be repulsed by his desires even if she is an incest survivor. But because Shelley and Aurora are lesbians, the social context was different. Alternative sexualities are fairly common, visible, and accepted. Thus Shelley found emotional support as well as outlets for her sexual interests with no trouble. Because the women were young, and they had been together only 3 years and were not financially intertwined nor raising children, there was little reason for them to stay together given their insurmountably discrepant sexual scripts. Ultimately, they separated, and Shelley became active in what is sometimes called the leatherdyke community. A healthy woman, Shelley was able to quickly absorb the support of her peers and friends and shed her self-hating attitudes.

Case Example: Discrepant BDSM Roles in a Couple. Mark and Kelly, both long term HIV-positive men in their 50s, had been partners for 15 years when they sought therapy. From their first meeting in a leather bar, the men had an S/M sexual relationship with Mark as the dominant (top)

partner and Kelly the bottom, or submissive. They sought therapy because sexual activity between them had first diminished and then completely stopped over the last 3 years. During their first consultation neither reported any sex drive, which bothered Mark a great deal, but not Kelly, who reported suffering from a lifelong depression for which he was being medicated. Kelly agreed to come for counseling out of concern for Mark's feelings, even though he reported no desire for sex. He had stopped masturbating, never fantasized about sex, and was comfortable with this, except for the discomfort it caused Mark. Shernoff, the therapist, suggested that they both get their serum testosterone levels checked, as hypogonadism is often reported in men living with HIV and AIDS. The results surprised them. Kelly's levels were normal, but Mark's were low, and his physician prescribed testosterone replacement gel in addition to steroids as he was suffering from mild wasting.

As therapy progressed, Mark began to regain weight as well as his sex drive. He began to discuss how confining being an exclusive top was for him. He expressed a growing number of fantasies that involved exploring being submissive. However, Kelly had never been interested in the dominant role even when he was feeling sexual. He certainly wasn't interested now. Up to this point the men's relationship had been sexually exclusive, and very physically affectionate even though now asexual. Mark raised the possibility of opening up their relationship now that he once again had a sex drive. Initially Kelly talked about his fears that with Mark looking outside the relationship for other partners and his not being at all sexual Mark would leave him. Mark spent several sessions empathizing with these fears and reassuring Kelly that he had no desire to leave him even though they were no longer sexual as a couple. His feelings were that the security and safety they shared was bedrock and would allow him to learn about an aspect of his sexuality that he had never previously had the opportunity to explore. Therapy was very brief and they agreed that it was acceptable for Mark to seek out partners for S/M sex where he could explore his bottom fantasies. In response to this Kelly told Mark that though he was not feeling sexual, he missed their S/M play sessions and still did desire nongenital S/M scenes where Mark could still be his top. Mark said that this really turned him on, but while respecting Kelly's lack of desire for genital sex, asked if it would be agreeable if during these scenes he used Kelly to achieve his own sexual release. Kelly was amenable to this. This case illustrates how S/M sex, while being erotic, may sometimes not have genital sex or even penetration as components of a bondage or flogging scene that both partners still experience as highly satisfying and sexy. In addition, its successful resolution was due in part to the fact that the clients were gay men, and thus reasonably ready to consider nonmonogamy as an alternative to a discrepant desire script.

Nonmonogamy and Polyamory

While gay men have been experimenting with nonmonogamous relationships for 30 years or more, and heterosexuals experimented with open marriage during the 1970s, there has been a recent upsurge of interest in nonmonogamy among people of all sexual orientations. One form of nonmonogamy is called polyamory (Anapol, 1997; Ravenscroft, 2004). Polyamory literally means many loves, and in its purest form is a movement promoting multiple, concomitant sexual, loving relationships. In reality "poly," as it is called, can range from a type of "swinging" to multiple relationships. Much of the energy driving the current polyamory movement is heterosexual and bisexual. In fact, bisexuals are prominent in the polyamory community, thus leading to stronger ties between poly people and gays, lesbians, and transgendered people. In addition, many lesbians have embraced poly (Munson & Stelbourn, 1999) because it epitomizes a form of nonmonogamy more palatable to women than the recreational sex often practiced by gay men.

Gay men, on the other hand, do not usually identify as polyamorous but in many ways they are the pioneers of contemporary nonmonogamy. The nonmonogamy of gay men is sometimes similar to polyamory but often involves negotiated agreements between partners that allow each the freedom to pursue more casual sexual relationships, rather than ongoing love affairs. Before AIDS, nonmonogamy was arguably the norm among male couples (McWhirter & Mattison, 1984), and in many areas it is still the norm today, at least for couples who have been together more than a few years.

Nonmonogamy challenges many basic assumptions about love and commitment. There is some data suggesting that sex outside a male couple's relationship may be related to dissatisfaction about the partnership (Saghir & Robins, 1973; Bell & Weinberg, 1978; Kurdek & Schmitt, 1985/1986). Yet, other studies find no significant differences in relationship quality or satisfaction between samples of sexually exclusive and non-exclusive male couples (Blasband & Peplau, 1985; Kurdek, 1988; Wagner, Remien, & Carballo-Diequez, 2000; LaSala, 2004). There is research confirming that nonmonogamy in and of itself does not create a problem for male couples when it has been honestly negotiated (Mendola, 1980; Silverstein, 1981; Blumstein & Schwartz, 1983; McWhirter & Mattison, 1984). Wagner et al. (2000) and LaSala (2004) found that in the second decade of AIDS, monogamous as well as self-described "open" male couples demonstrated higher levels of relationship quality and lower levels of psychological distress compared to couples who had not negotiated nonmonogamy but reported secret outside sexual activity.

When working with polyamorous/nonmonogamous clients, the most

common problems one will encounter are helping couples negotiate nonmonogamy, and issues of jealousy and insecurity.

Case Example: Nonmonogamy and Sexual Risk Taking. Willis and Larry were both HIV negative African American attorneys in their mid-30s and had been together for 3 years. They had just bought an apartment together prior to their first consultation and came to therapy to talk about how living together was affecting their relationship. Among the issues they raised was the possibility of stopping their use of condoms with each other. They reported being monogamous for the past 2 years and each had recently retested negative for HIV. Having worked with numerous couples who have elastic definitions of monogamy, the therapist (Shernoff) knew there was the possibility that, like many male couples, Larry and Willis might be practicing what Morin (1999) has labeled "modified monogamy." Morin defines modified monogamy as a situation where a couple negotiates accommodations that reflect the tension between their desire to be sexually exclusive and practical realities, that is, the wish to have more than one partner (Morin, 1999).

One example of modified monogamy is when a couple who define themselves as sexually exclusive have sex with a third person or a group of other people. With Morin's work in mind, Shernoff asked if their definition of monogamy encompassed having sex together with another person or with other people. At this point, they became noticeably uncomfortable. In an uncharacteristically sheepish manner, Willis asked: "Are we monogamous if we occasionally have played together with another guy?"

When asked if they had done that, both nodded affirmatively. The therapist responded: "The rules and definitions of your sexual relationship are up to you to decide. But this raises an important issue about safer sex that we need to talk about."

The concept of "negotiated safety" was then explained to them. Negotiated safety is an agreement between two gay men in a relationship to go through the process of getting ready to stop using condoms when they have anal sex. The basis is an explicit understanding that both know each other's HIV status and are both uninfected. The only time they do not use condoms is when they have sex with each other (Kippax et al., 1993). They were given the Web address (www.freedoms.org.uk) for a negotiated safety agreement that it was suggested they read, discuss, and bring in to a future session. Willis said, "While we're talking about condoms, what about Dan?" Dan was a semiregular third partner, also HIV negative, when they occasionally invited into their bed. Willis wanted to know if there was a point at which they could stop using condoms with Dan. Hearing this, Larry became angry. "Are you nuts? If he's screwing around with us, we can only assume there are other men he's sexual with as well. Even if he

tells us he's uninfected, I, for one, am not willing to trust either my health or yours to some other guy. I don't even want us to go there."

Case Example: Counseling a Three-Person Relationship. Bert and Ted had been partners for 14 years when they sought counseling. They reported feeling more in love with each other than at any time in their relationship. Both felt that their sex life has steadily improved over the years and is more exciting and satisfying now than ever before. They were sexually nonexclusive for only a short time, which ended as the AIDS crisis began to escalate. Both have tested negative for HIV antibodies. With the onset of AIDS, they decided to discontinue any independent extrarelationship sexual activity. They sought counseling because 4 months previously, while out dancing, they ran into Michael, a man with whom Ted had occasionally had sex. All three went home together that night. They have been spending Saturday nights together dancing and going home for exciting "threesomes" once or twice a month since. They agreed that the relationship with Michael is much more than merely sexual. The previous week they had all admitted to being in love with one another and had begun discussing whether or not Michael should move in with them. After three sessions of discussing how expanding their relationship and home to include Michael might affect them, it was suggested that Michael be asked to accompany them for a form of "prenuptial" counseling. Therapy took place weekly for 6 months, during which time these three men used therapy as a place to help them talk through a variety of emotional and practical issues including:

- How would they be ready to decide whether or not they were ready to live together?
- If they decided to live together, would they all share a bedroom or have separate bedrooms?
- What would the rules be if any of them wanted to have sex outside of the relationship?
- How were they going to insure legal protections for all of them if they decided to merge their finances or buy property jointly?
- What steps do they each need to take to strike the right balance of togetherness and autonomy?

They all agreed that in spite of the increased complexity, there were definite benefits to having a polyamorous relationship. Interestingly, one of the benefits they cited to forming this kind of a relationship was security. When one partner was not available emotionally or physically, there would always be a third person to turn to for support. Bert and Ted shared their concerns about learning not to exclude Michael and no longer relying entirely on one person for all of their needs.

After 6 months of working together, during which time Michael moved in with Bert and Ted, the frequency of sessions was reduced to once monthly. Before they ended counseling, Bert suggested, "Although there is the heightened opportunity for conflict, there is also another set of eyes and ears to help and understand what the basis of conflict truly is. So often in a traditional couple the partners become so overwhelmed by what they 'think' the problems are that they do not take the extra effort to really look deep inside and see what might be the true underlying problem." Michael reported, "The feeling of security with two amazing men laying on either side of you when you are feeling weak or vulnerable is unmatched by anything that I can think of—their warmth and love keeping the world away. I am not sure that I can ever be one-of-two again."

SUMMARY AND CONCLUSIONS

Although work within the queer community challenges the therapist to learn things not usually taught in graduate school, the clinician is enriched by exposure to such variety and uniqueness of sexual and gender expression. Practical things can be learned that generalize to all clients. For example, after several years of working with members of the S/M, or "leather" community, the staff at IPG noticed that S/M partners often had unusually good communication with each other about their sexual likes and dislikes. IPG therapists now teach some of their vanilla sex therapy clients how to use BDSM-style data-gathering interview techniques to learn about their partners.

Certain attitudes and behaviors are useful in working with sexual minority clients. First, one must erase all preconceptions about "normal" and "abnormal" sex. The therapist must be open to all possibilities of erotic variation, and be willing to suspend judgment. According to the authors' criteria, lack of consensuality and clear destructiveness are the only definite characteristics of "pathological" sex.

The therapist must also remember that work with this population requires suspending preconceived notions of gender and relationships as well as biases about sexual acts. Many clients who live on the sexual fringe desperately need to have their lifestyle validated by an "authority figure." This validation is surely a major aspect of the therapeutic experience for most clients who are socially stigmatized.

Although this chapter of necessity emphasizes differences, it is useful to remember that we are all more alike than we are different. Colorful and unusual differences in behavior and style may be prominent in sexual minority clients; nevertheless, most therapeutic interventions will not vary that much from interventions used in a more mainstream population.

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